AUCKLAND UNIVERSITY OF TECHNOLOGY

RESTORING:

A GROUNDED THEORY

OF RECOVERY

David John Healee

School of Health Care Practice

Faculty of Health and Environmental Sciences

A thesis submitted to Auckland University of Technology

in partial fulfilment of the requirements for the degree of

DOCTOR OF HEALTH SCIENCE

One's own discovery

I have become aware that a great majority of human beings were unaware of philosophy and logic and understanding and knowledge of their own soul. I found people seeing and feeling what others have told them, who in turn were told by someone else and so on. Is there no marvellous awareness of one's own discovery?

(Rinder, 1971, p. 157)

Table of Contents

List of Figures

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed

Student ID: 0016626

Dated   20 November 2013

Acknowledgments

Undertaking a research project is not a solo venture. It needs people, support, encouragement, and continual challenge throughout the whole process. There were many people who accompanied me on this journey to bring together the theory of restoring and played a role in its inception and deliverance.

There is an exceptional large thank you to my supervisory team. Associate Professor Antoinette McCallin's devotion to the methodology, whose guidance and support developed my methodological and academic skills, and made this process exciting, challenging and above all, gave me a reason to finish the study. Professor Marion Jones provided ongoing insight, support, and encouragement through her experience and attention to detail, along with prompting me to always find the carrot.

Thank you also to Jo and Shayne Rasmussen, my critical readers in the final phase, and Dr Anita Bamford-Wade who was a positive influence to starting my doctoral journey. Further, to the many work colleagues in Health Care Practice (HCP) who have encouraged and supported me over the six years, I extend my thanks. Having your encouragement and support made the work-study-life balance much easier to manage, as did the HCP doctoral support group in the early stages of thesis development.

In addition, I would like to thank Auckland University of Technology for receipt of the Vice Chancellor's Completion Scholarship that allowed me to have six months of uninterrupted time to develop my first full draft. Attendance at HCP sponsored writing retreats enhanced my thinking and writing development through being with like-minded people. I appreciated your questions, comments and challenges to my ideas and creations. I would also like to acknowledge the support and understanding I gained from Dr Barney Glaser, the Grounded Theory Fellows and other troubleshootee's when I attended the seminar workshops.

Notwithstanding, I must thank family and friends who gave me time away from being social and allowed my weekends to be spent immersed in the thesis. You were always in the background, and were there when I needed time out. I would like to

dedicate this study to my mother who passed away during its development. I know you have been sitting beside me throughout the journey.

Most of all, I would like to dedicate this thesis to the participants who were willing contributors and made this study possible. To each person who welcomed me into their home and talked of their recovery, my deepest thanks. Without your stories, this theory would not have been realised.

Ethical approval for this study was confirmed by the Northern Region Y Ethics Committee on 22 May 2009. Approval number NTY/09/03/020.

Ethics approval was also confirmed by the Auckland University of Technology Ethics Committee (AUTEC) on 23 July 2009. Approval number 09/143.

Abstract

In this thesis, the theory of restoring is presented. Restoring explains how older adults recover following a health event such as hip fracture. Understanding how the older age group manages recovery is important with ageing populations occurring around the world. Age-related health events impact at individual, community, and national levels. To date, research has tended to examine age-related recovery from perspectives that focus on factors relevant for professionally based care. Recovery though, does not just stop at discharge from those settings. It is an ongoing process. Yet, little exploration of recovery following the completion of interventional healthcare has taken place. Shorter healthcare episodes and longer lifespan mean older adults are returning to community settings to recover in their own way. It is important to understand what happens as older adults continue to recover after discharge from hospital.

A Glaserian grounded theory study has been undertaken. Twenty-one individual interviews were conducted. Data collection, analysis and theory generation follow the classical grounded theory methodological approach. The hallmarks of the methodology include constant comparative analysis, theoretical sampling, theoretical coding, and theoretical sensitivity. It is evident that the main concern was normalisation, which participants resolved using the process of restoring. Restoring consists of regaining and reasserting, which are continuously being balanced depending on the context and situation. Regaining is about pacing, spacing, and relying relative to the physical and social aspects of recovery. Reasserting is the permissioning, connecting, and reconciling that focuses on the psychological factors influencing recovery.

This research shows that older adults manage recovery according to their social memory, whilst adhering to professional regimes that are interpreted in terms of individual self-governance. It will be shown that individual social responsibility for managing recovery is continuously balanced against the social collective responsibility for the professional management of recovery in hospital and the community. Thus, individual-collective social responsibility determines the governance of restoration and the return to normality. Therefore, I argue that restoring is contextual and also influenced by social memory that is about people restoring normal patterns of behaviours to manage their recovery. Clearly, though, there is more to restoring normal

than simply managing the physical aspects of regaining function. While there are multiple ways to view normal, four contextual perspectives were evident from the data. These perspectives frame participants' interpretations of normal. They include a societal view, a physiological viewpoint, and an everyday perspective, all of which influence the fourth point of view, which is the individual perspective. The four views demonstrate how a collective social context influences recovery at an individual level.

The theory of restoring has implications for practice. Current practice reflects generalised recovery programmes that sit alongside medicalised processes of care managed by professionals. How the person manages recovery and restoring their normal once they return home, needs to be factored into care delivery. This research shows that people will manage their recovery irrespective of what clinicians say. Understanding this will have implications for how information is imparted to patients during recovery and at discharge. This will influence how people understand and adhere to the generalised recovery information that is provided when a person leaves hospital.

Chapter One

The idea for this study came about when I returned to clinical practice after several years working in other healthcare roles. The return to practice was relatively straightforward once I had adjusted to advances in technologies, pharmacological changes, and new management approaches. Although many aspects of practice were the same, I had changed. Personal experience and health management roles had added a different dimension of understanding about practising nursing in the changing New Zealand environment. I started questioning professional practice and examining previously taken-for-granted phenomena. All sorts of questions arose. For example, while there were numerous people with injuries being cared for in the orthopaedic ward where I worked, one specific group seemed to warrant both positive and negative attention. Older adults presenting with hip fracture stood out because they followed a particular clinical journey from admission to discharge. As a result, returning to the bedside highlighted clinical issues about what happened to these people during their recovery process. Did they, for example, have a particular set of problems that were perhaps unique for older adults?

In particular, I was aware that although recovery begins in hospital, much more takes place in the community once the patient goes home to their own place, or perhaps stays with family, or is discharged to a care facility. Many health professionals seem to assume that as long as the operation is successful and the patient goes home on time, recovery will take its course. My professional experience however, suggests that recovery is not necessarily such a simple process. Three decades of working as an orthopaedic nurse with older adults has provided numerous opportunities to observe what happens in hip fracture recovery. In the hospital setting there is an emphasis on stabilising the fracture, and mobilising the patient for discharge. For example, the nursing approach to the patient tends to be task-oriented as is seen in the following exemplar[1]:

---

[1]   This exemplar is based on my clinical practice experience

'Another fractured hip is on her way up. That's the third this shift. Get a bed ready; prepare the IV equipment; Nil by Mouth sign up; and admission notes to fill in. Where's the monitoring equipment? Will these patients get to theatre today? I doubt it - too many on the acute list already. It will probably be two days before surgery. Maybe I'll have to manage frustrated relatives. The patient will probably deteriorate physically and mentally because of the 'starve and feed' regime. What happened to this patient? She has had a fall. This is a familiar story. The patient can answer questions coherently. Hopefully, she should rehab well.

Next day, the patient is finally off to theatre. She returns to the ward, surgically stable, but presenting with the usual shock symptoms following major surgery. She is weak, frail and dependent. Monitoring, fluid regimes, analgesia, and all nursing cares are implemented. She seems a little indignant about the intrusion on her body. She is too tired to protest.

Day three and the patient is recovering from surgery. She is stabilising. It is time to start the 'rehab' phase. Mobilisation – where is the physiotherapist? Review her activities of daily living with the occupational therapist. Where will she go on discharge? I must talk to the social worker. The patient's pain is decreasing and she is managing with oral analgesia. Her independence is increasing. She should be ready for discharge soon.

Day seven and the patient is going home today with family to support her. This has been a successful case. The patient recovered well.'

This exemplar describes hospital care that meets the patient's basic needs, maximises physical recovery, and prepares the older adult for discharge. While there are clinical pathways of care (prescribed trajectories for typical conditions) to mitigate safe progress through the episode of care, I questioned the effectiveness of this apparently efficient approach to practice. For example, the person appeared to be lost in this pathway. The emphasis was on following through the biomedical plan. The care was compartmentalised into segments that were discipline-specific. Was there not more to recovery than this? Overall, patients seem to be treated according to their condition; that is, labelling as a 'hip fracture'. I also wondered if older adults were disadvantaged

further if they were shifted off operating theatre acute lists to accommodate other types of injuries (for example, younger patients with complex trauma).

I had observed that people were categorised depending on the point they were at in the generalised clinical pathway. Recovery management, for instance, focused on specific disciplinary input which was standardised to the older adult according to the type of injury and fixation used. Treatment depended on the individual surgeons' approaches to fracture management. Thus recovery was expected to conform to predetermined pathways, as medicine provided surgery and overall direction. Next, physiotherapy stepped in emphasising mobility, whereas, occupational therapy managed functional activity. Throughout the recovery process, nursing collaborated with all the disciplines to link the biophysical, social, and psychological factors. The systematic approach to managing the fracture emphasised a checklist style of care planning and delivery. According to this, recovery progressed if the individual patient met specific criteria that were identified in a multidisciplinary regime of care. For example, on day three, patients were expected to walk with the physiotherapist. Nurses seemed to administer the overall process. As a nurse returning to practice, however, individualised and holistic care during recovery was not always evident. This drew my attention to the fact that there are many ways to nurse and that practice is often influenced by the context in which it is delivered (McCloskey & Diers, 2005).

I had used a Salmond (1994, 2002) nursing model to frame my practice for several years . This model emphasises interdependent perspectives that include biophysical, sociological, psychological, and environmental elements of care. According to Salmond, these perspectives are always interpreted through cultural filters, such as gender, age, ethnicity, and religion. It is noteworthy to state that while my research will identify physical and social processes in regaining, and the psychological process of reasserting that are equally important during recovery, the meaning of commonly used terms is different. The Salmond model works well in the contemporary healthcare environment, as it emphasises the biophysical approach and interventional activity that is both typical of and relevant to the biomedical approach to healthcare delivery (Roberts & Wolfson, 2006). Moreover, the sociological, psychological, and environmental factors are congruent with nursing's holistic approach to care and caring, all of which influence recovery (McEwen & Wills, 2007; Monti & Tingen, 1999). However, while

Salmond's model strengthens the nursing approach to individual care, it reinforces the separation into parts that is inherent in the biomedical model. Indeed, McEwen and Wills (2007) discuss Rogers, Science of Unitary Human Beings (1970) that was instrumental in highlighting the issues of compartmentalisation in health care. For example, health professionals tend to care for patients in isolation, depending on the discrete functions or tasks required, without knowing the whole person. This contradicts nursing's holistic approach in which the whole is considered more than and greater than the sum of its parts (Orem, 1991; Parse, 1981; Rogers, 1970). Nurses tend to understand about recovery from the health professional perspective, while actively administering the process during the event episode. The multidisciplinary approach to recovery management divides recovery into discipline foci, areas, functions, and conditions, as well as generalising and individualising it. This perspective of recovery though is problematic, as the focus is on physical and functional recovery, which tends to be the one that follows the professional view. It is argued in this thesis that this presents a limited view of recovery, that in this study at least, is shown to be also influenced by the patient's social memory and self-governance.

This view is quite different to traditional approaches to recovery in which it is usual for clinicians to explain physical recovery and how it is influenced by psychosocial, cognitive, and emotional factors, which affect outcome. The traditional approaches stress the physical and functional nature of recovery management. As will be shown in Chapter Two, this emphasis dominates the professional literature. For example, clinically, the first stage of recovery is complete when the patient leaves hospital. This means that any problems the older adults might have and how they might manage them after discharge are not very often considered. The assumption seems to be made that the patient will continue to recover using information given to them at the time of discharge. This patient information relates to the condition, discusses specific aspects of care and procedures that are expected to be followed, without considering the individual needs of the person. What is not factored into the recovery process is that when the person is discharged from hospital, recovery management is returned to the community healthcare agencies, such as the general practitioner. Some aspects of the condition are managed externally through community based visits to the patient in their own home. Occasionally, there will be ongoing physical therapy and exercise programmes that take place in the home. The influence of the external agencies is limited to short visits or to

the management of specific issues. Therefore, it is important to find out what happens to older adults as they continue to recover after discharge, so that the knowledge base of recovery management can be extended.

Significance

The findings from this research are important. The concurrent influences of socio-political and economic cost-benefit for providing healthcare are weighed against the growing trend that people are living longer, which is impacting how recovery is managed individually and organisationally. Additionally, as people are experiencing healthier, and longer life-spans, so there is an increased potential for an age-related fall, which in turn has repercussions for the individual and the healthcare services (Accident Compensation Corporation, 2005; Ministry of Health, 2001, 2011)[2]. Moreover, the probability of longer-term survival from a hip fracture has increased. Credit for this is related to improved anaesthetics, surgical techniques, and better post-operative complication management, which have enhanced survival rates. Improved functional outcomes following surgery influence recovery, as they equate to perceived quality of life and generally include returning mobilisation, involvement in rehabilitation, all of which affect health status and satisfaction (Hallberg et al., 2004; Hass, 1999; Pande et al., 2006; Shyu et al., 2004; Van Balen, Essink-Bot, Steyerberg, Cools, & Habbema, 2003). While these studies provide some explanation of facets of recovery, primarily about hospitalisation and discharge, they overlook the older adult's interpretation of recovery, and what happens as individuals manage their own recovery at home. Acute care management emphasises functional recovery, often leaving out individual management responses to the event. This has an impact on the longer term view and how a person returns to normal. Irrespective of the emphasis on evidence-based biomedical care, older adults continue to recover once they leave the hospital. There is a gap in the knowledge base about recovery due to a lack of information on recovery once the event, like hip fracture, is considered professionally completed.

---

[2] In New Zealand, the Accident Compensation Corporation is a crown entity and the sole and compulsory provider of accident insurance for all work and non-work injuries. The ACC Scheme is administered on a no-fault basis, so that anyone regardless of the way in which they incurred an injury, is eligible for coverage under the scheme. Due to the scheme's no-fault basis, people who have suffered personal injury do not have the right to sue.

As already noted, the contemporary approach to recovery management has a biomedical focus. Patients are treated individually, relative to the condition they were admitted with. The treatment regimes are based on standardised medical protocols and guidelines. At the same time, patient- professional interaction focuses on immediate in-hospital recovery progression. Individual patient perception of the process is not likely to be considered unless there are complications that will impact the expected recovery timeline. Patients experience the event uniquely, but they are still treated according to a collective approach. Nevertheless, each influences the other. The experience could add to the collective understanding of recovery. However, the primary focus reinforces the professional point of view. In spite of all this, people live in and return to their social communities to recover.

The question that emerges is, what pattern of behaviour is used by the participants to manage their recovery once the health professionals have finished? Grounded theory research is useful here as, according to Stern and Porr, "the grounded theorist engages with participants to figure out participants' interpretations as to what is happening. What are their explanations of the how, why, when and where of what they and others are doing or experiencing?" (2011, p. 42). Understanding participants' problems during recovery post-discharge from hospital is important to extend knowledge in the area. At the beginning of this research it was assumed that knowing how older adults manage their recovery long term may have immediate and future benefits yet to be recognised. Discovering the processes older adults use to recover may help to improve the quality of care delivery both during the initial episode and for discharge planning.

The research project

The research project began with enrolment in a professional doctorate. This was a useful programme for me, as I was in clinical practice and it allowed me to develop my passion for improving nursing knowledge and being patient centred. Moreover, this programme enabled me to continue nursing in the early stages of the study. The professional doctorate provided an alternative journey to the traditional PhD trajectory. In this particular programme there are three (3) core papers. These are Health Systems

Analysis, Practice and Philosophies, and Research Practice and Methodologies[3]. In the first paper, I examined the national health system and its influences, context, and potential relevance to the topic. In the second paper, I explored philosophy and practice relationships, examining the topic of recovery from different theoretical perspectives and methodologies. In the final paper, I focused on research methodology and designing the research.

Aim of the research

The aim of this study was to generate a substantive theory that explained recovery from hip fracture from the perspective of older adults and find out how they managed it.

Purpose of the research

The purpose of this grounded theory study was twofold. The first purpose was to develop a theoretical explanation of the behaviours older adults use to manage their recovery, and second, to provide practical knowledge about the recovery process that would have application for the professional arena. The findings are expected to contribute to the current knowledge base as original research.

Methodology

Grounded theory is an inductive research method that provides a framework for research, along with flexibility for creative exploration that supports openness and emergence. Glaser (1978, 1998) states grounded theory is a suitable research method when an alternative perspective is required to view the familiar or currently understood subject area. Importantly, grounded theory begins with a general area of interest and does not have a hypothesis or problem identified prior to commencing the study. Therefore, I entered the field with a broad question by asking what is the main concern of older adults recovering from hip fracture and how do they resolve that concern?

---

[3] AUT, Faculty of Health and Environmental Sciences, Doctor of Health Science, Programme Outline (AK3664), March 2006.

Structure of the thesis

This thesis is presented in eight chapters.

Chapter One has set the scene regarding the purpose and relevance of the study and explained how the research topic was identified in the practice setting. The aim, purpose, and significance of this study, and methodology used, have been clarified.

Chapter Two explores the context of recovery. The methodological viewpoint on literature in a grounded theory is examined. The function of literature is discussed according to its relevance to stages of the research process. Recovery has a received view that is understood from a professional point of view. The social viewpoint, the healthcare viewpoint, the mental health perspective, and the physical view of recovery, are analysed. In addition, 'normal' and its influence on recovery are explored.

In Chapter Three the classical grounded theory methodology is examined. The positioning of grounded theory epistemologically is considered relative to the co-originators' backgrounds. The potential relationship of grounded theory to Peircean pragmatist philosophy is explored as an epistemological stance that fits with Glaser's atheoretical view of grounded theory. A review of methodological changes since the inception of grounded theory explores the evolution of grounded theory methodology and its associated epistemological positioning. Key methodological principles, such as the basic social process, constant comparative analysis, theoretical sampling, coding, conceptualisation, memoing, and theoretical sensitivity are discussed. Issues related to credibility and rigour are outlined in order to demonstrate meeting the grounded theory generation process.

In Chapter Four the methodological application is presented. This includes sampling, ethical considerations, data collection and analysis and generation of the

theory. The chapter is structured to present the processes undertaken, decisions made, and the discovery of the main concern and the resolution process. How rigour was maintained and the challenges that arose throughout the study are discussed.

In Chapter Five regaining, a subprocess of the theory of restoring, is presented along with its properties of pacing, spacing and relying, which are used to restore physical and social normal. Pacing is defined through time, age, perceptions and compromise. Spacing is the use of symbolic security and role shifting that influence restoring in terms of physical and social space. In contrast, relying is about self reliance, marshalling resources, and helping all of which are required in restoring normal.

In Chapter Six I present reasserting, as a subprocess of restoring which is about the permissioning, connecting, and reconciling that restores psychological normal. Permissioning is defined through the diverse expectations of restoring although it needs to be balanced with the developmental stage of older people. Connecting is dealing with the familiar and unfamiliar situations that occur during restoring while reconciling reflects how attitude, routines, and acceptance restore normal.

In Chapter Seven I introduce an overview of the findings. In particular, the specific findings of normalisation, a balancing act, social memory, and self-governance, are examined. Contextual considerations are examined relative to ageing and the socio-political background which influences recovery management and thus restoring.

In Chapter Eight I discuss the findings. An initial comparison of extant literature locates the theory of restoring in the knowledge base. The individual-collective social responsibility for recovery management is analysed. How individual self-management occurs in a generalised, evidence-based practice context is discussed relevant to modes of deliveries of care and the ageing population. Finally, traditional models of care are

reviewed against a potential quantum model of care delivery. An evaluation of the research, its limitations, implications and recommendations are provided in this chapter.

Chapter Two

The received view of the recovery

    Introduction

Recovery is contextual. There are multiple perspectives about recovery. In this chapter, I will review recovery from methodological, social, healthcare, mental health, and physical perspectives. I will also review perceptions of normal relative to recovery. As will be shown in this thesis, returning to normal is problematic during recovery therefore, it is important to understand how perceptions of normal in society may influence the process. The different viewpoints are a useful beginning in a grounded theory study, as they help identify inherent assumptions, which influence taken-for-granted understandings. Awareness of predetermined assumptions emphasises a received view of the world (Glaser, 1978). The received view, according to Glaser is the "latent or manifest assumptions of what ought to be found [*in the data*]" (1998, p. 69). Nonetheless, the total avoidance of prior knowledge is not possible. Understanding the place of literature in the grounded theory process lessens the influence of the received view on the research outcomes.

The received view of the world though was useful to theoretically sensitise myself to the extant knowledge base. In the first instance, the literature on recovery from hip fracture in older adults was reviewed and written up as a journal article. The review was a synthesis of literature to inform nurse clinicians of the different perspectives about recovery. The resulting article (Appendix 15) illustrated the physical, psychological, social, cognitive and emotional factors relevant to recovery, and suggested that recovery is a complex concept (Healee, McCallin, & Jones, 2011) [4]. Despite that, I still did not understand the problems of recovery as identified by patients who were recuperating from a hip fracture. This situation was an ideal place to begin a grounded theory study.

---

[4] Healee, D.J., McCallin, A.M., & Jones, M. (2011), Older adult's recovery from hip fracture: A literature review. *International Journal of Orthopaedic and Trauma Nursing*, 15(1), 18-28. Doi: 10.1016/j.ijotn.2010.06010 (Appendix 15)

The methodological viewpoint

Glaserian grounded theory is based on an assumption that pre-reading extant literature is potentially distracting because the researcher needs to enter the field not knowing the research problem (Glaser, 1978, 1998). The problem is identified by the participants once the research is underway. Glaser argues that because the researcher does not know what to look for, prior reading is not only a waste of energy, it may also capture the researcher's interests and potentially force received views onto the data collection, analysis, and theory generation. Glaser also states that pre-reading in the specific subject area may force pre-conception, and undermine the researcher's potential for conceptualisation by inhibiting creative thinking (Glaser, 1978, 1998). However, Glaser suggests that the researcher reads generally around different fields to develop theoretical sensitivity. While Glaser's approach to literature has valid methodological argument, there are numerous classical grounded theorists who recognise that pre-reading may have relevance if approached mindfully, so that it does not undermine the principles of the methodology (T. Andrews, 2006; Martin, 2006; McCallin, 2003, 2006; Nathaniel, 2006). These authors recognise the influence of professional experience and pre-reading, and suggest that methodological integrity can be maintained through trusting the method and judiciously adhering to its standards and processes.

Clearly, literature has a specific function in grounded theory as a data source to be constantly compared to the emergent categories during the latter phases of the research. Glaser notes "once a fundamental process is generated then a particular literature becomes apparent to review" (1998, p. 69). Literatures become more focused to the core process[5]. The possibility of a received view being forced onto the data is minimised, as the information is seen as data for comparison only as something that has potential to add detail and clarity, or be enhanced through the emergent theory. Thus, literature is not avoided in grounded theory; it is used at a time and place to support interpretation of the emergent methodological concepts. Methodologically, pre-reading and the potential for preconception is countered as the researcher enters the field with a broad research question only and a willingness to be open to problems

---

[5] Core process is the term that will be used throughout this thesis. Core process incorporates a number of terms used to label the resolution process that explains the pattern of behaviour. Terms such as, category and variable when used in direct quotes have not been changed however reflect the intent of the name core process.

defined by participants. However, an initial literature review, appropriately undertaken, situates the study in the current knowledge base. It "opens up the mind to the strengths and the limitations in received writing" (McCallin, 2006, p. 56) thereby raising awareness about the multiple interpretations of recovery and the potential gap in the knowledge base.

Nevertheless, I did not enter the field totally free from any prior knowledge of the topic. As already mentioned in Chapter One, I had questions about practice that initiated the study interest. At the same time I was continually keeping abreast of current specialty literature, the latest evidence, and general interest information. As a health professional researcher, I was always surrounded by information that was readily accessible via the electronic media. I had ready access to research studies, and papers about changes and influences on practice. Not being influenced by this literature prior to the research was therefore difficult. Similarly, my professional experience and background were influential, as was the expectation that a pre-field literature review be part of the doctoral process. Therefore, I argue here that undertaking the initial literature review situated the potential research in the received knowledge base, identified the potential knowledge gap, and supported justification of my research approach. I also understood that preconception had to be minimised. This meant that while knowledge was analysed, I was required to remain open to new ways of understanding the world. In order not to be over-influenced by the literature that had the potential to impact my interpretations of data, I completed this second literature review after the theory of restoring was developed. Therefore, literature was reviewed at different times as it should be, according to Glaserian grounded theory. This review focuses on general contextual issues that influence recovery.

Literature was accessed using a metasearch strategy. The initial search used the key words, older adults, hip fracture, and recovery. It was confined to material which had English titles and abstracts with the terms illness, injury, older adult, elderly, hip fracture or fractured neck of femur. The range of literature was broad and provided both general and specific themes on recovery. Full text versions of articles were reviewed if the search parameters were met. Searching was modified according to emerging categories. For example, recovery has relevance to a number of fields and disciplines, therefore the parameters became primarily healthcare focused. Under the process, secondary searches

sought other related fields including the social sciences, which provided broad background about the topic. These perspectives included social and healthcare views of recovery, the mental health approach to recovery, and recovery according to the physical health model. These various understandings will illustrate how explanations of recovery are contextual.

The social context

From a broad social perspective, the ongoing effect of an ageing population is reflected in epidemiological studies, and the social sciences, all of which influence professional knowledge and experience. Awareness of the general context of ageing has repercussions for understanding how recovery has shifted for both individuals and / or groups. Recognising that an epidemiological shift in ageing populations has the potential to impact all facets of social life is important when considering the social context of recovery. Because people are living longer due to improvements in living standards, environments and healthcare (Accident Compensation Corporation, 2005; Ministry of Health, 2002, 2004), this life span growth increases the risk for health related events, such as hip fracture (Accident Compensation Corporation, 2005; Horne, 2007; Johnell & Kanis, 2004). At the same time, while it was more usual for older people to recover in hospital in the past, today people return to the community to complete their recovery process (Hall, Williams, Senior, Goldswain, & Criddle, 2000; Hershkovitz, Pulatov, Brill, & Beloosesky, 2012). This has social implications for society.

One effect that influences understandings of recovery is that old is defined socially, politically and by the health professionals. In New Zealand, as in many western countries, old age politically and socially is considered to start at 65 years (Ministry of Health, 2002, 2004). Moreover, aged subcategories are created within this group. The oldest old for example, is a term used to describe people being treated for conditions in their nineties and hundreds and returning to the community (Fulop et al., 2010). This trend is evident in the orthopaedic literature, where there is evidence that hip fracture intervention in this older age group is more common (Shah, Aharonoff, Wolinsky, Zuckerman, & Koval, 2001; Tanaka, Tokimura, & Seki, 2003). Not surprisingly,

studies on ageing suggest that caring for very old people brings a new challenge to managing the inherent frailty of this older group of people (Gobbens, Luijkx, Wijnen-Sponselee, & Schols, 2010; Nicholson, Meyer, Flatley, & Holman, in press). As a result, there has been continued knowledge growth in the physical and social sciences about the various facets that influence ageing (Achenbaum, 2005; Hamerman, 2009). For example, social scientists have explored the increase in age related lifespan growth (M. L. Johnson, 2005; Powell, 2009; Powell & Biggs, 2000; Sheldon & Kasser, 2001). Older adults living healthier lifestyles with the longer life span has given rise to a plethora of studies on ageing in the social sciences. Kirkwood's (2002, 2005) research on the biological basis of human ageing suggests that understanding this process has potential developmental links to other fields and disciplines, such as sociology and psychology.

Some of these fields offer insights into issues that are embedded in the social context and influence older adults' recovery from hip fracture. For instance, the psychological approach to health emphasises a biopsychosocial viewpoint that examines wellness and illness from multiple dimensions (Hayden, 2009). Carman (1997) suggests the physical decline of the body has an impact on the psychology of a person's everyday living and activities. This influences a person's viewpoint on their health status. In contrast, Baltes, Freund, and Li (2005) offer a psychological perspective of ageing as shifting from a process of decline to a dynamic of gain and loss balancing. Moreover, contributing psychological attributes that affect ageing and recovery management include emotions and ageing (Labouvie-Vief, 2005), personality and ageing (Staudinger, 2005), and intelligence and wisdom (Sternberg & Grigorenko, 2005). Clearly, understanding the relationship between physical, emotional, psychological and social elements has generated substantial knowledge about individual perspectives of health and ageing (Blazer, 2008; Wilcock et al., 1998), including the alternative medicine influences (Kleine & Hughner, 1999). Overall, ageing is seen as a successful process in the lifespan rather than a decline (M. Andrews, 2009). These different perspectives influence understanding of health and healthcare, including recovery. The multiple factors inherent in ageing reflect the complexity of recovery and the changing nature of the social environment. As people are ageing healthier and living more active lives often with a coexisting condition, the

impact on the healthcare services is continually being questioned from a social perspective relative to its ability to manage the increasing ageing population.

The healthcare context

While the healthcare context is influenced by age related population growth, other factors such as political and economic issues have been included in research on ageing (Berger, 1998; Higgs & Jones, 2009; Kirkwood, 2002, 2005). Political and economic factors influence healthcare delivery via organisational and operational structures, systems and processes. This means that recovery occurs within a healthcare context that emphasises economic rationality, safety and efficiency, and managerial based decision-making (McCloskey & Diers, 2005). This in turn supports the biomedical model of care delivery through an emphasis on fix or cure and evidence-based practice (Hayden, 2009; Roberts & Wolfson, 2006). It is different to the mental health approach to recovery and the physical health recovery approach that will be discussed later in the chapter. Nonetheless, during the in-hospital period, efficiency and effectiveness drive healthcare delivery and recovery. This may have occurred in part, because the ageing population has increased demand for healthcare intervention. Improved diagnostic and interventional technologies have put pressure on healthcare systems that have responded with economic rationalism. That is, to be efficient and achieve the most possible, with the available resources. All these factors dominate the recovery context and affect the recovery process, including, what is available, how it will occur, who will be involved or not, and which approach is recommended. Many of these issues have the potential to impact older adults' recovery once they have left hospital.

Part of the problem is that the current healthcare context in New Zealand has undergone three decades of constant reform, and this has impacted recovery management (Gauld, 2001). Health care sector modifications changed managerial and professional relationships, influencing care delivery through economic control, efficiency gains, and improving quality of service to the population (Ashton, 2005; Boston, Dalziel, & St John, 1999; Devlin, Maynard, & Mays, 2001). As a result, recovery no longer includes a recuperation period in hospital, as early discharge is the

new norm. The average length of stay for most hospitalisation episodes has decreased slightly over a decade, from 8.0 to 7.6 days, despite the fact that the number of procedures has increased (Ministry of Health, 2011). Following the initial acute care episode, a person is discharged back to the community for ongoing recovery. Moreover, changes to primary healthcare accompanied the drive for shortened in-hospital stay (Ministry of Health, 2000, 2001), to include a strengthening of the primary healthcare sector and supporting community agencies. These initial strategies continue to influence recovery today. The early discharge strategy certainly influences recovery management. For the older adult, early discharge may mean having to rely on or stay with family initially, or go into short term care, or feel insecure until physically recovered. Early discharge strategies may benefit an organisation but appear limited for the individual who is wholly dependent on community support.

What is clear in this healthcare context is that healthcare delivery is dominated by the biomedical model of care (Hayden, 2009; Roberts & Wolfson, 2006). This contrasts with social science that is different, but can still influence healthcare delivery through shifting the focus of disciplines (Fisher et al., 2006; Koval, Chen, Aharonoff, Egol, & Zuckerman, 2004; New Zealand Guidelines Group, 2003). Consequently, it emphasises that healthcare is delivered in a particular paradigm (Porter, 1997). In this case the positivistic paradigm is influential. Porter notes medicine's historical and scientific dominance in healthcare that is situated in the positivistic, logical-deductive scientific paradigm, which underpins the biomedical model of care that shapes recovery. When older adults' recovery from hip fracture is viewed from this perspective, a cause is established, the effects recognised, and then a fix and cure is provided. In addition, restoring the physical body is central to recovery because conditions are viewed objectively as separate components of the whole. The processes though are compartmentalised. For example, older adults with a hip fracture have many common characteristics which respond to evidence-based and researched interventions. Therefore, a fracture can be treated in a particular way because there is clear evidence for managing that condition using specific disciplinary involvement.

However, if a holistic approach to care is desired in the healthcare context, a tension exists with the current biomedical model of care and evidence-based practice approach. Nursing authors have argued that nursing practice has been compromised by evidence-

based practice with its emphasis on pathophysiology, efficiency, and safety in today's healthcare context (Crookes & Davies, 1998; Morse, 1997; Playle, 1995; Watson & Foster, 2003). Moreover, contemporary authors suggest evidence-base practice should be the basis for the delivery of nursing care (Biesta, 2007; Burgers, Grol, Klazinga, Makela, & Zaat, 2003; Fineout-Overholt, Melnyk, & Schultz, 2005). Nursing issues with healthcare delivery are well documented in alternative understandings that encompass a holistic practice approach to recovery (Biesta, 2007; Burgers et al., 2003; Fineout-Overholt et al., 2005; Jennings & Loan, 2001).

Further examination of the healthcare context raises questions about recovery concepts within nursing, which are limited when text is examined (McEwen & Wills, 2007). Orem's *Self care deficit theory* is the only nursing theory to explicitly discuss recovery as a concept within nursing practice (Orem, 1991). Recovery from a nursing perspective has been linked to the biomedical model of care, which focuses on disease or injury, managed interventions, and the functional needs of the individual (McEwen & Wills, 2007; Morse, 1997; Watson & Foster, 2003). Nevertheless, recovery as a central concern to nursing practice, albeit implicit, is embedded in this theoretical approach and assumed as a function and outcome of caring. Nursing models provide a framework for care delivery through nursing assessment, planning, intervention and evaluation of a person. The goal of care is to promote recovery. However, recovery is taken for granted even though it depends on the healthcare context and complex interrelationships between the environment, biophysical, sociological, and psychological factors (McEwen & Wills, 2007; Salmond, 1994, 2002).

It is clear that recovery occurs according to the contextual environment in which it is located. The impact of ageing populations also influences healthcare delivery and recovery management. Individual health disciplines understand many of the factors involved in recovery however tend to emphasise physical functionality and delivery of care as separate from a holistic approach. This suggests that the background influencing recovery is dynamic and complex, and often condition specific as is seen with the mental health and physical approaches to recovery.

Recovery in mental health

The mental health view of recovery offers a broader consumer-driven understanding of recovery, as it emphasises the psychosocial and emotional factors affecting the process. These two aspects of recovery are important, although it will be shown in this thesis that they are only part of older adult's recovery. Wider issues need to be addressed if older adults are to return to whatever is defined as normal. Nevertheless, explanations arising from the mental health viewpoint have contributed to and influenced physical recovery perspectives (Salmond, 1994, 2002). Mental health disciplines generally use models of recovery, which emphasise subjective individualism and the consumer's rights (Roberts & Wolfson, 2006). These recovery models are flexible depending on the context. Over the last decade the importance of context has been recognised in national and international policies for mental health recovery in New Zealand (O'Hagan, Reynolds, & Smith, 2012), Australia, (Oades & Anderson, 2012), the United Kingdom (Le Boutillier et al., 2011), and the United States of America (Farkas, 2007; Jacobson & Greenley, 2001). The focus however, is on service models and the integration of individual and professional recovery outcomes. Mental health recovery concepts, based on the work of William Anthony (1993), emphasise the personal process, which is used to manage an individual's changing psychosocial responses to recovery. These consumer-oriented recovery models are patient driven and based on the core concepts of hope, security, self, support, environmental meaning, and coping strategies. There may be some professionally based activities, but generally the individual has more involvement in the decisions made about their recovery. This is a significant shift from a previous biomedical cure-recovery focus to working with the biopsychosocial factors (Roberts & Wolfson, 2006). It is similar to psychological views of recovery, that suggest illness and injury have biological factors that interlink with psychological and sociocultural components. These factors influence both recovery decision-making, treatment and outcomes (Hayden, 2009). They also recognise the importance of social and cultural factors that are located in the community, which affect recovery.

The consumer driven and individual-oriented approach to mental health recovery has influenced the health professional understanding of service delivery. To arrive at a better understanding of service delivery, the New South Wales Consumer Advisory

Group and the Mental Health Coordinating Council (2009) undertook a major literature review to gain insights about mental health recovery. The research aim was to establish both congruent philosophical and operational recovery notions and definitions to enhance understanding of mental health practice within a community setting. The report identifies the need for a coherent definition of recovery for practice. It also acknowledges that interpretations of recovery need to accommodate "consumers to define their own concepts of recovery to aid their own personalised journey" (2009, p. 2). What is pertinent to the mental health notion of recovery and definitions, is the significant inclusion of individual psychological and sociocultural components that influence recovery at an individual or group level. This suggests recovery is more holistic than a fix or repair stance.

Overall, the viewpoint of mental health recovery is that it is consumer centred and includes an individualistic understanding of recovery progression. It is also seemingly holistic in that numerous interdependent factors such as psychosocial, cultural, cognitive, and emotional factors influence recovery. However, the emphasis is on treating psychiatric illness, substance abuse, or other forms of psychological trauma that impact normal social behaviour (Farkas, 2007; Jacobson & Greenley, 2001; Roberts & Wolfson, 2006). Although mental health recovery is individually centred, taking into account the individual's socio-cultural and psychological background, the influence of institutions or disciplines remains. At the same time, the philosophy of recovery assumes a subjectivity of the process rather than an objective approach and centres on the individual patient as the focus of recovery. Moreover, this concept has relevance to older adults' recovery from hip fracture.

The recent developments in the mental health focus have influenced physical recovery through the inclusion of quality of life, satisfaction and other functional assessment tools. Tools to measure the psychosocial and emotional factors are available and are used to determine older adult recovery progression, although they tend to be complementary to the physical process. Health related quality of life tools for example, examine functional, psychological, and social health relationships during recovery (van Balen, Essink-Bott, et al., 2003). These determine an overall health related quality of life status. Even so, the comparative assessment favours functional measurement against the various impacts on a person's psychosocial health such as

gender, culture, experience, or meaning. During recovery, changes in health related quality of life may relate to actual or perceived measureable functional differences, which have a biophysical basis. Recovery becomes affiliated to quality of life measures, thus functional recovery remains dominant though it may be influenced by socio-cultural and psychological factors.

Experience of the psychosocial and emotional aspects adds a different perspective to understanding recovery. The meaning of the health event[6] suggests a psycho-emotional approach to recovery, which is similar to the mental health model of recovery. Initially, the person explains the event that in turn influences their perceived sense of resultant disability, which impacts how the individual views their long term future (Borkan, Quirk, & Sullivan, 1991; Hunt & Stein, 2004). Psycho-emotional elements may support patterns of behaviour which promote or inhibit the transition to recovery (Robinson, 1999). However, other noted experiences that influence recovery include the perception of injury, pain, recovery and disability (Archibald, 2003), or physical, social, and psychological changes that may follow a health event (Ziden, Wenestam, & Hansson-Scherman, 2008). Interestingly, Hunt and Stein (2004) explored expectations of recovery in a group of older adults who had not experienced a hip fracture. Their outcome predictions were optimistic when compared to their current life situation, suggesting current psychosocial and emotional health may have an influence on recovery prospects.

Overall, from the mental health viewpoint, it is without doubt that psychosocial and emotional factors are important to recovery. Psychosocial and emotional recovery contributes to the interplay of physical, cognitive, and emotional factors in the recovery process. However, while each plays a role in recovery, either as a separate entity or as a whole, the emphasis is usually health professionally oriented. The mental health model of recovery emphasises support of the individual experience in and of the recovery management. The individual and consumer oriented focus is becoming more evident in physical health. Tools are used to gather individual level information however this is usually aligned with physical functionality to produce a generalised approach to managing recovery or to enhance a specific discipline's

---

[6] Health event and event have been used interchangeably throughout the thesis. Health event refers a more specific event occurring, such as a hip fracture, whereas, event refers to the more general event and reflects the wider view and method.

knowledge base. It may be implied that these elements represent a segmentation of recovery by continuing to see the parts rather than the whole. It is the influence of individual elements that impact recovery from this perspective and understanding these influences enables improvements to be made to the process of recovery. While mental health recovery models aim to focus on the individual, recovering from physical trauma tends to have a condition oriented viewpoint.

Recovery in physical health

Recovery from a physically related health event emphasises fixing or repairing biological dysfunctionality. As noted earlier, the biomedical model of health underpins how physical recovery is perceived following a health event (Hayden, 2009; Roberts & Wolfson, 2006). Physical recovery is based in the concepts of body structure and function, in which clinicians determine and provide clear objective guidelines for recovery. Conditions are usually treated according to their impact on the physical body, in which recovery is relevant to physiological restoration. At the same time, organisations favour efficient systems that emphasise minimisation of external influences such as risk, or length of stay, hospital costs, and care delivery activity factors (Alaszewski, Harrison, & Manthorpe, 1998; Resnick & Remsburg, 2004). These are often determined by structural components, intervention outcomes, and minimising influences that influence the recovery process.

Structural components

A structured organisational approach to recovery from a physical injury or illness is usually defined by the healthcare specialty. How recovery occurs following a health event has been explored by specialty and some examples include: cardiac artery grafting (Barnason et al., 2008); cancer (Dorsett, 1991); stroke (Dowswell et al., 2000; Gallagher, 2011); abdominal surgery (Fearon et al., 2005; Zalon, 2004), and chronic illness (Bishop, 2001). The clinical pathway is a useful example of a structured approach to recovery, as this presumes commonality within a specific event. The pathway approach structures the process of recovery from event to discharge (Choong,

Langford, Dowsey, & Santamaria, 2000; Koval & Cooley, 2005). The aim is to minimise variation, reduce risk, and maximise results. These studies suggest that 'fast-tracking[7]' people through the process minimises potential complications, reduces time spent in institutions, and improves the likelihood of potential physical recovery, which in turn supports the need for efficiency in the institutional and professional structures. Nevertheless, research outcomes note that an understanding by clinicians does not necessarily correspond with the perceptual and contextual experience of the person's recovery process. Recovery in these studies is viewed from a body structure and function perspective and associated organisational and environmental influences.

Organisational environments have structurally based phases to recovery. Initially an acute phase centres on the biophysical regaining of body function and minimising potential complications. Either the individual is cured and discharged or moves to another phase, such as rehabilitation. People rehabilitated in specific facilities generally have better recovery prospects from the beneficial environment, the collaboration of healthcare teams and clinical best practice (Fisher et al., 2006; New Zealand Guidelines Group, 2003; Siu et al., 2006; Watters & Moran, 2006). Ganz, Peterson, Russo, and Guccione (2007) support the notion of the rehabilitation environment owing to its focuses on functionality, thus ensuring appropriate interventions and resources are directed to support recovery.

The use of clinical pathways to improve progression through the episode and specific units to cater for age related recovery has a benefit of collaboration between specialty medical teams. The enhancement of interprofessional cooperation improves recovery outcomes, positively influences the environment, and strengthens quality of service delivery. However, the separatist focus to physical recovery remains as each discipline undertakes specific interventions. Koval and Zuckerman (1994) reported that in the complex nature of recovery healthcare staff usually resort to a focus on interventions. While a collaborative approach to care delivery may result in improved psychosocial evaluation and social support, divisions occur according to condition and discipline. Moreover, healthcare is still driven by external influences and

---

[7] Fast-tracking is a term commonly used in the clinical field to mean that an organisational process is in place in which the patient is assigned to a specific clinical pathway and must meet pre-determined timeframes and goals. This is based on my experience.

organisational structures relative to clinician and specialty supporting interventional activity to manage physical recovery.

Intervention outcomes

Intervention outcomes focus on healthcare activities such as surgery, treatment regimes, and discipline related care delivery considered relevant to physical health recovery. For example, the relationships between surgical interventions, techniques, and functional recovery are examined to determine if appropriate treatment decision-making is effective to improve outcomes (Mouzopoulos et al., 2008; New Zealand Guidelines Group, 2003; Siu et al., 2006). These relationships are influenced by age, co-existing disease, general and local complications, which are significant for recovery prospects (Koot, Peeters, de Jong, Clevers, & van der Werken, 2000). While appropriate treatment regimes clearly improve recovery prospects there are multiple variables in the processes that impact physical health recovery management.

Interventional activities when examined from clinician specific care delivery suggests enhanced recovery prospects are likely. Medicine, physical therapy and nursing indicate that separate or collaborative interventions influence recovery. Oldmeadow et al. (2006) explore the benefits of post operative early versus delayed ambulation, concluding early ambulation promotes functional recovery, improves discharge rates and reduces functional impairment that otherwise may result in a need for higher level care. Continued targeted physical therapy post discharge will improve functional recovery prospects according to Tsauo, Leu, Chen and Yang (2005). They explore this concept by comparing in-home physical therapy treatment with standard in-hospital only therapy. While benefits are produced with physical therapy in care and post discharge, the impact on resources and practice is considered too prohibitive to be effective. Not surprisingly, interventional activities are driven by economic efficiency.

Nursing interventional activity generally reflects the biomedical model approach to recovery (McEwen & Wills, 2007). Barangan (1990) had earlier argued that nurses need to comprehend the multiple variables affecting recovery. These individually related factors include age, gender, type of intervention, general health, cognitive status, and iatrogenic complications as being more relevant to recovery. Jagmin

(1998) is more specific, suggesting recovery would be compromised if complications are not detected early enough through relevant nursing assessment and interventions. Although these works are dated, their original contribution remains relevant to the current healthcare context. Titler et al. (2006) however explain that person specific elements improve the chance of recovery and discharge but interventional activities and phases of the recovery are still relevant. The nursing focus throughout these studies suggests the biomedical approach influences the healthcare setting however there is a linking of a nursing practice perspective that moves recovery beyond the body structure–condition emphasis.

There is a growing research emphasis that recovery is the integration of physical and psychosocial, in which restoration of function alone through interventional activities cannot be viewed as a prime indicator of recovery (Hayden, 2009; Roberts & Wolfson, 2006). Horan and Clague's (1999) summation of a review of interventional recovery highlights the scant depth of knowledge on the person recovering from trauma. Noting an increasing growth in studies examining ageing issues along with an historical review of research activity, Horan and Clague discuss the gap in knowledge about the psychosocial aspects of recovery. Their analysis suggests recovery has at least three distinct aspects:

> (i) A return to function of injured body parts; (ii) a more generalised process of restoration of the deficits that arise from the acute and subacute changes that characterize the well-known ebb and flow of the injury response; and (iii) the psychosocial adjustment of the patient (1999, p. 897).

The changing emphasis to include psychological, social and other dimensions to facilitate recovery does not lessen the stress placed on physical recovery. This emphasis suggests a more holistic aspect is necessary along with relevant professional intervention.

The holistic perception of recovery is evident in Kearney's (1999) exploration of women's experiences of illness and trauma. Halcomb and Davidson (2005) examine traumatic injury recovery, and conclude an illness trajectory framework has potential for enhancing post-discharge interventions, and has application for nursing management. In contrast, Young and Resnick, (2009) examine the influence of attitude, self-determination and social factors on functional recovery. They conclude these traits are necessary attributes for recovery. Godfrey and Townsend (2008)

explore the changing nature of recovery by shifting the focus from particular conditions to an individual's perceptual and experiential aspects of the process, which in turn realigns patient and healthcare priorities and interventions. While, these studies discuss holism as an approach, most are interdependent with clinician interventional activity and other influences, which maintain the emphasis on discipline segmentation of physical health recovery process.

Minimising influences

So far, it is clear that multiple influences impact recovery before, during or after a health event. Interestingly, improving recovery outcomes may be determined through understanding the influences that lead to the health event occurrence, for example, age, health status or contributing factors. Age may relate to the event occurrence, as well as influencing the recovery prospects. Age related populations and potential for injury are considered when determining the minimisation of influences. New Zealand has a number of reports exploring, explaining and offering advice on the impact of ageing (Accident Compensation Corporation, 2003, 2005; Ministry of Health, 2002, 2004, 2007; New Zealand Guidelines Group, 2003). Minimising the potential for injury relatively reduces the need for managing recovery from the injury. Recognising that age and health state influence recovery, Norton et al. (1995) and Kannus et al. (1996) acknowledge that potential health events increase with advancing age especially in the over eighty-five year age group. Adults in their seventies and eighties generally, have a poorer recovery outcome (Kannus et al., 1996; Young, Brant, German, Kenzora, & Magaziner, 1997). A number of studies examine ninety years and over as a significant group within the ageing status (Shah et al., 2001; Tanaka et al., 2003). Being older at the time of a health event means that recovery outcomes can potentially be impacted resulting in physical decline. Titler et al. (2006) observe that age may affect recovery and discharge destination, while Young et al.(1997) report an increased complexity in how older adults recover. Age alone does not automatically reduce positive recovery outcomes although it certainly influences treatment decisions.

While age impacts fracture recovery, it is potentially more significant when coexisting conditions accompany the recovery process. Many older adults have a health status that includes pre-existing conditions such as cardiac, respiratory, musculoskeletal or neurological degenerative disorders. In spite of multiple issues people live successfully in the community when these are well managed. Nevertheless, coexisting conditions may influence recovery which requires increased resource use and longer hospital stays (K. P. Chang, Center, Nguyen, & Eismen, 2004; Ishizahi et al., 2004; Koval, Skovron, Polatsch, Aharonoff, & Zuckerman, 1996). Researchers examining the relationship between comorbidities and health recovery management generally agree that the complex interplay of treatments and coexisting conditions must be managed carefully, if the impact on recovery outcome is to be minimised. Moreover, the economic impact on the health sector is another influence to be considered. In the recovery management process, there is an attempt to minimise the impact of co-existing conditions on the recovery progression (Ishizahi et al., 2004; Khasraghi, Lee, Christmas, & Wenz, 2003; Koot et al., 2000). While appropriate interventions, therapy regimes and rehabilitation programmes improve recovery potential, complications however, are an ever-present influence on recovery, and may include an increased risk of death, decreased function, and longer length of hospital stay. Anticipating complications following surgery can determine where relevant resources and interventions will be best utilised (Cree, 2004; Tanaka et al., 2003). However, Giaquinto, Majolo, Roncacci, Sciarra, and Vittoria (2000) argue that even very old people can have a favourable outcome if influences are understood and managed appropriately.

Knowing the factors involved in recovery can help to minimise potential problems. Clinicians use comparative tools to help assess and predict recovery following a health event, including the appropriate allocation of resources (Eastwood et al., 2002; Giaquinto et al., 2000). These are primarily measurement tools, which centre on physical functioning activities. Tools examine activities of daily living, walking, transferring and grooming, levels of self-care, and cognitive, affective, and social functioning (Eastwood et al., 2002; Magaziner et al., 2003). Even when pre-existing conditions, age, and functional limitation variables are acknowledged, an expected permanent decline in function is a common outcome. Lin and Chang (2004) recognise issues related to functional decline, and conclude that most patients do not return to

pre-event status. Overall, it is clear that measurement tools concentrate on the variables inherent in recovery and potentially predict which influences may impact recovery.

Accompanying the knowing about and predicting the common variables influencing recovery in care episodes, is useful so that healthcare agencies can take into account the potential impact on future social health relative to ageing populations. National strategies aim to minimise potential risk and harm to individuals, and to minimise potential for increased levels of injury and associated healthcare for the wider population. Having strategies to reduce fall-associated injuries is significant. The *Preventing injury from falls: The national strategy 2005-2015* (Accident Compensation Corporation, 2005), covers the entire age range, however recognises the increased risk potential for older age groups. The report provides recommendations for reducing falls risk. Ageing populations are also recognised in national health strategies that aim to involve people in improving their personal health, as the primary and secondary health services interface is strengthened (Ministry of Health, 2001, 2007). Furthermore, keeping people healthy and free from harm has economic benefits. National strategies need to recognise and interface with the research. Knowledge provides theoretical explanations of healthy ageing.

It is clear that physical recovery aspects are well examined and explained according to structural, interventional and other influences (Horan & Clague, 1999; McEwen & Wills, 2007; New Zealand Guidelines Group, 2003). How a person recovers following an event may be described, prescribed, and predicted. The psychosocial and emotional factors influencing recovery are examined alongside physical factors. The interrelationship of the factors may explain why recovery occurs in a particular manner. Psychological, cognitive, and emotional events are considered specific fields of investigation and interventions relative to them are examined relative to recovery management. The emerging knowledge from these fields is being assimilated into physically-related healthcare and recovery management understanding. Recovery in physical health events is generally examined from a short term perspective and explained in-depth, although other explanations include a longer term view of recovery. Following the event for a longer period of time may gain

information about factors, aspects, or elements of recovery that could develop current interventions.

Overall, knowledge about recovery is varied and there are many different viewpoints. It can be seen that recovery is well researched and well-known as a procedural, interventional, and discipline focused phenomenon. The physical, social, psychological, cognitive, and emotional factors are generally known and explained in a particular context. It is clear that recovery has multiple perspectives. However, the perspectives can be problematic when they are managed by a discipline that stresses a compartmentalised approach. The person's involvement in the process tends to be interpreted according to the condition and what factors and influences will impact their recovery. Knowledge focuses on the initial recovery episode, primarily in care settings, with some occasional follow up studies to determine further functional recovery. What is not known is how people manage recovery once healthcare input has finished and how they determine their recovery back to normal. Having some understanding of the literature about normal is important at this point, as the main problem older adults had with recovery was returning to normal.

Interpreting normal

Older adults' interpretations of normal are multifactored and complex. Once again, it is clear that social and professional definitions influence understanding. What constitutes normal is based on individual and collective social processes. Normal, sociologically, is conforming to expected norms of behaviour. The term invokes a sense of people behaving in particular ways according to the situation or context. A norm is a social construct which defines what is expected as normal through roles, relationships, and societal order. This is based on the ideal ways to behave, and expected social roles and behaviours (Abercrombie, Hill, & Turner, 1988; Bilton et al., 1981). Abercrombie et al.(1988) clarified norms further by suggesting they are prescriptive guidelines for rule governed collective social action. However, they note social norms are not always actual behaviour and normative patterns are not always the most frequent. Abercrombie et al. suggest conformity of actions is implied with correctness or properness of behaviour. This suggests that the received view of norm

is an established pattern of behaviour shared by a social group to which a member is expected to conform. This introduces the influence of other perspectives establishing the expected pattern of behaviour and reinforces a received view. Within healthcare however, norms are seen as ideal standards of action or behaviour, for example, how to behave during recovery. Not surprisingly, social norms and expectations pervade current healthcare and are generally seen as the normalised approach to recovery.

Societal

The societal perspective of normal is underpinned by historical and contemporary sociocultural constructs. Sociological views of ageing are viewed from multiple perspectives, such as, sociology, psychology, and the health professions, and each determines expected norms for health and illness in older age (Baltes et al., 2005; Fulop et al., 2010; Gobbens et al., 2010; Kirkwood, 2005; Sheldon & Kasser, 2001; Staudinger, 2005). A well-known view of normal came from Talcott Parsons (1951) and has had an influence on expectations about recovery. Parsons's concept of the sick role has permeated societal views of age, health, illness, recovery and therefore understandings of normal (Bilton et al., 1981; Robertson, 1989). The sick role is viewed as the logical extension to illness behaviours, social functioning and the integration of medical care systems in which an individual accepts the healthcare system and professional input and responds with appropriate behaviours (Levine & Kozloff, 1978; Segall, 1976). Critiques continue however, and now include the growing issue of older populations living with chronic conditions (Varul, 2010).

Contemporary views on ageing, illness and chronicity have shifted Parson's traditional view of the sick role in society. For example, Blazer (2008) considered older adult's self-perception of health and well-being coincided with wider societal shifts such as, how ageism impacts health, and the biomedical model of healthcare (Angus & Reeve, 2006; Grant, 1996; Roberts & Wolfson, 2006). This suggests that the views on how ageing is perceived and managed within society shift according to the context even though the reality of physiology is a fixed factor to be reviewed when examining returning to normal during recovery.

Physiological

The physiological view of normal reflects the natural progression of ageing (Kirkwood, 2005). Getting older, living with a changing health status as body function and mental processes alter according to physiological changes within the body is a normal process. Any anatomy and physiology text will describe in detail the normal body and its changes through the lifespan. Scientifically defined, stages of ageing may be categorised, normalised and jargonised. From this perspective, normal is defined according to the examiners of ageing, rather than by the recipients of the process (Carman, 1997; Hamerman, 2009; Katz, 2000; Powell, 2009; Powell & Biggs, 2000). Powell (2009) picks up this aspect, discussing the issues of professional control inherent in healthcare, that are mediated through increasing technology, which impacts older peoples' lifestyles and life courses. This creates social meaning and expectations of normal health and illness behaviour. Interestingly, with the increase in health technologies and knowledge, professional understanding of normal physiology in social health behaviours is impacted. Professional healthcare disciplines may view their stance as indicative of how older adults should maintain health, age, and how they should be managed in health and illness, thus influencing recovery (Hamerman, 2009; Miller, 2009; Schulz & Heckhausen, 1996).

Though normal physiology is about progressive ageing, as stated previously, there is little doubt that the biomedical model dominates social perceptions (Roberts & Wolfson, 2006). This has implications for practice, because healthcare is redefined through innovative and developing technologies and interventions. However, what is not considered is that physiological normal has changed, as older adults are living longer. New sub-groups are formed as longevity impacts society and healthcare. For example, a new sub-group is the oldest old that is, people in their late nineties and early hundreds. This has created the new physiological concept of frailty being normal (Fulop et al., 2010; Gobbens et al., 2010). Although ageing is a fixed process, its application is fluid regarding how ageing is viewed in the everyday aspect of normal and recovery.

Everyday normal

The everyday view of normal reflects the stereotypical perceptions of society and its changing views on ageing, health, illness, and normal. Achenbaum (2005) describes ageing relative to historical sociocultural factors, suggesting that old age has always been present but its perception has altered because the contemporary social construct has changed. Tulle-Winton (1999) describes how gerontological research has shaped social constructions of ageing and old age discourse. Older adults are influenced by social, cultural, political and academic views and this influences understandings of normal. Whether through personal interaction, media or experience, views of ageing are formed, altered, and defined by individuals or groups. As a result, the everyday normal view of old age may be revered, scorned, accepted, denied, or cherished depending on the contemporary social construct of the moment. However, all may be present during periods of socio-cultural transition. For example, the negative stereotyping of old age may be present in a professional group (Higgins, Van Der Riet, Slater, & Peek, 2007), as new discourses and practices are evolving.

This illustrates well that the explanations of recovery from hip fracture have moved from pure survival experience to managing the oldest old (Magaziner, Simonsick, Kashner, Hebel, & Kenzora, 1989; Tanaka et al., 2003). In addition the growth in anti-ageism, and positive ageing is changing social constructs on age and ageing, therefore influencing recovery (Angus & Reeve, 2006; Grant, 1996; Katz, 2000; Lupien & Wan, 2004). Similarly, language use is constantly changing when discussing normal. Katz and Marshall (2004) describe the shift of language use of normal or pathological to functional or dysfunctional terminology. The sciences appear to be using functionality as a marker of successful living rather than the previous use of the descriptive normal. The everyday viewpoint represents the ever changing nature of language, ideas and definitions. Influenced by multiple sources, individuals, groups, and / or society constantly reassess how normal is perceived within a contemporary moment of time. This influences how older adults view their everyday normal and recovery.

Individual perception

Normal at the individual level is influenced by societal, physiological, and the everyday viewpoints. The factors influencing individual perception of normal are continuous and ever changing. For example, ageing as a natural process requires fluidity in how the individual perceives normal. With decline in physical function such as decreased ability or energy, the individual will make changes to their functional activities and subsequently their perception of normal. How people perceive health, illness and normality is a growing research focus. For example, Blazer (2008) describes self-perceptions of health relative to health outcomes in late life. Blanchard-Fields (2007) discusses problem-solving strategies used by older adults to manage their everyday interpersonal issues. Moreover, how older adults perceive, experience or manage normal relative to their physical, social, cultural, and psychological factors is explored in several studies that conclude context and personal theory influenced the perceived view of age and ageing relative to a person's normal (M. Andrews, 2009; Kleine & Hughner, 1999; Sanders, Donovan, & Dieppe, 2002; Schaie, Boron, & Willis, 2005; Sheldon & Kasser, 2001; Sternberg & Grigorenko, 2005).

Summary

This chapter has examined how varying forms of information are used in a Glaserian grounded theory study. Methodological protocols require a researcher to be cognizant of the influence prior experience and pre-reading can have on analysis and theory generation if not managed appropriately. Professional experiences exist and are acknowledged however, the researcher needs to remain open to all possibilities emerging from the data and not to preconceive. Literature reviews are ongoing throughout the research process. Pre-reading is undertaken to enhance theoretical sensitivity whereas, extant literature is introduced at different stages in the research according to the theory's generation stage. While literature is not avoided, it has relevant times where it is compared to the emerging concepts as data.

It is evident so far that recovery is contextual. The varying influences on recovery are from societal, healthcare, and professional viewpoints. This literature review has

demonstrated that there is a wide range of views on recovery on what determines recovery. In addition, the literature has illustrated that there is a predominant traditional and medicalised view of older adults' recovery, primarily as a return of functionality. Understanding of how individuals manage recovery is limited. When this aspect has been explored, it generally had a professional focus to improve care delivery. Peoples' perceptions of normal were also relevant to recovery. Different perspectives of normal influenced the multiple viewpoints of recovery, which in turn impacted how recovery was managed. Recovery as a professional process is well-understood. What is not well-known is how recovery continues once in-hospital and professional input has finished. Both society and individuals interpret recovery behaviours and responses according to preconceived ways of knowing. As one side of recovery has been examined in-depth, it is important to ask, what is the main concern of older adults recovering from hip fracture and how do they resolve that concern?

Chapter Three

Research methodology: Embracing discovery

Introduction

Glaserian grounded theory[8] is based on an epistemological stance that it is a general research method and not aligned to any specified philosophical or theoretical framework (Glaser, 1978, 1992, 1998, 2005; Glaser & Strauss, 1967). The research method claims neutrality from theoretical influences because the focus is on the discovery of participant centred issues and hidden patterns of behaviour that resolve a main concern. This means that for a grounded theory researcher, theoretical frameworks are viewed with caution as they can influence research design if assumptions are made that affect the choice of specific procedures and direction of the data collection. Nevertheless, it is important to understand where epistemology stands relative to the grounded theory approach. In this chapter, the grounded theory methodology and a pragmatist epistemological relationship will be discussed, according to the hallmarks of the classical approach. Finally, this study will be positioned in Glaserian grounded theory.

Epistemology of grounded theory

Honderich (1995) defines epistemology as "the branch of philosophy concerned with the nature of knowledge, its possibility, scope and general basis" (p. 242). Epistemology is concerned with the theory of knowledge. Bilton et al. outline epistemology in sociological terms as "concerns with knowing, i.e. what sort of statements will we accept to justify what we believe to exist" (1981, p. 629). Epistemology is about understanding reality in a manner that establishes what is real according to a specific stance.

---

[8] Glaser notes that grounded theory is the original 1967 version and his ongoing development of that. This is referred to as classical grounded theory or Glaserian to distinguish it from other versions of the method.

According to Holloway and Wheeler (1996) research tends to separate into two general types of approaches with underpinning assumptions about reality. These are termed qualitative or quantitative paradigms. Each has their own view of reality and influence how knowledge is attained and understood. Within each of these paradigmatic approaches are further delineations of how knowledge ought to be attained. The important point to be made is that philosophical foundations and assumptions underpin epistemological approaches. These assumptions influence how knowledge is assimilated into fields of study such as the physical or social sciences. Moreover, further assumptions include the relationship of the knowledge to practice, which in turn determines relevance and applicability based on paradigmatic significance. However, practice-related research has to link back to the philosophical foundations of understanding knowledge, which underpin assumptions that will frame the research questions, processes, and outcome. This epistemology provides the framework for how a study will be interpreted.

From a discipline and practice related viewpoint, Crotty (1998) defines epistemology as "the theory of knowledge embedded in a theoretical perspective" (p.3). Crotty refers to the notion of "how we know what we know" (1998, p. 8) and the need to identify, explain, and justify the chosen research methodological stance and theoretical perspective. Crotty outlines three different epistemological approaches to qualitative inquiry. For example, he offers objectivism as a reality that exists apart from any consciousness; constructionism where meaning is constructed according to the interrelationships that take place between individuals, groups, communities, and societies and objects; and subjectivism, where the meaning of reality is imposed or created, and the object does not contribute to the meaning.

Which perspective underpins a methodology therefore becomes important. In grounded theory the participant perspective is central and, as explained in Chapter Two, other perspectives are seen as received or existing views of the world. According to Crotty (1998), epistemology is underpinned by the theoretical perspective or a philosophical stance that influences the methodology. Glaser however, argues that grounded theory "is a general methodology. What counts are that grounded theory methods are not bound by discipline or data collection" (1992, p. 18).

Glaser highlights that discipline focused training will give a different perception to the research, which is at odds with the grounded theory emphasis on participants.

Crotty (1998) discusses epistemology and theoretical perspectives as separate but interrelated concepts. This is different to the Glaserian proposition that classical grounded theory is not influenced by any received perspective, which includes my personal assumption that epistemology and theoretical perspective are synonymous. I assume the study of knowledge in grounded theory logically cannot be free from an epistemological influence as it is embedded in social worlds and multiple perspectives. This is perhaps illustrated in the seminal work in the area. Classical grounded theory originally emerged from studies undertaken by Glaser and Strauss exploring dying in hospitals. The methodology was published in '*Discovery of grounded theory*' (Glaser & Strauss, 1967). Published at a time in which positivist social sciences dominated, the research method was explained using quantitative terminology and research language typical of the time. While the research language was clear, the underpinning epistemological stance was not explicit in the seminal work. What stood out nonetheless was that the purpose of the grounded theory approach was to offer an alternative form of research by emphasising the generation of theory from data, rather than testing theoretical hypotheses as was more usual at that time (Glaser, 1978; Glaser & Strauss, 1967). As a result, the epistemological stance of the methodology is not outlined in the seminal work, although assumptions have been made since, as various authors have made a range of interpretations drawing on knowledge about the co-originators backgrounds.

Glaser's background suggests positivist realist epistemology. His mentors included Lazarsfeld and Merton whose academic fields influenced Glaser and grounded theory development (Glaser, 1978; Glaser & Strauss, 1967). Building on the qualitative foundations of mathematics, inductive hypothesis testing, index formation, interchangeability of indicators, latent patterns, and coding, Glaser developed the principles of grounded theory while working with Strauss (Glaser, 1978; Glaser & Strauss, 1967). Strauss's epistemological background was influenced by his work in the Chicago School of Sociology, which was underpinned by Blumer's symbolic interactionism, and pragmatism (Corbin & Strauss, 2008) along with his interest in qualitative research (Glaser, 1998). The merging of Glaser's and Strauss's perspectives

developed the grounded theory method. This was, according to Glaser, "to harness the logic and rigor of quantitative methods to the rich, interpretative insights of the symbolic interactionist tradition" (2005, p. 143). Moreover, the discernible lack of an original epistemological stance in the seminal work has caused continuing debate over the decades (McCallin, Nathaniel, & Andrews, 2011; Nathaniel, 2011). Glaser (1992, 1998, 2005, 2011) however maintains a stance that classical grounded theory is atheoretical and that theoretical perspectives are not only irrelevant to the approach but also detrimental to application of the method. Using a professional framework, theoretical perspective or epistemological base according to Glaser, forces the assumptions of those models onto the research process. This shifts the focus of the research to the researcher's existing framework and away from the participants' main concern. There has been ongoing debate about the relevance of theoretical perspectives and frameworks to grounded theories. However, when classical grounded theory has been placed in an epistemological or theoretical paradigm, Glaser has continued to maintain his atheoretical stance (Glaser, 1992, 1998; Heath & Cowley, 2004; MacDonald & Schreiber, 2001; McCallin et al., 2011; McCann & Clark, 2003; Moore, 2009).

The general stance of classical grounded theory is that the methodology is free of theoretical frameworks and associated assumptions, however it cannot be assumed to be epistemologically neutral (Glaser, 1978; Nathaniel, 2011). As a result, grounded theory has been located in a number of epistemologies, such as interpretivism, realism, constructivism, and pragmatism (Holton, 2008, 2009) in the decades since the seminal work was published. The epistemological directions arising from more recent interpretations of the methodology have been reflected back to the seminal work of Glaser and Strauss (1967). This claims epistemological relevance for the evolved version. Classical grounded theory assumes no epistemological base supports the methodology and that this assumption-free approach fits with a pragmatic reality where the interests and actions of a group necessitate a practical bearing or action.

Grounded theory and pragmatism epistemology

Classical grounded theory and the epistemology of pragmatism appear to have comparable goals. The pragmatist belief that a group of similar people will initiate

actions or responses to a self-defined problem fits grounded theory's research raison d'être. Similarly, the pragmatic assumption that the determination of truth in statements is relative fits grounded theory's participant focus, which is observed through action or patterned behaviour (Glaser, 1978; Honderich, 1995). Therefore, discovering the main concern and resolution process of a group of people with a similar issue is the pragmatic reality of the social world where a problem is defined through meaning in statements, and actioned according to patterns of behaviours and practical application.

Pragmatism, viewed from a philosophical perspective is, according to Honderich, "efficacy in practical application – the issue of which works out most effectively" (1995, p. 710). Honderich further explains that three contexts exist when considering pragmatism. First, is the determination of truth in statements; the second context refers to rightness in the case of action; and the third context concerns value in the case of appraisals. From a philosophical perspective, the first context is only relevant as it relates to meaning and truth. This is the idea that the meaning of any concept that has application in the real world has observable results relative to practice application. The emphasis on meaning comes from the work of Charles Sanders Peirce (Honderich, 1995; Nathaniel, 2011) whose philosophical doctrine was primarily interested in a theory of meaning. This work is difficult to comprehend in simple terms. Peirce's prolific writings and multiple theories are more easily understood when studied philosophically. Over time though, Peirce's pragmatist philosophy has emerged as a single construct (Honderich, 1995; Nathaniel, 2011), usually known as the pragmatic maxim:

> Consider what effects which might conceivably have practical bearings, we conceive the object of our conception to have. Then our conception of these effects is the whole of our conception of the object" (Peirce, 1905, p. 166).

In the pragmatic theory of meaning, it is assumed that people are conscious so they experience the real directly. Thus reality exists whether a person is conscious of thought or not. Our ideas, however selective, are based on partial experience colouring our history, circumstances, and purpose. Therefore, our idea of anything is our idea; its sensible effects to finding true knowledge are that all our ideas are similar to

scientific hypotheses (Colapietro, 2006; De Waal, 2001; Magnani, 2005; Ormerod, 2006; Urmson & Ree, 1991). Peirce (1905) noted that every truth which follows from any of the other form can be deduced, while some errors can be avoided. Reality connects itself with a critical proof of its truth. In the logical order of investigation, usually a person first forms a hypothesis that seems more and more reasonable the further it is examined. It is only later that the hypothesis may become known as adequate proof. Peirce argues that this is how a person is guided on constructing new hypotheses from the remains of defeated ones. Then the person examines the norms for guidance when deciding which hypotheses are worth taking forward. Peirce modelled this inductive reasoning on statistical quantitative induction tests by sampling their consequences (De Waal, 2001).

Further, Peirce (1905) goes on to describe categories as classification aspects of reality expressed as objects relative to our direct perception of them. The uniformity we discover has meaning in so far as we can act regularly in their regard (De Waal, 2001). This needs to be understood from the logic of relations and introduces the logic of abduction. The term abduction was coined by Peirce according to Magnani in order "to illustrate that the process of scientific discovery is not irrational and that a methodology of discovery is possible" (2005, p. 265). Abduction had a logical form distinct from the prevailing induction and deduction ideal of Peirce's time. Reasoning which starts from reasons and looks for a consequence is called deduction whereas, when reasoning starts from consequences and looks for reasons, it is abduction (Magnani, 2005). Abduction is therefore about inferring facts or hypotheses that render some sentences plausible, that explains or discovers some phenomenon or observation. It is the process of reasoning in which explanatory hypotheses are formed and evaluated (Magnani, 2005). Peirce's numerous writings include multiple descriptions and discussion on meanings. However, some have more relevance than others when pragmatism is linked to grounded theory.

According to Nathaniel (2011), Peirce's pragmatism assumptions and scientific principles are consistent with classical grounded theory. Nathaniel offers an explanation of how pragmatic epistemology underpins classical grounded theory, one which does not erode or modify the original methodology. Nathaniel believes that Glaser and Strauss's (1967) seminal work failed to articulate the philosophical foundations of grounded theory, which has "lead to half a century of piecemeal explanations of the method's

ontological, epistemological and methodological underpinnings" (2011, p. 187). The argument is focused on the roots of pragmatism reflecting the mutual purpose of research, which is similar to grounded theory methodology. Two key points illustrate the consistency of the relationship between classical grounded theory and Peirce's pragmatism. Nathaniel suggests a legacy of people and pivotal ideas influence the relationship. Peirce's philosophical ideas had an influence on Glaser and Strauss's mentors. As already stated, the first of Glaser's mentors was Lazarsfeld and his work on the scientific method, which was influenced by James, Dewey, and Peirce's pragmatism discussions (Glaser, 1998; Holton, 2011). Glaser's second mentor was Merton whose work on statistics and social research is similar to Peirce's statistics of chance. Strauss's mentor Blumer, along with symbolic interactionism, arose from Mead, Dewey, James, and Peirce's significant influences on the Chicago School of Sociology (Glaser, 1998; Glaser & Strauss, 1967). The second set of pivotal ideas linking pragmatism and grounded theory include objective reality, latent patterns, and human perspective. Peirce, according to Nathaniel, set the stage for Glaser to develop conceptualisation through these central ideas.

Nathaniel (2011) suggests that objective reality centres on the inferences of Glaser's writings and word use. She cites three key points as an epistemological position for classical grounded theory:

> Glaser recognised that, (1) there is an objective reality that can be observed; (2) inasmuch as it is possible, the researcher gathers data from the perspective of the research participant, and (3) grounded theory sheds light on latent pattern (Nathaniel, 2011, p. 192).

There are similarities to Peirce who noted that there are real things, and if examined with experiment and observation, familiar everyday observations are surprising to us only because their familiarity prevents our noticing them (Honderich, 1995). Colapietro explains Peirce from the viewpoint of what's going on here (Glaser, 1978, 1998) as "experience as to be capable of helping us in the discovery of the way things are" (2006, p. 16). Nathaniel summarises Peirce's epistemology as "the process [*of scientific inquiry*] unfolds, what is real in a practical sense consists of both the object and the investigator's ability to understand and communicate it" (2011, p. 190). Therefore Nathaniel argues that objective observations in grounded theory are separate from the researcher. This is seen through the method's data collection and analysis, minimised

preconception, and the emphasis on letting "the data speak for itself" (Glaser, 1978, p. 8).

Latent patterns according to Nathaniel (2011) are the second integrative component of the grounded theory-pragmatism fit. Under the concept of metaphysical categories of firstness, secondness and thirdness, Peirce defines the respective relationship of one to the other. Firstness suggests a quality or existence of something, whereas secondness is the fact of something or its actuality. However, thirdness is relevant to grounded theory because of its relationship to habit or the regularity or generality of something. Through this approach, Peirce could demonstrate the systems and the emergence of relationships. The actuality of relationships gives rise to the possibility of emergent properties that become real, as they are placed in the higher level clearness concepts (Graves, 2007). Accordingly, "although the categories occur in all phenomena, one may characterise some phenomena as typifying one category more than others" (Graves, 2007, p. 244). This potential link to grounded theory helps to support the belief that there are observable predictable patterns of behaviour, which can be identified by constant comparison and abstraction (Nathaniel, 2011). In addition, Peirce's abduction principles, relative to grounded theory's constant comparison and abstraction processes, continually induce and deduce through hypothesising and testing until a true hypothesis survives elimination (Meyers, 1999). This describes an inference pattern that provides the best explanation of the process (Honderich, 1995; Magnani, 2005; Ormerod, 2006; Rosenthal, 2003).

The human perspective is the third integrative factor. According to Nathaniel (2011), Peirce's *Semiosis* was the integrating concept. Relative to the thirdness concept, Peirce underpinned semiosis with a theory of meaning (Honderich, 1995). The notion of interpretation is the key factor in understanding signs and symbols. There are three kinds of signs. First, icons (objects signified); second natural signs (clouds equal rain); and third, conventional signs (understood meaning). A sign is considered relational to the object, thus emerges as an icon, index, or symbol (Colapietro, 2006). Icon is related according to an inherent similarity to the object. The index is related by virtue of its casual connection to the sign and object, whereas the symbol is related to the object through habitual connection, either natural or conventional. However, Colapietro notes that signs are potentially interwoven and not separable functions. Nathaniel argues that

the second sign, index, has a relational connection with grounded theory. This occurs because Peircean indices underpin the constant comparative method and interchangeability of indices developed from Lazarsfeld's prior work (Glaser, 1998). According to both Peirce and Glaser, the human perspective is central to epistemology and hence, to the grounded theory approach. The interpretation and understanding of signs and indices is reflected in the maxim "study the problem that exists for the participants in the area, not what is supposed to exist... it is their main concern and their continual processing of it that is the focus of grounded theory"(Glaser, 1998, p. 116). Glaser affirms the human perspective through the questioning of the data and 'what is going on', and the conceptualisation of this.

Nathaniel summarises the grounded theory-pragmatist relationship stating: "Peirce created a philosophy of science that set the stage for Glaser's conceptualisations of observable patterns, interchangeable indices, tentative hypotheses and modifiable theories" (2011, p. 195). Interestingly, when reading interpretations of Peircean pragmatism, other concepts emerge that tentatively support the grounded theory epistemology (Colapietro, 2006; De Waal, 2001; Graves, 2007; Honderich, 1995; Magnani, 2005; Ormerod, 2006; Peirce, 1905). These include the logic of discovery, clarification of concept development, emergence, and "abduction as an inferential creative process of generalising a new hypothesis"(Magnani, 2005, p. 265). Nathaniel concludes that there is a strong relationship between pragmatism philosophy and grounded theory methodology, however not as a theoretical framework. Epistemological understanding of knowledge through a pragmatist approach reflects grounded theory having an underpinning epistemology. Nathaniel's arguments and positioning of grounded theory within the pragmatism epistemological relationship offers a researcher a stance from which to discuss Glaser's atheoretical positioning of grounded theory.

Changes in methodological focus

Grounded theory's evolving interpretations can influence which specific approach is used in a study (Morse et al., 2009). Understanding the differences in these approaches helps to decide which particular interpretation will be chosen. However, to make such a

decision, the researcher must first understand the split between Glaser and Strauss (Glaser, 1992), which has contributed to differences in the interpretation of and the development of epistemological diversity. For over two decades Glaser has continued with the seminal work and its intention to be free from received view frameworks thereby maintaining a stance that supports grounded theory as a general method, which is atheoretical. In contrast, Strauss moved grounded theory towards descriptive qualitative analysis (Strauss, 1987), an alternative methodological version, underpinned by the Chicago School of Sociology's pragmatism and symbolic interactionism (Corbin & Strauss, 2008; Glaser, 1992; Strauss, 1987; Strauss & Corbin, 1990, 1998). Since the initial divergence, there have been a number of interpretations of grounded theory. Strauss's (1987) interest in developing qualitative analysis for the social sciences influenced his divergence from the original work. Strauss and Corbin (1990, 1998) published alternate versions, aligning grounded theory to qualitative descriptive analysis (Glaser, 1992). Grounded theory was also linked epistemologically to the naturalistic[9] paradigm owing to the emphasis on inductive strategies of theory generation (Denzin, 1971; Denzin & Lincoln, 2003; Lincoln & Guba, 1985). Several years later Charmaz (2000) used a constructivist epistemology to underpin her approach to grounded theory. Other versions, such as Schatzman (1991), deepened the modes of analysis by introducing dimensional analysis to grounded theory. A recent version has been Clarke's (2003) elaboration on the conditional matrix into a situational analysis grounded theory. As new or modified versions of the methodology emerged, Glaser published reasoned accounts countering the 'new' version, comparing them to the seminal work. Glaser consistently argues that the new versions are not grounded theory and are qualitative descriptive analysis (QDA) (Glaser, 2003). According to Glaser, there is only one grounded theory and that is the original Glaser and Strauss (1967) and Glaser thereafter. Thus the co-originator split has enabled evolution of grounded theory, however with it, subsequent epistemological influences that according to Glaser,(1992, 1998, 2005, 2011) have moved the method from conceptualisation to qualitative descriptive analysis (Glaser, 2003; McCallin et al., 2011).

---

[9] Naturalistic inquiry is often interchanged with qualitative and interpretative inquiry. Though subtle differences occur with each, for the purpose of this paper, naturalistic inquiry is deemed qualitative and interpretative.

In classical grounded theory the methodology leads the researcher toward the objective nature of the emerging codes, categories and concepts. Thus emergent not preconceived ideas are fundamental to the methodology. Understanding the rationales and subsequent methodological divergence of grounded theory informs which choice of approach is made. The first significant shift to a symbolic interactionist theoretical perspective and qualitative description was Strauss (1987). Glaser responded to the changes with the publication of *Basics of grounded theory analysis,* (1992). Glaser argues that the Strauss and Corbin interpretation shifts the true emergence principle by emphasising preconceived assumptions and questions that influence data analysis. This results in conceptual description that is, qualitative descriptive analysis (QDA). The additional coding, the conditional matrix, and the assumptions of qualitative research inquiry force the data analysis and outcome away from theoretical emergence. Glaser (2005) further elaborates on the impact of symbolic interactionism on grounded theory noting that it is a data type like any other used in the general method of the research process. However, if symbolic interactionism is overlaid as a foundational theoretical perspective then the general method is lost. Symbolic interactionism has possessed, impacted and dominated discipline related grounded theory research as a foundational theoretical perspective. This influence has been accredited to Strauss and later Corbin's ongoing interpretation of grounded theory. Nursing for example connects to symbolic interactionism through its need for an ontological and epistemological perspective in research activities. Despite this, Glaser argues "the quest for ontology and epistemology for justifying GT is not necessary...GT is simply an inductive model for research... a paradigm for discovering what is going on in any particular arena" (2005, p. 145). Applying symbolic interactionism as a foundation theoretical perspective transfers the assumptions, tenets and preconceptions of the theory to the analysis. This leads to a conceptual description of what ought to be happening to participants in the data, rather than developing a conceptual rendering of what is happening that links the methodology to qualitative inquiry.

Similarly, the naturalistic inquiry paradigm provides a broad term to capture qualitative inquiry that is not specifically aligned to any particular theoretical construct (Denzin, 1971; Denzin & Lincoln, 2003; Lincoln & Guba, 1985). Simply put, it is a disciplined inquiry conducted in natural settings (the substantive field of interest), using natural methods (interviewing or observation), in natural ways by people who have an

interest in what they are studying (practitioners). The consequent methodology is then based on a pragmatic approach as to what best suits the discovery of the problem. Glaser argues that naturalistic inquiry assumes grounded theory is a form of qualitative data analysis (QDA). Glaser published *Description's remodelling of grounded theory methodology* (2003) to counter the naturalist inquiry invasion into classical grounded theory. He argues that qualitative inquiry's goal is to produce description compared to discovery through emergence. Linking the epistemological assumptions of naturalistic inquiry further erodes the classical grounded theory goal of emergent conceptual theory. Interestingly, it forces preconception, speculation, assumptive concepts, and researcher interests, that is, epistemological bias. Glaser notes, "When GT procedures are laced with the exhaustive, abundant requirements of QDA methodology, GT becomes distorted, ... derails the knowledge, hence grounding of GT, of what is really going on" (2003, p. 4).

The second significant epistemological shift was by Charmaz (2000). Her argument is that constructivist epistemological assumptions do underpin the grounded theory methodology. Further, constructivism-focused publications continued the discussions on epistemology relative to interpretative and constructivist perspectives (Bryant & Charmaz, 2007). In response, Glaser published *Jargonizing: Using grounded theory vocabulary* (2009) to argue Bryant and Charmaz's publication continues to erode the original grounded theory version through remodelling and the use of vocabulary. Their publication according to Glaser is a process for providing a modified grounded theory vocabulary relative to descriptive qualitative data analysis (QDA). He used classical grounded theory principles, such as constant comparison to argue the case. Glaser continues to argue "that all other versions leave out the two fundamental requirements of GT – no preconceptions and finding a core category" (2009, p. 74). However, he argues the points from a methodological approach rather than an epistemological one.

Glaser (1978, 1998, 2001, 2003) has consistently stated that a theoretical perspective applied to grounded theory research erodes the basic principles of openness and emergence thus creating a conceptual description of the findings rather than a conceptual explanation. Glaser notes "grounded theory provides a conceptual overview with grounded interpretation, explanations, impacts, underlying causes and so forth" (2003, p. 118), which makes the methodology complementary to either

qualitative or quantitative research approaches (Glaser, 1978; Glaser & Strauss, 1967). It can be used with any data, discipline, and theoretical perspective. However, as stated previously, these cannot be overlaid onto the methodology. Owing to grounded theory's approach to be as assumption-free as possible to the research, using a theoretical perspective undermines its principles of openness and emergence.

Grounded theory is about discovering a social groups' latent patterned behaviour that is used to resolve a main concern. It is assumed that the main concern is a self-identified problem that people find ways of dealing to, although they seldom discuss or acknowledge how they do it. Arguably, the analyst interprets and conceptualises. As explainable patterned behaviour is the outcome expected from the research, there is an assumption that a person is a socially organised and pattern making being, deriving meaning from actions and interaction, which can be discovered through a systematic analysis of empirical data (Nathaniel, 2011). These patterns of behaviour are explained through a rigorous and systematic method. The behaviours are generalisable. This participant stays central to the research, although the aim of theoretical generation is to explain group behaviour patterns. Thus subjectivity is maintained while the theoretical perspective is not central.

In summary, the epistemological debate is challenging. What is clear though is that classical grounded theory is inductive and participant-centred. Applying different frameworks to the methodology undermines grounded theory's emergent nature. I agree with Nathaniel (2011) and take the position that classical grounded theory has an epistemological stance that has 'fit' with Peircean pragmatist philosophy. The scientific approach to empirical data conceptualised through pattern recognition, comparisons, hypothetical relationships, and the human perspective being central, relates as an epistemological underpinning for classical grounded theory, thus maintaining the assumption-free, atheoretical stance.

Methodology

As stated earlier, the purpose of grounded theory is to uncover and explain hidden behaviours or basic processes that resolve the main concern of participants (Glaser, 1978, 1998; Glaser & Strauss, 1967). Glaser notes that the methodology is not linear or

a step-by-step procedural approach; it is messy and confusing. The confusion is a necessary part of the process owing to its paradoxical nature between being a systematic process and having creative freedom (Glaser, 1998). Glaser (1998) notes that staying true to the methodological principles of constant comparison, theoretical sampling, coding, and emergence, provides the researcher with a systematic process to achieve theory generation. At the same time, the methodology facilitates creativity, and flexibility, along with freedom to explore those discoveries without overriding, constricting theoretical assumptions. The aim of discovering a latent pattern of behaviour in a substantive area, conceptually explained in an emergent generated theory (Glaser, 1978, 1992; Glaser & Strauss, 1967), is linked to the maxim that "all is data" (Glaser, 1998, p. 8). Preconception is always inherent in information and may influence data collection, analysis, and method. Yet the principle of conceptualisation lifts the theory out of the unit of analysis, the individual, so that the researcher develops a generalised theory of group behaviours in a particular area. It is the theoretical explanation of the patterned behaviour that makes this methodological approach open to discovery, and facilitates emergence of a core process, which may be a basic social process.

Basic social process

The basic social process emerged from the Glaser and Strauss (1967) seminal work to explain a considerable portion of the action that participants use to resolve their main concern. Defined as "*processural* or process out, that is, they have two or more clear emergent stages" (Glaser, 1978, pp. 96-97), a basic social process is a type of core process which may be present in an emergent theory. While a core process will always be present, not all will elicit a basic social process. Glaser notes that actions are "labelled with a 'gerund'... to give a feeling of process, change and movement over time" (1978, p. 97). The gerund also helps direct the potential research question, which is 'what is the basic social process' that underlies the area of interest or main concern.

Two types of basic social processes can be identified in grounded theory: "a basic social psychological process and a basic social structure process" (Glaser, 1978, p. 102). The basic social psychological process (BSPP) indicates a social psychological process, which reflects a group patterned process such as, restoring. The basic social structure process (BSSP), on the other hand, refers to a wider social process reflecting "usually

growth or deterioration" (Glaser, 1978, p. 102), such as routinisation or centralisation and decentralisation. However, Glaser states a "BSSP may facilitate or be the social structure within which the BSPP processes" (Glaser, 1978, p. 102). Within contemporary grounded theory the BSSP is assumed, as the research tends to concentrate on the BSPP to discover behavioural patterns that do not need the social structure to understand it. Glaser reinforces basic social processes as a core process, as they are "pervasive since they are fundamental, patterned processes in the organisation of social behaviours which occurs over time and go on irrespective of the conditional variation of place" (Glaser, 1978, p. 100). Cutcliffe (2005) elaborates on a basic social process describing it as a core process that explains how participants resolve their key social-psychosocial problem. Identifying a core process is important, as not producing a basic social process, according to Glaser (1978), impacts the fit and workability of a theory and suggests that it is underdeveloped. To achieve a basic social process, the methodology is designed to structure how data is collected, analysed, and interpreted. Grounded theory has particular analytical tools that are important for developing a systematic, well-organised theory.

Methodology process and procedures

The hallmarks of grounded theory include constant comparative analysis, theoretical sampling, theoretical coding, and theoretical sensitivity (Glaser, 1978, 1992, 1998, 2005; Glaser & Strauss, 1967). Procedurally, these provide the logic and organisation for data collection and analysis, minimising researcher bias and preconception. The complexity of the methodology is reflected in its concurrent approach to data collection and analysis. The simultaneity principle is characteristic of grounded theory, which brings about an innate complexity in data analysis throughout the research process. The interdependence of data collection, coding, analysis, conceptualisation, and memoing in theoretical generation is not a strict linear process, although these will be examined in a linear manner here.

Constant comparative method

Constant comparative analysis is a central procedure to grounded theory. It is an ongoing process in which the researcher simultaneously collects and analyses data,

arranging it into codes and categories until a core process is identified. According to Glaser and Strauss, "comparative analysis is a general method" (1967, p. 21). Glaser further defines constant comparative analysis as:

> When the comparison is made between incident to incident, a category is generated (an index with meaning). To continually compare each incident to incidents and categories generates meaningful properties of categories... a far richer yield of concepts and relationships between them... A theory is generated (1978, p. 24).

Speculative hypotheses emerge from the comparison of data, identifying the main concern, codes, and categories. Once the core process is identified, further data comparisons take place in order to clarify and saturate it. Data not relevant to the core process are discarded. This systematic comparison of data enables the core resolution process to be discovered and verified.

The constant comparison method is underpinned by a concept-indicator model based on Lazarsfeld's *Interchangeability of Indicators Model* (Glaser, 1978, 1998; Glaser & Strauss, 1967). Conceptual specification becomes the focus. Comparative analysis enables the researcher to develop conceptual hypothetical statements about the relationship between concepts. Comparative analysis ensures similarities, differences, and degrees of consistency of meaning between incidents are confronted, thus generating an underlying uniformity to produce codes and categories with relevant properties. The concept-indicator model requires categories and the properties of the theory to earn their way into the theory through the systematic organisation of data. The method ensures the concepts that form the conceptualisations and theory emerge from the raw data and the analytical process. Highly regarded comparisons, that is, the connective relationships, increase the validity of the research process and findings (Boeije, 2002). Verification of the analysis and conclusions, using constant comparison, links the generated theory back to the real world participant data.

Data is usually collected through interviewing and observation. Interviewing in grounded theory has numerous factors to ensure relevant information is gained in the process and is congruent within the method. The question type, style, manner of asking and recording of the answers are methodologically based. Interviewing

according to Glaser (1978, 1998) should be undertaken using questions arising from the ongoing data analysis. The constant comparison method happens within the interview as the researcher compares data with emerging codes, concepts, and hypotheses, complementing analysis that has already occurred with previous data. Interestingly, Glaser (1998) details the type and extent of data that may result from questioning. Four data types are suggested. Baseline data is first and is the most accurate information. Properline data is second and refers to data whereby participants respond to the researcher, talking about issues they think the researcher wants to know. Third, interpreted data is where information is framed in a particular way to favour the professional view. The participants respond to the professional viewpoint, even though it may be against their normal interpretation of the information. Vaguing out is the final data type in which the participant does not wish to answer the question therefore responds in a very general manner. Understanding the differences in participant responses helps to improve grounded theory interviewing skills and data collection.

Theoretical sampling

Theoretical sampling is unique to grounded theory. It is sampling that follows the emerging concepts that are part of the theory (Glaser, 1978; Glaser & Strauss, 1967). All data collection is controlled by the emerging concepts, categories, codes, and properties as theory develops (Glaser, 1978). Theoretical sampling is "continuously tailored to fit the data and [is] applied judiciously at the right point and moment in the analysis... [the researcher] continually adjusts his control of data collection to ensure the data's relevance" (Glaser & Strauss, 1967, p. 48). Entering the field with an open mind supports theoretical sampling. Glaser notes that a researcher using "theoretical sampling cannot know in advance precisely what to sample for and where it will lead" (1978, p. 37). The process of data collection according to Glaser (1978) is controlled by the emerging theory. However, it is a joint process of analysis and coding, which are aligned with theoretical sampling in order to develop the theory.

The starting point of theoretical sampling, according to Glaser, is a context where "the initial sample is based on a general sociological perspective within the substantive

area" (1978, p. 37). The participants' interests are at the forefront as the researcher examines the understanding of people who experience the phenomenon. The initial participant group has to be big enough to note emerging patterns, but small enough to allow semi-directional interviewing to clarify emerging categories. Theoretical sampling is based on the inductive-deductive logic (Glaser, 1978). The aim is to induce concepts and categories from the gathered data through constant comparison. The emerging codes and properties then direct further data collection to theoretically develop the properties and hypothetical connections. Deduction in grounded theory is according to Glaser "used to derive from induced codes conceptual guides as to where to go next " (1978, p. 37). This also ensures the emerging codes and concepts have fit and relevance through testing them in the field with the participants. This continues until the core process explaining the main concern is clear. Ongoing sampling and interviewing of participants adds clarity and density to the core process and related properties only. When full theoretical saturation is reached, sampling stops.

Theoretical sampling suggests that participants have a dual role in the interview process. Underpinned by the inductive–deductive logic, participants provide information for constant comparison analysis, the inductive aspect. This *inceptive* role provides a large amount of data. This is where codes are generated and hypotheses developed. The new data gradually reduces as more participants are sampled, until new information is no longer offered. However, the deductive aspect elaborates on where next and with whom further data should be obtained. The second function for the participant in the interview is the *governing* role. This is where the induced codes and hypotheses are tested with participants through the clarification of emerging codes, subprocesses and core process. This governing role increases once the core category has emerged. Participants are theoretically sampled to saturate the core and related categories and properties that have fit and relevance to the main concern. Therefore, the inceptive phase is used primarily to collect data to add to the emerging codes, categories, and theory. The governing role aims to clarify those emerging codes, categories, and theory. This dual role in turn functions as a regulator for 'fit and relevance' to the emerging substantive theory and interviewing process. Figure 1 is a diagrammatic representation of my interpretation.

Figure 1. Participants' dual role in sampling

Initial /purposeful sampling group

Theoretical sampling group

A

Emergence

'Core Variable'

Verification

Theory

Concepts
Catergories
Codes

Constant Comparison Analysis

Clarification

Constant Comparison Analysis

Conceptualising

Conceptualising

Fit & Relevance

Information

Governing

CORE CATEGORY

&

MAIN CONCERN

IDENTIFIED SUBSTANTIATED

Information

Saturation Point

Sample

Clarification

Saturation

Sample size - 1

Inceptive

Governing

Sample

Participants role

Similar groups to Substantive Area

All participants can offer something owing to their experience and all can clarify meaning to codes / categories

Substantive Area

How solid / valid must the core category be before one can more into theoretical sampling? Do you weaken your emerging theory if you move to soon and do not have enough support from the data and conceptual rendering?

C

Theoretical sampling is testing 'concepts' associated with the core category in other similar groups.

How related to the initial substantive area / field of interest must they be for a Substantive Theory to be developed?

B

Inceptive

Participants Role in Sampling

Governing

Definitions:
Inceptive: - beginning, initial,indicates the beginning of action.

Governing: - to exercise restraint, to regulate or direct, decide or determine

2/05/2010

Coding – open, selective and theoretical

Grounded theory coding has two phases and types. An initial open coding is followed by a selective phase. Theoretical coding is the second type and usually emerges towards the end of the theory generation. The first phase of analysis following interview is to code the raw data. Seeking commonality among the data means possible relationships can be made under broad headings. These codes and later categories are flexible and open to change, and subject to further refinement as the analytic process advances. In initial open coding raw chunks of data are sorted for similarity. Thus the data is fractured (Glaser, 1978, 1998). This data-dependent substantive coding continues using constant comparisons until categories emerge. Fracturing the data forces any researcher-preconceived notions and ideas to be examined. Open coding according to Glaser, allows the analyst the full range of theoretical sensitivity to take a chance on generating codes that may have fit and work. Glaser's three coding questions are constantly used when analysing the data. These questions include, *What is this data a study of*? All data has relevance; however it may not be seen immediately by the researcher. If data is relevant to the participant, it has value within the theory. The second question is: *What category does this incident indicate*? Asking this question focuses the researcher on how data relates to other data and codes, and encourages inductive thinking. The third question is: *What is actually happening in the data*? This has a twofold purpose. One is to search for the main concern and the processing of it by participants. Second, the question encourages the researcher to focus on the patterns emerging amongst the incidences and encourages conceptual thinking. Glaser's intention is to focus the researcher on emerging patterns that yield codes, which will assist in conceptually rising above detailed description (Glaser, 1978, 1998, 2011).

The second phase of the coding process is selective coding. The core process has emerged, further data collection and analysis centre on saturating the core process and its relevant properties through delimiting data collection to these specific areas. By delimiting the core process the theory is refined to a parsimonious scope, as irrelevant data is discarded and only information relative to the emergent theory is gathered. Selective coding also provides an opportunity for gaps in the theory to be examined

allowing further collection or testing of concepts to be undertaken. Conceptualisation of the substantive codes which are integrated into a coherent theory is underpinned by the second aspect of grounded theory coding. Theoretical coding is an abstractive process which centres on the use of coding families to "weave the fractured data back together again" (Glaser, 1978, p. 72).

Glaser notes that often theoretical coding is confused with substantive coding, stating that "substantive codes are the categories and properties of the theory which emerge from [the] conceptual images [in] the substantive area" (2005, p. 11). In contrast, "theoretical codes conceptualise how the substantive codes of a research may relate to each other as hypotheses to be integrated into a theory. They, like the substantive codes, are emergent" (Glaser, 2005, p. 2). Theoretical codes are "abstract codes that allow the researcher to talk substantive categories and properties while thinking theoretically" (Glaser, 2005, p. 2). Glaser notes that theoretical codes from all fields and their perspectives along with staying open to them will enrich the grounded theory. It is important to study beyond one's own discipline or field to learn as many as possible. Theoretical coding is relevant during the sorting and write up of the theory. The appropriate code emerges as a framework with which to write up the hypothetical and integrative relationships of the substantive codes, concepts, and categories to the core process that resolves the main concern. Interestingly, suitable theoretical codes may emerge as the researcher develops theoretical sensitivity and engages in ongoing reading.

Theoretical sensitivity

A person enters a study with personal experience and knowledge of the area, but according to Glaser (Glaser, 1978), if the researcher does not have relevant theoretical sensitivity an insubstantial grounded theory may result. Theoretical sensitivity according to Glaser is "an ability to generate concepts from data and to relate them according to the normal models of social theories in general, and development in sociology, in particular" (1992, p. 27). Glaser (1978, 2005) further elaborates that many different fields contribute to theoretical sensitivity. The first step in acquiring theoretical sensitivity is to enter the research setting with as few pre-determinations as

possible, so that the researcher can conceptualise and formulate a theory as it emerges from the data (Glaser, 1978, 1998). Theoretical sensitivity is increased through the researcher being cognizant with literature, knowledge, and experience that deals with the kinds of variables and associated general ideas that can be used in the analytical process. This means the analyst reads widely in the substantive and related fields (Glaser, 1978). To achieve the "necessary theoretical sensitivity" (Glaser, 1978, p. 1), the researcher needs two essential characteristics. Firstly, he or she needs to have a personal and temperamental bent to maintain analytic distance, tolerate confusion and regression, while remaining open, trusting to preconscious processing and to conceptual emergence (Glaser, 1978, 1998; Glaser & Strauss, 1967). Secondly, the researcher must have the ability to develop theoretical insight into the area of research, combined with the ability to make something of the insight. In general, the researcher needs the ability to conceptualise and organise, make abstract connections, visualise, and think multivariately (Glaser, 1978, 1998), especially while using the constant comparison method. Age and experience do not necessarily equate to theoretical sensitivity, as it is an ongoing activity which develops over the years through being open to multiple viewpoints, reading and going outside one's comfort zones.

When a professional framework or theoretical construct is assumed by a researcher, as a theoretical perspective, this does not use theoretical sensitivity appropriately, as this is likely to create emergent implications. However, when the framework is perceived as potential data, openness is increased. Researcher involvement and preconception arguably arise from experience and knowledge that comes from working in the field of interest. The maxim of remaining open and avoiding predetermination according to Glaser is "the first step in grounded theory [that] is to enter the substantive field for research without knowing the problem" (1998, p. 122). Thus, suspending experience, including knowledge of the professionally related literature minimises the received aspects of the topic. To stop the researcher coming into the field with a professionally specific question, Glaser suggests that by laying aside previous knowledge, the emergence of the participant issues and resolution is supported. This improves the conceptual ability to see beyond current professional-based thinking, and limits non-participant related problems that might be forced onto the data process. However, it must be acknowledged that experience and knowledge

can assist with theoretical sensitivity. Thus conceptualisation needs to be seen in such a light.

Generating a substantive grounded theory

The grounded theory analysis process is determining the essential relationships between data and emerging theory. A conceptual code abstracted from raw data moves it from the concrete description to the abstracted, contextually free conceptualised name. Theory generation is developing hypothetical relationships between conceptual codes until one core process consistently relates to all other processes. It requires induction and deduction. The inductive phase is the researcher's coding and conceptualising from the participant data. The deductive aspect is the testing of the inducted concepts through theoretical sampling. Glaser (1978) suggests that the inductive-deductive approach is a complex thinking process. Carefully grounded inductions such as naming concepts, properties, or categories are verified through deductive sampling. This process promotes improved data sources for further induction. The inductive-deductive process delimits the study to finding the core process to resolve the main concern and is underpinned by the principle of parsimony.

Choosing the simplest explanation of a phenomenon is the one that requires the fewest leaps of logic. Parsimony has a preference for the least complex explanation for an observation (Honderich, 1995), as does the emerging concept explaining the hidden pattern of behaviour, which resolves the participants' main concern. The resolution process comes from the data. Therefore, let the data speak for itself. The theory then, has fit, relevance, and works for the people, and can be modified when new data are applied.

Conceptualisation

Conceptualisation is a core premise of grounded theory (Glaser, 2001). The generation of emergent conceptualisations into integrated patterns, denoted by categories and their properties, are woven together in the theory. Conceptualisation has two primary properties. First is that concepts are absent of time, place, and people

properties, and second, concepts have enduring grab (Glaser, 1978, 1998, 2001). This conceptualised approach to naming patterns emerging during data analysis has "imageric meaning" (Glaser, 2001, p. 10). Arising in a named pattern, imageric words have grab, capture and fit the conceptual image. Concepts describe something significant at a different level of thinking. To enhance conceptualisation during a grounded theory study, a researcher needs to be cognizant of three facets that assist with conceptualising. The first is theoretical sensitivity; second, theoretical coding families; and third, is theoretical sampling.

As already noted, Glaser has argued frequently that conceptualisation is compromised when theoretical or professional frameworks are overlaid on the grounded theory process (1978, 1992, 1998, 2001, 2003, 2005, 2011). This impacts conceptualisation at an abstractive level and keeps analysis at a descriptive level. While suitable for some research purposes, it is not congruent with the classical grounded theory approach. In conceptual description a concept is described continuously rather than constantly compared. When incident to incident comparison is not based on the interchangeability of indices and conceptual saturation, its conceptual properties are not forthcoming, but detailed descriptively. Glaser (1992, 2001) refers to this process as qualitative descriptive analysis (QDA). Glaser states that conceptualisation is only achieved through rigorous adherence to the classical approach. That is to analyse line by line, carefully comparing incident to incident, then concept to concept, and constant theoretical sampling, which ensures that the theory is conceptual. A significant and valuable process to assist with conceptualising is memoing. This captures the thinking that accompanies analysis.

Memo writing

Memoing is a central tool in the grounded theory process (Glaser, 1978, 1998). Memo writing is the articulation of a systematic and extensive writing process concerning the theoretical development of the data and the conceptual connections between categories (Glaser, 1978, 1998; Glaser & Strauss, 1967). Memoing helps the researcher achieve a conceptualisation that rises above description of the data and develops defining properties of categories. Working in conjunction with constant

comparative analysis, memoing adds to the coding and theoretical emergence of concepts. Memoing according to Glaser should be a continuous activity, simultaneously occurring whether the researcher is actively analysing or pre-consciously reflecting, thus ensuring theoretical developments are captured.

Writing memos enables the researcher to keep a "memory fund" (Glaser, 1978, p. 86) of developing ideas and thoughts during analysis. The tracking of ideas captures the moments of insight and clarity through the multiple phases of the research. In addition, the researcher must interrupt analytic activity to label the thoughts and insights arising from being immersed in the data. Ideas need to be identified immediately when they arise simultaneously with coding, demonstrating potential connections and relationships. As analysis continues, memos display the emerging relationships, substantive and theoretical codes and the shift from the concrete coding to the theoretical abstraction of ideas. Memo maturity ensures appropriateness of concepts and properties when reviewed for saturation and delimiting of their relationships to the core resolution process. The relevance of the core process for the main concern is conceptualised and assured (Glaser, 1998) and confirmed repeatedly in the memoing process. Sorting of memos is followed by the writing up of the theory. This is the "epitome of the theory generation process" (Glaser, 1998, p. 187). Sorting the conceptual build up of the theory from the continual memo writing, prepares the researcher for the write up. The sorting demonstrates the progress through the theory generation, how it emerged and was saturated to ensure fit, relevance and workability.

Lastly, Glaser (Glaser, 1998) warns against using technology to support memoing. He believes that using prescribed technological programmes could inhibit the ability of the researcher to freely capture thoughts and ideas. Using hand written notes captures the immediacy of the thinking, whereas a computer programme has the potential to stifle creativity. Scribbles, quick jottings, and simple words can reveal more to the researcher than the computerised programme, which may require a specific format to be followed. Formats may limit the freedom to pursue emergent ideas. Free thinking is the ultimate aim of memoing. Anything that stifles that creativity can inhibit the abstraction of ideas and reduce full conceptualisation to description thus impacting the credibility of the theory.

Credibility and rigour

Credibility and rigour will be discussed in Chapter Four. However, the principles ensuring trustworthiness of the theory are mentioned here. Glaser and Strauss (1967) point out two potential issues in conveying credibility of a grounded theory study. First, is getting the reader to understand the theoretical framework, and second, is how to describe the data studied so vividly that the reader can 'see and hear' the participants, in relation to the theory. In the seminal work, Glaser and Strauss note that "grounded theory has been developed in order to facilitate its application in daily situations… requires developing a theory with (at least) four highly interrelated properties" (1967, p. 237). The properties include, (a) theory must fit closely with the substantive area, (b) it must be understandable by all levels, (c) it must be general enough to be applicable to diverse situations within the substantive area, and (d) it must allow the user partial control over the structure and process of situations as they change through time. Glaser (1978) notes that fit, relevance, and workability are essential elements for credibility. He elaborates that a fourth criteria, modifiability is also relevant for credibility.

The fit relates to the everyday activities within the substantive area, induced from the data that supports the theory without the influence of preconception, overt and covert, that may end up forcing the theory. The fit and workability concepts of classical grounded theory are important to get at what is going on in the processes of the substantive area. A theory must apply to the situation and work when put to use. Fit is determined by the categories being readily applicable to and indicated by the data. Workability is determined by the meaningfulness and relevance to the explanation of the behaviour under study. Relevance is the applicability to the situation and participants. If the theory can withstand modification and reformulation, it is grounded and intimately linked to the data. It is minimally interpreted, not preconceived or forced, just inductively emerged from the data (Glaser, 1978, 1998; Glaser & Strauss, 1967). If the four criteria are met, credibility and rigour are established.

Positioning the research in Glaserian grounded theory

The decision to use classical grounded theory as a research method has been an interesting journey. I studied the method in the professional doctorate that provided opportunities to explore different research methodologies, to find one that suited both the topic, and supported my personal strengths. Following an initial examination of grounded theory, many useful discussions with my supervisor, and a sideways exploration of mixed methods, I finally selected Glaserian grounded theory as the most relevant method for the topic and my persona. Glaserian grounded theory has structure as well as flexibility and creativity. It balanced my need for process and challenged me to step outside of my professional understandings. Well versed in quantitative epistemology from a professional domain, the prospect of uncovering something unknown was intriguing.

Reading, talking, and exploring grounded theory cemented my choice of the method. Reading about alternative types of grounded theory was interesting. Strauss and Corbin appeared complicated and restrictive and seemed less creative. Charmaz's constructivist approach, plus Schatzman's dimensional analysis did not appeal to me. The elements of preconception and the need to follow the underpinning assumptions resulting in descriptive outcomes seemed limiting. Wide reading, alongside discussions with my supervisors developed further my understanding of the classical approach. Attending two grounded theory workshops at Mill Valley in 2011 and 2012, run by Dr Barney Glaser, augmented my learning, as I engaged with the co-originator of the methodology, the Fellows of the Grounded Theory Institute, and other international students using grounded theory.

Summary

Examining the potential philosophical foundation that underpins classical grounded theory has demonstrated relationship complexity related to epistemology, theoretical perspective, and methodology. A number of arguments have been reviewed to locate classical grounded theory epistemologically. However, classical grounded theory's inherent assumptions are its participant-centred perspective throughout the research

process. This assumes no predetermination, only the interaction of participant and their world. Epistemologically, grounded theory is intentionally atheoretical and does not answer to others' ways of knowing. Yet, Peirce's pragmatist philosophy offers an epistemological base for classical grounded theory. Peirce perceived that real things are independent of our opinions of them, and through the advantage of perception we can ascertain by reasoning, how things are. Classical grounded theory is about what is real for the participants, which could be discovered through analysis of their data. The practical application of a hidden pattern of behaviour to self-identified problem resolution aligns with Peirce's pragmatic reality. Epistemologically, Peircean pragmatism could underpin grounded theory, as the capacity to remain open ensures the participant remains central to the theory emergence not an overarching framework. Application of the grounded theory methodological principles relative to this study is discussed in the next chapter.

Chapter Four

Applying process: Doing grounded theory

Introduction

The doing of the study relates to how the research process unfolded, what worked
and the challenges that arose while discovering the core process and generating the
theory. This chapter examines applying grounded theory in practice and presents
process development and understanding of the theory's generation. The initial
beginnings outline a brief overview of the academic requirements to undertake the
study and the ethical issues that were considered in order to access the participants.
This section also presents starting the process of collecting and analysing data, and
highlights the issues that arose in the initial stages. The next section, moving forward,
demonstrates increasing confidence in applying the method. At the same time, the
confusion and complexity of coding, analysis, and conceptualisation had reached a
point where the main concern and a potential core process were identifiable.
Strengthening the core process details the theoretical sampling and further clarifies the
generation of the theory. Rigour and process problems are discussed accordingly. The
following diagrammatic overview of the method processes demonstrates doing
classical grounded theory within this study (Figure 2). Developing a diagram has a
threefold purpose for understanding the method (Artinian, Giske, & Cone, 2009).
First, it helps illustrate the process over time. Second, a diagram provides structure for
organising the process, and third, it visually presents my understanding of the process,
to the reader.

Figure 2. Applying the grounded theory method
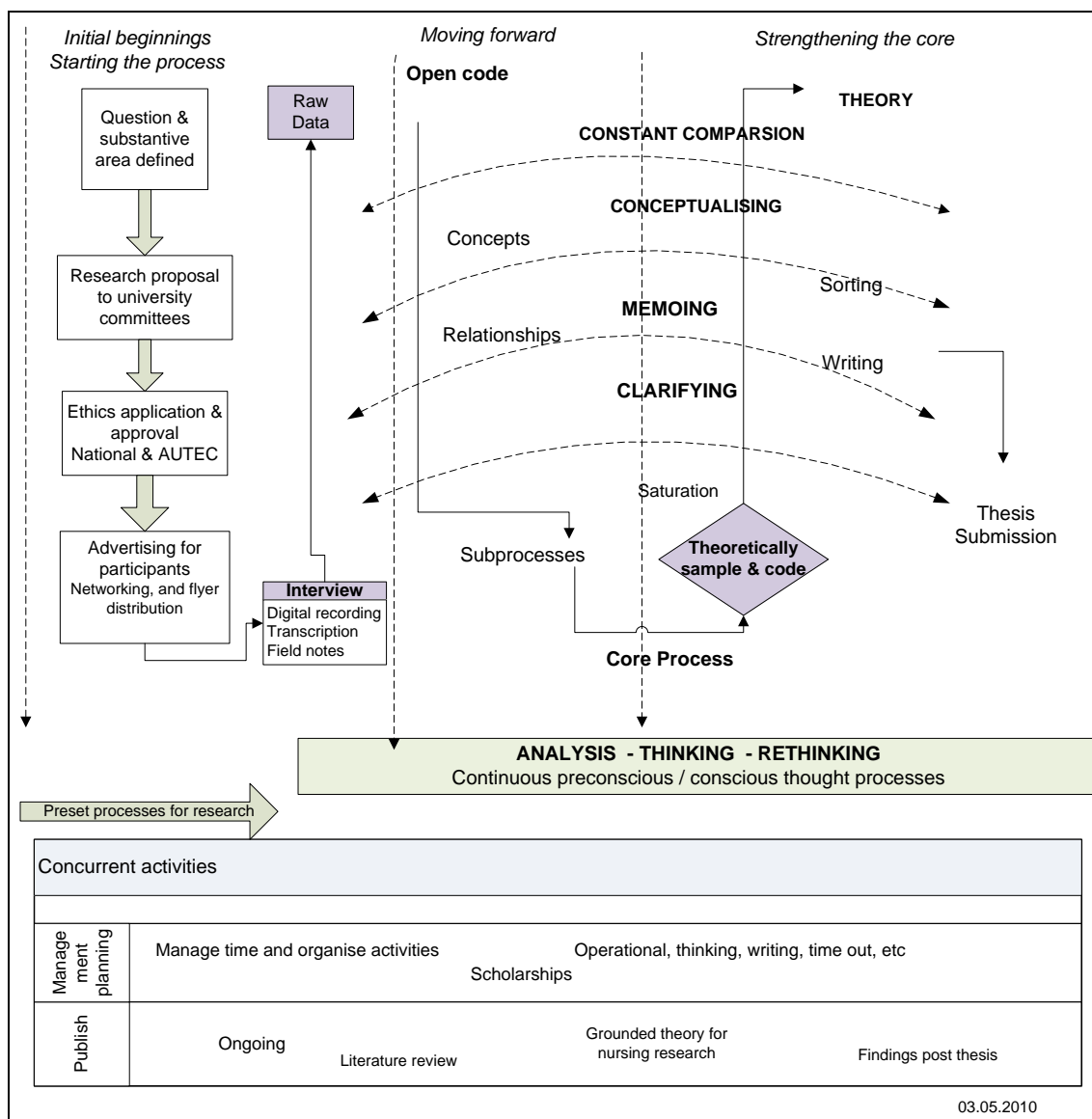
The initial beginnings

In this study, particular attention was given to informed consent, privacy, anonymity, and confidentiality especially as I was working with older adult participants, who are considered vulnerable. Obtaining ethical approval to conduct research on potentially vulnerable participants in New Zealand is tightly governed by legislative and regulatory processes (McCallin, 2010). To meet the strict criteria, how I advertised for participants and gained their consent to participate in my research had

to meet socio-cultural regulations and standards. Therefore, all consenting procedures, managing potential risk and vulnerability, how privacy, confidentiality and anonymity would be managed, had to be detailed. I was also responsible for ensuring that participant safety was managed in a way that met methodological relevancy and academic propriety.

DePoy and Gitlin (2005, 2011) suggest the involvement of vulnerable people in research has twofold aspects. First, excluding vulnerable people who are at risk related to their health condition, intellectual competence, comprehension, psychosocial stressor, or setting, may restrict information gathering, thus compromising generalisability of the research through underrepresentation of that group. This impacts knowledge development. Hence, these elements were considered as part of the inclusion and exclusion criteria for this study. The second aspect is the potential for coercion, when trying to include people who may be considered to be vulnerable, in a study. The research information, how it is written and given (verbally and / or in writing) must support the relevant decision making abilities of the participant. Again, this was reflected in the inclusion and exclusion criteria. Vulnerable participants are often highlighted in the ethical submission and are subjected to particular scrutiny from the approving ethics committees.

Ethical approval for this study was sought from the Northern Regional Ethics Committee, along with the University's Ethics Committee[10] (AUTEC) (Appendices 1 & 2). Institutional Ethics Committees, such as AUTEC are accredited by the Health Research Council of New Zealand. The following documents were submitted and approved: a participant information sheet, detailing the purpose of the research and the type and level of involvement required (Appendix 3); the consent form (Appendix 4); support group contacts in case issues arose during interview and follow up was required (Appendix 5). A supervising cultural advisor was obtained to oversee that the principles of the Treaty of Waitangi[11] were maintained to ensure cultural relevance throughout the research project.

---

[10] AUT University grants approval to the primary supervisor of the study, not to the student.

[11] Further information on the Treaty of Waitangi can be found at www.treatyofwaitangi.govt.nz

Research ethics within the New Zealand socio-cultural context aim to protect participants and are guided through the Health Research Council of New Zealand [HRC], (2005). This is critical because historically, health research activities denied informed consent, which resulted in detrimental health outcomes for a number of participants[12]. Protection of research participants also includes consideration of the Treaty of Waitangi (1840) that cements the relationship between the indigenous people (Maori) and the crown. Three key concepts of this Treaty are partnership, participation and protection that are sanctified in law and are enculturated into all social and political life within New Zealand. This includes health related research activity (Ministry of Health, 2006). The sanctification of the Treaty of Waitangi principles and protection of participants in health research ensures participants' rights are respected and supported through the ethics submission and ongoing study. Ethics committees have the legal obligation to ensure that participant rights are protected, potential harm is minimised, and that ethical principles are integrated into the study design (Ministry of Health, 2006).

Managing informed and voluntary consent is a key principle in gaining ethical approval. DePoy and Gitlin (2005, 2011), for example, define informed consent as the process in which participants are approached, informed and recruited, through the use of written information detailing the purpose and scope of the study. As the researcher, I was responsible for producing recruitment notices, information sheets, and a consent form based on the principles underpinning informed and voluntary consent. Interestingly, Glaser (1998) argues against using consent forms, as they have the potential for participants to properline information. However, research activity cannot take place in New Zealand without appropriately informed consent. Glaser recognises the pragmatic reality of ethical requirements and advises students to "just do it! Get the [grounded theory] experience, do not fight windmills..." (1998, p. 19).

To meet legal and socio-cultural facets, I made sure participant protection and respect for their rights met both Ethics Committee's approval standards. Through this process the rights to privacy and confidentiality are outlined along with how specific

---

[12] The Cartwright (1998) Report of the cervical cancer inquiry outlines the unfortunate experiments carried out on women without their consent. The Health & Disability Commissioner Act (1994) The Privacy Act (1993) and Health Information Privacy Code (1994), and Code of Consumer Rights (1996) all resulted from this original inquiry. McCallin (2010) has succinctly outlined the historical events and resultant actions.

social or cultural sensitivities would be managed. Privacy factors are protected under law in New Zealand ("Health Information Privacy Code," 1994; "Health Information Privacy Code," 2008; "Privacy Act," 1993). Therefore, as the researcher, I ensured that all information obtained throughout the study was used for the purpose of its collection and for the protection of the participants. At the same time, methodological design determines the level of identification of participants. However, as this was a grounded theory study, participant-specific information is minimised through conceptualisation, which removes individual identification and increases anonymity. Participant quotes are managed through non-specific identifiers and therefore maintain confidentiality.

The confidentiality aspect supported the ethical and privacy elements through the study's information management. To maintain security of information during the research, all participant consent forms were locked in a secure office. Participants were given copies of consent forms when requested, and a note made if a follow up report at the completion of the research process was requested. All computer data were password protected. Participant information, to preserve anonymity, such as individual interviews, was coded to number and year, for example, (#3/2009). Any quotes used within the study follow this coding method. Participant identity could not be linked directly to data other than through me or my primary supervisor. A further aspect of confidentiality management during research was how and where I contacted and interviewed participants. Where possible, all interviews were conducted in a participant selected area that was chosen to limit others overhearing the conversation. .

Methodological design is part of the ethics submission, which is also reviewed for potential harm, risk or potential for poor outcomes for participants (McCallin, 2010). The minimisation of risk to participants through the recruitment and data collection management also recognises the need for research honesty. The potential risks to the research itself arise from deception, lack of truthfulness, research adequacy, conflicts of interest, and respect for intellectual property. DePoy and Gitlin (2005, 2011) note three specific ethical considerations in a study. These include the rights of the participants, which have been discussed previously, the conduct of the researcher, and the question and design of the study. It may be considered that the ethical framework for participant protection also engineers the process through which the information

will be analysed, interpreted, and presented. Therefore, staying true to the grounded theory principles and design ensured the participant information would be appropriately managed ethically and methodologically.

Interestingly, academic honesty accompanies the ethical process with reference to misconduct by the researcher. The use of information gained from the participant is governed relative to socio-cultural standards. Moreover, methodological management of the information, along with academic presentation, is included in the ethical principles relative to research activity. New Zealand universities have governing rules and regulations regarding deception, truthfulness, conflicts of interest, and plagiarism when undertaking an academic study. Management of these aspects occurs through the rigorous application of the university's handbooks, guidelines, and relevant referencing style.

The participants

This study was undertaken in a large metropolitan city in the North Island of New Zealand. National databases such as the Accident Compensation Corporation and the Ministry of Health indicate a large proportion of people are discharged back to community settings, following hip fracture. However, this group has significant levels of diversity relative to age, cognitive ability, residence type, and time since injury (Accident Compensation Corporation, 2005; Ministry of Health, 2004, 2011). The inclusion criteria were that participants needed to be 65 years or over, as this was the recognised national classification of an older adult (Accident Compensation Corporation, 2005); had a history of hip fracture; were living in the community; and were willing and able to tell their story about recovery. The minimum time a post injury interview could be conducted was set at three months or over. Usually older adults have returned to the community then.

A decision was made not to include participants who were still in an acute care or a short term rehabilitation hospital. DePoy and Gitlin (2005, 2011) suggest that vulnerable people may feel coerced into participating in a research activity owing to the acute care environment and their perception that not contributing may impact care. Also, the rationale included consideration of the potential for participants to properline

while still in care[13]. Glaser (1998) suggests properlining occurs when participants tell the researcher what they think he or she needs to know rather than talking about what is actually happening. Other exclusion criteria included individuals with cognitive issues. A significant portion of older adults with hip fracture live in institutionalised care and have age related cognitive decline. In many instances this is a contributing factor to the injury (Accident Compensation Corporation, 2005). Their experience of the recovery process and concerns therefore, were likely limited. The story of their recovery would be dependent on proxy views from their families and caregivers. To include this group in the study may have impacted the principle of participant-centred grounded theory. Therefore they were excluded.

The sample group was a total of sixteen participants with twenty-one interviews completed. Participants were sourced using formal and informal networks. All participants were interviewed at a day, time, and location of their choice. Several were interviewed a second time as part of the theoretical sampling process, once the basic social process was identified. Co-existing health conditions and supports were fairly evenly spread with little significant bias. The age range demonstrates an older population with the majority living in the community. This presented a challenge in recruiting participants. Details about the sample group are presented in the following Figure 3.

---

[13] This decision was based on my experience and knowledge in clinical practice

Figure 3. Sample group of participants' recovering from hip fracture
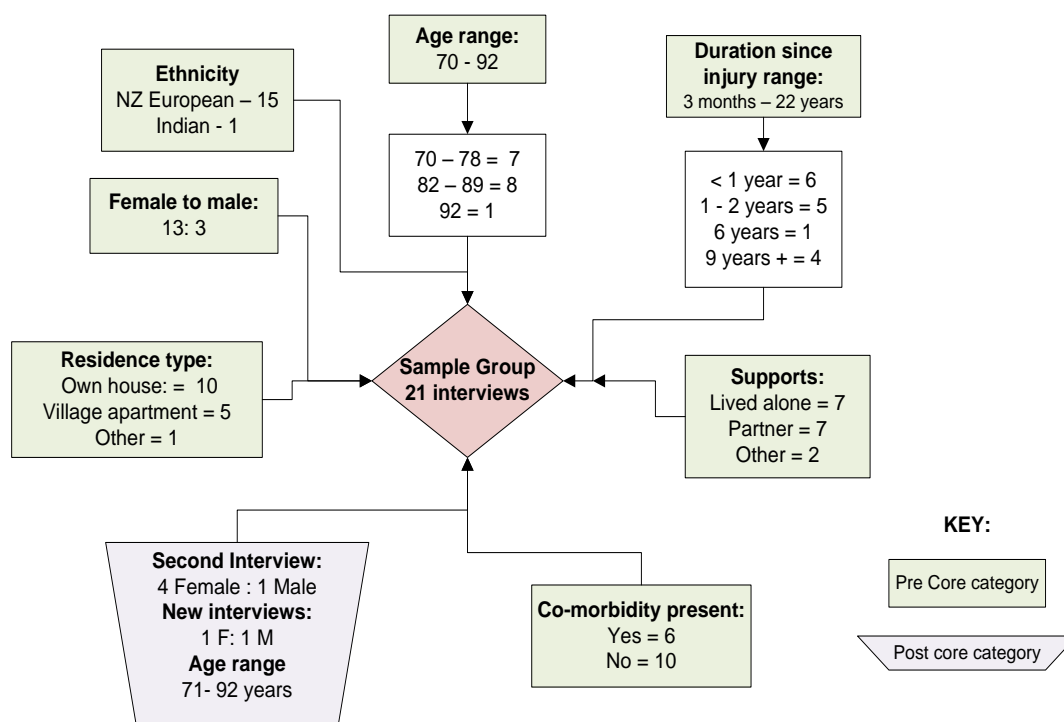
An important factor in grounded theory is to ensure an appropriate number of participants are sampled to identify the main concern and how it is resolved. Glaser discusses the issue of going outside the substantive area before the core process has been stabilised as a potential to undermine the "emerging theoretical framework" (1978, p. 50). To determine that the relevant number of participants has been reached and a stable core process achieved cannot be predetermined. Making assumptions that participants within the substantive area would be available for sampling undermined the process of accessing them. Operational issues will be discussed later; however reaching the core process through theoretical identification was possible with a smaller than anticipated sample group. Moreover, during open coding, the main concern and relevant processes emerged quickly even with a small initial group of participants. Verification, correcting and saturation of the concepts continued with ongoing initial sampling until the core process was stabilised. Staying within the confines of the substantive area ensured relevance, fit and workability (Glaser, 1978).

Delimiting of the data to one core process occurred prior to selective sampling. However, more than one core process may be present in the data (Glaser, 1978). Selecting which relevant core process had to be based on the data analysis and the theorising at the time. Even within this small sample group, an obvious core process was identified and followed through to selective sampling. But, in later analyses, after deeper thought and some supervisory challenging, the initial core process selection was determined to have a limited fit, which is discussed later in the chapter. The decision that the initial core process was not appropriate was finally demonstrated in the first write up. The telling of the story of how participants resolved their main concern did not fit with the initial core process. This illustrated the length of time a particular version of the theory dominated my theoretical thinking. In hindsight, a few more participant interviews may have minimised this presumptive core process selection.

Starting the process

An initial sample group had been identified along with a broad question with which to start the first data collection and analysis. The original intention to recruit using a number of channels, such as flyers in general practitioner surgeries, hospital outpatient clinics, and word of mouth met with varying levels of success. The general practitioner surgeries and outpatient clinics had very limited support from their parent organisations. They either required their own in-house research application process or each placement was to be contacted individually. For the latter, this meant multiple contacts of over one hundred plus practices all over the city. An alternative approach to advertise for participants using the parent organisation in-house electronic network system also met with little success. Eventually, informal networking through professional and personal contacts enlisted two participants. At the same time, visiting retirement village complexes and posting flyers in their common rooms or health clinics increased initial participant numbers. A further four were recruited for the study.

Open coding and memoing commenced from interview one (Appendix 7). Initial codes were plentiful and came fast during analysis of the first six interviews. Examples

of codes within the interviews included: chronic conditions, activity, restrictions, loss, support, positive attitude, expectations, and sameness. Initial categories were developed, for example, pacing, overcoming, and normalising. These terms were conceptually represented in the data text and seemed to have meaning in relation to the emerging processes. Tentative relational hypotheses were developing. For example, attitude is influenced by a person's life history; attitude is a mindset; the perception of losing control of activities impacts recovery progress; perceived loss of control is determined by life history; and the sanctity of independence is influenced by perceived loss of control.

However, it soon became evident that coding was biased towards mobilisation and functionality, all professional interests. Returning to the interviews a number of times, it was obvious that the general talk within the interviews had been overlooked. Initially, this data had seemed insignificant when I was preoccupied with mobility, which is important from a professional view point. Interestingly, words and phrases that were relevant to the participants, such as, family values, social history, or current life, had been ignored in the beginning, owing to my professional interest. After many weeks of thinking, I re-immersed myself back into the data and began to look at the information with an increasing openness. I gradually recognised my tendency to force data towards a professional direction. Supported by ongoing conversations with supervisors and continued reading of methods books made the preconception more noticeable. After many months of continued re-immersion in the data, remaining open to what was happening in the information, minimisation of professional bias occurred. Slowly, my preconceived ideas of hip fracture recovery faded.

On reflection, these first few interviews contained the basis of the core process and the theory, even though it was not obvious to me at the time. Each interview analysis and memoing followed Glaser's (1978) three question format relating to what the data was about, incident or concept relationships, and what was happening in the data. At the conclusion of the interview, my general thoughts about what had happened within the interview were noted. Field notes taken during the interview and my thoughts were combined to produce codes and memos. Key words and codes were handwritten on post-it notes and pinned to a cork board. These were continuously moved around. Along with the corkboard, thinking and analysis were presented as flowchart diagrams

to capture the analysis at that point in time. This helped to illuminate the potential main concern of the participants, subprocesses and their properties, and a core resolution process. An early example is Appendix 6. Notebooks were utilised as well to illustrate my theoretical thinking, methodological understanding, and reflections on reading. These approaches produced open codes, potential gerund processes, and a main concern from the first six participant interviews (Appendix 7). These techniques were used throughout the study.

At the completion of the six interviews, a problem recruiting further participants was encountered. There was no further response to the informal and formal networking that had been initially established. Continued access to retirement village complexes through a phone call or visit recruited two more people. Contact was made with local newspapers and older people's organisations. Advertising was possible however costs were prohibitive. The Aged Concern Organisation did publish a small advertisement through their regional newsletter, which had one or two responses. However, these calls were more to gain information for the caller, or related to elective hip replacement surgery, not recovery from a fractured hip. Another avenue of recruitment was required.

In order to manage the problems of recruitment, approval was gained from the Northern Regional Ethics Committee to change the participant recruiting conditions to include access to local hospitals (Appendix 8). A follow up letter was sent to the local hospitals to seek their approval as well (Appendix 9). Of the three hospitals contacted only one gave approval to recruit. Recruiting occurred in collaboration with the Charge Nurses of older adult units. They acted as an intermediary and identified suitable participants to be contacted. I then approached potential participants, described the research, and left an information sheet with the person. If they had agreed to participate, I followed up at three months with a phone call to confirm if they were still willing to participate in the study. All affirmative responses resulted in a day and time for interview. This new process recruited a further eight participants.

The first six interviews were taped and transcribed. The remaining 15 interviews were taped only. Field notes and memos of these later interviews were written. Being able to return to recorded data, not only provided security, it also improved my ability to code and conceptualise for theoretical development. Nevertheless, interviewing

participants for a grounded theory study is a learnt skill and required patience and ability. Grounded theory interviews consist of numerous factors to ensure relevant and useful information is gained in the process and is congruent with the method. Underpinning each question is the search for behavioural patterns that resolved the groups' main concern. Therefore, questions are required for information gathering and clarification based on the researcher's emerging conceptualisations. A skilled interviewer and researcher can interview and constantly compare these potential emerging factors within the interview. This was an ongoing development for me. In the initial interviews, everything appeared to have some relevance but this was dependent on what and how the questions had been asked by me. However, returning to the taped interviews not only provided more relevant data, continued analysis and conceptual terms, it also helped to improve my interviewing style relevant to grounded theory.

Interestingly, Glaser (Glaser, 1978, 1998) argues that only field notes should be taken during and immediately post interview as other methods of recording may detract and limit information shared by the participants. Glaser (1998) suggests taping and transcribing verbatim interviews has a potentially detrimental effect on the interviewing process, therefore should be avoided. Taping and consequent transcription slow or forestall theoretical sampling. A transcription of tapes delays the time taken to analyse the data and slows the sampling processes. It is at odds with the tempo of grounded theory that is about immediacy of coding and constant comparison. However, there needs to be a reliance on good, strong field notes. Despite Glaser's advice on taping and transcribing, and as I was an emerging grounded theory researcher, I preferred to tape interviews as a backup resource. In this study, taping acted as a security measure, by providing the ability to re-immerse myself in the interview at later stages of theoretical generation and to improve my confidence in interpretation.

Despite intense analysis, I was unsure about the main concern. A number of concerns were reviewed for commonality and tentatively named. Initial examples included: finding a way; changing gear; or marshalling resources. Open coding continued to produce additional terms although in retrospect, I found I had a tendency to focus on activity, attitude, self as a person, supports, and chronic conditions, all

professional interests. Interestingly, the supports older adults used during recovery illustrated a degree of connections that seemed to be relevant. Connections were developing into a taxonomy that suggested older adults gave different degrees of priority and involvement to people, things, and places. Moreover, three initial subprocesses, pacing, overcoming and normalising, had remained relevant through the six interviews.

Moving forward

The next eight interviews progressed with a more solid understanding of grounded theory. The main concern emerged reasonably early during these eight interviews. The main concern of the participants was getting back to normal that was conceptualised as normalisation. Data analysis suggested getting back to 'something' was a significant issue for the participants. Getting back to normal [normalisation] whether physical, social, emotional, family, occupation or health was evident in these and previous interviews. Moreover, these were often expressed by participants relating to activity, social, environmental or personal factors. The main concern was saturated and stabilised at the completion of the fourteen interviews. Appendix 10 is a sample of the main concern from interviews and Appendix 11, a sample of main concern memo. Before final confirmation of normalisation as the relevant label, a number of terms were considered. Figure 4 demonstrates the conceptual development of the term, normalisation from the data.

Figure 4. Main concern emergence
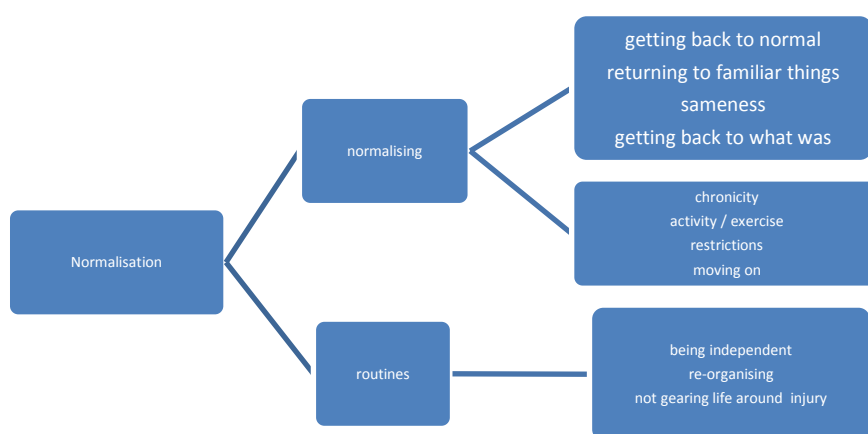
In the moving on period, codes and concept labelling changed continuously as new data was verified, corrected, as processes and their properties were saturated. During the coding process incidents within the data are abstracted into conceptual codes and indicate the relationships between them, along with the hypothetical integration for generation of a theory. The term indicator is not well defined within grounded theory methodology and often is misinterpreted or applied according to researcher understanding. A set of descriptive incidents form a concept that indicate an underlying pattern within them. An indicator is viewed as the link between data and concept (Glaser, 1978, 1992, 1998; Glaser & Strauss, 1967). Holton (2007, 2008) discusses indicators as a set within a concept and the relationships between the conceptual levels. Moreover, Holton (2008) links the indicator to incident in a defining manner. Therefore, it is important to define how indicators are used within this research. Indicators are the links between the raw data incidents and the emerging conceptual codes and categories / processes. Hence, indicators can be viewed at a multiple level throughout the coding processes. For the purposes of this research, process is defined as the core resolution method used by participants to manage their main concern. Subprocess is the next level down, a lower level conceptual code that supports or underpins the core process. Supporting each subprocess is another lower level concept which in turn is underpinned by properties indicating the relationship with the raw data or incidents.

Defining terms for the theory

Term	Definition
Process	This is the core category or variable used by the participants to resolve their main concern
Subprocess	This is a lower level abstraction of the process that inform or support the core
Concept	This is a lower conceptual term that captures the imageric intent of the properties that constitute the term
Property	This is the terms that relates / captures the link between the raw data and the conceptualisation

The subprocesses, pacing and overcoming remained consistent with additional data supporting them. The third process shifted as the early title of normalising had now become the main concern. At the same time, continued interviews and analysis focused

on explaining how the theory might come together I continually tested tentative names in an attempt to identify the core process. For example, was it resolving normalisation? This seemed to be a pattern of behaviour that encompassed phasing, perhaps multiform compensating, or self-organising, or re-engaging with routines. In addition, the subprocesses supporting the core process appeared to have potential stages or levels, which were attractive. Pacing as a subprocess was concerned with restriction, whereas, connecting as the second subprocess was aligned with relationships, and finally, controlling was about dealing with participation. Previous terms such as overcoming, spacing, or balancing were eventually subsumed into new subprocesses. Continued memoing helped develop my thinking about the subprocesses and a potential core process (Appendix 12).

I was still in a state of conscious processing, needing to talk to others. I was learning though to trust my own preconscious processing that accompanies analysis. Moments of insight occurred as reading, data analysis, and conversations introduced ideas that I explored and developed further. This occurred more in the later interview collections and analyses. Data collection, analysis, coding, and conceptualisation had been enhanced during these eight interviews. Glaser (1978, 1998) details the rationales and stages of grounded theory, however does not elaborate on the doing of the study that enables a new grounded theory researcher to competently manage the intricacies of the method. Reliance on supervisor feedback, reading and secondary sources improved my understanding along with doing the actual research activities. Working with new concepts and principles of the grounded theory method often led to difficulties with process or misinterpretation. Reading alternative versions of the theory occasionally helped my understanding. For example, reading Strauss and Corbin's (1998) writings on coding and memoing gave insight into the classical approach, or Boeije's (2002) article on constant comparison enhanced understanding. Cognizant of Glaser not recommending computer based programmes to assist coding and conceptualisation, flowcharting was an ideal tool for learning and reflection for me. My understanding of theory generation following interviews and conceptualising was assisted through flowcharting and diagramming. However, this was only used to support memoing along with developing thinking and ideas arising from the analysis and reading.

In the end, the main concern and a resolution process were identified after fourteen (14) interviews. A core process of negotiated positioning was tentatively present but needed more development to ensure theoretical saturation. At this point, there was an opportunity to attend a Grounded Theory Workshop in the United States in 2011. Presenting work in progress offered challenges and rewards. Appendix 13 was the work in progress presented. Feedback about the theory in progress was offered and stimulated further reflection.

Strengthening the core process

Post workshop analytical activities included, going back to the data, memos, notes and flowcharts. It became necessary to re-analyse and review the developing theory. At that point, the core process had been labelled as renormalising, as it linked with normalisation and had arisen in workshop feedback. Similarly, the subprocesses were renamed as moving, reclaiming, and reconciling. Relevant properties were present to support these. Workshop attendees had also suggested that there was a need for some strengthening of the relationships and properties of the process along with further hypotheses development. This feedback questioned my current theorising, thus further interviews were for the development of the theory's core process and related subprocesses. Enlisting new participants continued to be difficult even with continued advertising and informal networking. A decision was made to return to some of the original participants to clarify the emerging categories and properties. Four repeat interviews were completed with two new participants being recruited through informal networks. Little new information was identified during these interviews.

In the year following attendance at the grounded theory workshop, the theory generation process was confusing, messy, and frequently frustrating. During the process there were revelations and repeatedly my thinking was challenged. Several tasks occurred at this time. Codes and properties relative to the core process and subprocesses were reconsidered. Renormalising though, remained relevant for some time. However, the first subprocess, moving, seemed restrictive. It was limited as a conceptual term. Following data reviews, the term regaining seemed to encompass pacing, routines, and balancing, all the while including an apparent relationship to

physical functionality. Questions related to whether a critical juncture (Glaser, 1998) was part of the process were investigated and relinquished. For example, participants had talked of walking after the injury and repair being equivalent to functional independence. However, according to Glaser's (1998) critical juncture definition, participants could still recover post injury even if they did not regain mobility. Therefore, this did not create a critical process in the recovery progression.

At this stage, it appeared clear that regaining had a physical, functional focus. The second subprocess, reclaiming, centred on psychological factors. Reconciling linked to cognitive and emotional elements as the third subprocess. The psychological elements relative to ageing and recovery were seen in the data as personality. Along with connections with people, things, and places, permissioning occurred between the older adult and other people. Permissioning related to how much participation happened on either side of the process. Reconciling referred to the deliberative factors older adults used as they moved through recovery progression. There was an implicit suggestion of adjustment and acceptance, both relative to ageing and recovery. The potential relationship between normal ageing and recovery was therefore interpreted as a behaviour in which older adults managed both ageing and coped with their recovery. Figure 5, displays the main concern, resolution process, age and recovery at this stage of the theorising process.

Figure 5. Main concern and resolution process (2011)

Grounded theory of Renormalising

	REGAINING	RECLAIMING	RECONCILING
Fractured Hip Recovery	Physical Functionality	Cognitive / sociocultural responses	Psycho-emotional – individual perceptions
Properties of Sub processes / Theory	PACING ROUTINES BALANCING	PERMISSIONS SPACING CONNECTIONS	RELYING (others / self) ADJUSTING ACCEPTING
Natural Ageing	Maintaining / changing biophysiological normal	Maintaining / changing sociocultural normal	Maintaining / changing psychological/ developmental normal Individual perception

15.02.2011

Initiation, maintenance and adaption according to perceived views of normal – scientific, societal, everyday and individual

Further interviews and analyses challenged the notion that there was a relationship between normal ageing and recovery. In retrospect, it was evident that researcher bias still dominated thinking. Further analysis and conceptualisation continued until a potential theoretical code was identified. Balancing suggested an ongoing process between two subprocesses that was behaviourally significant for both recovery and normal ageing. Originally, balancing was a property before it started to stand out as a potential theoretical code. According to my analysis, the process of growing older was a balancing of the physical with psychosocial, emotional, and cognitive factors, which were relevant to recovery also. The third subprocess of reconciling was subsumed into the second, that of reclaiming, in this rethink and theoretical coding process to create the theoretical code, balancing. Despite increasing clarity, the complexity of generating theory and its relationships was challenging to understand and explain. Constant immersion in the data along with ongoing analysis required me to step out and view the data in a more conceptualised manner. Further analysis and thinking refined the theory representation to a simplified version moving away from the ageing and the notion of normal relationship (Figure 6).

Figure 6. A simplified version of the theory of renormalising (2012)
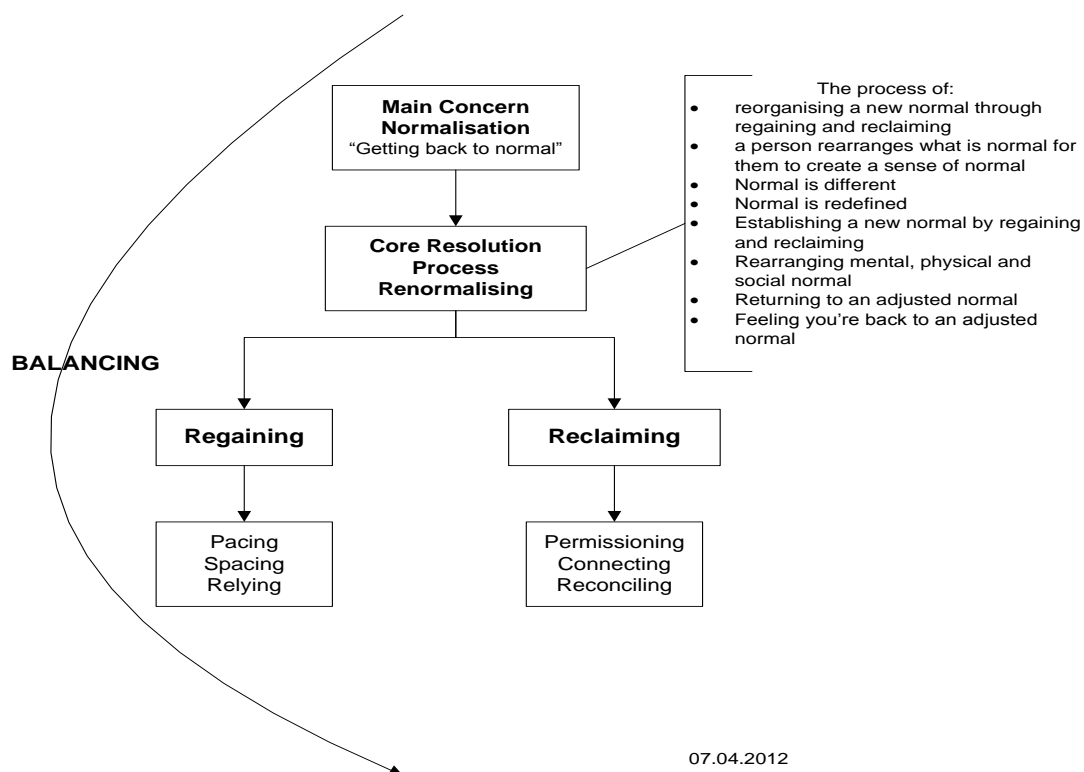
Through this simplified model theoretical development proceeded. Selective interviews clarified and verified concepts and processes. The interview focus was on following through concepts. When a participant was asked about a conceptual term, their response indicated its relevance. For example, targeting or goal setting as conceptual labels was passed over by participants. Earlier process names had been rethought owing to this process with the later versions being confirmed in interview. Further development continued, culminating in a theory that had fit and relevance to managing normalisation. There was a second opportunity to attend a grounded theory workshop in 2012, in which Figure 7 illustrated the theory generation at that time. The theory outline was presented as a work in progress (Appendix 14).

Figure 7. The theory of renormalising (May 2012)

RENORMALISING

"What Was-ing"

<div align="center">

REGAINING　　　　　**RECLAIMING**

Pacing / Spacing / Relying　　　Permissioning / Connecting /
Reconciling

Recovery

</div>
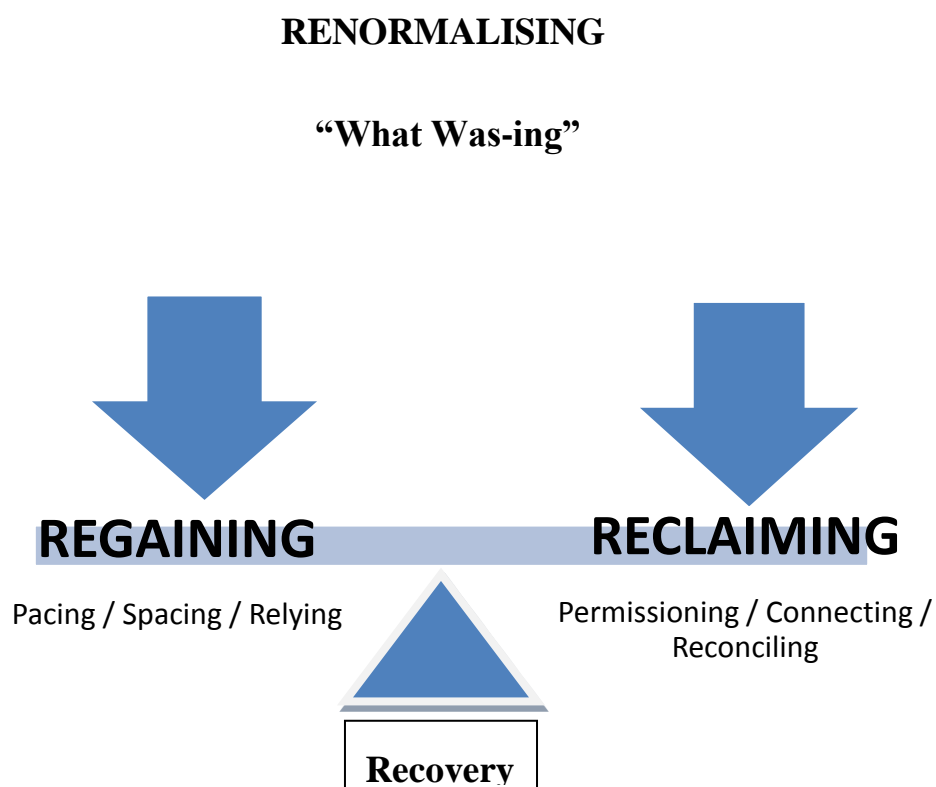
Peer feedback was useful and once again challenging. Moreover, further work was required to own the concepts and words and ensure I had supporting evidence from the data and in the conceptualisation. The challenge was to review the feedback relative to strengthening the theory.

A first full draft of the thesis was undertaken and submitted for review. Feedback illustrated inconsistencies, gaps in methodological argument, and illogical flow in telling the story of how the participants managed their main concern during recovery. The term renormalising did not fit how the theory of recovery was being written. There was an element of forcing inherent in the choice of the term. As noted earlier, the availability of participants contributed to an early choice of a core process, when in fact other core processes were present but not seen by me. Evidence within the first full working draft suggested the presumptive theoretical code had also assisted forcing the theory.

Armed with solid feedback, it was important at this time to go back to the key Glaser books to reread methodology and method to ensure that I had a solid base for

theoretical decision making. Understanding the rationales driving the study, how this would be significant, along with revisiting the hypothetical relationship, resulted in a new theory. The tentative theory of restorative renormalising became the theory of restoring. At that stage, the theory of restoring was about the regaining, reasserting and routinising that occur during recovery management and resolve the main concern of normalisation. A second full draft of the thesis was undertaken and submitted for supervisory review following this phase of the theory's generation. The theory was modelled as illustrated in Figure 8.

Figure 8. Theory of restoring (January 2013)
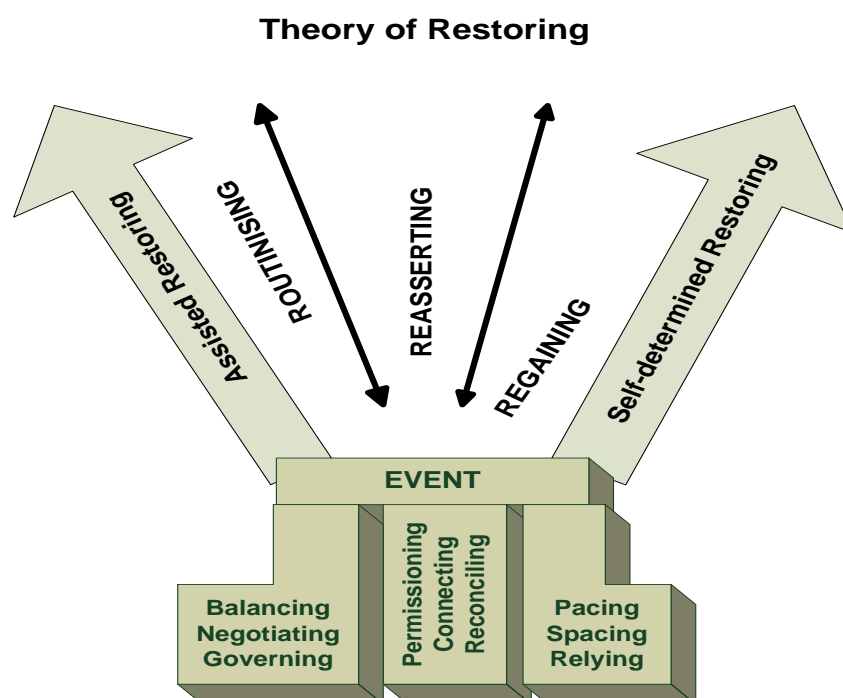
Comprehensive feedback indicated that the theory demonstrated relevance, fit, and worked to explain the core resolution process and main concern. Strengthening the relationship between the data and conceptual labels was required along with reviewing the theoretical code that bound the theory into a cohesive grounded theory study.

The second draft of the theory had used a typology approach to integrate the theory. This was the two types of restoring, assisted and self-determined. However, these types of restoring reflected indicators of a subprocess rather than bringing the theory

together and were subsequently moved. Following a re-immersion in the data and reanalysis of the hypothetical relationships, potential theoretical coding families were tested for relevancy. Starting with the Six C's family group (Glaser, 1978) context, consequences and interaction had some relevance, however the theory still did not come together easily. A weekend was spent resorting and reviewing whether two or three subprocesses were more appropriate along with testing which theoretical code fitted. Deciding the relevant number of subprocesses eventually resulted in clarification of the most appropriate theoretical code, that of balancing. Balancing had been present throughout the data, analysis, and in an earlier version of the core process. Moving balancing to become a theoretical code supported the use of two subprocesses and effectively wove the theory together.

Balancing: The theoretical code

The theory of restoring is integrated around the concept of balancing. This is evident in the subprocesses of regaining and reasserting which must be balanced as they are continuously acting together to manage an equilibrium state of normalisation. Balancing refers to the ongoing actions used by participants to facilitate the return to normalisation and manage all the factors within the event. Glaser's description of theoretical coding included the "paired opposite family" (1998, p. 171). Many paired relationships can go together, move back and forth easily to generate stability based on a continuous equilibrium state. These may reflect actions that address a situation to keep a person on an even level. For example, the manifest-latent paired opposite may have relevance to the theory of restoring. The manifest action is the physical and social elements in regaining which are visible factors such as changes to functioning following the health event. Their manifest visibility is explainable through physiological and sociological domains, and may be short or long lasting and is evident to all. In contrast, the latent action is the reasserting of psychological and often less visible behaviours used to balance the influences of the physical impact. Here I argue that the psychological factors are often manifest however, latent behaviour action in response to the physical event, is often based in longstanding personality actions underpinned by personal values and beliefs. Therefore, simple physical restoring is continuously balanced against psychological restoring.

Maintaining rigour

A major factor in any research outcome is the rigour and integrity of the process.
Glaser (1978, 1998) proposes that the detailed explanation of the data collection,
analysis, and theory generation process ensure credibility of the method. However, the
terms used to consider rigour in a grounded theory study differ from the standard
qualitative trustworthiness. Interestingly, while reading about rigour, a number of
grounded theory theses were reviewed to gain insight into the credibility aspect. The
majority of theses, including some classical approaches, measured rigour through the
qualitative criteria of credibility, transferability, dependability, and confirmability
(DePoy & Gitlin, 2005, 2011; Lincoln & Guba, 1985; Polit & Hungler, 1991).
However, as was argued in Chapter Three that classical grounded theory is aligned to
Peircean pragmatism and supports Glaser's atheoretical stance, therefore, aligning
credibility to a specific paradigm, such as a qualitative inquiry, undermines
methodological integrity. If any epistemological base were to be considered, Peirce's
pragmatism would be the only underpinning criteria. The alignment of Peircean
pragmatism to classical grounded theory (Nathaniel, 2011) supports the practical
approach reflected in the four criteria of fit, relevance, workability, and modifiability.
Integrity in this study was achieved by paying attention to the four grounded theory
criterion (Glaser, 1978, 1998). Rigour was maintained throughout the study with
regular supervisory feedback along with questioning of the emerging concepts.
Arguing for their relevance and fit was a developmental process, which also
strengthened the rigour of the method.

Fit is considered an alternative for validity. The question that corresponds to
validity in a grounded theory study is, did the emerging core process and subprocesses
adequately express the data? Fit was maintained through the constant comparison of
the data from the first interview through to the twenty-first. This means the core
process and subprocess terms emerged from and fit the participant data. Importantly,
they were not preconceived or forced onto the data, as initially happened in this study.
Moreover, the data-naming fit became increasingly relevant as the core process

emerged. Fit is critical and determines grounding of the data to the theory, which is critical to the method.

Workability according to Glaser (1998) is defined as "do the concepts and the way they are related into hypotheses sufficiently account for how the main concern of participants ... is continually resolved" (p.18). Therefore, the resolution process should explain how participants recover using this process to resolve the main concern. To stay out of conceptual description and move the analysis to a theoretical explanation is aided by memoing, which minimises description. Although conceptualisation was initially a difficult task in the early stages it became easier with time and practice, and with conversations with supervisors. Ongoing memoing augmented my conceptualisation development.

Relevance in relation to rigour is seen when the main concern is clear and the participant problem has instant grab (Glaser, 1998). Relevance is promoted through theoretical sampling. As concepts emerge they become questions to obtain participant feedback. Either they elicit an immediate response in which case the participant talks about the term with minimal prompts, or the term is not discussed at all. Minimal response usually implies the term is of little interest to the participant, as it is not very important. Professional preconception and theoretical frameworks are minimised through rigorous application of the method. Ongoing reflection and learning to put aside clinical experience and knowledge was not an easy process. This was evident in my primary emphasis on function and mobility, which were in the data but did not eventuate as the participant's main concern.

The final criterion for rigour is that of modifiability. Often defined as comparing new data to the theory, it just modifies the theory. Interestingly, modifiability underpins the process of classical grounded theory itself. From the initial interview, the data, codes, concepts, and theory are constantly modified as new data are gathered and new concepts emerge, only to be challenged by new data and abstraction. Modifiability was demonstrated through the multiple versions of the core process until it had fit, worked, and was relevant. Numerous flowcharts of potential core processes were developed during the research. Feedback from supervisors, grounded theory workshops, and continued reading of process, augmented the modifiability factor. The emergence of the theory would not have been achieved without absolute trust in

grounded theory and its processes. Interestingly, doing the method meant making methodological mistakes, preconceiving in the early phases, failing to let go of professional interests initially, and occasionally forcing these ideas onto the research process.

Challenges

There are always challenges when commencing a new project and learning about a new research method. Frustration and confusion are largely forgotten when the theory emerges through the 'eureka moment' (Glaser, 1998). Getting to grips with the methodology took time however. This was part of the journey and the process was well supported with knowledgeable and positively challenging supervisors. Attending the grounded theory workshops offered by Glaser and Fellows of the Grounded Theory Institute was a vital and necessary part of my research training. As the research process became more understandable, I gained confidence as a researcher, learned more about applying the methodology, and became free to generate a theory.

Learning constant comparative analysis was an ongoing developmental process for me. Constant comparison procedures are not explicitly outlined in the grounded theory method. This caused some misinterpretation and forcing that were based on personal and professional knowing. As a result, potential categories and concepts were probably missed initially. This was rectified by reading primary and secondary grounded theory resources that helped to improve my skills of constant comparative analysis. My development as an analyst was supported with good supervisor feedback.

A third challenge was gaining participants for the study. Interestingly, my initial thoughts prior to the research commencing, held professional and institutionally focused views of participants. According to the literature there were numerous cases of older adults with hip fracture, therefore I expected that they should have been easy to recruit. Also, I was interested in only talking to people who had been discharged from the acute care setting and returned to a previous community environment. Moreover, the limited response from the community advertising was unexpected. Gaining access was difficult, as most people following hip fracture repair and discharge resumed their previous lives and reduced their healthcare relationships. As a

result, informal networking and access through a hospital setting were the only viable approaches. Nevertheless, the sixteen people interviewed culminated in twenty-one interviews, and all contributed to the generation of the theory of restoring.

Summary

This chapter has discussed how the classical grounded theory approach was applied, rigor maintained, and the theory of restoring was generated during the research process. Learning to do grounded theory is not an easy process however the result has outweighed the inherent messiness and developmental ups and downs. While a relevant number of participants were needed to underpin the theory generation process, it was my thinking, conceptualisation, and application of the methodology that produced the theoretical explanation. This illustrates well that process can be learnt. Mistakes made helped to generate a better understanding of the method. Perseverance brought forth the theory. The following chapters present the findings relevant to the theory of restoring. First, the two subprocesses, regaining and reasserting, are presented in separate chapters, explaining how participants manage the issue of normalisation. Second, key conceptual ideas that were evident in the findings were explored.

Chapter Five

An overview of the theory of restoring

In this chapter I present an explanation of the theory of restoring. As stated in earlier chapters, the main concern, normalisation, referred to participants wanting to get back to normal. It was evident that during recovery participants had an issue with being able to do what they were doing before the fracture event. This concern referred to the elements of sameness and familiarity which influenced previous perceptions of being normal. Even though participants had gone through a major health event and had surgery for their hip fracture, normalisation dominated their thinking, actions, and behaviours. It was clear that normalisation encompassed the participants' response to their life situation, which was personal and relevant to their viewpoint.

> Returning to normal [is] very important – it's getting back to [being] useful (#16/2011).

> Always trying to show being normal (#17/2011).

In the theory of restoring normalisation explained a self-determined ideal state as it was interpreted by the participants. Individual self-determination was underpinned by the participants' life experiences and their previous interactions throughout life. The participants became involved in restoring some familiarity to their lives according to their previous lifestyle and patterns of behaviour. This main concern is the cause and motivator for the resolution process (Glaser, 1978, 1998). Therefore, the theory of restoring is presented as a resolution process for normalisation.

Restoring is a process of balancing the regaining of physical and social functioning and reasserting normal psychological behaviours during recovery, all of which restore normalisation. Restoring is influenced by two concepts, social memory and self-governance, which stood out in the study. As will be seen in Chapter Five, regaining was the pacing, spacing, and relying that occurred to restore the participants' physical and social activity relative to normalisation. Reasserting, discussed in Chapter Six, was the permissioning, connecting, and reconciling that were necessary to normalise the psychological self in restoring. Balancing these two subprocesses was influenced by a number of perspectives that included societal, physiological, everyday, and

individual viewpoints of recovery, which were also affected by social memory and self-governance behaviours.

I will argue in a later chapter that the theory of restoring is about the balancing of individual responsibility for recovery with perceived contemporary social and health responsibilities. The relationships and interactions that occur between these viewpoints are based on the concepts social memory and self-governance. Moreover, individual social responsibility is reflected in the self-management behaviours of the participants as they managed their recovery in the hospital and community environment. This self-management was different to the current emphasis in health practice that emphasises a generalised and segmental approach to recovery. This suggests that evolving models of care are challenging the traditional approaches to recovery. The theory of restoring will offer an alternative perspective to established practice. The following model (Figure, 9) represents the theory of restoring.

Figure 9. Theory of restoring (March 2013)

THEORY OF RESTORING

REGAINING

REASSERTING

Normalisation

Pacing / Spacing / Relying

Permissioning / Connecting / Reconciling

EVENT
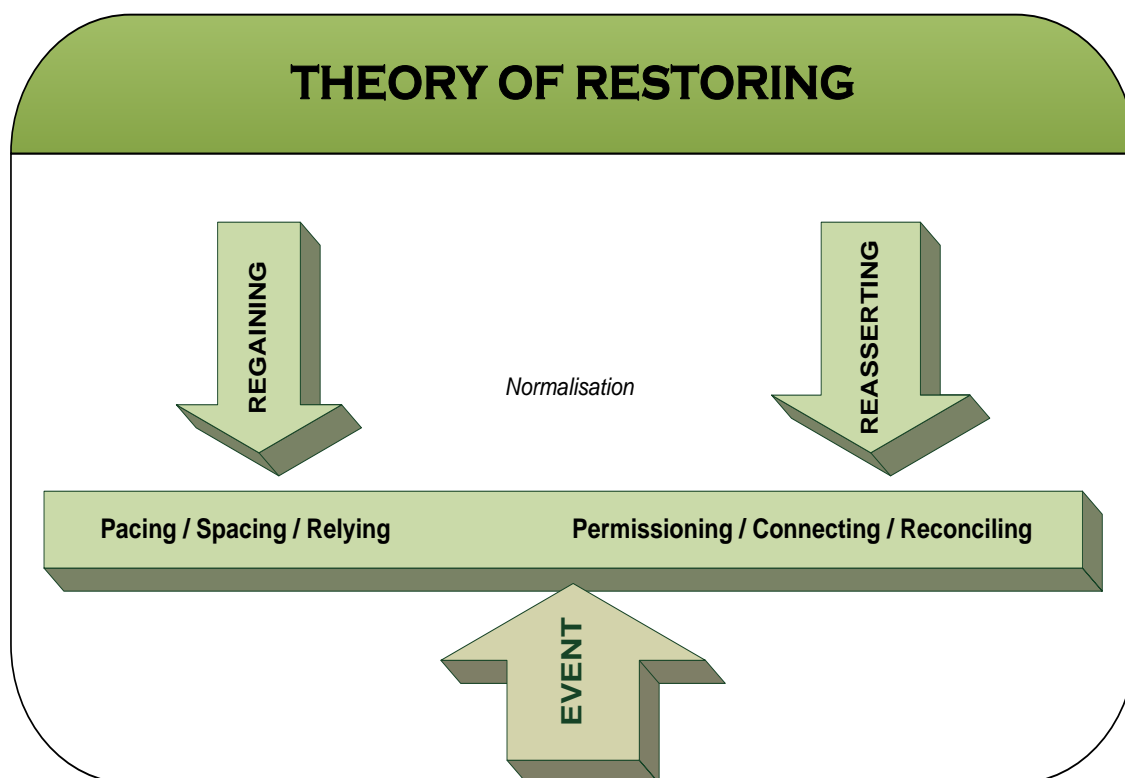
24 March 2013

Regaining

Regaining is the first subprocess to be presented in the theory of restoring. Regaining is defined as the pacing, spacing, and relying required for restoring normal physical and social functioning[14]. Pacing is the regaining of physical and social activity. Pacing is influenced by time, age factors, perceptions, and compromises that are required to achieve restoring normal. Spacing is the regaining of physical and social distance. This assists people in restoring functioning to their normal distance, which reflects different levels of closeness that are given to people and things. Relying is the regaining of a relative independence and relates to the types of help that are required for restoring normal. During regaining, people need some assistance until they are able to return to their own self-determined state of restoring. The participants' physical and social activity was something that they wanted restored. Regaining these activities during recovery addressed a sense of loss in relation to the previous normal, the participants felt:

It's about regaining something you have lost (#21, 2012).

In this chapter, regaining and its subprocesses will be presented, along with a diagrammatic representation. The components of regaining are presented in the following Figure 10.

---

[14] Functioning is defined, pursuant to the Chapter Two explanation, as the interdependent relationship between societal, physiological, and everyday factors that are the manifest and latent elements individuals use to behave and interact, as they live in their normal milieu.

Figure 10. Regaining subprocess and properties
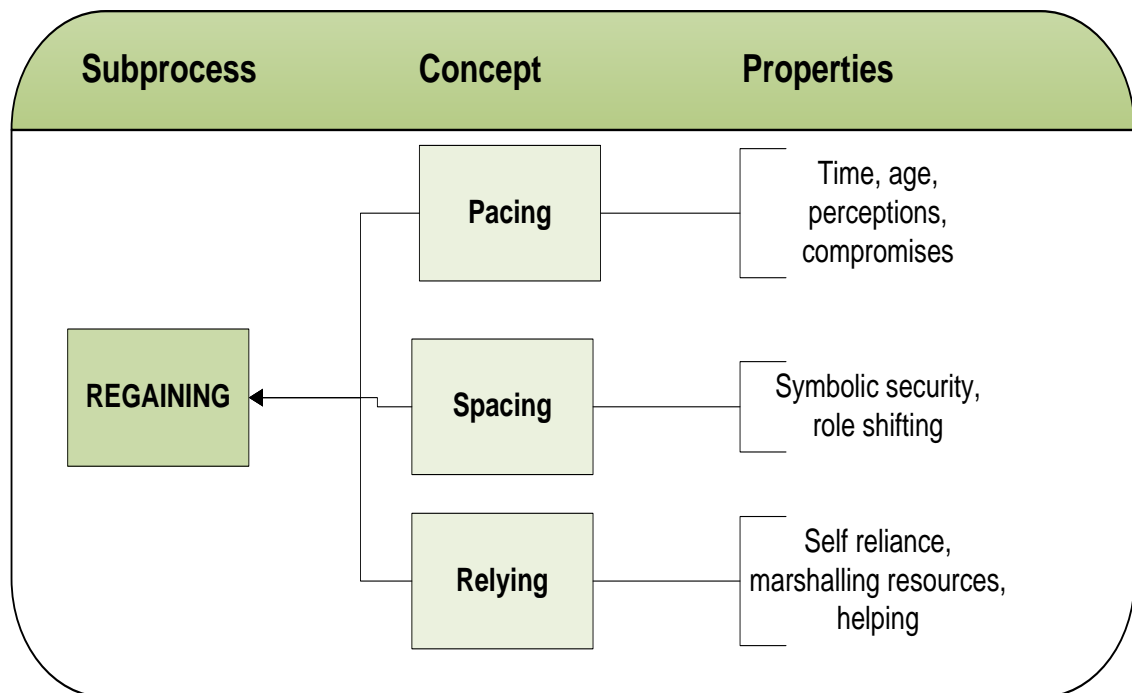
Pacing

Pacing is one concept of regaining that is defined according to participants' interpretations of restoring normal physical and social activity. The properties of pacing include, time, age, perceptions, and compromises, which are essential for regaining and restoring normal. What was evident in the data was that there was more than one perspective to pacing. Pacing referred to temporal pacing and an event-related pacing. Temporal pacing was time and age related, whereas event-related pacing reflected perceptions and compromises. These two elements of pacing were continuously balanced against each other during regaining. For example, time and age influenced actions and behaviours of pacing and consequently, affected perceptions and resulted in compromises:

> Yes, things have changed and [my] physical pace of life is different; ageing has [me] slowed down physically and socially. However, I definitely pace myself now... never used to... [this] has changed due to injury (#19, 2012).

Although pacing was temporal or an event-related process, it was also influenced by the context in which it occurred. Participants recognised that event-related pacing was relative to the setting they were in. This in turn, influenced the pacing of physical and social activities during regaining. For example, during initial restoration, the pace of activities generally reflected the healthcare context, where the emphasis was on regaining walking ability. This represented an event-related paced approach to restoring physical functioning, which related specially to restoration of function, in which the pace was set by others:

> [They helped] to get me mobile again; it was very slow. First I managed to get from the bed to the toilet. Then they took me for a walk down the corridor, and [I got] a little bit of physio to get me walking again (#12, 2010).

Moreover, while in hospital, the pacing of activities drew participant attention to the compromises needed to regain self-management of physical and social activity. Interestingly, the response to the pace set by the health professionals, varied along a continuum of adherence behaviours. Where participants were more likely to be compliant, they were generally passive about the temporal aspect of pacing. In those situations, the age of participants often influenced their pacing response. Participants responded with implicit assent until they were no longer reliant on the pace set by the health professionals:

> Generally [I] went with the flow unless something arose... [I was] glad to have someone take over (#7, 2010).

> [I] do as I am told...to an extent... [I do that because] somebody knows better than I did... (#12, 2010).

> [I had to] reclaim [my] right to do things at [my] own pace; showering on my own, I'm no longer reliant on others (#18, 2011).

However, a change of setting, such as returning to their previous residence, changed the rate of pace. Thus, pacing behaviours, while still influenced by the event, were related to the regaining of self-management of physical and social functioning. At the same time, compromises related to the perceived rate of restoration of physical and social functioning over time were required. In particular, the influence of temporal pacing, that of time and age, influenced restoring:

> Well, I suddenly want to do something and I have to think I need to slow down and have a rest / coffee and then do it. Like the vacuum cleaner sitting there and I have to think, "No, it can stay there a little longer"...I'm just slower. I am getting the same things done (#2, 2009).

> Suddenly you find yourself doing normal things rather than thinking twice... normal things don't mean vacuuming. Going to the letterbox is normal; having people come in for cups of tea and coffee, chat [is normal] ...I'm back to bowls.. I still do a little bit, just evenings for social activities (#2, 2009).

Clearly, pacing was context specific, as behaviours and interactions had to change, as shifts in responsibility for restoring moved. Pacing that occurred in the healthcare context was applied as a generalised baseline to determine time-specified progress. The healthcare professional pacing of activities provided guidelines for the incident management, interventions, and rehabilitation progression. This in turn reflected the nature and systems of the organisation, and the necessity to manage regaining of physical activity through a set pace. However, the shift for managing restoration of physical and social activities changed pace once healthcare personnel withdrew from interventional activity, or the participants were discharged. Thus the balance of responsibility was moved from the healthcare professionals to the individual participant. Four properties influenced pacing and restoring normal. As already stated time was particularly significant.

Time

Time was a property of pacing. During pacing, regaining was affected by participants' interpretations of the time it took for restoring. Time from their perspective was defined by either chronological time (ageing) or the course of time. Time-course was perceived by participants' reflections about the duration required for regaining physical or social activities. Sometimes it referred to a longer term view of restoring normal. Initially, time related to regaining physical and social activity was paced depending on the impact of the event on the person:

> Of course you have to pace. If you are weak therefore it will take time to recover. Sometimes it takes different times, pace or steps in achieving recovery (#17, 2011).

Moreover, time was used as a way of perceiving restoration of physical or social activity that was compared to the previous time taken for an activity, before the injury. Time and pace were inter-related:

> Whereas, before the fracture I walked half an hour and a reasonable distance, now I might walk twenty minutes and feel fatigued... (#6, 2009).

Time also impacted pacing behaviours if complications from the event were present. Physical and social activities were affected owing to the increased and unexpected time it took to regain familiar activities or manage compromises during the restoration to previously normal activities:

> If I hadn't broken the screws, I would be back walking again [and] working (#19, 2012).

> [I] used to walk, go to the gym... [I] had to give that all away... [it] impacted our life as a couple (#9, 2010).

Significantly, understandings of time indicated peoples' expectations of how normal physical and social activity should be regained. Not surprisingly, the anticipation of time and pace required to regain functioning was based on information available from others. A period of three months was the expected time span needed to regain normalisation. This time period was based on professional information and also on the participants expected timeframe for restoring normal:

> Well, I thought it would be 3 months or something like that; that is what the doctor said (#13, 2010).

> Actually, I think 3 months is quite enough to recover... (#10, 2010).

> I thought 3 months and I would be on the go again (#11, 2010).

However, the time to regain normal physical behaviours took longer than expected for most:

> I thought it would take 3 to 6 months but it doesn't work out like that (#7, 2010).

> [The] first month home was utter misery, just living... [my] muscles [were] weak; [it was] a shock to the system...it takes a long time to get over [a fractured hip; it] takes about 12 months or so (#18, 2011).

Moreover, the long-term effects of time and pace on regaining physical and social activity were not indicated by the healthcare professionals. The impact of time was not always explained to the participants beyond the immediate physical functional restoration:

> [I] lacked information on discharge from hospital; [I was] given physical instructions, [about] walking and stairs but not relative time [that it would] take to recover. [The health professionals did not mention] the social and psychological aspects or the adjustments that needed to be made (#8, 2020).

Thus time influenced pacing as the recovering participants regained physical and social activities. However, the resulting influences of developmental life stage time were not discussed at all. As a result, the span of time to restore normal functioning was often longer than expected owing to the nature of growing older. Further, the time effects depended on who would manage restoring and govern the pace of activities. Ageing clearly influenced pacing although it was not always recognised as a contributing factor to recovery.

Age

Age, another pacing property, had a temporal component in that chronological age affected the pacing in life and consequently regaining:

> Yes, things have changed and [the] physical pace of life is different. Ageing has slowed [me] down physically and socially. However, I definitely pace myself now... [I] never used to... [it has] changed due to injury (#19, 2012).

Thus age, time, and pace were inter-related in regaining and restoring normal. Often these interactions and their influence on participant behaviours were not always considered prior to the event. Initially, regaining of physical and social functioning was managed within the healthcare setting and provided a certain image of recovery. However, returning home, participants often noticed how age, time, and pace impacted their behaviours and influenced the restoration process:

> I think I have recovered very well...I felt fit, could walk around but I don't know. It's rather bewildering... No I don't feel right – I am all right for a little while then I have to go lie down...I am getting exhausted...I was alright before... It was disappointing because I was so good...probably when you get to my age it would take longer (#11, 2010).

Pacing, age, and the regaining process were interdependent. The older the person was and closer to the event they were, the more likely that their age influenced the time taken to restore physical and social activity. In contrast, the younger the patient was and/or the longer the duration since the event, age was recognised as separate to restoring normal:

> I have to be grateful but I am not doing as much as I was, but then I'm a lot older (#2, 2009).

Nevertheless, age influenced pacing in restoring normal. Interestingly, age was not considered inhibitive but part of self-managing life. People handled age differently. This influenced how they paced themselves, as they regained physical and social functioning:

> I never think I am old and I never think of growing old...I am not old. I am me and age doesn't come into it (#4, 2009).

> As you get older you have to find ways [to manage] but this becomes normal (#7, 2010).

Age influenced pacing and ultimately regaining. As a result, age was used to explain changes to physical activity, functional ability, or the length of time it took for restoring normal. The temporal elements of time and age influenced pacing, depending on perceptions and compromises.

Perceptions

During regaining, restoring normal was influenced by the property of perceptions. Pacing perceptions reflected the event related factors that affected the return to physical and social normal. Participants perceived the differences and similarities between their current situation at the time and what was previously considered normal. Perceptions reflected pacing progress:

> I didn't go far or very quickly but each day I would do a little bit of exercise and it just got a bit easier each day (#2, 2009).

Alternative perceptions of pacing were common as well. There were multiple ways to see the process of restoring of activity. Many points of view generally reflected the collective healthcare team behaviours, through to the individual actions and interactions. Therefore, pacing behaviours were more influenced by interactions. For example, the interactions varied between a person and the healthcare staff, or the person and their circumstances, such as living with and managing a coexisting condition:

> ... The home care people who came into assess me...gave me a big lecture about the stairs...I thought blow this, the physios show you how to walk the stairs and you tell me to go somewhere. My poor eyesight holds me back quite a bit...while I stay here I know where everything is (#6, 2009).

> Well, knowing what I had to put up with... [having a] muscle disease [I knew] something would have happened anyway... I suppose it has made it a little harder to get on top of, [to] keep going; [the fracture] happened to heal and everything is all right (#1, 2009).

In this latter situation, hidden perceptions about a chronic illness influenced behavioural possibilities.

Pacing perceptions could be positive or negative and focused on regaining activities that were achieved through a perceived self-measure:

> A measure of getting better is walking the corridor in hospital or walking to the letterbox at home (#17, 2011).

> Yes, you had to do that there [in hospital], just to show them I could do it. I thought if I can do that, I can do that at home (#12, 2010).

Alternatively, perceptions of pacing behaviours were sometimes influenced by the pre-discharge healthcare-determined activities. As already mentioned, the healthcare professional responsibility for restoring normal set and defined the pace and process of regaining physical activities. Health professionals had a perspective that a person should achieve a specific activity within a defined timeframe. This influenced regaining physical and social activity as people paced themselves according to the professionals' perceptions. These perceptions shaped interaction and behaviour:

> I do as I am told; I obey until I can be independent... (#10, 2010).

Other peoples' perceptions of regaining behaviours influenced how the participants restored normal. Not surprisingly, being compared to others had a negative influence on progress behaviours as normal was restored:

> My husband was comparing me to others in the village that had hip replacements and were walking faster than I was. He could not see the difficulties I was having and I felt I was being pushed (#8, 2010).

Overall, perceptions influenced pacing in a number of ways. Participants had to balance their own perceived restoration progression with the healthcare teams' perception of regaining physical and social activity. The setting supported this pacing perception, in which activities were defined initially, according to other's points of view. However, the pacing perception changed and was regained by individual participants, once the health care professionals withdrew interventional care and people returned to their normal residential setting. Perceptions impacted compromises participants would make in restoring normal physical and social activity.

Compromises

Compromises was another property of pacing. During regaining, compromises in relation to pacing were required in order to manage restoring. In other words, the

pacing of physical and social activity was influenced by compromise. This was more evident in people whose restoring took longer than expected, or resulted in long term complications. Some compromises made were impacted by personal relationships:

> Being pushed by my husband versus managing myself... I had to find a compromise (#9, 2010).

On occasions, a change in pace due to complications prompted compromises:

> [I] just do the best I can. I need the stick, even to the letterbox. [We] had the garden re-landscaped to reduce hazards to walking, from tiles and shrubs etc... Now [I] can get around... Family activities are curtailed... [The] grandchildren have to watch Nan-Nan now (#9, 2010).

> I make compromises to manage, for example, removing the hedge to minimise future falls off the ladder (#20, 2012).

> ... [It depends on] what limitations are around you...for example, I have eight steps in the front of the house and sixteen at the back. I always use the front. [It's] easier (#16, 2011).

As already mentioned, pacing compromises were also influenced by coexisting conditions that individuals had. This influenced their perception of self-management relative of their condition. This had both a direct and indirect impact on pacing. Coexisting conditions had the potential to influence the effects of time, age, perceptions, and compromises on pacing. People perceived the coexisting condition did not necessarily influence pacing as the condition was inherent to their usual life style. However, irrespective of the coexisting condition, pacing was perceived as the interplay between age and the health event and required some compromise:

> I don't know whether it's the fracture or it's the increasing age I'm fighting the fact that I mostly don't feel old...I don't say it's due to the fracture. Perhaps it was a wakeup call. Perhaps I have been slowing down anyway and also not being able to move very fast at this stage. I really felt that was difficult to understand... (#6, 2009).

In summary, pacing was not a static or sequential process in regaining physical and social functioning. The ongoing balancing of temporal aspects of pacing in restoring normal was continuously balanced and weighed against the

event impacts and managed through perceptions and compromises. This was a significant aspect in regaining physical and social activity. It suggests that pacing is more than just the physical tempo of activity. Pacing's relationship to time is influenced by perception and the viewpoints of others. An outcome of balancing time, age, and perceptions, resulted in compromises being made, all of which influenced the pace of restoring.

Spacing

Another concept of regaining, spacing is defined as the participant's interpretation of physical and social space, and how these are used to facilitate recovery. Spacing is the creating of physical and social distance according to the participant's needs. The properties of spacing are symbolic security, and role shifting, both of which are essential for regaining and restoration. The physical distance that underpins spacing, depends on the participant's needs and the context. It is also influenced by previous social interactions. Behaviours in spacing are about balancing these distances in restoring. This relates to the creating, moving, or removing of physical and social distance contingent on the degree of closeness required. Spacing is influenced by physical determinates on the one hand and by family, healthcare professionals, and the public on the other, during regaining. For example, the event is about the need for professional assistance and balancing that with the usual personal distance needed by the participants. Initially, healthcare personnel are involved in the participant's very personal space for a short period. However, the distance is increased as participants regain physical and social functioning. In other words, the close patterns of behaviour required in the acute episode of care are withdrawn and replaced with the familiar social distance behaviours as normal is regained:

> Creating ...space, to have some privacy...it depends on how much it mattered in the first place. It is about what we are used to (#20, 2012).

Symbolic security

Symbolic security, a property of pacing, was the participants' interpretations of the appropriate physical and social distances required to manage their spacing behaviours. The use of devices such as symbols, created messages which indicated a desire for

physical space. Security referred to the social space, usually family, friends and neighbourly supports that provided a sense of safety during regaining. Symbolic security was inter-related and interdependent in the spacing behaviours used by the participants. However, together they provided a sense of social safety during restoring. Although security was interdependent with symbol use, the sense of safety was enhanced when physical and social activities came together to create a safe distance for the participants:

> It's a security thing and I am happy to have that walker...so if anybody sees you with one of those, they naturally steer clear of you, don't they (#13, 2010).

Physical spacing became a symbolic security during regaining. The amount of physical space required was continuously balanced against physical and social functioning. Moreover, the use of devices as symbols that something was not quite normal provided a sense of security for participants. Following the event, walking devices supported physical functioning. These were used short-term or sometimes became permanent devices to assist activity. These devices conveyed messages to others, thus enhancing feelings of safety. For example, a walking device was a symbolic message which created physical distance or suggested that potential assistance may have been required. Such devices increased visibility and space:

> Ok, so I use a stick when I go out...I need secure hold...yes it's a symbolic thing, which means [it] just gives me space (#3, 2009).

Devices also signalled that assistance might be required:

> Even now...I intend to take my big black stick, just so I am visible and if I ask for help they won't look at me sideways (#6, 2009).

The participants need for symbolising physical space was subject to multiple interpretations. However, while symbols increased visibility and thus safety, they also sent unintended messages about what was happening during recovery. The participant's distance or assistance message could be interpreted differently by others. Unsolicited help from strangers was unwelcomed and considered intrusive. To other

people, the symbolic message of the walking aid suggested vulnerability. But, during regaining, offers of assistance were a choice and not a forced interaction, which impacted the participants' sense of safety and privacy:

> You get people who want to do their good deed for the day.... [They are] walking a fine line between familiarity and respect for other people's privacy (#3, 2009).

Alternatively, an unintended message from using assistance devices was a symbolic statement that physical illness and disability were present, and others needed to give space to the person. Participants who used devices for mobility assistance valued them for this reason, however, being in public with the walking aid also created unintended physical spacing messages. A potential for physical weakness was considered when using the device, as it symbolised a need for a safe space through physical distance, time, or assistance. Interestingly, the type of device used sent different messages. On the one hand, a walking frame drew attention to a person who was unwell:

> Everybody knows you are a sick person or disabled. [The walking frame becomes] a sandwich board (#10, 2010).

On the other hand, using crutches or a stick minimised the perception of weakness and the need for physical distance. Therefore, from the participant viewpoint, symbolic meanings from a device reflected variable messages. Interpretations of the need for physical spacing were more mixed and depended on what a participant would allow:

> I think I can manage by myself but it doesn't mean I don't want any help...but at the same time, they must think I am the man (#10, 2010).

Spacing from a professional viewpoint, emphasised symbolic security and the physical assistance needed for restoring. While the focus was physical, it included a component of social protection during recovery. Regaining physical activity followed professional behaviours until the appropriate degree of participant independence had returned to be considered safe, according to clinicians. The use of devices also secured privacy and freedom of action thus regaining normal social space for the participants. However, before full restoration of normal social spacing occurred, participants often

relinquished personal privacy while in care yet managed these interactions to maintain the sense of safety. In the following instance the simple presence of a person provided social support and a sense of security in an unfamiliar space:

> I have never had anyone shower me before; it was ghastly...I got used to it...having someone watch me...otherwise I wouldn't bring myself to do it (#11, 2010).

Symbolic security as social spacing during regaining included the participants' relationship with healthcare professionals, and the stable influence of regimes, which promoted a sense of safety while in the hospital. The participants' previous social spacing behaviours changed in the hospital setting. The level of adherence to hospital regimes and the healthcare personnel reflected both normal social behaviours and the current situation:

> ...I used to walk without the help of the physiotherapist or the nurse... [They] told me not to do it without them...they said I have to [wait for them] but I decided when (#10, 2010).

> Professionals...looking after me...sometimes I listen, other times I don't listen (#17, 2011).

Other symbolic security measures were useful to manage social spacing. Participant relationships with social groups, such as family, people, and community were important for regaining social functioning. Family relationships created a sense of security for social space although there was always a need to balance the actual need with the perceived need. Family supports were recognised as essential for the initial recovery and continued as security long after the event. Social space and security were more evident when the influence of specific family members, such as partners or children, provided a safety net to pre-empt problems:

> I sat in the chair and no-one spoke to me. I thought am I supposed to stay in the chair or get back into bed? So I rang my daughter and I said, "I have been in the chair all day... no-one had said anything to me"... I should have said something (#11, 2010).

However, social spacing as a security measure in terms of family support was moveable. Participants noted the role of family in regaining both physical and social activity. Security from family had to be continuously balanced so that social input did not have a detrimental impact on the family. Participants talked of giving space to family members during restoring. Social spacing was a two-way process. The social spacing of family, especially the participants' children, requiring space and time for their own lives, impacted interactions and behaviour:

> They [family] came to see me in hospital and then after that, once I was back here in the village. They knew I had [my husband] and they knew I would be looked after. With my daughter teaching and my son with his own business, they were both very busy, so they were not part of my recovery. Once the operation was over and they knew everything had gone right, they had no more worries and responsibilities (#4, 2009).

Family were often more visible in the hospital phase although input to further restoring was limited. But, normal family social spacing was restored when the participants' safety was considered no longer at risk. At the same time, restoring normal family relationships increased a sense of security as usual social behaviours resumed. Social space increased on return home and required balancing with a need to have family members living-in, staying overnight, or calling in regularly. Support in the social space enhanced the sense of safety and promoted individual self-management:

> The daughter... she helps me, she stays here at night so I don't have to call on anybody (#13, 2010).

It has been shown so far that symbolic security was the interplay of physical space and social spacing behaviours that had to be balanced during recovery to provide an ongoing sense of safety. Normal social space shifted according to the sense of physical distance needed during regaining. Initial responses to the event required closer social spacing for the participants until their physical functioning was regained. Nevertheless, physical spacing changed as restoration occurred and influenced how social spacing was interpreted and actioned throughout restoring. Responsibilities also changed roles according to the context.

Role shifting

Role shifting, a property of spacing, was the action participants took to shift physical and social roles within their relationships so that they could manage restoring. Role shifting was another process to manage spacing of physical and social activity, which overlapped with symbolic security. Shifting roles had temporary and permanent elements within regaining. Temporary elements were time-limited aspects in which participants created space for others to take over their normal social or physical roles for a specific period. In contrast, permanent role shifts occurred owing to health related physical decline in which others facilitated or took over roles during restoring. Moreover, role shifting was a balancing act used by participants during the regaining period to manage different processes in restoring physical and social functioning.

Temporary role shifting during the event and regaining began with an individual taking on different roles, such as a patient. The social interactions with professionals and family were temporarily changed to accommodate the impact of the physical trauma. The role shift from a previous active role to passive role behaviours enhanced or inhibited interactions as restoring proceeded. For example, complying with healthcare regimes tended to enhance recovery prospects through a perceived notion that the patient was recovering well because they were interacting and behaving as was expected of them. Participants acknowledged taking on the patient role and doing what was asked of them:

> You have to do as you're told, you know it's for your own good, so you try and do it... (#13, 2010).

Role shifting also involved actions of compliance, taking on the patient role, which often meant participants' usual social role, was not always acknowledged. Social spacing favoured the healthcare professionals. The participants' social perspective was temporarily limited to the extent that their normal spacing behaviours were minimised. For participants in a patient role, it meant following others' expectations of behaviour, taking on a social role as patient and regaining physical functioning according to social conceptions. Indeed, restoration depended on doing things based on someone else's criteria and justifying it:

You are very rarely asked if you want to. However, sometimes you need to be 'bristled up'. It's another step so you allow it...there were times when I didn't want to do it...but you do it anyway because you are told to (#18, 2011).

Role shifting within family relationships was temporary though for the initial event but reverted back quickly to normal behaviours as participants regained previous family roles such as supportive parents or being supported by children or partners:

I have my youngest daughter here... she still has problems...I take her to lunch on Saturdays and slip her a bit of the you know what...I support her...she needs it (#3, 2009).

[He was] just so helpful, [taking] over my role for a little while...not that long. I just sort of eased back in gradually (#2, 2009).

Spacing associated with role shifting allowed family to be supportive until the unexpectedness of the event was settled and normal roles were regained. Therefore, temporary role shifting was situational, as all the different aspects of the event were balanced in the course of the restoration.

In contrast, permanent role shifting altered according to the participants' normal independent living behaviours. This required both physical and social spacing changes. Other people took over some of the participants' usual functioning roles, so that they retained some independence. Permanent role shifting occurred when full-time assistance was required for physical functions. A decline in physical function meant dependence on others to maintain a normal lifestyle. Spacing was re-interpreted to allow others to step into roles within the participants' home environment. Physical roles within the home setting were permanently shifted to home help, carers, spouse, family, or neighbours. These ranged from assistance with personal tasks, taking over the role of caring for the home or garden, or allocating certain tasks to others:

I did a lot of things myself, for economic reasons and for choice, which I find I am limited [with] now. I can't do [some things]. I haven't yet because I haven't the confidence, like washing the bathroom ceiling because it means standing on the edge of the bath. I just haven't the confidence. It's a big ask. I like to do my own carpets, but I don't know who is going to lift the Rug Doctor up... but it's good to know that there is help there (#6, 2009).

This illustrated balancing of the physical activities with usual social functioning. It suggested that role shifting may be a socially conditioned response to a health event, such as being a patient, or it may be using others to maintain a social role of independent living. Nevertheless, spacing was clearly a decision process participants used to manage physical and social roles in regaining. Spacing actions and behaviours are also used to balance physical and social relationships during restoring. Therefore, self-reliance or relying on others is intimately linked to the interactions.

Relying

Relying, a concept of regaining physical and social activity is necessary for restoring. Relying is defined as the self-reliance, marshalling resources, and helping behaviours needed for regaining. Self-reliance was the participants' personal management that was influenced by their historic social behaviours and life experiences. In contrast, marshalling resources referred to the wide variety of external assistance needed to regain physical and social functioning. Helping was the balancing of needing help against self-help that occurred in restoring normal. This was the self-help behaviours normally used to manage events and life situations, which determined the assistance necessary for restoring normal. There was often a need to cooperate socially with the wider community, in order to regain physical activity:

> Even in hospital as a patient you have to get the cooperation of everybody (#10, 2010).

When physical activity is temporarily or permanently changed, previous self-reliance interactions and behaviours had to change to accommodate this. For example, using help for certain household tasks supported self-reliance, as resources were marshalled, and relevant assistive help activated:

> That I have to be really, really, really stuck to ask for help...not sit back and wait for someone to tell me what to do, ... [or] wait for somebody to help me (#3, 2009).

Relying is the active management of balancing self-reliance and marshalling resources through the amount of help used to support regaining physical and social functioning. Moreover, relying was about regaining familiarity and restoring normal:

> ...back with familiar things helps you become normal again. [It's] important to get back to your own bed and own toilet, own your own pad. Back to your own routines (#18, 2011).

Self-reliance

Self-reliance is a property of relying, which shifted according to participant need during regaining. Self-reliance was the behaviours and interactions participants normally used before the event. Interpretations of their pre-event life affected restoring normal:

> So I figure I am pretty darned independent. I look after myself; make my own meals [as] I like to eat well. [Also, I like to] read a good book... (#1, 2009).

> The carer at night comes a bit early, at half past four, and you have to get into your night gear. But she has others to go to... I don't have my meal while she is here. She will get it ready if I need her to but I don't usually... [The meal] is something I can pop into microwave ...when I want to (#12, 2010).

Nevertheless, in the very early event period of recovery, self-reliance behaviours were limited because patients needed healthcare assistance and expertise. Once the temporary shock of the event had dissipated, participants commenced regaining some of their previous physical and social behaviours. Self-reliance was slowly restored. However, self-reliance depended on the normal patterns of behaving in similar situations. Requests for cooperation were balanced against usual self-reliant behaviours and tempered by the current physical state:

> Being weaker or sick, you need to rely on other people; it is just being human (#17, 2011).

Participants' self-reliant behaviours were not always taken into account. Participants' historic behaviours underpinned current self-reliance and influenced the normal management of family, home, and life. To remain in their normal setting, it helped if participants had a history of self-managing along with being independent with activities. If familiar self-management behaviours were limited as occurred in the hospital setting, self-reliance declined. Decisions for action were made according to other people's criteria:

> I was nearly [shipped] off to a home or to my daughter's place, which I couldn't take... she has enough work without me...why should they be saddled with you... (#11, 2010).

However, some participants insisted on retaining their self-reliance and returned home to living alone, thus, restoring their self-management behaviours. Sometimes, self-reliance required extra assistance. Interestingly, participants considered themselves to be self-reliant even when using carers or home help.

> I am mostly alone. I mean I have a carer in the morning and night but I am mostly on my own... [my] daughter comes in once a week with the shopping (#12, 2010).

> She helps me but I am independent. It means I can get up any time, walk anywhere, get whatever I want when I want (#10, 2010).

During regaining, self-reliant behaviours were balanced according to interpretations of restoring normal. There was usually a temporary reduction in self-reliant behaviours that accompanied the initial event however, as physical capacity was restored, normal physical and socially based self-reliant behaviours were regained. Moreover, self-reliance is not an independent entity. It is usually located within multiple elements, termed resources.

Marshalling resources

Marshalling resources, as a property of relying, was a logically derived term used to explain the multiple factors participants used to activate resources as they regained

physical and social functioning. The amount and type of resources needed for restoring included the use of people, beliefs, things, or environment:

> ...nobody can do anything by themselves; you need assistance...if it is family you can't do it without the cooperation of other family members (#10, 2010).

Activating people resources was often commenced during regaining. While family, friends, neighbours, and community were a constant throughout restoring normal, temporary resources such as the healthcare professionals assisted with immediate physical restoration. However, marshalling healthcare resources was generally confined to the event and interventional activity needed for regaining physical functioning. These healthcare resources were beneficial in this initial process of restoring normal. In some cases though, relying on healthcare resources was a concern:

> I think when you are dependent...if you will get a pan on time...that is a big worry...once I got walking and I could go when I felt like it; it was a big thing (#11, 2010).

Once participants returned home though, marshalling resources in the form of support people was necessary to manage physical and social activity. For some, this was a new experience, whereas for others, it became a permanent arrangement:

> The ACC lady came and helped me shower; very competent woman; and I got equipment from ACC. The hospital OT came... [but it was my] son [who] put in a handle in the shower (#6, 2009).

> Well, I got used to them coming, the home help, here. If they didn't come I just couldn't bring myself to do it, shower, housework (#11, 2010).

Moreover, participants had other resources to assist them on the return home that were part of their usual social relying:

> Well my son was very good, he came the week after I came out of hospital and he left me with meals, what have you. And the church group down there came and left me meals and what have you (#6, 2009).

Family resources were useful to help with normalisation during regaining. Family interactions and family ties were important in restoring:

> Being together with my husband and family is my rock. Friends and church support me; a big network sits around me (#9, 2010).

> [I] rely on my daughter's phone call; [we] talk in a way you wouldn't with anyone else (#18, 2011).

> My wife is with me so I have nothing to lose... (#10, 2010).

In contrast, other participants had ongoing relationships with neighbours who were useful resources when family was not living close by:

> I have excellent neighbours, both sides. It was the environment (house) and knowing that I had supportive neighbours on each side (#12, 2010).

On the other hand, village residents had built-in support systems that could be used as a resource system, but that depended on the role the neighbours and village community had for people. Social activity had to be balanced against being reliant on others:

> Some people I don't think they will really adjust to this type of [village] living...you are walking a fine line between familiarity and respect for other people's privacy. But I haven't got any close, close, tell you everything friends here because I've moved so often (#3, 2009).

> I have a few friends here, [in the village] ... there is just so much to do here. You don't come in here because you are old; you come in here, and I always tell people you come in here to open up a new chapter in your life (#4, 2009).

Restoring normal physical and social activity also included marshalling faith as a resource, and managing the environment. Spiritual faith sustained regaining. Participants' beliefs supported their restoring normal through maintaining a link to an inner resource. Faith was a resource that contributed to regaining physical functioning. It was demonstrated through overt signs, or was part of the everyday normal behaviours for the participants:

> What helped me when I came out of hospital...I had put this up on wall opposite where the chair was where I sat (a notice "With God's help – I can, I will"). It was a mindset I suppose (#5, 2009).

Technological resources, such as computer or telephone supported interactions too, in the participants' normal environment:

> ... and then [there is] the old computer. I 'Skype'. Well I can talk to my sons overseas and see them. Oh yeah, turn the stupid thing on every morning to see who is there. Just keeping in touch, even emails; the children send me pictures; I print them off, I got myself a printer... it keeps me in touch with everybody (#1, 2009).

> And the other thing that I find quite comforting is the fact that you have access to the telephone. I didn't have a cell phone but they brought the cordless phone, so that enquires from outside, I could handle. So, I wasn't in any way cut off (#6, 2009).

Managing the environment was regaining physical and social functioning by marshalling familiar resources. This included alterations to the house or garden that restored a sense of normalisation. Relying on a change to the participants' environment was on the one hand using marshalling the resource through adaption. On the other hand moving to new accommodations, such as in a village complex, was another way of marshalling resources to restore normal:

> I came home and stayed with my daughter and son-in-law. I stayed a couple of days with them, and then I came up here and then went back to them. I needed to have a walk in bathroom put in, so I had to stay with them. I had the bathroom redone. [It took] about three weeks. All tiled, walk in, sit down, turn on the shower. With that, I came home and here I am (#1, 2009).

> I think I have been here several years now; [it had been] redesigned... into your own double apartments... So we moved up here. Oh yes, it's lovely, because we are completely independent. I can order my dinner, go downstairs if I want to or if they are putting on a nice light lunch over at the Coffee Inn, I look at it and think oh yes, I like that, so I have a meal over there and then I just have fruit for tea at night, and if I want to I can pop on a bus and go out, have a meal out somewhere (#4, 2009).

Marshalling resources combined many factors such as the family, support networks, appliances, environment, or familiar activities all of which helped to restore normal interactions and behaviour. Moreover, some participants preferred less interaction with others and balanced being more self-reliant, whereas, others preferred the use of

their many available resources as they regained physical and social functioning. Helping, whether self-related or from others, was a continuous back and forth process according to the situation and context.

Helping

Helping is a property of relying and was about the balancing of assisted-help with self-help that were necessary in regaining. Assisted-help was the use of multiple factors during regaining physical and social functioning whereas, self-helping was the self-determining amount of help needed for restoring normal. Moreover, assisted-help did not necessarily mean participant dependence and relying on others. Assisted-help had various meanings. On the one hand, there were the types of help needed to regain physical and social activity, and on the other hand, there was the assisted-help participants gave to their family and community. Self-help was the ability to self-manage what was normal for the participants or obtain resources to restore normal. Determining who was responsible for the type of help needed, moved back and forth between participants and other people:

> I think it is important to get help and have it offered to you. When they stopped sending the person to help me with showering, I needed someone to help with shopping. I have that because of asking... it was important (#7, 2010).

Assisted-helping inferred different meanings for the participants. This influenced how and who they interacted with during regaining. Assisted-helping to restore normal was the people and devices, along with physical and environmental changes that occurred during restoration of physical functioning. For example, using healthcare teams to assist in regaining physical functioning became important:

> I like to mention the hospital service, very kind, and always very helpful to patients because I know I could not walk on the first week. I was told not to get out of the bed unless it was with them, to call them. So they came and helped me, and they lifted me and put me into the wheelchair, and if I wanted to go for toilet, they took me to the toilet, they waited there until I finished; and after I [had] finished they brought me back to the bed. And even for the shower, they took me; they helped me (#10, 2010).

The use of assisted-helping in the community was also necessary for restoring normal. Participants remained in the home setting, by drawing on assistance for normal activities from other people and agencies. The type of help ranged from personal cares, to house and garden work:

> [I have] home care help one day a week for shopping and one day a week for housework. Then I have another one just for showering (#11, 2010).

> Yes, but I have more help coming in, cleaners and things Well I have carers now that come into help me but they don't have to help me walk (#12, 2010).

> I still have a carer; she is a nurse, and she vacuums for me once a week. I rely on her because I do find the pushing makes me very tired. I know a good job is going to be done and I don't have to worry about it (#6, 2009).

Assisted-helping also included the normal activities participants used to manage social and family matters or their community:

> I keep in touch as much as I can, help them [the family] out when I can...yeah, so I can help [with money], and I love to (#1, 2009).

> So I thought it would be nice to have a group of people interested in painting. So I started an art class. I have been given talent; I use my talents to help other people [I also did volunteer work in the village] (#4, 2009).

Although individuals became involved in helping others their own needs for self-helping were still important, and these determined the amount and type of help needed for regaining. This was achieved either through the participant's idea of normal and sustaining it, or obtaining and using resources to maintain normal. For example, maintaining usual activities meant balancing the understanding of normal with the practical reality of living normal. Self-reliance and marshalling resources were used depending on what the participants determined normal.

Helping moved between assisted and self according to the need and the situation. Interestingly, during the acute care hospital episode, assisted care was overt and dominant, with a primary focus on restoring physical functionality. However, once mobility was restored to independence, the amount of assisted care lessened but remained until people returned home. While assisted care still occurred in the home setting, this was self-helping rather than assisted. Therefore, helping is the behaviour of balancing regaining's needs against maintaining normal. Relying in restoring normal is the balancing of self-reliance and marshalling resources in the form of using self-help and assisted help.

Summary

Regaining has illustrated that restoring normal was more than just getting back to physical functioning. The interplay of physical and social interactions and behaviours was about restoring normal according to participants' interpretations. On the one hand, the pacing inherent in regaining was influenced by time, age, perceptions, and compromises. Spacing on the other hand was the balancing of distance using symbols that enhanced security and assisted with role shifts. Spacing focused on the social interactions between people, places, and environment, all of which were important to support regaining. At the same time, relying was the effective managing of self-reliant activities that were balanced with resources marshalled from multiple sources. Constant movement between pacing, spacing, and relying occurred during restoring normal. Each property interacted with the others. As participants recovered, properties continuously moved to manage restoring normal. While regaining has presented the physical and social elements of recovery, the following chapter will examine the psychological aspects that are required to restore normal.

Chapter Six

Reasserting

Introduction

Reasserting is the second subprocess to be presented in the theory of restoring. Reasserting is defined as the permissioning, connecting, and reconciling required for restoring normal psychological processes. Permissioning is the reasserting of the participants' normal responses, interactions, and behaviours. Permissioning is influenced by the participants' developmental life stage and the diverse expectations that influence restoring normal behaviour. Connecting is reasserting the self back into interactions and relationships. Familiar patterns of interactions and relationships assist in restoring normal psychological responses recovery that is actually an unfamiliar situation for many. Reconciling is the reassertion of the usual psychological behaviours. These behavioural responses are seen in the restoring of participants' normal attitude, routines, and ways of accepting, which occur in their normal life.

Reasserting had two components. The first component was the reasserting of the self during restoring. The self was defined as the distinct identity and characteristics of the older adults, presented publicly through their personality and behaviours during restoring. Second was the reassertion of the older adults' position within the many groups they encountered during restoring. The older adults' personality influenced behaviours and the position taken in these groups. Interactions and behaviours were contextual and depended on the individual response to the recovery situation. For example, in the early recovery stage, the older adults' interaction with health professionals was influenced by their unfamiliar position and the differing views within the health professional group. In the later recovery stage, a change of situation or place, repositioned the older adults' behaviour. This reflected familiar patterns of behaving of the self, within normal groups such as family, friends, and community.

The psychological process used in reasserting is defined as the cumulative influences of family, socialisation, experiences, and life span events that are described as a person's personality. Personality is the qualities, traits and characteristics that

make up and define a person. The dynamic and organised set of characteristics possessed by a person uniquely influences his/her cognition, motivation, actions, interactions, responses, and behaviours. Psychological responses to events are influenced by peoples' thought processes and actions. The particular combination of emotional, attitudinal, and behavioural responses is intimately linked to a sense of the self. The self uses filters, such as social history, roles, culture, faith, and values as a pragmatic response according to the situation and context. The person's past underpinned their actions during restoring:

> Don't forget your past, it makes you... (#13, 2010).

Self-response behaviours had to be balanced with wider interactions that occurred in the recovery situation. Moreover, there are multiple selves that transition according to time and context. Reassertion of the participants' psychologically normal behaviours underpinned responses to the immediate event, and had to be managed in a way that was acceptable for the longer term:

> I mean this is how it is...deal with it...nobody else can do it for me... (#3, 2009).

> As you get older you have to find ways, but this becomes normal (#7, 2010).

Part of reasserting, in the wider context, involved comparing the self to other peoples' ways of behaving during recovery. Personality traits and characteristics were considered against expected patterns of behaving:

> I mean even with some marriages and some lives, people don't have to develop certain traits others have, do they? [The fracture] was just something in passing. Yes, it didn't reduce me to a helpless wreck. It was just a blasted nuisance. I know it was because you see I was in an orthopaedic ward, which is very educational... it was so screamingly obvious the one who [were] martyred people (#3, 2009).

> I was going to say that you don't just suddenly have a personality change, some people do of course. They have a fracture and that's the end of the world as far as they are concerned; they mentally fall to pieces. You don't make a conversation [of it] for the rest of your life (#3, 2009).

In this chapter, reasserting and its concepts and properties will be presented along with a diagrammatic representation of the subprocess. (See Figure 11).

Figure 11. Reasserting subprocess and properties

Subprocess	Concepts	Properties
REASSERTING	Permissioning	Developmental life stage, diverse expectations
	Connecting	Familiar situations, unfamiliar situations
	Reconciling	Attitude, routines, accepting
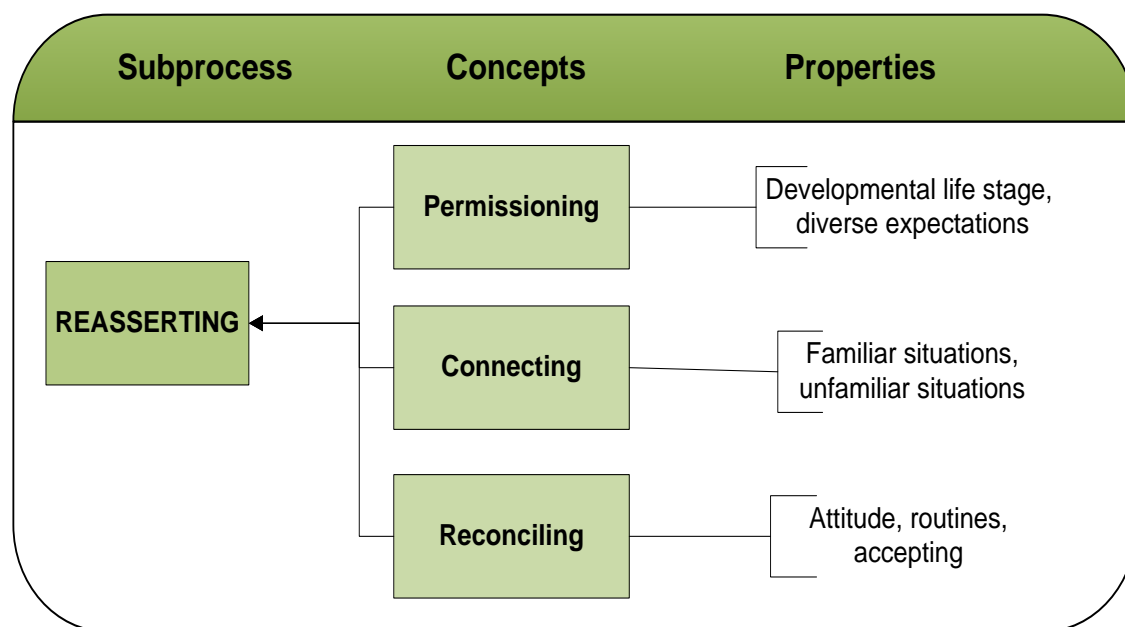
Permissioning

Permissioning is one concept of reasserting that is defined by differing contextual and situational interpretations of behaviours during restoring. The properties of permissioning include developmental life stage, and diverse expectations. Therefore, developmental life stage influenced self-permissioning and diverse expectations impacted behaviours seen in professional interactions. It was evident that the recovery context influenced permissioning. There were professional and self-permissioning behaviours that affected recovery. In the acute period, recovery was professionally-directed and situational. This impacted how permissioning was interpreted by older adults. At the same time, professional expectations and understandings influenced the older adults' responses and the timing of reasserting self-permissioning. Reassertion of self-permissioning was initially limited until professional permission was given to the older adults' to be independent within the hospital:

> Well, after I had been getting up to the toilet with the nurse...[She] said to me, you can walk on your own now...I thought I must be well and walking okay (#11, 2010).

Self-permissioning overlapped with the health professionals' permissions during the hospital phase. However, as recovery progressed, older adults reasserted normal psychological behaviours that would be used after their discharge from hospital. In the immediate recovery stage, older adults gave unspoken permission to the healthcare professionals to manage the beginning recovery processes, which resulted in individuals adhering to the professionally-directed regimes, or not acting independently, until professional permission had been given:

> You have to be obedient because you don't know what is happening. I knew there was something wrong with me, so I knew it was my duty to listen to them [health professionals]. I had to trust people. I had to. I was happy that there was somebody worrying about me; I really appreciated it (#10, 2010).

On the other hand, some participants were more active in seeking permission. They reasserted their usual personality and interactions and became more involved with the health professionals. Rather than waiting for permission to be given, some individuals reasserted their authority by confirming permission with the healthcare personnel:

> Got the doctor's permission for my discharge. I always told them that I was going. [I] already had my carers set up at home (#12, 2010).

Permissioning was tempered according to the contextual setting. In the hospital context, professional permission for self-management was important, as it facilitated the reassertion of normal behaviours. As the patients' independence increased professional permissioning declined. This had a psychological effect on the older adults who began to display self-management restoration management and psychological responses similar to at-home behaviours. Therefore, permissioning moved from professional control to self, and reflected participants' normal behaviour and choices they made:

> I did what I normally did however, not telling anyone...asking for help was making a choice to allow others to get involved (#16, 2011).

Once participants returned to their previous residence, self-permissioning helped to restore normal patterns of behaviour:

> You give yourself permission to do or not to do things (#18, 2011).

In the home setting, while self-permissioning was reasserted there was still room for healthcare professional input. The influence of professional permissioning at this later stage though was balanced with self-permissioning. Thus older adults reasserted their control, and determined which at-home professional regimes were useful to their needs:

> Because I tend to think [about] the stuff I didn't like [to do]; I put [that] right away [exercise programmes]. Out of sight, out of mind. (#2, 2009).

The situational difference between the two types of permissioning is that professional permissioning did not explicitly acknowledge the older adults' developmental life stage, personality characteristics, and attitudes. Primarily, health professionals dealt with the body but left individuals to manage their psychological restoring. Self-permissioning was eventually reasserted though and the older adults' usual behavioural responses occurred. The older adults' personality characteristics and attitudinal responses were shaped according to the influence of developmental life stage and diverse expectations.

Developmental life stage

The developmental life stage, a property of permissioning, influenced the behavioural interactions in permissioning, as participants' personality characteristics, ways of thinking and attitudes about recovery were reasserted during restoring. The term was logically derived from the data to represent the variance inherent in older adults' developmental life stage and its subsequent influence on restoring. There were many developmental factors that influenced participants reasserting normal psychological behaviours. For example, attitude, mindset, and personality:

> I made sure I didn't develop tunnel vision about any particular aspect about how I was living. [I] tried to keep a broad view and a balance to what I was doing... In other words, I am self-disciplined... there is some value in being like that. We are living longer but on the average, when you get to 85, you

sort of move on... Instead of making a fuss, you just put up with it (#3, 2009).

Nevertheless, the developmental life stage influenced participants' psychological responses to reasserting. For example, the older the participant was at the time of the event, the more likely they were to wait for professional permission to become independent. This was often seen in the participants' conduct towards healthcare professionals and adherence to regimes, reliance on assistance, and general appreciation of the care received:

I like to be very grateful... to the hospital service... [They were] very kind and helpful...[but] you have to be obedient because you don't know what is happening (#10, 2010).

The development life stage affected if reasserting occurred or not. Older adults tended to respond passively in some instances, and were happy to cooperate without question:

I was happy to cooperate. Whatever they considered necessary, then I was okay [with it]. Well, nobody likes being in hospital if they don't have to. But I can't complain about the hospital. Just getting home, I like to be at home. That is very important (#7, 2010).

On other occasions, older adults' passivity impacted them emotionally as professional permissioning continued during recovery:

I was so excited and nervous at the same time, in being able to get out, as I had never been in a place where you were not allowed to move and get out to go home. There was this ghastly feeling of helplessness. I knew that I didn't have the strength to go anywhere on my own. I knew I couldn't move very far, I was controlled sort of up to a point. The point is where you realise you can't go where you like (#11, 2010).

In contrast, some participants saw permissioning as a shared responsibility. They were more active in reasserting their own ways of thinking according to their personality traits and customary habits:

> I started to argue about having a shower. The lady would say to me, "you are having a shower this morning". I said, "No, I am not. I am just having a wash. That is all. I am not having a shower; I will have a shower tomorrow". Well I don't shower everyday... I have never showered every day in all my life. [I] have a full wash because we never had enough water... (#11, 2010).

Younger participants' permissioning depended on the relationship they had with others. These participants controlled permissioning accordingly:

> You create your own space and you give permission for others to help you (#16, 2010),

This type of attitude promoted self-permissioning.

Irrespective of the developmental life stage, participants who lived alone, reasserted their way of thinking as quickly as they could:

> Well I think I am alright. [I have] this lady here [who] comes every Monday morning to help with the vacuum cleaning and she does the ironing for me. Then another one on Wednesday who comes and she could wash me if I wanted, [but] I'm a bit independent... I try to help myself and she is handy if needed (#13, 2010).

More often than not, older adults' hospital self- permissioning behaviours were similar to their at-home ways of thinking. When an unexpected event occurred, their normal psychological behaviours were interrupted. As recovery progressed and psychological reassertion strengthened, older adults began to question professional permissioning and actions:

> I do think it would be better if the doctor did talk to you. Doctors don't tell you a lot, they never do. Well a funny thing happened when I first came out of surgery. In the next couple of days the doctor came through [and] he said, "how are you feeling, do you feel alright?" I said, "I have a bit of pain down here (indicated my knee area)". I was only saying what he wanted to know and he turned to his... whatever it was [Registrar/ House Surgeon] Oh, she has just has a big operation and she feels some pain. Well he did ask, what did he want me to say? Sometimes, someone would come through and pass a remark, ask something but [I] didn't know who it was (#11, 2010).

The attitudes, ways of thinking, and behaviours were evident in the diverse expectations older adults had to respond to during recovery.

Diverse expectations

Expectations, a property of permissioning, were the multiple viewpoints older adults encountered during recovery. The diversity was evident in the behaviours of the many people involved in the process of restoring. Expectations were the beliefs and assumptions people made about recovery, which were interpreted through their developmental life stage or professional equivalent. These assumptions were reflected in the ways of thinking, attitude, and actions of those involved. Older adults' expectations influenced reasserting of normal psychological behaviours, along with the responses to professional permissioning and self-permissioning. During restoring, older adults' expectations were continuously balanced against professional, family/community, and time-related expectations. The older adults' expectations emphasised a restoration attitude that was reflected in the recovery outcome:

> [I] never thought that I wouldn't get back to my normal life (#9, 2010).

> I never thought of not recovering, it never came into my mind. I thought I am going to hospital, I'm having an operation and after that I'll be fine, and I'll be back (#4, 2009).

Professional expectations were balanced with the older adults' reassertion of self-permissioning, which influenced their expectations during recovery:

> I don't know if I will ever recover because the doctor said you don't really recover properly from a hip operation. Well, I thought it meant that you would never get walking.... not how you walked before kind of thing, you know, that it would upset the [normal] walking. I thought it would be about 3 months or something like that – that is what the doctor said. I think I remember my Dad breaking a bone and it took him about 3 months (#13, 2010).

Older adults expected to be involved in the recovery process and that health professionals would interact accordingly. This also included gaining permission from the older adults for healthcare interventions:

> They don't tell you anything. One of my daughters was up one day and
> started talking about blood transfusions, and I sort of wondered why she was
> bothering and I said "I've never had a blood transfusion". She said "Yes
> you have"... I was a bit brassed off about that. They could have said, "this is
> what we are going to do". I don't think they even asked either of my
> daughters to sign for it. [I was] just annoyed that nobody had bothered
> telling me. [I] hadn't been involved at all [but] you get over these things
> (#7, 2010).

On the other hand, some participants' expectations were met during the hospital stage.
Professional permissioning was accepted and interpreted depending on the older
adults' ways of thinking. This was reflected in their later recovery and influenced their
viewpoint on responding to professional advice:

> I just thought it was fixed and that was it. Providing always that I did what
> they [health professionals] suggested to do. They suggested that I walk and
> why did I do it because I thought why not do it. They tell you or suggest to
> you certain things. Whatever it is, you should do it. We have seen people
> in here [the village]. We have been in here 3 years ... we've got to know
> people... but there are some of them [who] are not doing what the doctors
> have advised them to do after their operations or whatever. They've let it
> go, [and it] becomes their disadvantage (#5, 2009).

The hospital period influenced permissioning and expectations about immediate
recovery. Reasserting normal psychological behaviours was seen to be beneficial, but
the older adults' expectations reflected their attitude to the recovery process:

> You have to do as you're told. You know it is for your own good so you try
> and do it, don't you. But I think I had a lot of freedom in that hospital and
> to be able to get out of the bed and walk along the hallway and go to the
> lounge. Then the doctors used to come around at certain times each day, so
> in a way you looked forward to seeing them because it was like having a
> visit, I thought from the doctor (#13, 2010).

Older adults continually balanced and interpreted family/community expectations
during restoring. This was dependent on the type of relationship the older adults had
with family members and other people in their usual environment. Family member
expectations shifted according to the context during recovery. During the acute stage,
family members responded to the health event and provided expected support,
reasserting family interactions and behaviours:

My daughter, well she isn't soft with me but she does everything and we have a few laughs together and all that you know. Without her, I would probably be a little bit lost. We have always been friends together [and] she makes sure that I am okay (#13, 2010).

[It's] great to have them present, but [I] worry about intruding into their lives, their time, costs and effort... (#7, 2010).

At the same time, older adults self-permissioning and support behaviours reflected family roles, reasserting their normal psychological responses to family members:

Well, [family] are scattered. I only have my youngest daughter in Auckland. She was worried silly, more than I realised at the time. She was scared stiff I was going to die seemingly. I do support her. She needs it; she is still trying to find her feet. I mean a broken marriage is not a good thing (#3, 2009).

I have a daughter in ill-health. She was going to be on her own, should I go [and die]. I didn't have to worry; the choice was made for me. Get up and get on with it. I had no choice (#6, 2009).

As family roles and expectations reverted to normal behavioural patterns fairly quickly during recovery, reasserting normal interactions with home based and community people followed after discharge. Self-permissioning behaviours returned to the usual patterns typical of the home environment. However, expectations about the self varied:

Well I wasn't able to anything very much. I just had to exist until I could cope. Bloody-mindedness I guess. I have never had anything like this before. New experience, absolutely, totally and one I don't want to repeat (#7, 2010).

I probably found that as the help dried up after awhile, eventually they sent a nurse to evaluate me, for what I needed and what I didn't need. She recommended that I had help for another 8 weeks. She said, "it doesn't mean you'll get it, but that was her recommendation". I got it for another 6 weeks, which was very helpful (#7, 2010).

Home help were fantastic but overgenerous. [I was] glad when [it] ran out, [as I was] over it. [There is a] point where the help is no longer help but interruption or hindrance... [I] had enough but they were supportive people (#9, 2010).

On the other hand, older adults' expectations varied about people in the community. Participants' normal psychological behaviours to manage the recovery process were compared with other peoples' responses to health events:

> You know people moan and groan. They do that anyway because that is their temperament. You deal with it. That's life sorted out. Survival is the name of the game. I would say it's a total attitude, yes, yes because you have met the types that go into a decline and talk about my operation, spare me. It doesn't mean that your whole life is forever geared around before I fractured, after I fractured, while I was fractured. I think it is important people realise that they can be very tedious and boring (#3, 2009).

Older adults' self-expectations influenced their responses to restoring and were interpreted through permissioning in different contexts and time-related expectations. Professional permissioning was followed in the initial hospital period until interventional activities were significantly reduced. Older adults reasserted self-permissioning behaviours at this point, as professional permissioning no longer seemed relevant. Even if the time frame for recovery was short, older adults reasserted normal self-permissioning behaviours:

> Getting permission to do something went against what I normally did...Why did I need someone's permission? (#16, 2011).

In a different context, such as returning home, older adult expectations of the time it took to recover had to be reinterpreted to reflect the situation:

> I am a little bit disappointed in that umm, I expected to be able to get back totally to what I was before and I find that this muscle fatigue is annoying. [Before] I was walking; you know my little walk, my half hour walk. I find I'm puffing and feeling fatigued half way through. I had hoped to be right back to normal (#6, 2009).

> I thought three months and I would be on the go again... probably when you get to my age, it takes a little longer (#11, 2010).

Self- permissioning was reflected in older adults' expectations and normal behaviours were reasserted as recovery progressed:

> As soon as I felt strong enough to walk on my own. That's the thing that it makes the difference (#11, 2010).

> [I'm] just doing what I have to do. I'm very good at not doing things. I suppose I'm lazy, probably born lazy and just expending the least amount of energy [I] have to. You have to be comfortable, don't you? [Which] means being able to do what I have to do. I'm a bit lucky being here [in the village], I don't have to do it and that suits me beautifully (#7, 2010).

Developmental life stage and diverse expectations influenced the types of permissioning that occurred. Reassertion of the older adults' normal attitude, ways of thinking and actions contributed to their sense of self and place in the recovery process. Instrumental to reasserting normal psychological behaviours was the older adults multiple ways of connecting.

Connecting

Connecting was another concept of reasserting. Connecting is defined as the process used to manage familiar and unfamiliar situations during recovery. Situations were defined as the connections older adults had with people, places, objects, concepts such as faith, environments, and customary habits. Familiar situation connecting refers to the normal relationships, attitudes, and responses older adults used in familiar interactions. Unfamiliar situations meant connections had to be reinterpreted by the older adults according to their normal psychological responses. Unfamiliar situational connecting was usually short term and contextual, which resulted in interactions to clarify the situation:

> I was hospitalised that night... and they said they wouldn't operate until the Monday. Lo and behold, on the Sunday night they operated... By Monday lunchtime, everybody was showering and I said, "Am I showering?" They said, "Yes, off you go"... here arrives a walker and a carer (#6, 2009).

Connecting was not static and continually changed according to the needs of the participants. Nevertheless, restoring psychological connections was important. Reasserting the older adults' thought processes and actions used in familiar situations enabled the unfamiliar ones to be managed. How older adults dealt with familiar situations reflected their personality and interpretation of connecting accordingly:

> To me everything is connected altogether, it is part of the way my brain functions; it just happens; it's all part of memory...you are the sum of your past in the present through being connected (#20, 2012).

It was evident that connecting was about the relativeness of familiar situations. The more familiar the older adult was to a person, place, object, concept, or support, the more likely their attitude, ways of thinking and behaviour would be supported by those connections during recovery. In contrast, the less familiar participants were with people or supports, the more likely they were to fall back on familiar connections to help manage the situation.

Familiar situations

Familiar connecting was a property of connecting that was interpreted by participants according to their relationships with usual situations such as, people, or supports. It was the interpretation of the familiar that supported reassertion of the older adults' personality, attitude, and interactions during recovery. Familiar connecting emphasised family members as a basis for restoring, which provided a network that enveloped the older adults. While this increased the potential for reasserting normal behaviours, it was often specific members of the family that created the sense of familiar:

> My children are an incentive to move forward (#7, 2009).

> [My] husband [was] most important as [my driver] however, [the] rest of family being there in the background [was] important (#8, 2010).

> Being with my son...we enjoy life together and that is what I wanted to get back to (#11, 2010).

The familiarity of connections had many interpretations other than close family members. Non-family people and community supports were also part of the familiar network that was used during restoring:

> A big network sits around you – husband, family, friends, church... Trying different things and using connections to try and find a remedy (#9, 2010).

> A husband, family generally, but he's the only one handy. [My] daughter lives in [another city]. [My] son is [here] but he is so busy. [I have] lots, lots [of friends, including] bowls naturally. Moving here [to the village] was only at the beginning of this year and [I] met some terrific people. Instead of being all by yourself, it is just the friendliness of people, people that I hadn't known before really, doing helpful things but I think that helped [me to] manage very well, because [I] couldn't stay where [I was], as

it was a big place to look after, lots of outside area. Stuff that I used to do I can't do it now (#2, 2009).

Connecting with community supports were usual relationships that older adults continued to interact with once they had returned home. Neighbours tended to have more importance for participants especially when they lived alone:

Yes, it is important to keep contacts; I'm very much on my own. You come in as an outsider; no matter when the chips are down... [You] have to make connections with neighbours, however superficial (#16, 2011).

There are people [neighbours]around here,... they are younger people but they all connect with me...you see them and say hello...we don't have a lot to do with each other but if we see each other we acknowledge each other (#13, 2010).

Older adults used other familiar situations to support the reassertion of their usual psychological patterns of behaving. For example, faith in the self, along with spiritual faith, was an inner familiar connection, older adults used during restoring:

Because I think positive...if you are going to go whinging and whining, not been able to do this and not been able to do that, not me... It doesn't matter what happens, there is a silver lining in every cloud and I figure well when I did fall and break my hip...I just have to get on with it (#1, 2009).

[I am a] practising Christian. Right from a little girl, as soon as I could talk, I was taught to say my prayers and I have said my prayers every night, every morning, every night since... I've just got a positive faith. I don't take risks but things happen. It's how I deal with it. I said my prayers before surgery and I said a thank you after. I'm not silly with it; it's just part of me (#4, 2009).

Alternatively, familiar connecting was strengthened when participants returned to their previous residence. Participants managed at home, often with helpers, who were already an everyday established part of their lives. The participants' residence or home based-technologies were familiar forms of connecting. For example, within a village complex, participants connected with a number of activities that were interpreted as familiar interactions:

There is just so much to do here. You don't come in here because you are old. You come in here, I always tell people you come in here to open up a new chapter in your life. We have a beautiful big art and craft room, we can

> teach any sort of art, any sort of craft. We go on trips, out to lunch, go to
> the ballet, to the opera, and I am going into the Town Hall next week.
> There's the Philharmonic Society (#4, 2009).

Familiar connecting's focus on the home setting, helped to strengthen normal behaviour patterns:

> It's being connected with the house, I know where everything is and if it is
> moved... I am at risk (#16, 2011).

> You make the most of it... There's a lot to enjoy, you know, the garden, the
> flowers, [and I have] got nice neighbours (#1, 2009).

In the home environment technology helped to reassert familiar connecting. For some participants computers connected them to people and places that provided a sense of participation in family life:

> My eldest grandson got married [overseas], my oldest son took his laptop,
> set it up on the front seat and I saw the whole wedding. Just like being
> there. No jet lag, it was fabulous. I could hear the whole ceremony,
> everything. It was wonderful. It has diminished the world, yeah, it keeps
> everybody right here...I bless the day I learnt to email and use the computer
> (#1, 2009).

While connecting with familiar situations supported older adults in their recovery process, some aspects were unfamiliar. The unfamiliar situation was often contextual and situational. This had older adults connecting with unfamiliar people, processes, or environments.

Unfamiliar situations

Unfamiliar situations, the second property of connecting, occurred during recovery. They tended to be short term and contextual. An unfamiliar situation happened when older adults encountered circumstances that were not part of their normal life situations. These included unfamiliar people, processes, behaviours, and places. The most common unfamiliar situation was the unexpected admission to hospital. In this context, older adults initially struggled to connect. The situation interrupted normal psychological behaviour and presented a different set of pattern of interactions. The unfamiliar situation divested the older adult of control of the process:

[I was] not sure who did the operation but it wasn't the specialist surgeon. [I was] not told anything, [I was] furious about it but could not talk or tell anyone about it. [There was] a lack of care overall. [There was] no physio [to teach me about] walking, exercises, crutch use, [or managing] stairs. [I] just lay in bed then [I was] discharged. [I had] no control over what happened. [It was a] big problem [as I was] left out of everything [and] not being listened to. Due to the fall, [I] had no choice in who treated [me] but you [do] expect competence (#9, 2010).

Participants often noted a lack of involvement in the unfamiliar situation of the recovery process and that their responses to these situations were not always taken into account:

You are rarely asked if you want to [do something]. There were times you didn't want to, but you did it anyway because you were told to (#18, 2011).

Overall, the unfamiliar situation resolved fairly quickly. The unfamiliar became familiar. The older adults' reassertion of familiar ways of responding occurred, but the unfamiliarity of the environment continued to interrupt on occasions. Ongoing interactions with health professionals influenced reasserting. These were mostly positive but there were negative instances. The older adults' responses to these unfamiliar situations varied however. It was usually the attitude of health professionals that impacted the situation:

Well I just couldn't eat really; I found I couldn't eat when they brought the food in. [It was] a very unusual way of cooking. What it is I don't know, very peculiar. They would grumble at me because I couldn't eat it. I just felt I wanted to throw up. I told them, [but] they said try, try to eat. I said I can't, and then they started giving me 'Fortisip' (#11, 2010).

Mostly I found them [nurses] to be very good, but I struck one nurse who said – "I'm not your slave you know". I shed a few tears and another girl came in and she said " what's the matter?" and I told her what had happened and I didn't see that girl again [the first nurse] – I said keep her away from me and I didn't see her again (#12, 2010).

I think most of the nurses were doing their job. [No matter what you think or] whatever you feel is too bad. Well everything is automatic with them and you wonder sometimes if they listen to you at all. It is all just work. Just sort of all routine – just a job and that is it. You have got to fit in that's for sure (#11, 2010).

Unfamiliar connecting merged into familiar situations during the hospital episode. Older adults continued to reassert their usual personality and attitude, and the environment often supported their ways of thinking until they were ready to return home:

> What helped me? The fact that they [health professionals] were confident; they were relaxed, they were obviously not worried about anything, so why should I be? Obviously I wasn't well prepared for a hospital visit. Other than that, it was well organised, well run and I was able to relax. The surgeon came the next day with his houseman and I was obviously in good hands. I won't say it was quiet or restful because it was a transitional ward and it was like a railway station. [But] I thought the ward was excellent and it was like a cocoon; it was nice; it was comfortable, I didn't have to worry about anything but there comes a time when you want to move on... boredom, restrictions, in [these] surroundings. You can go that way or that way and stop. You don't want to do that forever. The quicker you go, the quicker you get home… I [was] ready (#6, 2009).

On return to the community, unfamiliar situations occurred. These were usually short-term but represented an interruption in older adults' normal behaviour. For example, not being able to drive meant using other forms of transport. Overcoming the apprehension of using buses, a once familiar connection, changed actions and sometimes contributed to psychological restoring:

> I'm very apprehensive of buses. I hate buses. My son put me on the bus...once I could get on the bus, which was quite an adventure in itself, it was okay...I didn't drive for another six weeks and then just limited (#6, 2009).

During initial recovery, the unfamiliarity with the healthcare setting, its people, processes, and environment, older adults increased their familiar situations connecting, while managing the unfamiliar. The unfamiliar situations more often than not became familiar however that depended on the personality, attitude, and response behaviours of the older adult. The normal patterns of behaviours used by older adults were often the result of life's influences that was a way in which they reconciled the unfamiliar with the familiar.

Reconciling

Reconciling is the third concept of reasserting and is defined as attitude, routines, and accepting that influence recovery and the process of restoring normal. Reconciling is where older adults will attempt to accommodate, resolve, and accept any and all changes that impact during restoring. The older adults' personality traits, psychological behaviours, and usual situational responses underpin reconciling. Moreover, these characteristics facilitate psychological restoration during recovery, through the interpretation of attitude, reassertion of routine, and self-acceptance behaviours. Attitude was a mindset older adults' focused on during recovery. Interestingly, their attitude reflected the normal personality of the older adults. Attitude was also a way in which the impact of recovery was reconciled as acceptable or not for the older adults. Routines were everyday patterns of behaving that were based on normal psychological processes older adults used to manage the sense of self relative to their life stage. Accepting was an ongoing process in the older adults emotional, intellectual and behavioural responses to situations and context. The older adults' usual reconciling of life situations was according to their personality, attitude, and emotional responses and was often seen during recovery:

> ...because I want to get on with life, I'm not going to sit here and be miserable because my hip is broken (#2, 2009).

Even when complications sometimes occurred following hip fracture, older adults used their normal reconciling behaviours to continue their recovery:

> Complications [from the fracture] changed my ability to mobilise, and socialise [but I] found solutions to these...until [the] complications [were] fixed (#9, 2010).

Reconciling was a usual psychological response older adults used to interpret the influences of ageing. This was reflected in their interpretations:

> I am very grateful for having a life of not having problems. I appreciate that now, much more than I did. I appreciate my good health much more than I ever did, while I had it. I have had to adapt my thinking; I'm not as good as I thought I was. I think it's hard to realise you're not as good as you used to be. I think as you get older you have to find ways of doing things and after a while it becomes normal to do it (#7, 2010)..

Because I am not as agile as I used to be. I think when you age, you must slow up. Well I have got used to myself and how things are. I am very lucky in a way because I can get out there when the sun is shining and sit on the seat, and I can even get to the letterbox in a funny sort of way. I try to do my best. It is an achievement I suppose (#13, 2010).

Reconciling was the psychological management of the impacts from the health event, in which the older adults reasserted their sense of self through personality and behavioural responses. This was reflected in their attitude, routines, and acceptance responses during recovery.

Attitude

Attitude, a property of reconciling, was a mindset older adults used as a reconciling behaviour during recovery. This mindset was a psychological response developed from historical, social, and family influences. The older adults' attitudinal characteristics were interpreted as thinking positively, which had a significant influence on their recovery:

I think you have to [think positively] don't you, as you could lie there and feel terribly sorry for yourself. But I don't see much point. I think probably but I have never had to face this before. You have got to think positively no matter how rotten you feel. You have really got to think positively otherwise I think I would go under (#2, 2009).

Things haven't changed that much really, I reckon... because I think positive... and I just have to get on with it (#1, 2009).

Moreover, older adults' positive thinking was reflected in their usual attitude. This was supported by a history of family values and psychological responses to situations:

Attitude is a value; it is about how you were brought up; it's a family thing, and you just get on with it, and make the best of it (#15, 2011).

I think attitude counts for a lot; from the family I learnt I had to put up with quite a bit (#13, 2010).

Because it's an attitude that goes within our family...they have always looked on the bright side (#12, 2010).

Attitude definitely. Well, my son is the same, and my daughter. They have been brought up [like that] and my husband has always had a very, very positive attitude (#4, 2009).

Conversely, older adults noticed that some peoples' behavioural traits reflected a negative attitude for recovery:

Lying there being a weak female isn't me...people don't have to develop [those] certain traits do they? (#3, 2009).

Psychologically, keeping a positive attitude could be difficult at times. For example, if complications had arisen or recovery was taking longer than expected. Sometimes older adults realised that there were occasions when it was harder to reassert their positive attitude:

Well, I wouldn't say I am positive all the time, as there have been times when I have been quite fed up with everything...but you have those days don't you (#13, 2010).

I have said it before – mainly think positive. If not, that's your biggest problem. Everybody gets nights where you lie in bed thinking – why me, I want to do something but I can't. Why? But if you think positive about the things that you can do and you have a very helpful person in the next room, it makes a big difference (#2, 2009).

You must think positive. Look there have been plenty of times... even today, I think I don't want to get out bed and walk, I don't want to get out of bed and do anything but if you've got it ingrained into your mind that you have got to do it then you will get up and you will walk, whether your mind tells you to or not. It is very easy to become lackadaisical, too easy. I don't [but] there are times that I don't want to go walking, there are times when I don't want to go the gym, but I go [anyway] (#5, 2009).

A positive attitude supported recovery but it also influenced other aspects of reconciling such as reassertion of the older adults' normal routines.

Routines

Routines, another property of reconciling, were the psychological management of older adults' everyday life through patterns of behaviour that were normal customary

practice. Reasserting normal patterns of behaviour by restoring routines enabled older adults to reconcile the impact of the recovery processes. Routines were increasingly important to older adults as they grew older, because they tended to provide psychological stability and an anchor point during reasserting:

> Very important as you get older, it is something to cling into; routines are an anchor for you, comforting (#21, 2012).

Routines were evident as stabilising forces in reasserting normal psychological behaviours. Older adults interpreted unexpected events as potential threats to this stability:

> Routines are evident throughout early and later lives, as they provide stability, security and balance...the elderly thrive on routines, you don't want too many surprises anymore (#20, 2012).

> Routines were more important that I thought (#18, 2011).

Routines were self-determined behaviours. They were often adapted to accommodate ongoing change that occurred throughout the life stages. Routines were a part of older adults' reconciling behaviours in which they managed life events. Any impacts on the usual routines were interpreted accordingly. Older adults managed these impacts through normal ways of thinking, and accommodated the changes into their normal behaviour patterns:

> [I am] not spontaneous now, [I] used to be... [I] have routines. Now especially after the injury and complications...routines underpin all my activities within the home, etc...(#19, 2012).

> Well, what I do now is I have a routine, to give each day its own character. So I have a routine for each day and when I have done that routine I can tick that off...it's my choice (#6, 2009).

In the restoring process restoring routines was influenced by delays or complications that occurred during recovery. However, these were usually temporary. The older adults' psychological response to delays or complications included temporary changes to their routines. These were minor changes in which the participant required different responses to managing the patterns of daily life for a

short period. When a major environmental change, such as bathroom alterations, ramps were installed, or help was needed in the home setting, older adults incorporated these into their previous routines. The older adults' psychological response was not to change normal routine patterns but to reassert the self and reconcile the behaviour supporting them:

> Yes, getting back to my previous routines, walking with my neighbour however slower now but the routine is present (#16, 2011).

> I've lived here for seven and a half years. [I am] well settled in, back to normal routines. How I get around may be different, but [I am] normal for being back home (#7, 2010).

Professional routines had an impact on older adults during restoring. In the hospital period, health professionals' routines took precedence. At the same time, the healthcare routines provided an element of psychological security for the older adults managing the unfamiliarity of the event and the strange environment. These professional routines were generally reconciled by the older adults as an accepted part of the recovery process:

> Routines in hospital, you accepted their routines...had no choice really...tend to go along with them (#18, 2011).

Notwithstanding, healthcare routines only interrupted psychological reasserting to a point, during recovery. Once the health professionals considered the older adults independent, any continued emphasis on professional regimes was viewed as a hindrance to their restoring. While in hospital older adults' basic self-care routines needed to be re-established. These were viewed as temporary until the older adults returned home. Although, adherence to hospital routines was perceived a necessary part of recovery, different routines in care were an integral part of reconciling back to old routines:

> To get back to what I was, that is what I wanted, my old routines just as I was... (#11, 2010).

Reconciling was a behavioural response to accommodating changes and impacts during recovery. This action was seen in the routines and behaviour patterns the older

adults. While routines offered a psychological stability, reconciling of the impacts on these were underpinned by the older adults' attitudinal response to accepting.

Accepting

Accepting, the third property of reconciling, was an ongoing active process in reconciling, not an end state. Accepting was the attitudinal, emotional, and value-laden ways of thinking older adults used to respond to the multiple factors that occurred during restoring. During recovery, accepting reflected the reasserting of older adults' normal psychological response to life situations. Accepting was a psychological behaviour older adults used to restore a sense of self in the recovery process. Accepting tended to reflect their normal psychological processes used in everyday life situations, such as getting older or managing situations. Moreover, it was evident that there was a pragmatic reality to accepting. Older adults interpreted growing older as a natural occurrence, therefore accepting was about taking an active role in the process:

> Our acceptance of ageing is happening because we are involved in it (#20, 2012).

However, part of the accepting process included being honest with oneself. There were some reluctant responses to the changes that needed to be accommodated during recovery:

> Being honest with myself... you never quite get back to normal (#18, 2011).

> Being comfortable with what you can do now (#18, 2011).

This honest approach to reconciling the changes required also involved accepting that help in the home was required to stay in their place:

> [With] some chores [it is] necessary [that I] use others; I'm keeping my door open to stay in my space (#16, 2011).

Reasserting normal acceptance behaviours had an added benefit for older adults during recovery. For example, being able to reconcile activity restriction required the use of an assistive device. Psychologically, this was acceptable, as it benefitted restoration of functioning. Sometimes these devices became permanent. Older adults

reconciled this fact by the reassertion of a psychological response that accepted age and device were interdependent factors:

> I am getting on now, [although I am] not as young as I used to be. I do manage to do things and get around with the walker and everything now... (#13, 2010).

Reasserting psychological behaviours during recovery occurred fairly quickly for older adults. Although, when delays or complications occurred, some frustration was evident. For some, when recovery was taking longer than expected, the older adults' normal psychological response to such situations influenced accepting:

> [I] did what I could, not worrying about what I could not do; life has not changed that much... [I] adapted back to my walker, getting meals and adapted my thinking... (#7, 2010).

> I don't know...just accepting the way things are. Could be a lot worse, I don't have to look very far to see someone worse off than I am (#1, 2009).

Acceptance of delays and complications were interpreted according to the older adults' normal psychological response to managing situations. Older adults' reassertion of their usual patterns of behaviour reflected a life history and values, all of which contributed to accepting and how they behaved and interacted during recovery:

> Working with your limitations and being realistic, [realising] you're not a kid anymore (#20, 2012).

> [I was] raised at the Crack Hardy School...we were told you know, instead of making a fuss, crack hardy, put up with it in other words...Shut up and put up so you didn't bellyache (#3, 2009).

Accepting was the reconciling of all the events that had occurred in older adults' lives. Accepting was based on the accumulation of the older adults' life experiences, which was not interpreted as an end point, but as a continuous balancing act relative to context and situation. While some older adults accepted that the event was inevitable owing to their health status, others interpreted it as a more general factor of life. Whichever interpretation was held, it reflected the participants' normal psychological responses to situations. More importantly, reassertion of the older adults' normal psychological responses influenced their acceptance of the recovery and the many behaviours inherent in the process.

Summary

Reasserting has demonstrated that psychological responses are important to recovery. Restoring normal older adult psychological behaviour illustrated that permissioning, connecting, and reconciling were interdependent processes used by older adults to help them recover. Permissioning inherent in reasserting was influenced by developmental life stage and the diverse expectations of the people involved. Connecting with familiar situations helped older adults to reassert a sense of self in unfamiliar situations that occurred during recovery. Reconciling was the process older adults used to interpret reasserting of normal patterns of behaviour into the recovery process. To restore normal psychological process, older adults used attitude, routines, and accepting behaviours to restore their sense of normal self.

Reasserting provided the psychological balance to the physical regaining restoring. Restoring was the continuous balancing of regaining and reasserting subprocesses. Each had relative weighting according to the time and context of restoring. However, neither was more dominant in the process, it was about how they worked together during recovery. The following chapter will explore four key conceptual ideas that came out of the theory of restoring and its subprocesses, regaining and reasserting.

Chapter Seven

Exploring key conceptual ideas from the theory of restoring

Introduction

The aim of this study was to generate a substantive theory that explained recovery from the perspective of older adults and how they managed it. The research question was: what is the main concern of older adults recovering from hip fracture and how do they resolve that concern? The main concern was normalisation which is resolved through a process of restoring. Restoring is a process in which older adults balance the regaining of their physical and social activities, while reasserting their normal psychological behaviours during recovery.

This new knowledge about recovery is not as clear cut as the literature and experience suggest. Recovery is more complex and integrated than the segmental approaches often discussed by health professionals indicate. I argue that recovery involves individual interpretation of the situation. Nonetheless, professional and societal understandings also influence on the older adults' interpretation of recovery. While existing understandings focus on the recovery of physical, social, or psychological functionality from contextual and / or situational perspectives, the theory of restoring offers a new viewpoint about the process of recovery.

What is significant and different from the previous understandings of recovery is that the theory of restoring identifies the main concern, normalisation, which links three factors, physical, social, and psychological, as an ongoing interplay. These factors are not separate, and should not be viewed as discrete entities during recovery. These three components form an integrated process, which older adults continuously balance during returning to normal. In this restoring pattern of behaviour, older adults use a balancing act to regain and reassert normalisation. Normalisation is supported by the older adults' social memory and self-governance behaviours. Social memory reflects the psychological behaviours individuals have used throughout their lives and is seen in everyday actions as self-governing behaviours that are used to manage their physical and social activities.

Hence, social memory that is evident in reasserting influences older adults' responses and interactions during recovery. Regaining physical and social activities during recovery, illustrated the older adults' usual self-governing behaviours. It was also evident that if restoring was to take place, a balancing act was necessary to maintain a continual relationship between regaining and reasserting. Thus normalisation motivated older adults to restore normal.

In this chapter, I explore four key conceptual ideas that were prominent in the analysis. They are normalisation, a balancing act[15], social memory, and self-governance. These will be examined against extant literature and discussed relative to their theoretical generation from the analysis. First, though, the theory of restoring is compared to current understandings of restoring

Comparing the theory of restoring to the wider literature

A metasearch engine was used to search relevant databases to find out what was already known about restoring and how it compared to this theory of restoring. The search parameters included the terms, restore, restoring, and restoration. Six themes about restoring were identified in the literature. These included ecology, environment, justice, practice, nursing, and individual function. The sample of literature selected represented the commonalities inherent in each of the theme's approach to restoring. Overall, each of the themes had an everyday understanding that reflected restoring as a process that referred to a sense of returning something to a previous state. The similarities and differences of the six themes were compared with the processes identified in my theory of restoring. Two of the restoration themes, ecology and justice, only offered everyday and theme-specific restoration information. However, their emphasis was quite different and knowledge could not be compared to the theoretical definitions that compromised the theory of restoring. In the restorative theory context, several concepts that resonate with the theory of restoring stood out. They were environment, practice, nursing, and individual function. Restorative environment theory offered one similarity relative to reasserting: connecting to

---

[15] I have purposefully used 'a balancing act' as it represents an action by the participants whereas 'the balancing act' suggests a noun.

physical place. This similarity reaffirmed the importance of familiar situations and space that have been seen to be critical during recovery.

In the theory of restoring it was evident that the right environment can have a restorative effect during recovery. The theory of restoring highlighted that the hospital and home environments were significant factors in the recovery process. The hospital environment focused on regaining physical restoration through an appropriately built physical environment. However, in order to reassert psychological behaviours and social interactions, the home environment was more significant to restoring. The older adults' main concern was normalisation and returning home was an important factor in getting back to normal. Environment influenced pacing, spacing, and connecting during recovery. Older adults' behaviours, responses, and interactions occurred according to the environment. These were seen in permissioning while managing diverse expectations during the hospital stay. Once back to the home setting, older adults reverted to their normal ways of behaving. For the older adults returning home motivated restoring normalisation. While the home environment stood out as a motivating force for normalisation, there have been ongoing studies into the relationship between people and their environment and physical place.

A seminal work on people's relationship with their environment was the Kaplan's person-environment compatibility fit model (1983, 1992). This theory focuses on the restoration and reduction of psychological stress through the relationship with the person's environment, which may induce calm and pleasant feelings. While Kaplan's model is different to the theory of restoring, it discusses the interrelationship of affect and visual stimuli. The implication that restorative environment can influence recovery is evident. Along the same lines as the theory of restoring, Kaplan (1983) suggests the physical environment can influence the psychological processes people use to restore usual behaviours. Kaplan (2001) looked how a view from a window can assist restoration, noting that familiar views such as being in the home environment, increase satisfaction and a sense of well-being,. Moreover, Kaplan notes that a built environment, such as a hospital, can provide satisfaction; it does not necessarily contribute to a sense of well-being as will being in the home setting. The theory of restoring supports the concept of a familiar view and environment-fit, as it improves reasserting of psychological behaviours, increases self-permissioning and connecting,

and therefore must influence reconciling of any impacts from the injury and recovery process. Nonetheless, some authors believe that favourite places (Korpela & Hartig, 1996) support the suggestion of the home environment having restorative value, noting the potential improvement in self-regulation and supportive mechanisms for restoring emotional and psychological behaviours.

More recently Scopelliti and Giuliani (2004, 2006), used Kaplan's (1983, 1992) person-environment compatibility fit model to review the potential of restorative environments on perceived quality of life though the relationship of personal needs and restoring tendencies, all of which are influenced by physical place. Scopelliti and Giuliani (2006) suggest that different interactions occur in the natural environment compared to the built environment, such as occurs in hospitals or people's homes. Their study suggested that the natural environment is considered the person's home whereas the built environment is the healthcare facility. There are similarities here with the theory of restoring. During recovery, the older adults' interactions and responses within the built environment were tempered by the need for physical regaining. Once older adults became familiar with the built environment (hospital) routines, their usual psychological behaviours were reasserted. This was seen as interactions moved from a focus on professional permissioning to the self, during the hospital period.

In the theory of restoring the environment supported recovery in two ways. The built environment influenced recovery through the regaining of physical activities and influenced older adults' social relationships while in hospital. Social and physical needs were balanced according to the older adults' interpretation of their recovery progress. Second, the natural environment of the home supported the reassertion of usual psychological patterns of behaviour such as getting back to routines, social activities, and self-permissioning, all of which supported normalisation. Clearly, the environment influenced recovery physically, socially, and psychologically. Older adults were motivated to return to their home setting because it assisted in restoring normalisation.

Another theory that has some similarity to the theory of restoring is restorative practice. What stands out in particular is that restorative practice is a philosophy and process for managing the diversity and range of connections that occur between

people. Restorative practice is based on an educational philosophy and defines restoration as the belief that decisions are best made by the people who are directly involved in them (Costello, Wachtel, & Wachtel, 2009; Drewery & Kecskemeti, 2010; McCluskey et al., 2008). This is conceptually similar to the theory of restoring in which older adults discern their main concern and determine the process that resolves it. It was clear in the theory of restoring that being involved in the process improves connections, and self-permissioning, and facilitates the regaining and pacing of physical and social activities. There are overlaps with restorative practice (Costello et al., 2009), where people are more likely to make positive changes in their behaviour if professionals engage with the person rather than just direct them. For example, in the theory of restoring, when professional permissioning had a higher emphasis over self-permissioning, restorative behaviours were not as effective in the setting.

Further analysis of restorative practice suggests that it is about building and managing relationships, learning to deal with conflict, educating, and instilling appropriate social behaviour (Drewery & Kecskemeti, 2010; McCluskey et al., 2008). This is achieved through motivational activities to support individual development and social responsibility. It is quite different to the restoration of recovery where health professionals care for, and prepare patients for their discharge back into the community. The professional emphasis during recovery is on the management of physical concerns. A restorative practice concept of person development and social responsibility is reflected in healthcare, but it reflects a health professional focus on cooperation, productivity, and permissive behaviours. This is in contrast to the theory of restoring which argues that it is about the older adults restoring usual behaviours to manage their recovery. While personal development and social responsibility are part of recovery, restorative practice implies the older adult is the recipient rather than an active participant in the process.

Alternatively, Jenkins (2006) considers that restorative practice should be reviewed according to what is to be restored, for whom, for what purpose, and in whose interests restoration is likely to occur. Jenkins ideas add some support to the theory of restoring by highlighting that the purpose and practice of restoration is by focusing on people, their needs, and their ways of thinking, rather than just on the process itself. While restorative practice originates in educational philosophy, and ways of behaving in

schools, the concepts of relationships and interactive behaviours link to the theory of restoring through the essential factor, in that restoration is best achieved when the people who are undergoing it are directly involved in the process.

Restorative nursing reflects a specific practice approach and has more in common with the theory of restoring. Restoration nursing is defined as the improvement or maintenance of an older adult's physical function, along with assisting them to find ways to compensate for any functional impairment. Restorative nursing focuses on what the person, usually a residentially care based older adult, can do, and maximises those abilities through an individualised restorative (functional) programme (Atchison, 1992; Bonanni et al., 2009; Resnick & Remsburg, 2004). The programme centres on improving motivation, function, and comfort for residents rather than concentrating on underlying disease processes. This helps older adults to achieve and maintain function congruent with their ability. The practice of restorative nursing has the goal of improving a person's level of independence and self-image within a residential care context. This approach emerged as a counter to the "warehousing" (Atchison, 1992, p. 8) approach previously used in long term care facilities. Warehousing was a management approach in which older adults had everything done for them until they died. In contrast, the growing professional interest in improving quality of care in long term facilities has offered restorative nursing as a way to improve delivery of care (Atchison, 1992; Bonanni et al., 2009).

The restorative nursing practice approach has some similarities to the theory of restoring in which regaining physical functionality is weighed against peoples' psychological processes and the congruency of their abilities. However, restorative nursing emphasises the physical component and not necessarily the balancing of multiple factors inherent in physical, social, and psychological older adult's recovery. The difference to my theory of restoring is in the specificity of the nursing approach. The philosophy of restorative nursing focuses on physical functionality, which concentrates on improving or maintaining an older adult's abilities. While there may be some social or psychological benefits arising from the nursing practice, it does not focus on the person's concerns or processes to resolve issues. The practice of restorative nursing enhances routines and core behaviours that enhance quality of life functionally. As a result, restorative nursing is a philosophy of care that is delivered in

residential care facilities. In contrast, the theory of restoring is about recovery from the older adults' perspective and incorporates individual ways of responding, interacting and behaving.

The emphasis on restoring individual functioning falls into two approaches, which are both similar and different to the theory of restoring. One approach stresses physical while the other focuses on psychological factors. Restoring individual physical and psychological function is underpinned by the medical paradigm that focuses on individual impairment, professional help, functionality, and safety, which is usually represented as a paternalistic approach (Tower, 1994). Paternalism tends to be underpinned by systems and organisational rules that perceive caring as an institutional and health professional role. In this approach, patients are thought to benefit from care because the organisation and health professionals know what is best for them (Abercrombie et al., 1988). Hence, recovery is perceived as a professionally defined process, which can be measured, predicted, and dictates when recovery has occurred. While individual physical restoring occurred in regaining in the theory of restoring, pacing and relying in the initial stages were within the realm of the health professionals. This was a similar approach with most physical conditions in which health professionals' viewpoints emphasised restoration processes rather than the patients (Angel, Kirkevold, & Pederson, 2009; Guccione, Fagerson, & Anderson, 1996; J. L. Johnson & Morse, 1990). This emphasis is contrary to how older adults interpreted their individual physical recovery. During the regaining of their physical activities, older adults balanced a psychological process to support recovery.

There are some similarities here with discussions about psychological factors of individual functional restoration in the literature, which were about self-determination theories (Radel, Pelletier, Sarrazin, & Milyavskaya, 2011; Zhou, Sedikides, Wildschut, & Gao, 2008). These theories influenced how health professionals delivered care in restoring psychological functioning. Self-determination theory notes that psychological restoration is best achieved if the person determines the process. It is a person-oriented process rather than a professionally-directed one. At the centre is the person who needs to participate in the process, alongside the health professionals. However, while the focus is person-centred, it does not recognise the complex interplay of factors that need to be managed by people. Whether physical, social, or

psychological functional restoration is occurring, self-determination theory does recognise that there is more to the restoration process. Self-determination theory and its associated model of care delivery depend on the organisational systems and approaches in which it is delivered. Yet, the process of restoration remains contextual and situational. Nonetheless, self-determination theory provides support for older adults' recovery process in which restoring is more likely to occur in the home situation, once the older adult has been discharged from hospital. The persons' usual ways of behaving are reasserted as they take control of the recovery process.

The comparison of similarities and differences in the restoration themes, such as environment, practice, nursing, and individual function, to the theory of restoring has illustrated existing knowledge centres on the professional approach. The processes used by people to manage the problems inherent in their recovery were not always acknowledged or evident. The restoration themes reviewed did not suggest the interplay of components or a balancing that was evident between the physical and psychological processes in my theory of restoring. The separate approaches to the understanding of restoration provide support for aspects within the theory of restoring. For example, the physical elements of environment, nursing, and individual restoration support regaining. At the same time, the psychological factors in reasserting can be seen in the restorative practice, nursing and individual psychological functioning. What is not evident in these themes is that while all these elements contribute to restoring as parts of the process, restoring is a more than just a collection of individual components. It is a pattern of behaviour that is the complex interplay and integration of physical, social and psychological factors, which are being balanced by older adults to manage their normalisation.

Four key conceptual ideas from the theory of restoring

In this section, several ideas that stood out from the theory generation were normalisation, a balancing act, social memory, and self-governance, are explored. Normalisation emerged as the main concern early in data analysis and influenced the older adults' interpretation of the recovery process. A balancing act was evident in the theoretical analytical process and explained how older adults managed their recovery

by balancing physical, social and psychological factors according to their interpretation of returning to normal. Social memory emerged from the analysis to support the psychological processes older adults used to interact and respond during the recovery process, which were underpinned by their normal psychological behaviours. Finally, self-governance was the actions and behaviours older adults used to manage the physical and social aspects of their recovery as they were regaining these activities, influenced by their social memory and interpretation of normal. Therefore, the older adults' interpretation of normal influenced how the balancing act would be used to restore their everyday lives. At the same time, social memory influenced the interpretation of normalisation and balancing, which was enacted as self-governance behaviours. Each conceptual idea is presented and is related to the theory of restoring and relevant literature. Normalisation is discussed first.
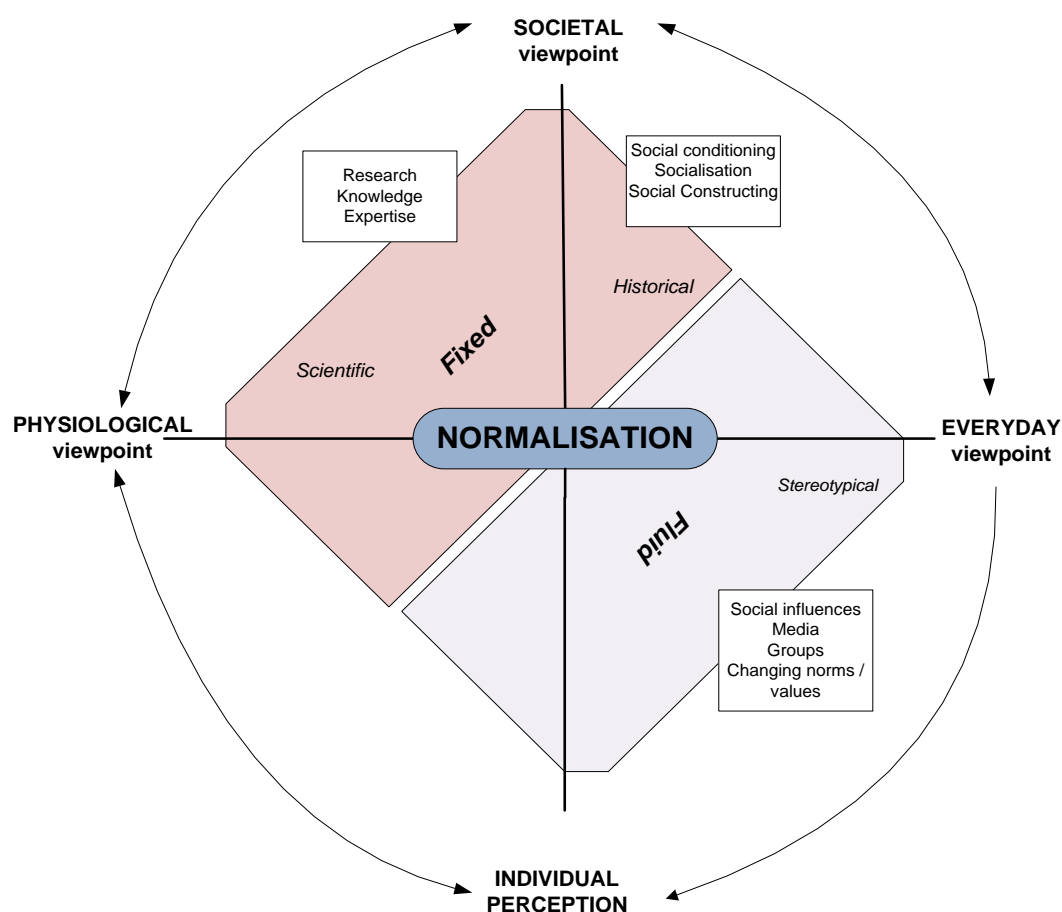
Normalisation

Normalisation was one of the key conceptual ideas evident in the theory of restoring. Normalisation was the main concern for the participants and required further exploration to examine how normal was interpreted by older adults. Four reference points were identified during an exploration of normalisation, which were labelled as categories in order to sort information. These were societal, physiological, everyday viewpoints, and individual perception. An initial review of the information suggested that the four categories were interrelated, were influential to the interpretation of normalisation by older adults. Furthermore, my interpretation of the information suggested that there were fixed elements and fluid factors in each category. The fixed elements in each of the four categories represented historical, scientific, and established roots that underpinned societal, physiological, everyday understandings of the viewpoints, as well as how it influenced the individual perspective. In contrast, each category also had fluidity, and changed as factors within them shifted.

The interrelationship of the four categories required a format to develop my contextual understanding of normalisation. To make sense of the multiple interpretations and understandings I used a diagrammatic approach to bring together all

the factors that influenced normalisation. This approach also enabled any socio-cultural and economic-political influences to be included. Using this diagrammatic approach confirmed that the interrelationships had some fixed aspects of normalisation such as physiology, which influenced societal and individual perceptions. But it also noted that other relationships, such as concepts of ageing or recovery were fluid and continuously evolving. What was significant was that the individual perception of normalisation was influenced by the other viewpoints and these influences represented how older adults interpreted their normalisation. Figure 12, is the diagrammatic representation of normalisation.

Figure 12. Normalisation viewpoints

The diagram provided the structure for examining the socio-political and ageing influences, which impact normalisation and recovery, and assisted in developing interpretations of the relationships between the four viewpoints. As age and ways of

behaving seemed to indicate that older adults' individualised perceptions of normalisation influenced their recovery, it was appropriate to examine the relationships between normalisation, ageing, and social factors. Moreover, any changes in any of the four viewpoints appeared to impact older adults' perceptions of normalisation. Thus, normalisation influenced how recovery was interpreted and managed by older adults, and was a key concept in the theory of restoring that linked with the other three findings: a balancing act; social memory; and self-governance. The context influencing normalisation is discussed next.

In the New Zealand context, socio-political changes have influenced perceptions of normalisation, the process of recovery, and how people are restored to normal. The changes that have occurred from the early 1990s have shifted from government-led responsibility for a welfare state, to an individual responsibility, and market-oriented focus. An example of this is changes to the way healthcare is managed, which altered state involvement. Government has shifted from being a total provider of all cares to funding public institutions with governance oversight. This has been mirrored in other western countries where similar changes have occurred over the past decade (Michailakis & Schirmer, 2010). This ideological shift emphasised a market based, consumerist approach which has impacted at multiple levels of society, including views of ageing and healthcare through an approach that stressed individual responsibility for health instead of government (Ashton, 2005; Casey & Balshaw-Greer, 2005; Craig, 2003; Gilleard & Higgs, 1998; Michailakis & Schirmer, 2010). As these major societal trends occurred, sociological critique was also evident. The Third Way political aim was supposed to temper economic market ideology with the addition of social justice and values (Clark, 2001; Clasen & Clegg, 2004; Craig, 2003). This trend maintained individualism as an underlying focus.

The social justice influence on restoring normalisation was through its emphasis on individuals needing to take more control and responsibility for his/herself, their lifestyle, and health behaviours. Social justice concepts aimed to reduce the increasing demand on health resources from ageing populations by an economically focused government. As economic resources decreased in healthcare, operational impacts resulted that impacted delivery of care. This was offset however, by improved technologies and delivery settings. Reducing the length of stay for patients in hospitals

was one economic outcome, which resulted in patients having shorter in-hospital recovery times. People went home earlier to continue their recovery with a greater reliance on their community connections. Healthcare had shifted its operational aspects to the individual to accommodate the limitations placed on it by external agencies (Gilleard & Higgs, 1998; Higgs & Jones, 2009; McCloskey & Diers, 2005). While economics and politics influenced the length of hospital recovery period, health professionals' interests were in improving an older adult's prospect of getting back to normal. Reducing potential risks to the older adult, and stressing standardised approaches to care delivery, was accompanied by an increasing emphasis on scientific, sociological, and psychological interpretations of age and ageing.

Theories on ageing have been numerous and diverse, and have influenced the four viewpoints of normalisation as outlined in figure 12 (page 161). Ageing has historically been approached from a physiological perspective, which concentrates on the natural changes that occur to the body along with the complexities inherent in pathological conditions that impact ageing (Kirkwood, 2005; Miller, 2009). These physiological influences underpin approaches to managing ageing and the process of recovery, which are supported by a biomedical model (Hayden, 2009; Roberts & Wolfson, 2006). Therefore, recovery is solely about restoring physical function compared to the person's age. Conversely, ageing has been examined from alternative perspectives, which include sociological, and psychological viewpoints and as such, influence views of normalisation.

The most relevant link between the theory of restoring and sociological perspectives on ageing was continuity theory, which focuses on roles, relationships, and peoples' ability to compensate for change (Bilton et al., 1981; Deci & Ryan, 2000; Gino & Desai, 2012; Greener, 2008; Miller, 2009; Sheldon & Kasser, 2001). Continuity theory (when applied to ageing), is the basic patterns of behaviours that support people throughout their life. It includes consistent lifespan patterns of personality, values, morals, roles, and activities. Ageing in the later stages of life is modified by physiological change but retains the influences of the earlier stages (Miller, 2009). Continuity theory has a key concept that personality is often more entrenched in later life, along with patterns of a lifetime, which determine behaviour and action in older age. This includes coping mechanisms and adjustments made according to context and

situational events (Miller, 2009; Moody, 2006). All these factors influence recovery, the process of restoring, and views of normalisation. This was evident in older adults' comments about the influence of family relationships, familiar situations, and attitude, and how these underpinned their interactions and responses to situations. Another sociological approach to ageing was activity theory, which was an understanding that remaining active and engaged in society equated to living a satisfactory life (Miller, 2009). Here the focus was on wellness in ageing and maintaining social activities, rather than withdrawing from society. However, activity theory is dependent on the physiological state of the individual. This had limited congruence with the theory of restoring, but there was some relationship to rehabilitation settings which emphasised physical restoring to improve functionality.

Psychological ageing theories reflect more recent thinking about the relationships between the physical, social and psychological aspects of ageing (Baltes et al., 2005; Berger, 1998; Blanchard-Fields, 2007; Carman, 1997; Hewer & Roberts, 2012; Kirkwood, 2005; Labouvie-Vief, 2005; Schaie et al., 2005; Sternberg & Grigorenko, 2005). Moreover, these views influence normalisation and recovery perspectives. Psychological theories on ageing emphasise cognitive, emotional, and personality statuses that occur with change in the natural process of growing older. Baltes, Freund and Li (2005) outline four levels of psychological ageing theories that have relevance to perspectives of normalisation and the process of recovery. Level one reviews and focuses on the biological and cultural perspectives relevant to ageing. This views ageing as a normalised state and includes a general scope that shapes humans. Level two is about the lifespan changes that influence functional gains and losses. Normal behaviour at this level is seen as resilience. However, these processes are about compensation and regulation of loss. Level three views successful ageing as psychological adaptation, to optimise and compensate gains and losses. Level four examines specific psychological functions and domains such as intelligence, cognition, personality, and self, all of which influence normalisation and consequently the process of restoring. Interestingly, all four levels about psychological ageing are reflected in the theory of restoring, through the many filters older adults used to manage recovery while balancing the physical losses and gains. More recently, psychological theories have been linked with sociological and biological theories to counter biomedical models of health and ageing. The biopsychosocial model of health

(Hayden, 2009) takes the perspective that illness and injury in ageing have biological, psychological, and sociological components, and all three influence ageing and health as a perceived normal.

It is evident so far that the older adults' perceptions of recovery are influenced by many factors, which in turn are influenced by their interpretations of normalisation. Recovery and normalisation share common factors that are shaped through the societal, physiological, everyday, and individual viewpoints. Recovery and normalisation share a stronger relationship if viewed through the physiological viewpoint. Traditional approaches to recovery are based in physiological science, underpinned by historical and clinical reasoning, and supported by social constructs according to contemporary contexts. The biomedical understanding and approach to managing the physiological factors of recovery defines, measures, and examines the process as segments of a continuum. The physiological emphasis in turn, influences the way normalisation is interpreted by older adults during the process. An example has the health professional measuring the degree of hip flexion, recording it and evaluating the amount according to criteria, whereas the older adult's focus is on the process of how to get to the toilet. Both views of recovery are normal, depending on the viewpoint. While views of recovery and normalisation come together at the physiological viewpoint, there are diverse interpretations of what is important. The divergence was evident in the older adults' data. Recovery was influenced by ageing, and restoring was about normalisation however, the older adult interpretations were different to the explanations seen in the extant literature. Figure 13 demonstrates how the four reference points interrelate for normalisation and recovery at the physiological viewpoint.

Figure 5. Recovery and normalisation relationship
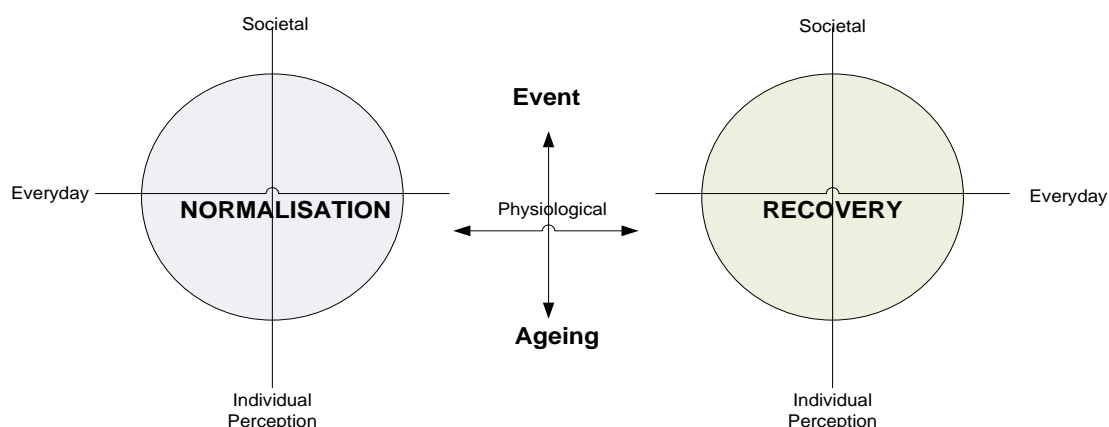
August 28, 2011

While physical recovery was an important part of restoring normalisation through regaining physical and social activities, older adults also reasserted their usual psychological ways of behaving in response to how recovery was progressing for them.

A balancing act

A balancing act was the second significant conceptual idea that required further exploration to understand its relevance as an integrating code in the theory of restoring. During recovery, a balancing act was the continuous process older adults used to maintain normalisation. They were making compromises, balancing professional and self- permission, managing diverse expectations, spacing distance, or weighing up self-reliance with marshalling resources, all of which come together as a balancing act. Balancing occurred at both a macro and micro level during restoring. Balancing at a macro level was the continuous shifting between physical/social and psychological factors required to maintain a sense of normal during restoring. At the micro level, balancing was the constant accommodation of physical, social or psychological factors in order to manage a short term situation to support normal. Balancing was simply the ongoing adjustments people made throughout the process of restoring, in order to return to normal.

Balancing from the macro perspective was seen in the amount of regained functioning achieved relative to the psychological response needed to manage the process of restoring and normalisation. The balancing act at the macro level was situational and contextual. If the older adult's regaining of physical functioning was similar to their previous state, then having to reassert their usual psychological behaviours was not required. There was a short-term interaction with health professionals, repair of the fracture and regaining of physical activities. Normalisation was restored as this was a short-term process. Reassertion of normal psychological behaviours occurred as soon as self-reliant activity was restored. A balancing act depended on the older adults' interpretation of normalisation. If physical functioning was not regained to a similar previous state, the psychological responses increased to balance out the changes. This again could be short-term but occurred outside the hospital. An example was using agency help for a period of time until normal was restored. Nonetheless, longer term physical issues, such as complications compounding recovery, required the older adults to make compromises, for example, having home help or carers in the home setting, or changing the environment around them. Balance was restored again, albeit, with a new normal.

Balancing at the micro level was about physical, social or psychological factors, which were continuously shifted to accommodate and manage a sense of normal during recovery. For example, the necessity of using mobility aids to accommodate a temporary decline in walking ability was balanced with the need to mobilise, be safe, and pain free. The pacing of physical activity was balanced with self and professional permissioning. Older adults increased self-pacing, or made short term compromises to manage restoring their normal during recovery. Similarly, the amount of social support older adults needed during the early phase of restoring was balanced against the normal family patterns of behaviours. Connecting with familiar situations, such as significant family members, was increased to provide a sense of security and connection. Once, physical activity required less dependence on others, self-reliance increased and family relationships returned to normal.

The physical and social accommodation is relatively easy to explain. However, psychological factors were often more complex and subtle in a balancing act. The multiple influences that impact older adults' psychological behaviour are filtered

through social, cultural, spiritual, and personal viewpoints in response to the situation and context. For example, a social behaviour response for some older adults was the gaining of professional permission before undertaking any activity while in hospital, whereas others reasserted their expectations throughout the recovery process. Therefore older adults' interactions, responses, and behaviours while recovering involved the complex interplay of historical life experience, psychological behaviours, and balancing multiple accepted ways of managing returning to normal while regaining physical and social activities. The main concern, normalisation, was the motivator to recover. A balancing act was a process that linked the actions required to restore usual physical, social and psychological normalisation for the older adults.

Balancing, as a grounded theory integrating process for the theory of restoring, is also evident in other studies as a process. Balancing has an everyday definition of weighing up two or more factors to achieve an outcome. Restoring normalisation after hip fracture is the outcome older adults wanted to achieve. Regaining and reasserting processes were in continual juxtaposition during recovery until normalisation was achieved. Balancing as a process or integration code is used in other studies. While the concepts are relevant to the specific study, there is a common interpretation that factors are in continual motion to achieve a desired outcome. Murdaugh (1998) described how quality of life issues in HIV disease were balanced against the unpredictability of the disease. Achieving a balance was the process to manage enhanced or diminished perceptions of quality of life. This was achieved through everyday living requirements balanced against controlling one's life as the disease progressed. Similarly, Thulesius, Hakansson, and Petersson (2003) used balancing as a process in end-of-life care. The stages of weighing, shifting, and compensating, indicated how the physical and psychosocial needs of both participants and care-givers met the outcome, compromising. Giske and Artinian, (2007) described the patterns of balancing behaviour that occurred with people waiting for a diagnosis following gastroenterological investigation. Balancing occurred between the feelings of hope and despair while waiting for the diagnosis. More recently, McMillan's (2010) unpublished thesis on taking control after hip fracture is about people balancing help and risk as they attempt to regain independence and control, following a hip fracture.

Balancing is a process that uses two or more factors and adapts, changes, or shifts them around to support achievement of an outcome. The theory of restoring has balancing within the process. Older adults needed to make short or long term compromises during recovery to achieve normalisation. Physical functioning was the commonly affected factor resulting in social and psychological behaviours being changed, shifted or adapted to manage recovery until normalisation is achieved. However, balancing was not straightforward and has multiple influences that impact how older adults respond to and action restoring normalisation. The influences that underpinned how older adults interpreted their balancing act was in their social memory and self-governance behaviours.

Social memory

Social memory is another key conceptual idea that was evident in the theory of restoring. It captured the multiple intricacies inherent in patterns of behaviour that are grounded in historical and socio-cultural connections. For example, family, and social relationships had influenced responses and actions to contemporary events. In this study, social memory is defined as the cumulative experience of a life lived. This is influenced by life experience, life course, and life span that underpin how older adults define normalisation. Life experience is the result of an individual's life history that has had value, significance, and has expanded a sense of self or their life perspective (Merriam & Clark, 1993; Trice, 1990). Life span is a subfield of psychology, which examines and describes emotions, cognition, and motivation relevant to an individual (Schulz & Heckhausen, 1996). Life course is a sociological perspective to explain how embedded social roles interplay between situation and social location (Blane, Higgs, Hyde, & Wiggins, 2004). Life span may also be viewed as the biological life span from birth to death, whereas life course is shifting the focus to the early influences in life, and associated social, family, and economic factors, which represent a quality of life state (Blane et al., 2004). The stance taken in the theory of restoring is that life experience is a person's accumulation of multiple perspectives and experiences that help to explain their interpretation of physical, social and psychological influences on their social memory.

Social memory according to the theory of restoring underpins the responses and actions older adults use during recovery and in restoring normalisation. Further to this stance, social memory does have a particular definition within psychology that supports aspects of my interpretation. According to Hewer and Roberts social memory is defined as the "dynamic interplay between history, culture and cognition" (2012, p. 167). Therefore, social memory is contextual creating subjective views of historical realities. Hewer and Roberts explain social memory as the changing nature of viewing the past when individually perceived compared to a fixed collective memory of an historical event. The definitional relationship to the theory of restoring suggests individuals subjectively interpret past activities to assist in managing current ones. Injury and recovery are personal events not collective memories, however family, and social connections may contribute to personal interpretations of events, and influences responses and actions. The familiar situation assists in managing the unfamiliar ones.

According to Bendien (2012), social memory may also be construed simply as remembering the past and using it to act in the present. Bendien argues remembering is not factual reviving but re-evaluating the past if it is used as an everyday tool. This differs from a structured reminiscence process, although either process supports psychological wellbeing. Bohlmeijer, Roemer, Cuijpers, and Smit (2007) provide a different viewpoint to social memory. They explain the influence of reminiscence is that it enhances meaning in life, through remembering past experiences, acquired values, and past plans. Moreover, this restores a sense of mastery, control, and confidence that may influence problem solving, help overcome events, and contribute to healthy ageing. Bohlmeijer et al., suggest mastery is how people focus on their inner resources and recall of how one coped in the past in order to manage the present. Reminiscence is the process used to achieve this.

Social memory from the psychological points of view assist in understanding elements of the theory of restoring, but it does not explain the complexity of the finding according to older adults' process of recovery and restoring normalisation. While reminiscence and reviving may have an influence in recovery, older adults also connected with their socio-cultural environment to restore normalisation. However, the psychological explanations appeared to be only part of older adults' usual psychological responses, actions, and behaviours to manage returning to normalisation.

Echterhoff and Hirst (2009) suggest social memory may be influenced by social influences. Social memory is shaped by changing perceptions over time. Changes can be shaped through contacts with people and environment. These influences support the formation of personal constructions of reality, knowledge, and identity. This was demonstrated in self-permissioning in which older adults' developmental life stage and expectations had to be reconciled with the health professionals' construction of recovery and normalisation. Quinn and Rosenthal (2012) though, suggest social memory underpins a complexity within perceptions of the self and others through the use of social categorisation and stereotyping. This is further influenced by an individual's identity, ethnicity, gender, age, and numerous other factors. Therefore, how and what behaviours occur reflect peoples' self- perception and expectations of others. Older adults responded to the hospital setting according to historical and social norms developed through their connections with family, and community. Social memory may be reflected in older adults' lifestyle, as it incorporates values, attitude, and personal identity. These factors influence the responses and behaviours older adults had to the hospital setting, health professionals, home, family, and help. This reflected their reliance on others, familiar connections and reconciling of physical, social and psychological changes that have occurred over a lifetime.

Finally, social memory has an autobiographical viewpoint according to Gino and Desai (2012). Conway and Pleydell-Pearce describe autobiographical memory as a fundamental experience relative to the enduring experience of personhood, that is, "an individual in a culture, over time" (2000, p. 261). These authors suggest that successive cues and activities shape memory knowledge and therefore influence goals for the self. This may be reflected in general event memories, lifetime periods, or event specific knowledge. An autobiographical viewpoint suggests ongoing experiences shape responses to events.

The theory of restoring offers an alternative explanation to the autobiographical, sociological, and psychological viewpoints of social memory. Older adults did not appear to be shaped by their recovery experiences. Individual perception, recollection of events, remembrance and re-evaluation of past experiences contribute to normalisation. These life course experiences shape older adults' recovery. Social memory is the psychological factors of the person mirrored in their personality,

attitude, life experiences, and ways of behaving, during recovery and in their normal life.

Self- governance

Self- governance is another key conceptual idea that will be explored. It was important to examine and define a person's ability to exercise control over restoring their normalisation. Self-governance is exercised during the process of restoring and is influenced by the older adult's social memory. Restoring normalisation therefore is relative to the context and the ability to self-govern. An everyday viewpoint of self-governance suggests that authority and control are important factors. Authority can take many forms but in this research it was evident that it is interpreted as the right or power to exercise control over others or oneself. Control, on the other hand, suggests the power to direct, manage, or govern activities or events that influence an individual, group, or community. Moreover, forms of control are often interpreted as interchangeable definitions with determination, and management. Self is defined in this instance, as representing an individual.

A key aspect of self-governance was control in the context of restoring normalisation. Control was interpreted by older adults as the reasserting of their usual behaviours, interactions, and responses to an event that had impacted them, such as the hip fracture. Regaining physical activities and social connections was about reasserting usual routines that support normal life. Control over these activities has multiple meanings dependent on the context. From the older adults' perspective, regaining physical and social independence during recovery meant reasserting control back over their normal activities and behaviours, that is, self-governance. However, control was often interpreted differently during the hospital recovery. Health professionals' expectations of recovery included control over the activities and the nature of the recovery, that is, professional governance. Older adults talked of professional permissioning, relying on health professional help, and having paced activities within the hospital recovery period. Reasserting control by the older adults though occurred at varying points in the recovery but it usually mirrored their familiar ways of behaving, this was according to their social memory. Hence, some older adults gave tacit

permission for health professionals to manage the recovery process until they were discharged, whereas others became involved in the process much earlier.

Self-governance also suggests choice occurs during the recovery process. People choose to be involved in their recovery to a level that is congruent with their social memory. This reflects individual differences within the older age group; however, it also suggests that choice and self-governance is reasserting a form of control as part of the process of restoring normalisation. This is reflected in compliance or adherence to healthcare regimes and programmes. People who desire more control and participation in the recovery choose to be more involved. This response is sometimes perceived as being less compliant when compared to the health professional approach. However, self-governance is contextual, as control tends to be restored in the home setting. Any adherence to home-based professional regimes is not under professional scrutiny, so normal self-governance actions, such as control and choice, are restored. Older adults manage whether these will be used.

Self-governance and reasserting control was important to older adults and highlighted that restoring normalisation was a complex interplay of physical, social, and psychological factors the older adults balanced during recovery. The interrelationship of the four findings is mirrored in self-governance. These are the actions and interactions that are visible, interpreted and expected by multiple people involved in recovery. Control has been examined in other health events suggesting that people do try reasserting control following a health event in an attempt to self-govern. For example, the restoration of control has been examined in breast cancer care, myocardial infarction, and hip fracture. Truant and Bottorff (1999) investigated how women determine and access complementary theory during breast cancer. The determining and access process assisted in the women's decision making and thereby helped to restore control over their lives. Similarly, an earlier study had explored regaining control following a myocardial infarction (J. L. Johnson & Morse, 1990). A number of personal strategies were used by people to regain control and mastery of the situation. More recently, McMillan's (2010) thesis on taking control following hip fracture reinforced that a sense of control was lost during a health event. Interestingly, the process taking back control reduced the sense of loss and restored self-efficacy.

Self-governance in the theory of restoring illustrated that there were possible tensions between self-governing behaviours of the older adults and professional governance during recovery. Context and interpretations of control influenced actions and interactions during restoring normalisation. Self-governance is the active reasserting of normal ways of behaving, by older adults, to manage their familiar connections, routines, pacing of recovery, and spacing of activities and people. That is, social memory was acted out. At the same time, control over recovery is accepted by older adults when expertise is required but self-governance is to be restored when physical, social, and psychological elements are in balance to enable restoring normalisation. A tension arises, when self-governance by older adults is not accommodated within professional governance. Older adults perceive reclaiming rights and power back as an important factor in reasserting control and the sense of self, and conceptually, self-governance:

> [When you are] sick, [you] become weaker, less powerful. [You] are not strong enough to face that, as other people [appear] more powerful. [I] am always thinking about how to make myself whole, safe, and powerful. [You do this by] reclaiming your rights [and] your power by getting better and stronger, so you reclaim your sense of self (#17, 2011).

Summary

The theory of restoring has been compared to the extant literature to examine its relationship to what is known and what has stood out from this study. Several ideas have been explored further. These were normalisation, a balancing act, social memory, and self-governance that emerged from the analysis and generation of the theory of restoring. Restoration as a concept reflects a return to something or a former state. The current understandings of restoring suggest it is occurs within specific domains that can explain a definable process. These may be physical, social or psychological. The theory of restoring suggests that these are not separate processes but a complex interplay of all three within the individual to manage a concern and its resolution. Furthermore, defining restoring must be through the older adults' interpretations of the process and perceptions of recovery and normalisation.

Normalisation was a key finding that linked the other findings. However, multiple influences impact normalisation and older adults' interpretations of recovery and restoring. A balancing act between regaining physical and social functioning and reasserting usual psychological ways of behaving, illustrated how older adults managed their concern and resolution process. Moreover, balancing was a complex interaction of older adults' social memory and self-governance behaviour patterns. The familiar situation influenced how unfamiliar situations were to be handled. These four conceptual ideas demonstrate the influence they have on interpretations of individual and collective social responsibility, and how older adults self-manage their recovery within traditional healthcare and evolving models of care.

Chapter Eight

Discussion

Introduction

The generation of the theory of restoring shows that older adults use their own processes to recover and restore normalisation. The complex interplay of physical, social, and psychological factors used by older adults all link to their interpretation of normalisation. This is different to the current understanding of recovery, in which parts or combinations of parts are explained through a health professional lens. During the early examination of how older adults recover from hip fracture, it was highlighted that health professionals defined and managed the recovery process. It was also noted that healthcare delivery was presumed to be a standardised process, but it was also segmental in its procedural approaches. Segmental was interpreted as occurring when different health professionals entered and left the older adults recovery process, depending on when their input was required. The exemplar, background, and literature review in Chapters One and Two, supported the health professional understanding about managing older adults' recovery. In the acute care episode, recovery was usually professionally led, and standardised. As a result, recovery was generalisable, definable, measureable, and predictable. Thus, older adults' recovery followed an expected pattern. This illustrates that a biomedical and scientific approach underpinned the recovery process, rather than a broader understanding of how an individual might progress. While older adult's pertinent individual factors were usually taken into account, these were interpreted through health professional lenses. In addition, socio-political and economic contextual influences impacted healthcare delivery. Therefore, the process used to recover older adults was more likely to meet the needs of healthcare system rather than the individual.

This study makes an original contribution to the knowledge base on recovery by generating a substantive grounded theory which is the conceptualised process, the theory of restoring. The generation of this substantive theory, which is more than a description of concerns, facilitates a different understanding of the processes involved in recovery from the participant perspective. In doing so, it provides health

professionals with the main concern and resolution process of older adults during recovery and presents this to assist in understanding recovery from a different point of view. The key outcomes for practice are two-fold. One, older adults process their recovery through the interplay of physical, social, and psychological factors according to their interpretation, and two, timing of restoring normalisation occurs much earlier in the recovery process than currently understood. This implies a change is needed for how professionals assess, plan, intervene, and evaluate recovery relative to the person not to the condition. This needs to be built into the design of care delivery.

In this chapter, the theory of restoring, the findings and its significance will be critically analysed using three themes. These include: individual-collective social responsibility within recovery, individual self-management of recovery in the current healthcare context, and third, a review of traditional forms of managing recovery against evolving models of care. These three themes emerged out of the analysis, conceptualisation, and the generation of the theory. As has been seen in previous chapters, what was significant during recovery for older adults was that they continually had to balance their individual interpretation of recovery with the collective social and professional understandings of the process. In addition, the return to normalisation and self-management had to be understood in the contemporary perspectives of recovery processes. Finally, the older adults' process of recovery is set in traditional modes of delivering healthcare. Models of care continually evolve with new knowledge and ongoing research therefore, delivery of care that supports the older adult process of recovery may influence future healthcare delivery. The chapter will conclude with a review of the implications, limitations, and recommendations arising from this study.

Individual-collective social responsibility

The individual-collective social responsibility theme was evident in the analysis of data and findings. It represents the tension that occurs between the older adults experiencing the recovery, and the multiple others who participate in the process. Reflected in these multiple participants are viewpoints of normalisation and recovery, all of which hold validity for those perspectives. The older adults' viewpoint reflected

their interpretation of social responsibility and the recovery process supported by their usual social memory and self-governance behaviours. In contrast, health professionals social responsibility is based on discipline and society's validation of knowledge and control of the process (Roberts & Wolfson, 2006; Robertson, 1989).

Social responsibility is a concept underpinned by social structures, socialisation, and a collective consciousness (May, 1992, 1996). The socially responsible person is motivated to interact with the world around him/her according to a sense of self that is underpinned by social conditioning. This has some similarity to the concept of social memory. According to the older adults, connecting with familiar situations such as, family values, long-held beliefs, and understandings of the world as it is interpreted by them, is their sense of self, and is often reflected in how they act, and behave in unfamiliar situations. May (1996) argues that the self is largely a product of social factors, which is the result of the ongoing interrelationship of family, communities, and nation. Being socially responsible and having a clear sense of self underpins how individuals respond to situations.

Individual social responsibility is the way in which people interact and behave in situations and contexts according to their specific social structures and consciousness. Furthermore, social responsibility influences perceptions of normalisation, health, and recovery. Personal health beliefs are complex and integrative, which evolve with knowledge and experience, which has been supported by an autobiographical interpretation (Conway & Pleydell-Pearce, 2000; Deci & Ryan, 2000). The theory of restoring showed that older adults shape their experience of recovery through their personal social memory and self-governance behaviours, rather than being shaped by the process of recovery. Their sense of self, participation in the recovery process, and interactions reflect a history of managing situations. Introducing an unfamiliar situation, such as a hip fracture, impacts the older adult's behaviour. Hence, individual social responsibility for the older adult in this case, is to respond to the traditional model of healthcare delivery. This reflects the professional permissioning that occurs within the early phase of recovery. But, there is an older adult self-defined point in which self-permissioning is reasserted. Individual social responsibility is restored according to the older adult's interpretation. Kleine and Hughner (1999) support this view, when they argue that people's individual mindsets about health and healthcare

beliefs, do not always follow health professionals' points of view, or fit neatly into society's traditional approaches to managing health. Recovery occurs according to the context in which the older adult is in. Continued hospitalisation for a physical rehabilitation purpose creates a point of tension. Older adults have a self-perceived recovery from the initial injury and surgical intervention, and have regained independent mobility, but remain within a context that reflects collective social responsibility. The older adult's interpretation of restoring normalisation has to occur within the health professional context and their sense of collective responsibility for recovery. Individual social responsibility is the implicit act of behaving in a situation according to convention and social norms. However, individual social norms do not necessarily correspond with the wider social expectations, hence multiple interpretations occur. Managing the multiple individual interpretations of social expectations has numerous implications for the health professions and delivery of care.

May (1996) notes that collective social responsibility is the social structures that support a collective consciousness to act, behave, and respond in certain ways according to the social norms. Therefore, people are bound up in the identities, labels, conditions, and expectations that constitute group affiliations, for example, nationhood, or roles within society, such as being a patient. In healthcare, collective social responsibility has both context and circumstance influencing its perception. The context in healthcare is viewed as having a collective obligation to promote, provide and manage the health and well-being of people within society (Porter, 1997). This is usually promoted through socio-political directions, responsibilities, and the professional groups within healthcare. Health professionals take collective responsibility for managing health by responding to need or in preventative ways, by providing services for a defined societal need. Roles and expectations are created, defined and promoted accordingly to that need, that context and that circumstance. Therefore, society reinforces its health institutions, knowledge, and processes through the actions of its people by the creation of, and ongoing support for the way healthcare delivery occurs (Abercrombie et al., 1988; Higgs & Jones, 2009; Robertson, 1989).

However, while older adults' recovery is a collective responsibility to be managed within the healthcare domain, it reverts to the individual as a responsibility to manage once discharged from care. This suggests that collective social responsibility in

healthcare is defined through social constructs and acceptance for managing illness and disease (Michailakis & Schirmer, 2010). It also shows that contemporary management of healthcare's social responsibility is two-fold. First, healthcare delivery is underpinned by two dominant approaches. The biomedical model (Roberts & Wolfson, 2006), and the biosociopyschological approach (Hayden, 2009). Within each of these approaches is a legitimised social responsibility for defining and managing health. One approach focuses on physiological management with limited social and psychological context to explain illness or disease. The other approach centres on psychological management, but recognises that social and biophysical aspects influence psychological manifestations. The second social responsibility is the efficient and effective use of the nation's resources to manage healthcare delivery. Michailakis and Schirmer note that the political system legitimises how social needs are met and managed through agencies of the state. Therefore, people are the social group that legitimise the collective social responsibility for healthcare and subsequently recovery. The group collective is made up of people who participate in or through agencies and roles, thus approve the politicised structures they interact with. Brownell et al.(2010) note that collective action supports personal social responsibility and is a blend of individual choice and collective responsibility.

Yet a tension exists between individual and collective social responsibility. The reason the tension arises within the individual social responsibility is two-fold. First, people have a social responsibility for maintaining or managing their self-health. This usually occurs according to their social memory and is managed as self-governance activities and behaviours. Individual social responsibility has to occur in both good and ill-health. Second, people have an individual responsibility to their family, community and the social expectations of the nation state. As a result, people have to respond appropriately to socially acceptable systems and structures, while remaining responsible to their sense of self. What is more, the individual creates and supports the collective systems; going against its advice is not the accepted norm, and is therefore considered irresponsible behaviour. But, individual social responsibility tends to revert back to individuals once they step out of the system. The individual-collective social responsibility is both supportive and an obstacle at the same time, and has to be managed according to the context. For example, according to May, being in

a patient role while in hospital, "in this sense, responding to who one is, may mean responding to the relationships one finds oneself in" (1996, p. 93).

Hence, the tension results from the older adults' individual social responsibility to conform to expected social norms while in care, follow the rules and advice of health professionals, yet revert to being individually responsible for self-care on return to the community. The diverse expectations encountered illustrated the complexity within relationships and interactions that occurred during recovery. On one hand, older adults' were influenced by their developmental life stage, in which their expectations of recovery had to be balanced against the family's and health professionals' expectations. On the other hand, while the older adults were in an unfamiliar situation, this resulted in a role-shift to that of patient, which meant taking on a collective social role, until a sense of self was reasserted. Their interactions and behaviours reflected this role-shift initially by adhering to professional permissioning. However, at a self-defined point in the recovery process, older adults interpreted that the collective group involvement in their recovery was no longer necessary. The regaining of physical and social functionality along with reasserting normal psychological behaviours created a tension for the older adults. Individual responsibility for self-management of the process had to be managed within a context in which collective responsibility still dominated until the older adults were discharged from hospital. The issue arising is that the collective social responsibility for managing health rests with health professionals and their agencies. Moreover, the added socio-political emphasis on efficiency within the agencies creates a context in which older adults meet the organisational structure and system needs rather than their individualised approach to recovery and self-care management.

Self-management in contemporary settings

Self-management of recovery responds to the question of how do older adults manage their recovery, but within the current context of healthcare delivery and thus, restore normalisation. Self-management is used synonymously with self-governance, yet there are subtle differences. Self-management reflects procedural or action-oriented behaviours associated with a situation (Barlow, Wright, Sheasby, Turner, &

Hainsworth, 2002; Blanchard-Fields, 2007; Bodenheimer, Lorig, Holman, & Grumbach, 2002; Greener, 2008; Kralik, Koch, Price, & Howard, 2004). In contrast, self-governance is more than self-management as it represents the more complex outcome of the interplay of social memory and self-governing behaviours that are the accumulation of a life time of multiple experiences. Self-management therefore, has to be seen as a behavioural response to the recovery process according to the context. When viewed from this perspective, who takes responsibility for the day-to day activities involved in recovery is reflected in the interactions between older adults and health professionals. Healthcare settings and professionals either promote self-management or inhibit it. A tension emerges between older adult's individual approach to managing their recovery and the collective approach embodied in health professionals, health agencies, structures, and systems of care delivery.

Older adult self-management was considered as the outcome of restoring their control over usual actions, behaviours, routines, and activities during recovery. The restoration of self-management commenced with the regaining of physical and social functioning as an important part of returning normalisation. Individual self-management through regaining physical and social independence was highlighted by older adults when they talked of returning to normal. Initially, older adults' tacit acceptance of help required to manage the hip fracture, illustrated reliance on professional permissioning but only to a point in the recovery process. At this point, a tension is often created as to whether the older adult is prepared or ready to self-manage. This reflected the professional permissioning and control of the recovery process. Further, once permission was interpreted as allowing independent activity, older adults wanted to pace their own activities along with the routines around their recovery. The context, at this point, either promoted or inhibited self-management as differing interpretations support or hinders the older adults' individual recovery progression. Older adults had to balance the multiple interpretations during this period in order to restore control of self-governing activities.

Self-management in the acute care context was limited, as the restoration of functionality was important along with an increased reliance on expertise and assistance. This approach was expected and generally welcomed until the older adult could pace themselves, and control their activities. Once the older adults were shifted

to a rehabilitative focus, health care professionals generally encouraged self-management albeit according to a controlled approach (Brent & Coffey, 2013; E. Chang, Chenoweth, & Hancock, 2003; Ganz et al., 2007; Guccione et al., 1996; Koval et al., 2004; New Zealand Guidelines Group, 2003). The professional impact on self-management meant that health professionals had expectations that the older adults would meet specific criteria, which demonstrated an ability to physically function in a safe manner. Another tension point occurred because the older adult's expectation to self-manage in the hospital setting did not match the health professionals.

It was evident in the data that older adults regaining of physical and social activity at this point in the recovery process was accompanied by the reassertion of their usual psychological behaviours. Because they had recovered to a point in the process where they could walk, toilet, and shower with limited assistance, older adults' usual routines and self-managing ways were being reasserted. However, because of the hospital setting context, self-managing activities tended to follow the health professional regimes, protocols, and pacing. The older adults responded with a balancing act. There was an understanding that improving their physical functionality came at a price, which was a short-term compromise to regain independent activity, and ultimately discharge. Health professional expectations of the recovery progression followed established routines and evidence, as they prepared the older adults for discharge, for example, as per the exemplar in Chapter One. Furthermore, because health professionals emphasise prevention and promotion of safety, and problem-solving throughout recovery, there is a tendency to marginalise the patients as passive recipients of care, through the structures and systems used to benefit them (Brent & Coffey, 2013; E. Chang et al., 2003; Russell, Daly, Hughes, & Op't Hoog, 2003; Wilson & Neville, 2008). This illustrates that recovery occurs according to professional expectations, making the older adult a passive participant in this process. An example is the point at which self-governance is restored to the older adult, usually at time of discharge from hospital, not earlier. Moreover, the point in which older adults' self-management of recovery occurs in the hospital setting does not appear to be negotiable. This reflects the agency's need to manage the system, rather than work with individuals' self-management routines.

Perhaps not surprisingly, discharge from hospital promotes self-management behaviours. Most older adults returned to their environment with health professional information and instructions to manage ongoing physical recovery (Accident Compensation Corporation, 2003). Nonetheless, older adults tend to revert to normal behaviours and manage their ongoing recovery according to their social memory and usual self-governance behaviours. They marshal their normal resources to assist with recovery, and reassert familiar situational mechanisms to restore their usual routines. Older adults demonstrated an ongoing balancing act between physical, social, and psychological normal to manage recovery in the home context. If physical functionality was limited or restricted, there was an increase in social connecting, which was reconciled as part of returning to normal. An increase in family support, or connecting with neighbours, church, or community occurred. In addition, short or long-term home assistance was accessed to help restore self-management. Moreover, health professional information was followed only if it supported regaining physical functioning; otherwise older adults relegated the information to non-essential and focused on reasserting their own normal ways of behaving. Recovery then followed the older adults' routines and expectations supported by a familial history of self-management.

Lorig and Holman (2003) describe self-management as getting a person to understand how to change behaviour, by having a set of skills to achieve this, which results in an ability to decision make and problem-solve. This is reflected in rehabilitation programmes that are used to enhance functionality post injury. Alternatively, Kralik, Koch, Price and Howard (2004) suggest by understanding the meaning of self-management rather than the experience, it can be used as a process to bring a sense of order into peoples' lives. Moreover, that order can be helped, or hindered, by social networks such as family, friends, and healthcare teams (Gallant, Spitze, & Prohaska, 2007). Connecting was a support mechanism older adults used to manage the unfamiliarity of the health event; however this was continually balanced against the family needs. Autonomy as a factor in self-management (Radel et al., 2011) relates to the environment and contexts in which the setting may help or hinder self-management behaviours. Interestingly, Radel et al. argued that a setting that deprives a person of their autonomy may ironically also be the motivating force for restoring it. Reasserting usual psychological behaviours reflected an autonomous management

approach by the older adults. This influenced the balancing that occurred between self-permissioning and professional permissioning, which occurred in the hospital setting. The older adult being told what to do or having to ask permission once functionality was restored, reflected the different views of autonomous behaviour and self-management. Further, if autonomy and self-management though is viewed as a process to reflect a person-centred approach to care delivery, it still remains professionally driven. Health professionals perceive self-management as a way to position the patient at the centre of decision making and control within the practice setting (Tower, 1994). Tower highlights the benefits of self-management behaviour in healthcare because it emphasises that individual behaviours do have relevance, especially in medical and rehabilitative environments. Self-management in this sense suggests patients are the resource to make the recovery process happen.

These points highlight as well that self-management of recovery for older adults is, once again, contextual and situational. This may be at odds with contemporary healthcare environments, which aim to enhance patient-centred approaches to delivery of care. However, the practice setting suggests otherwise. Self-management conceptually, is an approach to ensure patients have reached a point in their recovery so that they can be safely discharged. But, self-management of recovery, from the older adults' perspective, has a different interpretation of the process. While in care, older adults are managed through recovery with varying input into the process. A tension arises between the older adult's perception of self-management and the health professional expectation of what the older adult can or should do. Current healthcare environments have multiple influences that dictate or impact the operational activities of delivering care. Therefore, self-management is defined according to the professional context or situation. However, the findings from the theory of restoring suggest that self-management for the older adult has a different interpretation. Self-management is the older adults restoring normalisation by balancing their physical regaining with reasserting their usual ways of managing, which is more than just regaining physical functionality that is stressed by health professionals. Older adults' self-management behaviours often do not occur in the hospital setting, however they are able to take control of the process once they return home. The pacing of activities, spacing of activities and people, and relying on self and others is restored to the older adult. Self-management becomes normalised back to usual

ways of behaving. The experience of recovery is managed by the older adult, not the process of the event.

Traditional versus evolving models of care

What stands out in the theory of restoring is that older adults' recovery tends to occur in environments that practice traditional models of care. These environments may accommodate evolving modes of care delivery. Models of care delivery are defined by the underpinning paradigm or philosophy that supports how they function. They can be a generalised and socially accepted approach to care delivery, such as the biomedical model (Roberts & Wolfson, 2006), or a more disciplined focused approach such as psychology (Hayden, 2009). However, within these overarching approaches are smaller defined models of care that support particular groups, such as nursing or mental health, to practice in specific ways (Orem, 1991; Parse, 1981; Repper & Perkins, 2003; Rogers, 1970; Salmond, 1994, 2002; Tiedeman & Lookinland, 2004). Traditional models of care reflect the well-established structures, systems and processes that are in place and tend to underpin contemporary healthcare delivery models. In contrast, evolving models of care propose a shift in focus from the traditional care approach. The aim is to move beyond the current paternalistic emphasis, which creates a separation of parts rather than managing the holistic whole (Tower, 1994; Zohar & Marshall, 1994). The shifts occurring in the evolving models of care can be as extreme as redesigning the healthcare system to incorporate a quantum model of care (Zohar, 1997; Zohar & Marshall, 1994), through to changing the emphasis within current systems. Quantum models highlight the contemporary socio-political context and their influences in an attempt to link corporate, market and societal factors into health care systems. While this multi-level complexity of healthcare redesign emphasises changes to the system, a less radical approach is shifting the focus from professional to patient lead care. This growing emphasis on person-centred care is refocusing care from a compartmentalised to a more holistic approach (McCormack, 2004; McCormack & McCance, 2006).

Traditional models of care

As stated, contemporary healthcare delivery and practice is immersed in a biomedical paradigm (Porter, 1997; Roberts & Wolfson, 2006) and alongside socio-political ideology that influences the operational aspects (Ashton, 2005; Boston et al., 1999; Craig, 2003). What currently drives delivery of healthcare is that a health condition is to be returned to a prescribed normal state through interventional activity, amidst appropriate resource utilisation. The biomedical model of care is governed by a set of beliefs about people, health, disease, and illness (Aggleton & Chalmers, 1999). These beliefs form the basis of medicine, while also influencing nursing practice, allied health, and health delivery. The nature of people, in this model of care, is that a person is a complex set of anatomical and physiological systems who reacts to the surrounding environment and exhibits social and psychological behaviours that are the result of physiological and biochemical functions. Brown (1995), takes a different view though, arguing that illness is a social construction, which not only names the diagnosis but also frames the sociological response to defining, managing, and the acceptance of it. Brown also suggests that the biomedical emphasis, when applied, places the experience of the condition as secondary.

This perhaps illustrates that traditional models of care provide guidelines and protocols for managing conditions, which are based in the biomedical or biosociopyschological models (Boyd et al., 2005; New Zealand Guidelines Group, 2003). However, Paulson (2004) suggests that taking an objective approach to caring of people through the biomedical model, tends to depersonalise people owing to the emphasis on professional care aspects. Objective care includes the management of physiological conditions, teaching patients to live with that condition, and providing relevant information or support for the condition. The traditional models of care are historical, but change with socio-political contemporary influences. The older adults in this study inferred that the biomedical approach was a dominant thread during recovery. The emphasis on care by health professionals, with an aim of restoring physical functionality, followed specified criteria and routines. The older adult was taken care *of* rather than being cared *for*, in the sense that a holistic approach was not always evident. Data suggests that a common occurrence for older adults was keeping to professional regimes and gaining permission, during hospital care. For some, those

regimes were expected to be followed on discharge. The focus was on restoring physical functionality, whereas the social and psychological components of recovery belonged to the person, and therefore did not appear to concern the health professional. However, there has been a shift to deliver care that places the patient at the centre of the recovery process. While this refocuses the professional-led approach to the patient, this shift in hospital care delivery was not evident in the data.

Person-centred care

A person-centred model of care and its delivery has an ontological philosophy that older people are more individualised at this stage of life owing to ongoing life experience, lifespan, and physiological changes (Lutz & Bowers, 2000; McCormack, 2004; McCormack & McCance, 2006; Mead & Bower, 2000; Snaedal, 2011). Person-centred care is a guiding principle for a practice approach to working with older people (Landers & McCarthy, 2007; McCormack, 2004; McCormack & McCance, 2006). Ideally, the focus shifts from the health professional to the older adult and places care delivery central to the person's needs and expectations. McCormack (2004) discusses person-centred care as having four core concepts. These include: being in relation; being in a social world; being in place; and being with self. These core concepts reflect that people have relationships with others, are social, exist in context and are recognised, respected, and trusted as persons. According to McCormack, these core concepts underpin a person's values, behaviours, and preferences made in life. This in turn helps them to manage the incongruity of a situation and make sense of things. Nevertheless, the person-centred concept is about collaboration in care between older people and the healthcare team. This suggests that a form of care planning is based on older adults' self-governance and social memory behaviours.

Person-centred care concepts reflect a counter to traditional models of care. The approach is currently used within gerontological residential care centres, however has not yet shifted to the acute hospital environments. Person-centred models of care encourage the older person's connections with their social context and familiar situations, which supports restoring normalisation. Moreover, person-centred care has a focus on the person's social memory and self-governance behaviours that helps health care professionals plan care. Therefore, person-centred care is a step in a direction that encourages a more individualised approach to care delivery. However,

for this model to achieve some status within an acute care environment, the current models of delivery, which are medicalised and influenced by socio-political factors, would require a major shift. While socio-political influences are in a state of constant flux, thus encourage changing models of care, the biomedical model remains rigid and challenged. Economy and efficiency of delivery of care currently underpin how recovery occurs, therefore older adults recovery will continue to be managed accordingly until they are discharged from hospital, to self-manage. Interestingly, this influences the interpretation and perceptions of quality of care delivery.

Quality of care delivery

Quality of health care is a quality improvement focus to determine how delivery of care happened, and how it could be understood from multiple perspectives, and that it could also be defined and made measureable (Donabedian, 1988). Quality of care symbolises a number of aspects, from the systems, structures, and processes of the organisation through health professionals' performance and skills, to the patients /families using the services. The influence of quality improvement on healthcare has primarily been in the way care is delivered in an effective, safe, and efficient manner with an emphasis on the organisational structure-quality outcome (Herald, Alexander, Fraser, & Jiang, 2007). Interestingly, the quality emphasis enhances economic efficiency. Further developments to improve the quality of care delivery include the increasing use of specific indicators (Steel et al., 2004), patient–centred care (Robb & Seddon, 2006), or discipline specific approaches (Sidani, Doran, & Mitchell, 2004). Moreover, the quality of care depends on the focus placed on it. Improving quality of care is making the patient central to care delivery; however that is according to the perceived view that shared decision-making occurs and the patient is the expert in the process (Robb & Seddon, 2006). While the patient may be kept up front and central in this approach, in practice, efficiency of actions and economics tend to dominate. Quality of care is often measured through decreased complications, shorter lengths of stay, decreased mortality rates, shorter time to surgery, or lower infection rates. The patients' perceived quality of care is generally measured through satisfaction surveys, compliments received and a successful discharge[16].

---

[16] This interpretation is based on my roles in clinical practice and in quality management.

Theory-practice contextual relationships

The theory of restoring has explained how older adults manage recovery following a hip fracture, which occurs within traditional healthcare systems and care delivery models. Moreover, groups of health professionals are questioning this approach and refocusing the position of the patient within care processes. Traditional models of care reflect and are interpreted through the emphasis on separate working parts, segmental approaches, and fragmentation. This approach ensures predictability, control, and determinism (Abercrombie et al., 1988; Zohar, 1997; Zohar & Marshall, 1994) From this perspective, a health condition can be managed according to the nature of the cause, be fixed, and follow specified guidelines (New Zealand Guidelines Group, 2003). Traditional approaches reinforce the concept that parts are more important than the whole, and there is a hierarchical and reactive management approach to the delivery of care. With the constantly changing socio-political landscape, change is inherent in healthcare delivery. However, rather than radically re-organise health care delivery, the current systems just react and force tighter controls on managing healthcare. The contextual nature of the world needs be seen within the holistic realm, along with the relationships that occur within it. This encourages the multiple components of care delivery to be interactive and reciprocal rather than separately managed. With this approach, care delivery shifts from a primary focus on one aspect of health such as physiology, to incorporate all factors as relevant and necessary components in care delivery. The theory of restoring has shown that older adults manage recovery according to their interpretations of and ways of restoring normal. Therefore, current healthcare models and practice-based models of care should not be separate parts of the process but become holistic to emphasise the person-centredness of the process of recovery.

This study commenced with questions and an exemplar from the practice setting that initiated a research process to discover how older adults managed their recovery following hip fracture. Traditional models of nursing care were the original context in which the questions were raised. All of this was influenced by nursing care, which has been developed according to evolving theories, ongoing research, and knowledge expansion over the years. While numerous theorists have contributed to nursing's knowledge and application to practice, Salmond (1994, 2002) in particular has

influenced my practice for over a decade. The Salmond conceptual model of practice brought together the physiological, sociological, and psychological triad as components in delivery of nursing care. A component was emphasised according to the condition state. The acute state emphasised physiological care, whereas, chronic states were sociological, and the disability state stressed psychological care. While all three components were present, their emphasis shifted according to the presenting condition. The theory of restoring acknowledges Salmond's triad approach but promotes the complex interplay of the three components as the process of recovery and restoring normalisation. The Salmond model emphasised the health professional rather than the people experiencing the recovery process. Moreover, the cultural filter through which patients and health professionals interpret the process of recovery supports the concept of social memory but does not go far enough.

More recent social and economic influences impact how nursing is practiced in the contemporary environment (McCloskey & Diers, 2005). While nursing practice is continuously modified by external influences, its underpinning philosophy, epistemology, and practice continue to reflect a patient-centred focus through holistic care delivery (McEwen & Wills, 2007). The contextual setting in which practice occurs, however, creates a tension between traditional models of nursing practice and the contemporary environment. Interestingly, the greater the influence of economic rationality on healthcare delivery, the more likely holistic care delivery tends be limited. This was evident in the exemplar in Chapter One, which focused on the tasks to achieve a satisfactory discharge. Even within the rehabilitation focused centres, nursing practice reflects traditional and biomedical approaches to care delivery. Older adults talked of following regimes, rules, and hospital protocols even when considered independently active. Nursing practice is impacted by external forces that tend to dictate how care delivery happens. That practice is seen in the interaction between health professional and patient and reflects the delivery of quality care.

Tower (1994) compares the medical-rehabilitation paradigm of care with the independent living paradigm, by examining the underpinning elements. The influence of the paradigm impacts the method of care delivery and focuses the health professionals accordingly. For example, the medical-rehabilitation paradigm has a focus on impairment, problem-solving, patient as a social role, professional control,

and outcomes based on functionality and safety. In contrast, Tower notes the independent living paradigm focuses on levels of dependence and reliance needed, self-determination, consumer as a social role, independent control, and outcomes based on quality of life values. Tower's analysis highlights two approaches to care delivery and suggests that both may be necessary. In the initial stages of injury and surgical interventions, the medical-rehabilitation model is important as it links with the independent living element of seeking professional expert help for something that cannot be managed alone. However, transferring care control back to the person does not occur owing to the professional emphasis on social role understanding, impairment and functionality to ensure safety. Interestingly, Tower's review of the two paradigms suggests evolving models of care, such as person-centred care, are a link between accommodating both the patient and health professionals focus.

According to Kleine and Hughner (1999) "consumer [patient] mindsets about health are not watered-down versions of practitioner viewpoints...but their personal [health] theories are complex amalgams knowledge and new information" (p.1). Therefore, treating people as individuals within the process of recovery and enabling them to make decisions and choices about care practices supports a person-centred approach. What is important to the person from their perspective becomes central to developing and organising care delivery. Moreover, person-centred care is about providing care that is responsive to individual preferences, needs, and values through key concepts within the practice setting. These key concepts include improving person-professional communication, negotiated degrees of involvement, empowerment of the person to increase participation, partnership, trust, and choice. Assuring the person has an increasing degree of involvement in decision-making based on their values, guides health professional assessment, decision-making, and improves the experience and outcome for both the person and the health professional.

The theory of restoring adds another dimension to the evolving models of care, especially when considering the person-centred approach. Person-centredness is an evolving focus in care delivery, as it can be seen to link both consumerism from the market viewpoint, and holism from a nursing perspective through the decision-making processes involved in recovery. Decision-making creates a tension point in which the economics of healthcare have to be balanced against the holistic needs of the person.

Both views suggest an increase in quality of care delivery, effectiveness of outcomes and efficiency of throughput, but there is a tendency for traditional medical-rehabilitation paradigms to dominate. The argument that economic rationality assists in maximising limited healthcare resources for the majority is countered by the person-centred approach. Proponents of person-centred care (Landers & McCarthy, 2007; McCormack, 2004; McCormack & McCance, 2006) would argue that this health care approach improves quality of care, effectiveness of outcomes, and efficiency, because the emphasis shifts to the person controlling the process. Therefore, assessment, communication, information, involvement, and choice are more effective, as they are based on the individual's needs and values, not the standardised one-fit-all condition approach. The theory of restoring supports the needs and values approach of person-centred care. This was demonstrated through the processes and behaviours older adults used to manage their recovery both within the healthcare system and outside of it.

The regaining process used by older adults during restoring normal reflected how physical and social factors influenced their recovery. Pacing, spacing, and relying demonstrated how older adults assessed their level of needs, perceived trust in those involved, participated accordingly, and communicated their choices and decisions within an environment that often emphasised and prioritised care according to the traditional medial-rehabilitation model. Reasserting of older adults' normal psychological responses to restoring during recovery influenced the permissioning, connecting, and reconciling processes. Decision-making in these instances often reflected how older adults managed recovery during the initial stages, by adhering to health professional and medical-rehabilitation recovery concepts. Going with the flow, obeying, and complying were techniques used to determine the older adults' level of involvement while in care settings. Empowerment and decision-making over the recovery processes was restored once the older adult returned to their home. Therefore, the central concept of person-centred care in that decision-making is focused on the older adults' needs and values. This was evident in the restoring processes they used to balance regaining physical and social activity with normal psychological behaviours. Moreover, once pain had settled, and mobilisation recovered, the older adults restoring normalisation processes commenced. The ideal of person-centred care directed by the older adult should begin at the earliest possible

time while in care, that is when the person is ready, not based on the current environment in which problem-solving functional safety issues are the healthcare professionals' main concern.

The theory of restoring shows that older adults manage their recovery according to their values and needs. This is in spite of the traditional views seen with current models of care that are commonly offered by health professionals. Traditional models of care are acute care linked and provide care designated to meet specific physiological needs. In contrast, the more recent person-centred model of care focuses on the individual preferences of the older adult. However, this approach to care has to occur within a context that is influenced by socio-political factors and traditionally-based models of care. This theory suggests that individually-based holistic recovery is the desired approach to care delivery, but practice settings have a strong influence on how that care will be provided. The viewpoints evident in this research relating to how recovery should be managed are diverse. This has implications for practice and future research.

Implications

Studies on recovery from physical health events have generally focused on understanding the physiological and functional factors that occur during and post event. These studies emphasise the traditional medical-rehabilitation models of care and health professional interests. This study focuses on the behaviours older adults use to manage their recovery from unexpected injury and how they restore normal. The theory of restoring has introduced a level of complexity into recovery that goes beyond the current understanding and adds to the evolving models of care arena, such as person-centred care. While this study centred on older adults with hip fracture, further theoretical sampling in other areas, such as elective orthopaedic surgery, other types of physical injuries and surgeries, and other systemic health conditions, could be generalised to situations in which recovery occurs. Moreover, with wider theoretical sampling outside of the health arena, the theory could be generalised to have wider application to other recovery-based situations.

The clinical practice-based implications emerging from this theory have the potential to assist health professionals to understand recovery beyond the physical – functional perspective. If applied in current practice settings, the theory can augment health professional assessment and care planning of older adults by explaining the complex balancing of physical, social, and psychological factors that occur in recovery. This may move the control of recovery from the health professional to the older adult. The theory adds to the person-centred care model by supporting first, the holistic model of care, and second, it emphasises that older adults have values and needs that direct their recovery management. Above all, this theory highlights the fact that older adults have ways of managing their recovery that are potentially more effective and efficient than current practice. Further research is therefore required to understand how the theory of restoring has applicability to the person-centred model of care, along with examining how it may be applied when managing other health conditions. Unexpected injury has been explored from multiple viewpoints and this theory has added a new perspective. But, how the theory might be applied to elective surgery recovery management in different age groups, with different types of conditions, requires further development through research.

As recovery does not occur in isolation, it is a collective social responsibility; the perspectives from others involved in the process may add another level of complexity to recovery management. This research studied a specific sample group to gain an understanding of recovery relative to a certain age group within a substantive area. Further studies are required to explore others' perspectives of the recovery process such as, health professional views, carers of older adults, or people recovering from injury or surgery, and family members of people undergoing recovery. Research in all these areas has the potential to develop further knowledge about the recovery process. Also, establishing if the theory of restoring has relevance to people with chronic illness and how they manage, is another potential investigation study.

Limitations

Three limitations are relevant for this study. These were the recruitment process, exclusions to the sample group, and theoretical sampling was limited. Recruiting

people for the study followed methodological, academic, and ethical processes. The process was not as simple as expected. Hip fractures occur in many older adults, however recruiting them was more difficult than anticipated. The intention to sample people who could talk about their recovery, and were not limited cognitively, influenced recruitment strategies. In hindsight, the follow up recruitment process of meeting people while in hospital, gaining permission to contact them later, was more likely to have resulted in a larger number of participants, more quickly. However, this did not detract from the community dwelling people who offered their views of recovery. The exclusion criteria had rationale, but it also reduced potential participants. The final participant sample group were positive and motivated people. However, they reflect a specific portion of the older adult group recovering from hip fracture. The large population of older people living in residential care facilities were not approached. Gaining permission to enter the premises and interview people in these settings was not actioned because a decision was made to minimise potential contextual influences. Any future data collection from these sources will test the modifiability of the theory.

A further limitation for consideration was that recovery does not occur in isolation and many people are involved in the process and management of recovery. This study has not ignored that recovery involves other people such as, health professionals, family members, support groups, community agencies and carers. However, the aim of the research was to focus on one perspective that of the older adult recovering from hip fracture, to discover their concerns and resolutions process. Future research with other contributors to the recovery process will add to the knowledge base.

Recommendations

Recommendations emerging from this research have three foci. The first set of recommendations has relevance to the clinical practice setting. The second set of recommendations relates to care delivery, and the third, to publications and future research. In the clinical practice setting, health professionals need to understand that people recover at their own pace and according to their interpretation of how recovery should be managed. People do require health professional input and interventions

initially. They may demonstrate adherence to professional regimes and routines because of this. Nevertheless, there is a self-defining point at which older adults will want to manage their own recovery. More often than not, this occurs while the older adult is still in a hospital setting. Changes in how older adults and health professionals interact need to be re-examined. For the older adult, communication and trust of the recovery processes has to be evident. These need to empower the person and encourage participation so that these become normal elements for the older adult in the recovery process. For this change to occur, health professionals within the clinical setting, need to review how they practice, reflect on what underpins that practice, and consider how care is perceived during the recovery event. The theory of restoring recommends that health professionals refocus their assessments, so that they strengthen the holistic aspects. This shifts the focus from a purely physical and functional approach to include the values and needs of the older adult when providing care. Professional interpretations of recovery need to be managed in conjunction with understanding how older adults perceive and manage recovery within the many contexts they will find themselves situated. A key message emerging from this research is that older adults want more control over the process of recovery once pain has been controlled and a form of independent mobility has been regained. Therefore improving communication between older adults and health professionals should reflect the older adults' values and needs not the professionals.

Recommendations for care delivery are more complex, as they must account for the complexity of socio-political influences while models of care continue to develop. Traditional models of care delivery dominate recovery management and these influence the structures of organisations and processes used to facilitate recovery. That influence can emphasise economic rationality, efficiency, safety and determine how processes are used to meet these objectives. However, these objectives can still be met through the introduction of other care delivery models. Transitioning care between the acute episode, rehabilitation, and the community requires a different approach. The person-centred care concepts that focus on a holistic approach need to be more evident in the acute and rehabilitation settings. The theory of restoring has explained how older adults use a balancing act to restore normalisation, which is the regaining of physical and social activity with reasserting their normal psychological behaviours. These processes support the central concepts of person-centred care, which emphasises

a higher degree of control be situated with the older adult. Introduction of the person-centred approach in rehabilitation settings is the first step. While these units are generally underpinned by medical-rehabilitation paradigms, the shift to a person-centred focus is feasible and more quickly implemented. As the focus is returning the person to the community, understanding and working with their values and needs, along with their management processes fits within the rehabilitation realm. However, introducing the concepts of older adult's control, values and needs as a driver for care delivery in the acute setting is more complex. The majority of older adults regain physical functioning within a few days, along with a reduction in pain. At this point, the theory of restoring demonstrates that older adults are starting to restore their normal behaviours, interactions and responses that reflect self-governance. Two options occur at this point. First, the older adult may be transferred to a rehabilitation unit for further functional recovery. Second, the older adult may remain in an acute unit, where functional safety and early discharge are the norm. The recommendations emerging from this study suggest that understanding the older adult's perspective early in the process has more value in achieving recovery than aiming specifically for a safe functional discharge. Therefore, holistic assessment remains the key recommendation to improve the recovery prospects for the older adult, irrespective of the setting. Care delivery is focused on the needs of the older adult not the organisation, which in turn improves communication, empowerment, trust, and participation on both sides.

To inform clinicians about the relevance of the theory of restoring and its potential influence on practice, the following recommendations are suggested. Publication of the research and theory need to occur to disseminate the findings to a wider audience. High impact journals with a wide audience of clinicians should be the first approach to publication. Once achieved, further publications that inform the substantive area should be written. This links the theory to the practice setting and its application within the substantive area. Aside from these publications, exploration of the theory's relationship to person-centred care should be examined and offered for publication. Moreover, further publications could argue the wider implications of the theory along with small projects to test the theory's modifiability. Once the theory is established within the professional journals, informing nursing and other practitioner curricula should follow. Alongside publication, conference presentations should help disseminate the theory, findings and influence on practice. Venues such as

professional associations and organisations offer annual and bi-annual conferences. These range from orthopaedic specific through to older adult / aged care organisations.

Conclusion

The theory of restoring offers an alternative perspective to recovery following a health event such as hip fracture. This study has enabled me to discover a perspective that could not have been perceived of, earlier. My professional emphasis on physical functional restoration through interventional activity to ensure recovery has been thoroughly overturned. However, while there are similarities to the orthopaedic practice model used to underpin my practice, the theory of restoring has strengthened and widened that practice model. Discovering a pattern of behaviour that resolves a main concern was a unique experience. My professional concerns that accompany the process of recovery still have some relevance but are now located within a broader understanding. This substantive theory has added to the knowledge and practice of recovery. The role older adults play in their recovery is emphasised and strengthens the need to provide a quality of care that reflects their needs and concerns, during all stages of the recovery journey. I am grateful to all the participants who shared their recovery journey, without this information; this theory could not have been discovered.

References

Abercrombie, N., Hill, S., & Turner, B. S. (1988). *The Penguin Dictionary of Sociology* (2nd ed.). London, United Kingdom: Penguin Group.

Accident Compensation Corporation. (2003). *Otago exercise programme to prevent falls in older adults*. Wellington, New Zealand: Author.

Accident Compensation Corporation. (2005). *Preventing injury from falls: The National Strategy 2005-2015*. Wellington, New Zealand: Author. Retrieved from http://fallsstrategy.govt.nz

Achenbaum, W. A. (2005). Ageing and changing: International historical perspectives on ageing. In M. L. Johnson (Ed.), *The Cambridge handbook of age and ageing* (pp. 21-29). Cambridge, United Kingdom: Cambridge University Press.

Aggleton, P., & Chalmers, H. (1999). Chapter 3. The medical model of care. In P. Aggleton & H. Chalmers (Eds.), *Nursing models and nursing practice* (pp. 26-30). Basingstoke, United Kingdom: Macmillan.

Alaszewski, A., Harrison, L., & Manthorpe, J. (Eds.). (1998). *Risk, health and welfare: Policies, strategies and practice*. Buckingham, United Kingdom: Open University Press.

Andrews, M. (2009). The narrative complexity of successful ageing. *International Journal of Sociology and Social Policy, 29*(1/2), 73-83. doi:10.1108/01443330910934736

Andrews, T. (2006). The literature review in grounded theory: A response to McCallin (2003). *The Grounded Theory Review: An International Journal, 5*(2/3), 29-33.

Angel, S., Kirkevold, M., & Pederson, B. (2009). Getting on with life following a spinal cord injury: Regaining meaning through six phases. *International Journal of Qualitative Studies on Health and Well-being, 4*, 39-50. doi:10.1080/17482620802393492

Angus, J., & Reeve, P. (2006). Ageism: A threat to "aging well' in the 21st century. *The Journal of Applied Gerontology, 25*(2), 137-152. doi:10.1177/0733464805285745

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990's. *Psychosocial Rehabilitation Journal, 16*(4), 11-23.

Archibald, G. (2003). Patient's experiences of hip fracture. *Journal of Advanced Nursing, 44*(4), 385-392.

Artinian, B. M., Giske, T., & Cone, P. H. (2009). *Glaserian grounded theory in nursing research*. New York, NY: Springer Publishing.

Ashton, T. (2005). Recent developments in the funding and organisation of the New Zealand health system. *Australia and New Zealand Health Policy 2*(1), 9-16. doi:10.1186/1743-8462-2-9

Atchison, D. (1992). Restorative nursing: A concept whose time has come. *Nursing Homes, 41*(1), 8-12.

Baltes, P. B., Freund, A. M., & Li, S.-C. (2005). The psychology science of human ageing. In M. L. Johnson (Ed.), *The Cambridge handbook of age and ageing* (pp. 47-71). New York, NY: Cambridge University Press.

Barangan, J. D. (1990). Factors that influence recovery from hip fracture during hospitalization. *Orthopaedic Nursing, 9*(5), 19-28.

Barlow, J., Wright, C., Sheasby, J., Turner, A., & Hainsworth, J. (2002). Self-management approaches for people with chronic conditions: A review. *Patient Education and Counselling, 48*, 177-187.

Barnason, S., Zimmerman, L., Nieveen, J., Schulz, P., Miller, C. A., Hertzog, M., & Rasmussen, D. (2008). Relationships between fatigue and early postoperative recovery outcomes over time in elderly patients undergoing coronary artery bypass graft surgery. *Heart & Lung, 37*(4), 245-256. doi:10.1016/j.hrtlng.2007.09.003

Bendien, E. (2012). Remembering (in) the past perfect: Ethical shifts in times. *Memory Studies, 5*(4), 445-461. doi:10.1177/1750698012439198

Berger, K. S. (1998). *The developing person through the lifespan* (4th ed.). New York, NY Worth

Biesta, G. (2007). Why "what works" won't work: Evidence-based practice and the democratic deficit in educational research. *Educational Theory, 57*(1), 1-22.

Bilton, T., Bonnett, K., Jones, P., Shear, K., Stanworth, M., & Webster, A. (1981). *Introductory sociology*. London, United Kingdom: Macmillan Press.

Bishop, M. (2001). The recovery process and chronic illness and disability: Applications and implications. *Journal of Vocational Rehabilitation, 16*, 47-52.

Blanchard-Fields, F. (2007). Everyday problem solving and emotion: An adult developmental perspective. *Current Directions in Psychological Science, 16*(1), 26-31.

Blane, D., Higgs, P., Hyde, M., & Wiggins, R. D. (2004). Life course influences on quality of life in early old age. *Social Science & Medicine, 58*, 2171-2179. doi:10.1016/j.socscimed.2003.08.028

Blazer, D. G. (2008). How do you feel about...? Health outcomes in late life and self-perceptions of health and well-being. *The Gerontologist, 48*(4), 415-422.

Bodenheimer, T., Lorig, K., Holman, H., & Grumbach, K. (2002). Patient self-management of chronic disease in primary care. *Journal of the American Medical Association, 288*(19), 2469-2475.

Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality & Quantity, 36*, 391-409.

Bohlmeijer, E., Roemer, M., Cuijpers, P., & Smit, F. (2007). The effects of reminiscence on psychological well-being in older adults: A meta-analysis. *Aging & Mental Health, 11*(3), 291-300. doi:10.1080/13607860600963547

Bonanni, D. R., Devers, G., Dezzi, K., Duerr, C., Durkin, M., Hernan, J., & Joyce, C. (2009). A dedicated approach to restorative nursing. *Journal of Gerontological Nursing, 35*(1), 37-44.

Borkan, J. M., Quirk, M., & Sullivan, M. (1991). Finding meaning after the fall: Injury narratives from elderly hip fracture patients. *Social Science and Medicine, 33*(8), 947-957.

Boston, J., Dalziel, P., & St John, S. (1999). *Redesigning the welfare state in New Zealand: Problems, policies, prospects*. Oxford, United Kingdom: Oxford University Press.

Boyd, C. M., Darer, J., Boult, C., Fried, L. P., Boult, L., & Wu, A. W. (2005). Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases. *Journal of the American Medical Association, 294*(6), 716-724.

Brent, L., & Coffey, A. (2013). Patient perceptions of their readiness for discharge following hip fracture surgery. *International Journal of Orthopaedic and Trauma Nursing, In press*. doi:101016/j.ijotn.2013.01.001

Brown, P. (1995). Naming and framing: the social construction of diagnosis and illness. *Journal of Health and Social Behavior, 35*(Extra), 34-52.

Brownell, K. D., Kersh, R., Ludwig, D. S., Post, R. C., Puhl, R. M., Schwartz, M. B., & Willet, W. C. (2010). Personal responsibility and obesity: A constructuive approach to a controversial issue. *Health Affairs, 29*(3), 379-387. doi:101377/hlthaff.2009.0739

Bryant, A., & Charmaz, K. (Eds.). (2007). *The Sage handbook of grounded theory*. London, United Kingdom: Sage.

Burgers, J. S., Grol, R., Klazinga, N. S., Makela, M., & Zaat, J. (2003). Towards evidence-based clinical practice: An international survey of 18 clinical guideline programs. *International Journal for Quality in Health Care, 15*(1), 31-45.

Carman, M. B. (1997). The psychology of normal aging. *Psychiatric Clinics of North America, 20*(1), 15-24.

Casey, J. P., & Balshaw-Greer, A. (2005). British Conservative party health reforms of the 1980s and 1990s: Ideology or inevitable? *Quality Management in Health Care, 14*(4), 248-251.

Chang, E., Chenoweth, L., & Hancock, K. (2003). Nursing needs of hospitalised older adults: Consumer and nurse perceptions. *Journal of Gerontological Nursing, 29*(9), 32-41.

Chang, K. P., Center, J. R., Nguyen, T. V., & Eismen, J. A. (2004). Incidence of hip fracture and other osteoporotic fractures in elderly men and women: Dubbo osteoporosis epidemiology study. *Journal of Bone and Mineral Research, 19*(4), 532-536. doi:10.1359/JBMR.040109

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage

Choong, P. F., Langford, A. K., Dowsey, M. M., & Santamaria, N. M. (2000). Clinical pathway for fractured neck of femur: A prospective, controlled study. *The Medical Journal of Australia, 172*, 427-435.

Clark, D. (2001). Latham and the third way: Radicalising neo-liberalism? *Journal of Australian Political Economy, 51*, 57-76.

Clarke, A. E. (2003). Situational analysis: Grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553-576.

Clasen, J., & Clegg, D. (2004). *Does the third way work? The left and labour market policy reform in Britain, France, and Germany.* doi:10.1093/0199266727.001.0001

Colapietro, V. M. (2006). Charles Sanders Peirce. In J. R. Shook & J. Margolis (Eds.), *A companion to pragmatism* (pp. 13-29). Oxford, UK: Blackwell Publishing.

Conway, M. A., & Pleydell-Pearce, C. W. (2000). The construction of autobiographical memories in the self-memory system. *Psychology Review, 107*(2), 261-288. doi:10.1037/0033-295X.107.2.261

Corbin, J., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Thousand Oaks, CA: Sage.

Costello, B., Wachtel, J., & Wachtel, T. (2009). *The restorative practices handbook for teachers, disciplnarians and administrators.* Bethleham, PA: International Institute for Restorative Practices.

Craig, D. (2003). Reterritorialising health: Inclusive partnerships, joined-up governance and common accountability platforms in Third Way New Zealand. *Policy & Politics, 31*(3), 335-352.

Cree, M. W. (2004). Hip fracture-related changes in health ratings of older patients with cognitive impairment. *Aging & Mental Health, 8*(6), 524-529. doi:10.1080/136078604123331303810

Crookes, P., & Davies, S. (Eds.). (1998). *Research into practice: Essential skills for reading and applying research in nursing and health care.* London, United Kingdom: Bailliere Tindall.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* Sydney, Australia: Allen & Unwin.

Cutcliffe, J. R. (2005). Adapt or adopt: Developing and transgressing the methodological boundaries of grounded theory. *Journal of Advanced Nursing, 51*(4), 421-428.

De Waal, C. (2001). *On Peirce.* Belmont, California: Wadsworth.

Deci, E. L., & Ryan, R. (2000). The 'what' and 'why' of goal pursuits: Human needs and the self-determination of behaviour. *Psychological Inquiry, 11*(4), 227-268. doi:10.1207/S15327965PLI1104_01

Denzin, N. K. (1971). The logic of naturalistic inquiry. *Social Forces, 50*(Dec), 166-182.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2003). *The landscape of qualitative research: Theories and issues* (2nd ed.). Thousand Oaks, CA: Sage

DePoy, E., & Gitlin, L. N. (2005). *Introduction to research: Understanding and applying multiple strategies* (3rd ed.). St. Louis, MI: Elsevier Mosby.

DePoy, E., & Gitlin, L. N. (2011). *Introduction to research: Understanding and applying multiple strategies* (4th ed.). St. Louis, MI: Mosbey.

Devlin, N., Maynard, A., & Mays, N. (2001). New Zealand's new health sector reforms: Back to the future? *British Medical Journal, 322*(7295), 1171-1174.

Donabedian, A. (1988). The quality of care. *Journal of the American Medical Association, 260*(12), 1743-1748.

Dorsett, D. S. (1991). The trajectory of cancer recovery. *Scholarly Inquiry for Nursing Practice 5*(3), 175-184.

Dowswell, G., Lawler, J., Dowswell, T., Young, J., Forster, A., & Hearn, J. (2000). Investigating recovery from stroke: A qualitative study. *Journal of Clinical Nursing, 9*, 507-515.

Drewery, W., & Kecskemeti, M. (2010). Restorative practice and behaviour management in schools: Discipline meets care. *Waikato Journal of Education, 15*(3), 101-113.

Eastwood, E. A., Magaziner, J., Wang, J., Silberzweig, S. B., Hannan, E. L., Strauss, E., & Siu, A. L. (2002). Patients with hip fracture: Subgroups and their outcomes. *Journal of American Geriatric Society, 50*, 1240-1249.

Echterhoff, G., & Hirst, W. (2009). Social influence on memory *Social Psychology, 40*(3), 106-110. doi:10.1027/1864-9335.40.3.106

Farkas, M. (2007). The vision of recovery today: What it is and what it means for services. *World Psychiatry, 6*(2), 68-74.

Fearon, K. C. H., Ljungqvist, O., Von Meyenfeldt, M., Revhaug, A., Dejong, C. H. C., Lassen, K., ... Kehlet, H. (2005). Enhanced recovery after surgery: A consensus review of clinical care for patients undergoing colonic resection. *Clinical Nutrition, 24*, 466-477. doi:10.1016/j.clnu.2005.02.002

Fineout-Overholt, E., Melnyk, B. M., & Schultz, A. (2005). Transforming health care from the inside out: Advancing evidence-based practice in the 21st century. *Journal of Professional Nursing 21*(6), 335-344. doi:10.1016/j.profnurs.2005.10.005

Fisher, A. A., Davis, M. W., Rubenach, S. E., Sivakumaran, S., Smith, P. N., & Budge, M. M. (2006). Outcomes for older patients with hip fractures: The impact of orthopedic and geriatric medicine cocare. *Journal of Orthopaedic Trauma, 20*(3), 172-180. doi:10.1097/01.bot.0000202220.88855.16

Fulop, T., Larbi, A., Witkowski, J. M., McElhaney, J., Loeb, M., Mitnitski, A., & Pawlec, G. (2010). Aging, frailty and age-related diseases. *Biogerontology, 11*, 547-563. doi:10.1007/s10522-010-9287-2

Gallagher, P. (2011). Becoming normal: A grounded theory study on the emotional process of stroke recovery. *Canadian Journal of Neuroscience Nursing, 33*(3), 24-32.

Gallant, M. P., Spitze, G. D., & Prohaska, T. R. (2007). Help or hindrance? How family and friends influence chronic illness self-management among older adults. *Research on Aging, 29*(5), 375-409. doi:10.1177/0164027507303169

Ganz, S. B., Peterson, M. G. E., Russo, P. W., & Guccione, A. (2007). Functional recovery after hip fracture in the subacute setting. *Hospital for Special Surgery Journal, 3*, 50-57. doi:10.1007/s11420-006-9022-3

Gauld, R. (2001). *Revolving doors: New Zealand's health reforms*. Wellington, New Zealand: Victoria University of Wellington

Giaquinto, S., Majolo, I., Palma, E., Roncacci, S., Sciarra, A., & Vittoria, E. (2000). Very old people can have favorable outcome after hip fracture: 58 patients referred to rehabilitation. *Archives of Gerontology and Geriatrics, 31*, 13-18.

Gilleard, C., & Higgs, P. (1998). Old people as users and consumers of healthcare: A third age rhetoric for a fourth age reality? *Ageing and Society, 18*, 233-248.

Gino, F., & Desai, S. D. (2012). Memory lane and morality: How childhood memories promote prosocial behavior. *Jounral of Personality and Social Psychology, 102*(4), 743-758. doi:10.1037/a0026565

Giske, T., & Artinian, B. M. (2007). Patterns of 'balancing between hope and despair' in the diagnostic phase: A grounded theory study of patients on a gastroenterology ward. *Journal of Advanced Nursing, 62*(1), 22-31. doi:10.1111/j.1365-2648.2007.04523.x

Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions* Mill Valley, CA: Sociology Press.

Glaser, B. G. (2001). *Conceptualisation contrasted with description*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (2003). *The grounded theory perspective II: Description's remodelling of grounded theory methodology*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (2005). *Grounded theory perspective III: Theoretical coding*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (2009). *Jargonizing: Using the grounded theory vocabulary*. Mill Valley, CA: Sociology Press.

Glaser, B. G. (2011). *Getting out of the data: grounded theory conceptualization*. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New Jersey, NJ: Aldine Transaction.

Gobbens, R. J. J., Luijkx, K. G., Wijnen-Sponselee, M. T., & Schols, J. M. G. A. (2010). Towards an integral conceptual model of frailty. *The Journal of Nutrition, Health & Aging, 14*(3), 175-181.

Godfrey, M., & Townsend, J. (2008). Older people in transition from illness to health: Trajectories of recovery. *Qualitative Health Research, 18*(7), 939-951. doi:10.1177/1049732308318038

Grant, L. (1996). Effects of ageism on individual and health care providers' responses to healthy aging. *Health & Social Work, 21* (1), 9-15.

Graves, M. (2007). Peircean approaches to emergent systems in cognitive science and religion. *Zygon, 42*(1), 241-248.

Greener, I. (2008). Expert patients and human agency: Long-term conditions and Giddens' structuration theory. *Social Theory & Health, 6*, 273-290. doi:10.1057/sth.2008.11

Guccione, A. A., Fagerson, T. L., & Anderson, J. J. (1996). Regaining functional independence in the acute care setting following hip fracture. *Physical Therapy, 76*(8), 818-826.

Halcomb, E., & Davidson, P. (2005). Using the illness trajectory framework to describe recovery from traumatic injury. *Contemporary Nurse, 19*(1-2), 232-241.

Hall, S. E., Williams, J. A., Senior, J. A., Goldswain, P. R., & Criddle, R. A. (2000). Hip fracture outcomes: Quality of life and functional status in older adults living in the community. *Australia and New Zealand Health Journal of Medicine, 30*(3), 327-332.

Hallberg, I., Rosenqvist, A. M., Kartous, L., Lofman, O., Wahlstom, O., & Toss, G. (2004). Health-related quality of life after osteoporotic fractures. *Osteoporosis International, 15*, 834-841.

Hamerman, D. (2009). A new curriculum to link the basic science of aging with geriatric practice. *Perspectives in Biology and Medicine, 52*(3), 355-363.

Hass, B. (1999). Clarification and integration of similar quality of life concepts. *The Journal of Nursing Scholarship, 31*(3), 215-220.

Hayden, J. A. (2009). Introduction to health psychology. In *Introduction to health behaviour theory* (pp. 1-22). Sudbury, MA: Jones and Bartlett

Healee, D. J., McCallin, A. M., & Jones, M. (2011). Older adult's recovery from hip fracture: A literature review. *International Journal of Orthopaedic and Trauma Nursing, 15*(1), 18-28. doi:10.1016/j.ijotn.2010.06.010

Health Information Privacy Code 1994.

Health Information Privacy Code 2008.

Heath, H., & Cowley, S. (2004). Developing a grounded theory approach: A comparison of Glaser and Strauss. *International Journal of Nursing Studies, 41*, 141-150. doi:10.1016/S0020-7489(3)00113-5

Herald, L. R., Alexander, J. A., Fraser, I., & Jiang, H. J. (2007). How do hospital organisational structure and processes affect quality of care. *Medical Care Research and Review*, 1-41. doi:10.1177/1077558707309613

Hershkovitz, A., Pulatov, I., Brill, S., & Beloosesky, Y. (2012). Can hip-fractured elderly patients maintain their rehabilitation achievements after 1 year? *Disability & Rehabilitation, 34*(4), 304-310. doi:10.3109/09638288.2011.606346

Hewer, C. J., & Roberts, R. (2012). History, culture and cognition: Towards a dynamic model of social memory. *Culture & Psychology, 18*(2), 167-183. doi:10.1177/1354067X11434836

Higgins, I., Van Der Riet, P., Slater, L., & Peek, C. (2007). The negative attitudes of nurses towards older patients in the acute hospital setting: A qualitative descriptive study. *Contemporary Nurse, 26*(2), 225-237.

Higgs, P., & Jones, I. R. (2009). *Medical Sociology and old age: Towards a sociology of health in later life*. London, United Kingdom: Routledge.

Holloway, I., & Wheeler, S. (1996). *Qualitative research for nurses*. Oxford, United Kingdom: Blackwell Science.

Holton, J. A. (2007). The coding process and its challenges. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 265-289). Thousand Oaks, CA: Sage.

Holton, J. A. (2008). Grounded theory as a general methodology. *The Grounded Theory Review: An International Journal, 7*(2), 67-93.

Holton, J. A. (2009). Qualitative tussles in undertaking a grounded theory study. *The Grounded Theory Review: An International Journal, 8* (3), 37-49.

Holton, J. A. (2011). The autonomous creativity of Barney G. Glaser: Early influences in the emergence of classic grounded theory methodology. In V. B. Martin & A. Gynnild (Eds.), *Grounded theory: The philosophy, method, and work of Barney Glaser* (pp. 201-223). Boca Raton, Florida: BrownWalker Press.

Honderich, T. (Ed.). (1995). *The Oxford companion to philosophy*. Oxford, United Kingdom: Oxford University Press.

Horan, M. A., & Clague, J. E. (1999). Injury in the aging: Recovery and rehabilitation. *British Medical Bulletin, 55*(4), 895-909.

Horne, G. (2007). Hip fracture management - we need to do better. *The New Zealand Medical Journal 120*(1254), 2535-2536.

Hunt, M. G., & Stein, C. H. (2004). Living life to the fullest: Well elder's view of hip fracture. *Ageing International, 29*(2), 178-198.

Ishizahi, T., Imanaka, Y., Oh, E., Kuwabara, K., Hirose, M., Hayashida, K., & Harada, Y. (2004). Association of hospital resource use with comorbidity status and patient age among hip fracture patients in Japan. *Health Policy, 69*, 179-187. doi:10.1016/j.healthpol.2003.12.018

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52*(4), 482-485.

Jagmin, M. G. (1998). Postoperative mental status in elderly hip surgery patients. *Orthopaedic Nursing, 17*(6), 32- 42.

Jenkins, A. (2006). Shame, realisation and restitution: The ethics of restorative practice. *Australian & New Zealand Journal of Family Therapy, 27*(3), 153-162.

Jennings, B. M., & Loan, L. A. (2001). Misconceptions among nurses about evidence-based practice. *Journal of Nursing Scholarship, 33*(2), 121-127.

Johnell, O., & Kanis, J. A. (2004). An estimate of the worldwide prevalence, mortality and disability associated with hip fracture. *Osteoporosis International, 15*, 897-902. doi:10.1007/s00198-004-1627-0

Johnson, J. L., & Morse, J. M. (1990). Regaining control: The process of adjustment after myocardial infarction. *Heart & Lung: The Journal of Critical Care, 19*(2), 126-135.

Johnson, M. L. (Ed.). (2005). *The Cambridge handbook of age and ageing*. Cambridge, United Kingdom: Cambridge University Press.

Kannus, P., Parkkari, J., Sievanen, H., Heinonen, A., Vuori, I., & Jarvinen, M. (1996). Epidemiology of hip fractures. *Bone, 18*(1 Supplement), 57S-63S.

Kaplan, R. (2001). The nature of the view from home: Psychological benefits. *Environment and Behavior, 33*(4), 507-542. doi:10.1177/00139160121973115

Kaplan, S. (1983). A model of person-environment compatibility. *Environment and Behavior, 15*, 311-332. doi:10.1177/0013916583153003

Kaplan, S. (1992). The restorative environment: Nature and human experience. In D. Relf. (Ed.), *The role of horticulture in human well-being and social development* (pp. 134-142). Portland, OR: Timber Press.

Katz, S. (2000). Busy Bodies: Activity, aging and the management of everyday life. *Journal of Aging Studies, 14*(2), 135-152.

Katz, S., & Marshall, B. L. (2004). Is the functional 'normal'? Aging, sexuality and the bio-marking of successful living. *History of the Human Sciences, 17*(1), 53-75. doi:10.1077/0952695104043584

Kearney, M. H. (1999). *Understanding women's recovery from illness and trauma*. Thousand Oaks, CA: Sage.

Khasraghi, F. A., Lee, E. J., Christmas, C., & Wenz, J. F. (2003). The economic impact of medical complications in geriatric patients with hip fracture. *Orthopaedics, 26*(1), 49-54.

Kirkwood, T. B. (2002). Evolution of ageing. *Mechanisms of ageing and development, 123*, 737-745.

Kirkwood, T. B. (2005). The biological science of human ageing. In M. L. Johnson (Ed.), *The Cambridge handbook of age and ageing* (pp. 72-81). Cambridge, United Kingdom: Cambridge University Press.

Kleine, S. S., & Hughner, R. S. (1999). Paradigm shifts in health care: Consumers' personal theories of health. *Alternative Health Practitioner, 5* (3), 187-2002. doi:10.1177/153321019900500302

Koot, V. C. M., Peeters, P. H. M., de Jong, J. R., Clevers, G. J., & van der Werken, C. (2000). Functional results after treatment of hip fracture: A multicentre, prospective study in 215 patients. *European Journal of Surgery 166*, 480-485.

Korpela, K., & Hartig, T. (1996). Restorative qualities of favourite places. *Journal of Environmental Psychology, 16*, 221-233.

Koval, K. J., Chen, A., Aharonoff, G. B., Egol, K. A., & Zuckerman, J. D. (2004). Clinical pathway for hip fractures in the elderly: The hospital for joint diseases experience. *Clinical Orthopaedics and Related Research 425*, 72-81. doi:10.1097/01.blo.0000132266.59787.d2

Koval, K. J., & Cooley, M. (2005). Clinical pathway after hip fracture. *Disability & Rehabilitation, 27*(18-19), 1053-1060. doi:10.1080/09638280500056618

Koval, K. J., Skovron, M. L., Polatsch, D., Aharonoff, G. B., & Zuckerman, J. D. (1996). Dependency after hip fracture in geriatric patients: A study of predictive factors. *Journal of Orthopaedic Trauma, 10*(8), 531-535.

Koval, K. J., & Zuckerman, J. D. (1994). Functional recovery after fracture of the hip. *The Journal of Bone and Joint Surgery, 76-A*(5), 751-758.

Kralik, D., Koch, T., Price, K., & Howard, N. (2004). Chronic illness self-management: Taking action to create order. *Journal of Clinical Nursing, 13*, 259-267.

Labouvie-Vief, G. (2005). The psychology of emotions and ageing. In M. L. Johnson (Ed.), *The Cambridge handbook of age and ageing* (pp. 229-236). Cambridge, United Kingdom: Cambridge University Press.

Landers, M. G., & McCarthy, G. M. (2007). Person-centred nursing practice with older people in Ireland. *Nursing Science Quarterly, 20*(1), 78-84. doi:10.1177/0894318406296811

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented guidance. *Psychiatric Services, 62*(12), 1470–1476. doi:10.1176/appi.ps.001312011

Levine, S., & Kozloff, M. A. (1978). The sick role: Assessment and overview. *Annual Review of Sociology, 4*, 317-343.

Lin, P. C., & Chang, S. Y. (2004). Functional recovery among elderly people one year after hip fracture surgery. *Journal of Nursing Research, 12*(1), 72-82.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Newbury Park, California: Sage Publications.

Lorig, K., & Holman, H. (2003). Self-management education: History, definition, outcomes, and mechanisms. *Annuals of Behavioural Medicine, 26*(1), 1-7.

Lupien, S. J., & Wan, N. (2004). Successful ageing: From cell to self. *Philosophical Transactions of The Royal Society, London. B, 359*(1449), 1413-1426. doi:10.1098/rstb.2004.1516

Lutz, B. J., & Bowers, B. J. (2000). Patient-centered care: Understanding its interpretation and implementation in health care. *Scholarly Inquiry for Nursing Practice, 14*(2), 165-183.

MacDonald, M., & Schreiber, R. S. (2001). Constructing and deconstructing: Grounded theory in a postmodern world. In R. S. Schreiber & P. N. Stern (Eds.), *Using grounded theory in nursing* (pp. 35-53). New York, NY: Springer

Magaziner, J., Fredman, L., Hawkes, W., Hebel, J. R., Zimmerman, S. I., Orwig, D. L., & Wehren, L. (2003). Changes in functional status attributable to hip fracture: A comparison of hip fracture patients to community-dwelling aged. *American Journal of Epidemiology, 157*(11), 1023-1031.

Magaziner, J., Simonsick, E. M., Kashner, T. M., Hebel, J. R., & Kenzora, J. (1989). Survival experience of aged hip fracture patients. *American Journal of Public Health, 79* (3), 274-278.

Magnani, L. (2005). An abductive theory of scientific reasoning. *Semiotica, 153*(1/4), 261-286.

Martin, V. (2006). The relationship between an emerging grounded theory and the existing literature: Four phases for consideration. *2006, The Grounded Theory Review: An International Journal*(5), 2/3.

May, L. (1992). *Sharing responsibility*. Chicago, IL: The University of Chicago Press.

May, L. (1996). *The socially responsive self: Social theory and professional ethics*. Chicago, IL: The University of Chicago Press.

McCallin, A. M. (2003). Grappling with the literature in a grounded theory study. *Contemporary Nurse, 15*(1-2), 61-69.

McCallin, A. M. (2006). Methodological issues: Have we forgotten the place of thinking here? *The Grounded Theory Review: An International Journal, 5*(2/3), 51-57.

McCallin, A. M. (2010). International perspectives of ethical approval: The New Zealand scene. *The Grounded Theory Review: An International Journal, 10*(3), 43-50.

McCallin, A. M., Nathaniel, A. K., & Andrews, T. (2011). Learning methodology minus mentorship. In V. B. Martin & A. Gynnild (Eds.), *Grounded theory: The philosophy, method and work of Barney Glaser* (pp. 69-84). Boca Raton, Florida: BrownWalker Press.

McCann, T., & Clark, E. (2003). Grounded theory in nursing research: Part 2 - critique. *Nurse Researcher, 11*(2), 19-28.

McCloskey, B., & Diers, D. (2005). Effects of New Zealand's health reengineering on nursing and patient outcomes. *Medical Care, 43*(11), 1140-1146.

McCluskey, G., Lloyd, G., Kane, J., Riddell, S., Stead, J., & Weedon, E. (2008). Can restorative practices in schools make a difference? *Educational Review, 60*(4), 405-417. doi:10.1080/00131910802393456

McCormack, B. (2004). Person-centredness in gerontological nursing: An overview of the literature. *International Journal of Older People Nursing 13*(3a), 31-38.

McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. *Advanced Journal of Nursing, 56*(5), 472-479. doi:10.1111/j.1365-2648.2006.04042.x

McEwen, M., & Wills, E. M. (2007). *Theoretical basis for nursing* (2nd ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

McMillan, L. (2010). *A grounded theory of 'taking control' after surgery for fall-induced hip fracture*. Glasgow Caledonian University, Glasgow.

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science and Medicine, 51*(7), 1087-1110.

Merriam, S. B., & Clark, M. C. (1993). Learning from life expereince: What makes it significant. *International Journal of Lifelong Education, 12*(2), 129-138. doi:10.1080/0260137930120205

Meyers, R. G. (1999). Pragmatism and Peirce's externalist epistemology. *Transactions of the Charles S. Peirce Society, XXXV*(4), 638-653.

Michailakis, D., & Schirmer, W. (2010). Agents of their health? How the Swedish welfare state introduces expectations of individual responsibility. *Sociology of Health & Illness, 32*(6), 930-947. doi:10.1111/j.1467-9566.2010.01262.x

Miller, C. A. (2009). *Nursing for wellness in older adults* (5th ed.). Philadelphia, PA: Wolters Kluwer Health / Lippincott Williams & Wilkins.

Ministry of Health. (2000). *The New Zealand Health Strategy*. Wellington, New Zealand: Aurthor. Retrieved from www.moh.govt.nz

Ministry of Health. (2001). *Primary Health Care Strategy*. Wellington, New Zealand: Author. Retrieved from www.moh.govt.nz

Ministry of Health. (2002). *Health of older people strategy*. Dunedin, New Zealand: Ministry of Health publications, Wickliffe Retrieved from http://www.moh.govt.nz

Ministry of Health. (2004). *Ageing New Zealand and health and disability services 2001-2021*. Wellington, New Zealand: Ministry of Health. Retrieved from http://www.health.govt.nz/publication

Ministry of Health. (2006). *Operational Standard for Ethics Committees*. Wellington, New Zealand: Author.

Ministry of Health. (2007). *Older People's Health Chart Book 2006*. Wellington, New Zealand: Author. Retrieved from http://www.moh.govt.nz

Ministry of Health. (2011). *Hospital Events 2007/08* (978-0-473-37365-3 (online)). Wellington, New Zealand: Ministry of Health.

Monti, E. J., & Tingen, M. S. (1999). Multiple paradigms of nursing science. *Advances in Nursing Science, 21*(4), 64-80.

Moody, H. R. (2006). *Aging: Concepts and controversies* (5th ed.). Thousand Oaks, CA: Pine Forge Press.

Moore, J. (2009). An exploration of the origin of classic grounded theory. *Nurse Researcher, 17*(1), 8-14.

Morse, J. M. (1997). Responding to threats to integrity of self. *Advances in Nursing Science, 19*(4), 21-36.

Morse, J. M., Stern, P. N., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A. (2009). *Developing grounded theory: The second generation*. Walnut Creek, CA: Left Coast Press.

Mouzopoulos, G., Stamatakos, M., Arabatzi, H., Vasiliadis, G., Batanis, G., Tsembeli, A., ... Safioleas, M. (2008). The four-year functional result after a displaced subcapital hip fracture treated with three different surgical options. *International Orthopaedics, 32*, 367-373. doi:10.1007/s00264-007-0321-1

Murdaugh, C. (1998). Health-related quality of life in HIV disease: Achieving balance. *Journal of the Association of Nurses in AIDS Care, 9*(6), 59-71.

Nathaniel, A. (2006). Thoughts on the literature review and gt. *The Grounded Theory Review: An International Journal, 5*(2/3), 35-41.

Nathaniel, A. (2011). An integrated philosophical framework that fits grounded theory. In V. B. Martin & A. Gynnild (Eds.), *Grounded theory: The philosophy,*

method, and work of Barney Glaser (pp. 187-200). Boca Raton, Florida: BrownWalker Press.

New Zealand Guidelines Group. (2003). *Acute management and immediate rehabilitation after hip fracture amongst people aged 65 years and over*. Wellington, New Zealand: New Zealand Guidelines Group.

Nicholson, C., Meyer, J., Flatley, M., & Holman, C. (in press). The experience of living at home with frailty in old age: A pyschosocial qualitative study. *International Journal of Nursing Studies*. Retrieved from www.elsevier.com/ijns doi:10.1016/j.ijnurstu.2012.01.006

Norton, R., Butler, M., Currie, R., Lee-Joe, T., Campbell, A. J., Reid, I. R., & Gray, H. (1995). Hip fracture incidence among older people in Auckland: A population-based study. *The New Zealand Medical Journal, 108*(1010), 426-428.

NSW Consumer Advisory Group, & Mental Health Coordinating Council. (2009). *Developing a recovery orientated service provider resource for community mental health organisations: Literature review on recovery*. Retrieved from http://www.nswcag.org.au http://www.mhcc.org.au

O'Hagan, M., Reynolds, P., & Smith, C. (2012). Recovery in New Zealand: An evolving concept. *International Review of Psychiatry, 24*(1), 56-63. doi:10.3109/09540261.2011.651447

Oades, L. G., & Anderson, J. (2012). Recovery in Australia: Marshalling strengths and living values. *International Review of Psychiatry, 24*(1), 5-10. doi:10.3109/09540261.2011.651447

Oldmeadow, L. B., Edwards, E. R., Kimmel, L. A., Kipen, E., Robertson, V. J., & Bailey, M. J. (2006). No rest for the wounded: Early ambulation after hip surgery accelerates recovery. *ANZ Journal of Surgery, 76*(7), 607-611.

Orem, D. E. (1991). *Nursing: Concepts of practice* (4th ed.). St Louis, MO: Mosby Year Book

Ormerod, R. (2006). The history and ideas of pragmatism. *The Journal of the Operational Research Society, 57*(8), 892-909. doi:10.1057/palgrave.jors.2602065

Pande, I., Scott, D. L., O'Neill, T. W., Pritchard, C., Woolf, A. D., & Davis, M. J. (2006). Quality of life, morbidity, and mortality after low trauma hip fracture in men. *Annuals of the Rheumatic Diseases, 65*, 87-92.

Parse, R. R. (1981). *Man-living-health: A theory of nursing*. New York, NY: John Wiley

Parsons, T. (1951). *The social system*. Glencoe, IL: The Free Press.

Paulson, D. S. (2004). Taking care of patients and caring for patients are not the same. *Association of Operating Room Nurses, AORN Journal, 79*(2), 359-366.

Peirce, C. S. (1905). What pragmatism is. *The Monist, 15*(2), 161-181.

Playle, J. F. (1995). Humanisn and positivism in nursing: Contradictions and conflicts. *Journal of Advanced Nursing, 22*, 979-984.

Polit, D. F., & Hungler, B. P. (1991). *Nursing research: principles and methods* (4th ed.). Philadelphia, PA: J.B. Lippincott.

Porter, R. (1997). *The greatest benefit to mankind: A medical history of humanity from antiquity to the present*. London, United Kingdom: HarperCollins

Powell, J. (2009). Social theory, aging, and health and welfare professionals. *Journal of Applied Gerontology, 28*(6), 669-682. doi:10.1177/0733464809335596

Powell, J., & Biggs, S. (2000). Managing old age: The disciplinary web of power, surveillance and normalization. *Journal of Aging and Identity, 5* (1), 3-13.

Privacy Act 1993.

Quinn, K. A., & Rosenthal, H. E. S. (2012). Categorizing others and the self: How social memory structures guide social perception and behaviour. *Learning and Motivation, 43*, 247-258. doi:10.1016/j.lmot.2012.05.008

Radel, R., Pelletier, L. G., Sarrazin, P., & Milyavskaya, M. (2011). Restoration process of the need for autonomy: The early alarm stage. *Journal of Personality and Social Psychology, 101*(5), 919-934. doi:10.1037/a0025196

Repper, J., & Perkins, R. (2003). *Social inclusion and recovery: A model for mental health practice*. London, United Kingdom: Bailliere Tindall

Resnick, B., & Remsburg, R. E. (2004). Overview of restorative care. In B. Resnick (Ed.), *Restorative care nursing for older adults: A guide for all care settings* (pp. 1-12). New York, NY: Springer.

Rinder, W. (1971). *This time called life*. Millbrae, CA: Celestial Arts.

Robb, G., & Seddon, M. (2006). Quality improvement in New Zealand healthcare: Part 6: Keeping the patient front and centre to improve healthcare quality. *Journal of the New Zealand Medical Association, 119*(1242), 2174-2182.

Roberts, G., & Wolfson, P. (2006). New directions in rehabilitation: Learning from the recovery movement. In G. Roberts, S. Davenport, F. Holloway, & T. Tatton (Eds.), *Enabling recovery: Practice of rehabilitation psychiatry* (pp. 18-37). London, United Kingdom: Gaskell.

Robertson, I. (1989). *Society: A brief introduction*. New York, NY: Worth

Robinson, S. B. (1999). Transitions in the lives of elderly women who have sustained hip fractures. *Journal of Advanced Nursing, 30*(9), 1341-1348.

Rogers, M. E. (1970). *An introduction to the theoretical basis of nursing*. Philadelphia, PA: Davis.

Rosenthal, S. B. (2003). Pragmatic process philosophy: A uniquely powerful paradigm. In G. Debrook (Ed.), *Process pragmatism: Essays on a quiet philosophical revolution* (Vol. 137). Amsterdam, Holland: Rodopi.

Russell, S., Daly, J., Hughes, E., & Op't Hoog, C. (2003). Nurses and 'difficult' patients: Negotiating non-compliance. *Journal of Advanced Nursing, 43*(3), 281-287.

Salmond, S. W. (1994). Conceptual model for orthopaedic practice. In A. B. Maher, S. W. Salmond, & T. A. Pellino (Eds.), *Orthopaedic Nursing* (1st ed., pp. 2-10). Philadelphia, PA: W.B. Saunders

Salmond, S. W. (2002). Orthopaedic wellness. In A. B. Maher, S. W. Salmond, & T. A. Pellino (Eds.), *Orthopaedic Nursing* (3rd ed., pp. 1-26). Philadelphia, PA: W.B. Saunders.

Sanders, C., Donovan, J., & Dieppe, P. (2002). The significance and consequences of having painful and disabled joints in older age: Co-existing accounts of normal and disrupted biographies. *Sociology of Health & Illness, 24*(2), 227-253.

Schaie, K. W., Boron, J. B., & Willis, S. L. (2005). Everyday competence in older adults. In M. L. Johnson (Ed.), *The Cambridge handbook of age and ageing* (pp. 216-228). New York, NY: Cambridge University Press.

Schatzman, L. (1991). Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research. In D. R. Maines (Ed.), *Social organizations and social process: Essays in honor of Anselm Strauss* (pp. 303-314). New York, NY: Aldine De Gruyter.

Schulz, R., & Heckhausen, J. (1996). A life span model of successful aging. *American Psychologist, 51*(7), 702-714.

Scopelliti, M., & Giuliani, M. V. (2004). Choosing restorative environments across the lifespan: A matter of place experience. *Journal of Environmental Psychology, 24*, 423-437. doi:10.1016/j.jenvp.2004.11.002

Scopelliti, M., & Giuliani, M. V. (2006). Restorative environments in later life. *Journal of Housing for the Elderly, 19*(3-4), 203-226. doi:10.1300/JO81v19n03_11

Segall, A. (1976). The sick role concept: Understanding illness behaviour. *Journal of Health and Social Behavior, 17*(June), 163-170.

Shah, M. R., Aharonoff, G. B., Wolinsky, P., Zuckerman, J. D., & Koval, K. J. (2001). Outcome after hip fracture in individuals ninety years of age and older. *Journal of Orthopaedic Trauma, 15*(1), 34-39.

Sheldon, K. M., & Kasser, T. (2001). Getting older, getting better? Personal strivings and psychological maturity across the life span. *Developmental Psychology, 37*(4), 491-501. doi:10.1037//0012-1649.37.4.491

Shyu, Y.-I. L., Chen, M.-C., Liang, J., Lu, J. R., Wu, C.-C., & Su, J.-Y. (2004). Changes in quality of life among elderly patients with hip fracture in Taiwan. *Osteoporosis International, 15*, 95-102.

Sidani, S., Doran, D. M., & Mitchell, P. H. (2004). A theory-driven approach to evaluating quality of nursing care. *Journal of Nursing Scholarship, 36*(1), 60-65.

Siu, A. L., Boockvar, K. S., Penrod, J. D., Morrison, R. S., Halm, E. A., Litke, A., ... Magaziner, J. (2006). Effect of inpatient quality of care on functional outcomes in patients with hip fracture. *Medical Care, 44*(9), 862-869.

Snaedal, J. (2011). Person-centred medicine for older adults. *Journal of Evaluation in Clinical Practice, 17*(2), 379-380.

Staudinger, U. M. (2005). Personality and ageing. In M. L. Johnson (Ed.), *The Cambridge handbook of age and ageing* (pp. 237-244). New York, NY: Cambridge University Press.

Steel, N., Melzer, D., Shekelle, P. G., Wenger, N. S., Forsyth, D., & McWilliams, B. C. (2004). Developing quality indicators for older adults: Transfer from the USA to the UK is feasible. *Quality & Safety in Health Care, 13*, 260-264. doi:10.1136/qshc.2004.010280

Stern, P. N., & Porr, C. J. (2011). *Essentials of accessible grounded theory*. Walnut Creek, CA: Left Coast Press

Sternberg, R. J., & Grigorenko, E. L. (2005). Intelligence and wisdom. In M. L. Johnson (Ed.), *The Cambridge handbook of age and ageing* (pp. 209-215). New York, NY: Cambridge University Press.

Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge, United Kingdom: Cambridge University Press.

Strauss, A. L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* (1st ed.). Thousand Oaks, CA: Sage

Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Tanaka, J., Tokimura, F., & Seki, N. (2003). Outcomes of hip fracture surgery in patients aged > 90 years. *Orthopaedics 26*(1), 55- 58.

Thulesius, H., Hakansson, A., & Peterson, K. (2003). Balancing: A basic process in end-of-life cancer care. *Qualitative Health Research, 13*(10), 1353-1377. doi:10.1177/1049732303258369

Tiedeman, M. E., & Lookinland, S. (2004). Traditional models of care delivery: What have we learned? *Journal of Nursing Administration, 34*(6), 291-297.

Titler, M., Dochterman, J., Xie, X.-J., Kanak, M., Fei, Q., Picone, D., & Shever, L. (2006). Nursing interventions and other factors associated with discharge disposition in older patients after hip fracture. *Nursing Research, 55*(4), 231-242.

Tower, K. D. (1994). Consumer-centered social work practice: Restoring client self-determination. *Social Work, 39*(2), 191-196.

Trice, L. B. (1990). Meaningful life experiences to the elderly. *Jounrnal of Nursing Scholarship, 22*(4), 248-251. doi:10.1111/j.1547-5069.1990.tb00223.x

Truant, T., & Bottorff, J. L. (1999). Decision making related to complementary therapies: A process of regaining control. *Patient Education and Counseling, 38*(2), 131-142. doi:10.1016/S0738-399(99)00060-9

Tsauo, J.-Y., Leu, W.-S., Chen, Y.-T., & Yang, R.-S. (2005). Effects on function and quality of life of postoperative homed-based physical therapy for patients with hip fracture. *Archives of Physical Medicine and Rehabilitation, 86*, 1953-1957. doi:10.1016/j.apmr.2005.04.020

Tulle-Winton, E. (1999). Growing old and resistance: Towards a new cultural economy of old age? *Ageing & Society, 19*, 281-299.

Urmson, J., & Ree, J. (1991). *The concise encyclopaedia of western philosophy & philosophers*. London, United Kingdom: Routledge.

Van Balen, R., Essink-Bot, M. L., Steyerberg, E. W., Cools, H. J. M., & Habbema, J. D. F. (2003). Quality of life after hip fracture: a comparison of four health status measures in 208 patients. *Disability and Rehabilitation., 25*(10), 507-519.

van Balen, R., Essink-Bott, M. L., Steyerberg, E. W., Cools, H. J. M., Dik, J., & Habbema, F. (2003). Quality of life after hip fracture: A comparison of four health status measures in 208 patients. *Disability and Rehabilitation, 25*(10), 507-519. doi:10.1080/0963821000090443

Varul, M. Z. (2010). Talcott Parsons, the sick role and chronic illness. *Body & Society, 16*(2), 72-94. doi:10.1177/1357034X10364766

Watson, J., & Foster, R. (2003). The attending nurse caring model: Integrating theory, evidence and advanced caring-healing therapeutics for transforming professional practice. *Journal of Clinical Nursing, 12*, 360-365.

Watters, C., & Moran, W. (2006). Hip fractures - a joint effort. *Orthopaedic Nursing, 25*(3), 157-165.

Wilcock, A. A., van der Arend, H., Darling, K., Scholz, J., Siddall, R., Snigg, C., & Stephens, J. (1998). An exploratory study of people's perceptions and experiences of wellbeing. *British Journal of Occupational Therapy, 61*(2), 75-82.

Wilson, D., & Neville, S. (2008). Nursing their way not our way: Working with vulnerable and marginalised populations. *Contemporary Nurse, 27*(2), 165-176.

Young, Y., Brant, L., German, P., Kenzora, J., & Magaziner, J. (1997). A longitudinal examination of functional recovery among older people with subcapital hip fractures. *Journal of Geriatric Society, 45*(3), 288-294.

Young, Y., & Resnick, B. (2009). Don't worry, be positive: Improving functional recovery 1 year after hip fracture. *Rehabilitation Nursing, 34*(3), 110-117.

Zalon, M. L. (2004). Correlates of recovery among older adults after major abdominal surgery. *Nursing Research, 53*(2), 99-106.

Zhou, X., Sedikides, C., Wildschut, T., & Gao, D.-G. (2008). Countering loneliness: On restorative function of nostalgia. *Psychological Science, 19*(10), 1023-1029.

Ziden, L., Wenestam, C.-G., & Hansson-Scherman, M. (2008). A life-breaking event: Early experiences of the consequences of a hip fracture for elderly people. *Clinical Rehabilitation, 22*, 801-811. doi:10.1177/0269215508090204

Zohar, D. (1997). *Rewiring the corporate brain: Using the new science to rethink how we structure and lead organisations*. San Francisco, CA: Berrett-Koehler.

Zohar, D., & Marshall, I. (1994). *The quantum society: Mind, physics and a new social vision*. New York, NY: William Morrow.

Glossary

Term	**Meaning**
Balancing:	the ongoing actions used by participants to facilitate the return to normalisation and manage all the factors within the event.
Connecting:	is a process used to manage familiar and unfamiliar situations during recovery.
Normalisation:	refers to the participants' main concern of getting back to normal.
Pacing:	refers to temporal pacing and event-related pacing, which was indicated by time, ageing, perceptions, and compromise.
Permissioning:	refers to actions participants used in response to the context, situation, developmental life stage, and diverse expectations.
Reasserting:	refers to the permissioning, connecting, and reconciling required for restoring normal psychological processes.
Reconciling:	is the attitudes, routines, and accepting that influence recovery and the process of restoring.
Regaining:	is the pacing, spacing, and relying required for restoring normal physical and social activities.
Relying:	is the self-reliance, marshalling resources, and helping behaviours needed for regaining physical and social activities.
Restoring:	is the process of balancing the regaining of physical and social functioning and reasserting normal psychological behaviours during recovery.
Spacing:	is the participants' interpretation of physical and social space achieved through the use of symbolic security, and role shifting.

Appendices

Appendix 1: Northern Region (Y) Ethics Committee approval letter

**Health
and
Disability
Ethics
Committees**

Northern Y Regional Ethics Committee
Ministry of Health
3rd Floor, BNZ Building
354 Victoria Street
PO Box 1031
Hamilton
Phone (07) 858 7021
Fax (07) 858 7070
Email: northerny_ethicscommittee@moh.govt.nz

22 May 2009

**Mr David J Healee
School of Nursing - A-9, Health Care Practice
AUT Northshore Campus
90 Akoranga Drive, Northcote, Auckland**

Dear David

A grounded theory study of older adult's recovery from fracture of the hip.
Investigators: **David Healee. Supervisor: Dr Antoinette McCallin.**
Ethics ref: **NTY/09/03/020**
Locations: **Auckland region.**

The above study has been given ethical approval by the **Northern Y Regional** Ethics Committee.

Approved Documents
-Contact for support services
-Advert dated February 2009
-Typist confidentiality agreement version 2 dated 05/05/2009
-Participant Information Sheet and Consent Form version 2 dated 05/05/2009

Accreditation
The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Progress Reports
The study is approved until **30 December 2012**. The Committee will review the approved application annually and notify the Principal Investigator if it withdraws approval. It is the Principal Investigator's responsibility to forward a progress report covering all sites prior to ethical review of the project in **22 May 2010**. The report form is available at http://www.ethicscommittees.health.govt.nz. Please note that failure to provide a progress report may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Amendments
It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation eg advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

**Amrita Kuruvilla
Northern Y Ethics Committee Administrator**
Email: amrita_kuruvilla@moh.govt.nz

Appendix 2: AUTEC approval letter

MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Antoinette McCallin

From: **Madeline Banda** Executive Secretary, AUTEC

Date: 23 July 2009

Subject: Ethics Application Number 09/143 **A grounded theory study of older adult's recovery from fracture of the hip.**

Dear Antoinette

I am pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 13 July 2009, subject to the following conditions:

1.Clarification of who will pay for any travel necessary for the participants to attend interviews, especially given their likely mobility limitations.

I request that you provide the Ethics Coordinator with a written response to the points raised in these conditions at your earliest convenience, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires written evidence of any altered documents, such as Information Sheets, surveys etc. Once this response and its supporting written evidence has been received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application.

When approval has been given subject to conditions, full approval is not effective until *all* the concerns expressed in the conditions have been met to the satisfaction of the Committee. Data collection may not commence until full approval has been confirmed. Should these conditions not be satisfactorily met within six months, your application may be closed and you will need to submit a new application should you wish to continue with this research project.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

Yours sincerely

Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: David J. Healee david.healee@aut.ac.nz

Appendix 3: Participant information sheet.

Participant Information Sheet

Date Information Sheet Produced: 18 February 2009

Project Title: Older adult's recovery from hip fracture

An Invitation

I, David Healee, am undertaking a research project as part of a Doctor of Health Science programme at Auckland University of Technology (AUT) to examine how older adult's recovering from a hip fracture identify their concerns and what processes they use to manage their concerns. I am inviting people, aged 65 years and older who have a hip fracture (broken hip) over 3 months ago to participate in this research project. Participation is voluntary and any participant may withdraw at any stage of the project.

What is the purpose of this research?

The purpose of this research is to undertake a project as part of the Doctor of Health Science programme. Identifying participant concerns relating to hip fracture recovery is limited and this research aims to contribute to the knowledge base about hip fracture recovery. On completion of the project, a dissertation will be produced along with potential articles for publication on the outcome of the research findings.

How was I chosen for this invitation?

Flyers have been posted in Clinics and GP offices to invite interested people to contact the researcher. An invitation to participate in this research is voluntary.   If you meet the criteria you will be asked to participate in the project.

What will happen in this research?

Up to 35 people will be interviewed in 1 or 2 sessions. The interview will be taped and then transcribed. Each transcribed interview will be analysed for themes and patterns and continually compared until one core theme is identified. Your individual information will not be identifiable in the final analysis of the interview material. Your involvement will be to participate in at least <u>one</u> interview for up to 90 minutes. If required a second voluntary interview may be requested from you.

What are the discomforts and risks?

The only potential discomfort is the length of the interview.

How will these discomforts and risks be alleviated?

At your request the interview may be stopped and another convenient time set to finish the interview, if you wish to continue to participate in the study.

What are the benefits?

This project allows you to tell your story of recovering from a hip fracture.

The information gained from your stories may influence future hip fracture care

How will my privacy be protected?

You will not be identifiable as the findings will be a consolidation of the group's information rather than individual information.

You may chose an alias if you wish for the interview data

What are the costs of participating in this research?

The cost of participating in this research is the time required for the interview(s).

What opportunity do I have to consider this invitation?

Following initial contact you may take up to 2 weeks to consider your involvement, or longer by negotiation if you wish to consult with family / whanau.

How do I agree to participate in this research?

You will need to sign a consent form that will be given to you when you feel you have completely understood your participation in the project and all your questions have been satisfactorily answered.

Will I receive feedback on the results of this research?

Result from this research will not be available for approximately 2 - 3 years following the interview. If you wish to receive a copy of the findings, please advise the researcher by ticking the appropriate box on the consent form.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Antoinette McCallin, amccalli@aut.ac.nz or phone 921 9999 extension 7884

Concerns regarding the conduct of the research should be notified to the Executive Secretary, Northern Regional X Ethics Committee, Telephone, (09) 580 9105.

Whom do I contact for further information about this research?

Researcher Contact Details:

David Healee, School of Nursing, Auckland University of Technology (AUT)

Phone 921 9999 extension 7642 or mobile 021 0405131 or

email david.healee@aut.ac.nz

Project Supervisor Contact Details:

Dr Antoinette McCallin, amccalli@aut.ac.nz or phone 921 9999 extension 7884

Approved by Northern X Regional Ethics Committee on *22 May 2009*

Reference number *NTY/09/03/020*

Appendix 4: Consent form

Consent Form

*Project title: **Older adult's recovery from hip fracture***

*Project Supervisor: **Dr Antoinette McCallin***

*Researcher: **David Healee***

I have read and understood the information provided about this research project in the Information Sheet dated 08 February 2009.

I have had an opportunity to ask questions and to have them answered.

I understand that notes will be taken during the interviews and that they will also be audiotaped and transcribed.

I wish to receive a copy of the transcript and / or tape   Yes [ ]   No [ ]

I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be offered to me or destroyed at my request

I have been allowed sufficient time to discuss this project with Whanau/Family

BEFORE SIGNING THE CONSENT FORM.

I agree to take part in this research.

I wish to receive a summary of the findings from the research (please tick one): Yes◯   No◯

Participants signature ....……………………………………………………

Participants Name:...................……………………………………………………

Participantes psuedonym…………………………………………………………….

Participants Contact Details (if appropriate):

…………………………………………………………………………………..

…………………………………………………………………………………..

…………………………………………………………………………………..

…………………………………………………………………………………..

Date:

Approved by the Northern Y Regional Ethics Committee on 22 May 2009

*Reference number **NTY/09/03/020***

Note: The Participant should retain a copy of this form

Appendix 5: Support services form

Contact for Support Services

Patient Advocacy Services – Health & Disability

Free phone: 0800 555050

Address: PO Box 41246

 St Lukes

Aged Concern Auckland Inc.

Telephone: (09) 820 0184

Address: 57 Rosebank Road
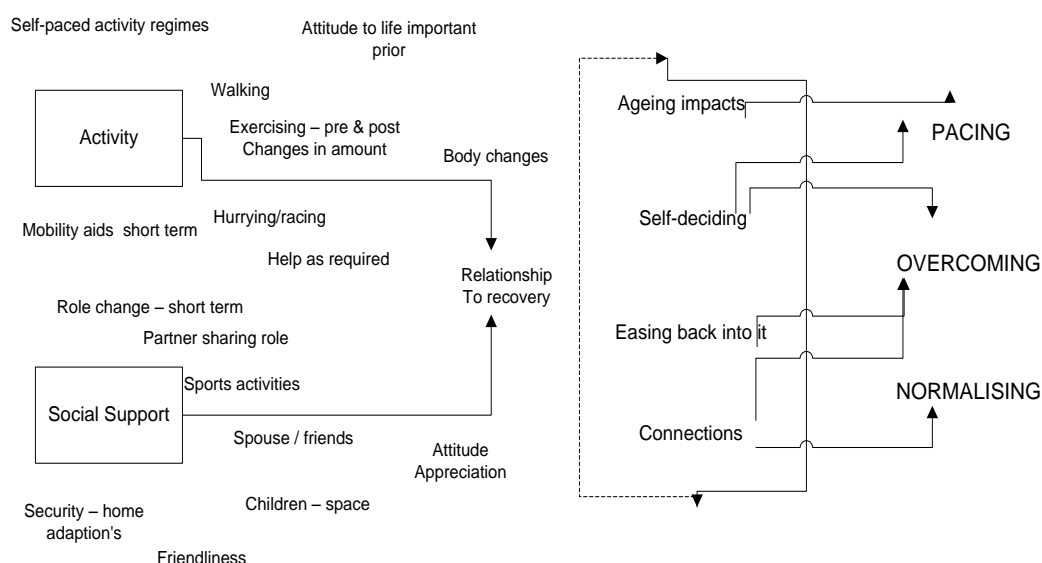
        Avondale

Citizens Advice Bureau

Free phone: 0800 367222

Address: Check telephone book for nearest branch

Appendix 6: Initial coding and memo example

Memo 2 - Interviewed 01/09/09 - revisited 26/02/10

Overall concept coming out of this interview was the continual comments reflecting spousal support / helper being important. Second theme noted was pacing – activities, social, self care, spouse, friends ageing.

Assumptions made:

It is 10 -11 years since injury and has had a THJR since; therefore need to be cognizant that recovery may include both fracture repair and surgical replacement. ? Is that OK as both have recovery components and both impacts on lower limb mobility therefore could assume recovery concepts emerging irrespective of whether fracture or replacement related?

Accessing participants who time frame / duration since injury is a long time, query does this suggest proper -lining or filtered memory or should this interview be used as an end point of a potential phased recovery??

Interestingly have given space to their children owing to the busyness in their lives so indicated a reliance on spouse and friends. What if no spouse or limited friend network – would children be required to fill gap? Or if participant single what social supports would be required?

Defining 'normal/ - doing normal things as defined by participant – as a recovery function does this relate to the medical perception that mobility function is recovery or does participation back in normal life more relevant to the individual therefore indicative of recovery ?

Another Caucasian female, economically viable, query potentially stoic in outlook and just gets on with life because it is expected – e.g. children have own life

Though positive attitude mentioned within interview did not appear to dominate – social support especially spouse seemed to be the central theme.

Activity – spouse taking over role allowing her to ease back into it, recognising changes from age and conditions impact on activity. Was self deciding about mobility aids and pacing of activities such as housework, exercise, sport?

Social Support – attitudinal and related to this specific couple, seen as helper but only as required / needed

Concepts arising

Pacing – related to activity and supports – self determined (included spouse) to return to normal / recover

Overcoming – awareness of limitations and finding a way to manage activities, getting back to an adapted life situation, connections , easing back

Normalising – getting back to normal but a redefined normality

Codes appear relevant to this interview:

| Activity | Exercising pre and post, sports, age related activity, manageable, walking, body changes, hurrying/racing, self deciding when to stop crutches (mobility aids), self pacing regimes, |
| Social supports | Sports activities and relationships, spouse helper role change, easing back, give children space, friends, partner sharing activities, attitude of appreciation, friendliness, helpfulness, emphasis on spouse, security from spouse , determination to achieve, home adaption's, |

Potential Categories

Pacing	Easing back, self determining, self pacing activity, age related impacts
Overcoming	Just back to normal happening, role changes short term, use of social supports
Normalising	Connections, back to 'normal things though adapted according to current stage
Concern?	Finding a way Changing gear

Questions for next interview:

Activity: - pacing as a concept needs to be explored as a method for managing physical or functional activity

Young age when fractured – does this make a difference than when older?

Linking to previous interview(s)

Social supports: - connections, differences evident in children involvement

differences in technology use

independence therefore perceived differently ?

Attitude:- common – positive attitude

emotions noted – frustration – not in first

self care, activity, managed by both

Ageing / Chronicity – increase in emphasis – 1st

decrease in emphasis – 2nd

decrease in mental activities when physical activity decreased – both

Sameness - related to activities as previous

Overcoming

Find yourself just doing it

Get around to it

Get over it

Today is the day you live

Appendix 7: Early coding and concepts

Categories & Concepts (as of 01/03/2010)

Main Concerns	Patterns of behaviour(s) to resolve	Concepts (Theoretical)
Each interview appears to have the following central concern: **Finding a way** **Changing gear** **Keeping the right attitude** **Spousal support / helping role – not taking over / driver role - role changes** **Self determining** **Occupationalised health** **Being involved** **Marshall resources** **Open Codes** Thinking positive Expectations Independence Restrictions Support Balance Sameness/familiar Loss Security Degeneration Activity Helping Accepting Networks Choice Life situations Levelling Awareness limitations Technology / aids Faith	**Activity** Walking Driving ADL's **Attitude** Thinking positive Accepting Balance **Locating self/ Leveraging the past** Independence Activity Loss Sameness Restrictions **Connections (Taxonomy of connections)** **Levels of connection –** **Close personal; personal; acquaintances; professional; helping careers; helping strangers; strangers.** Support Being involved Help Expectations **(values) Links with the past** **Chronicity** Degeneration Restrictions Security	**PACING** **(Is this the process used?)** Synonyms – gait, measure, step, tread, momentum, motion, progress, rate, speed, tempo, time, determine, mark out, measure) **OVERCOMING** **(Is this an end point / interim point in the process?)** **(Is this a paced activity or a process also?)** Synonyms – beat, best, be victorious, come out on top, conquer, master, get the better of, overwhelm, overthrow, prevail, render incapable, rise above, subjugate, surmount, triumph over) **NORMALISING** **(Is this a defined point, negotiated, evolved from the overcoming?)** Synonyms – accustom, acknowledge, average, common, conventional, habitual, natural, routine, ordinariness, typicality, usualness, adjustment, balance) Redefining;

Appendix 8: Follow up ethics application letter

School of Nursing (A-9)   Amrita Kuruvilla

Health Care Practice   Northern Y Ethics Committee Administrator

AUT Northshore Campus   Ministry of Health, 3rd Floor BNZ Building

90 Akoranga Drive   354 Victoria Street

Northcote   HAMILTON

AUCKLAND

Ethics ref: NTY/09/03/020

23 November 2009.

Dear Amrita,

I wish to apply for an amendment to the following section (D 1, D 2, D 3, D 4) of the ethics application NTY/09/03/020. Amendments are in italics.

I also require approval for the attached professional profile sheet.

The reason for the amendments is that to date there has been limited participant responses to the flyers advertising this study.

Following discussion with my supervisors, it is suggested that approaching potential participants in the Auckland DHB's, with relevant approval from each DHB to access these areas, to introduce the project and the researcher. Each potential participant will then be asked if they wish to be contacted after 3 months to participate in the study. Those who agree will be contacted after 3 months and asked if they wish to participate. If they are interested, a further explanation of the study, information sheet and a negotiated time to meet will be arranged. The process will then follow the already approved ethics process.

Changes in italics.

D. Privacy and Confidentiality   *(Operational Standard Paragraphs 44-49)*

D1. How will potential participants be identified?	Through access to areas that potential participants may be followed up on discharge from hospital e.g. General Practitioner surgeries and Orthopaedic Outpatient Clinics in public hospitals. *With approval from the relevant DHB, access to rehabilitation wards and discussion with Charge Nurse to identify potential participants.*
D2 How will participants be recruited? (e.g. advertisements, notices)	Notices / flyers in GP Surgeries and Orthopaedic Outpatient Clinics advertising the study. (Appendix D) *Initial contact will be made with older adults identified as potential participants outlining the project and the researcher profile. Information Sheet (D) and Professional Profile sheet*

	(E) to be left with the person. Contact will be made after 3 months if the person is agreeable.
D3 Where will potential participants be approached? (e.g. outpatient clinic) If appropriate, describe by type (eg students)	Flyers / notices will be placed in GP surgeries and Orthopaedic Outpatient departments to draw attention to the study and invite interested older adults to participate *From approved access to rehabilitation wards in Auckland DHB's.*
D4. Who will make the initial approach to potential participants?	Staff in GP surgeries and Orthopaedic Outpatient clinics will introduce potential participants to the flyers/notices and may offer a copy of flyer to be taken away with the person. Any interested participant will then contact the researcher for a description of the study and the commitment involved. *With agreement from the DHB and the Charge Nurse of the rehabilitation ward, the researcher will make the initial approach.*

Yours sincerely

Researcher   Principle Supervisor

David Healee, RGN, MA (Appld Nsg), BA, ADN, ONC,   Dr Antoinette McCallin, PhD

Attachment: Researcher Professional Profile

CC: Madeline Banda, Executive Secretary

Auckland University of Technology Ethics Committee (AUTEC)

Ethics Application Number 09/143

Appendix 9: Letter to local hospitals

David Healee RGN, MA (Appld Nsg), ADN, ONC, Doctorate Candidate
Nursing Lecturer
School of Nursing
Auckland University of Technology (A9)
90 Akoranga Drive
Northcote

AUCKLAND 0627

November 2009

General Manager
DHB
Private Bag

AUCKLAND

Dear Sir

This letter is to request access to the older adult rehabilitation wards to advertise for participants in a research project. As a doctorate candidate in the AUT Doctor of Health Science programme, my research topic is a grounded theory study of older adult's recovering from hip fracture.

The participants for this project are older adults, 65 years and older who have had a hip fracture. My intention is to interview the participants in a location of their choice, and preferably out of an acute hospital setting. The sample group will include any older adult post hip fracture, willing to participate in at least one, 1-hour interview where they can tell their story of recovering from a hip fracture. This particular perspective has not been explored in the current literature on hip fracture recovery.

The grounded theory methodology is to simultaneously data collect and analyse participant information until one core category emerges from the data. This core category should explain the participant's main concern and their continual resolution of this and generates a substantive theory for future health care practice.

I have Northern X Regional Ethics Committee (NTY/09/03/020) and AUTEC (09/143) for this project.

My request is to have access to the older adult rehabilitation wards and to meet with the Charge Nurse to identify potential participants for this study. When identified, I will approach the individual patients to discuss possible participation at a later date.

Thank you for considering my request

Yours faithfully

David Healee

Attachments:

- Participant Information sheet

- Professional Profile

- Study Flyer

Appendix 10: Samples of main concern

12/07/10	**Getting back to normal**

Main Concern - links to interviews: # 7, 5, 4, 1

- Getting back to being normal, getting better, to feel as I did before - came out early in interview
- Codes – time; helping; adjust/adapt; balance; pushing; resignation; incentivising; helping; redefining

Relationship to Concepts/Categories:

Main concern was simply stated as 'getting back to normal' then discussed pacing as time related expectations – took longer than expected though time helped recovery- physical function - interesting introduced the concept of two-sided aspects – walker – liberating and inhibiting - helps to operate physically but awkward – gets in the way – social stigma. Activity was paced according to previous activity levels and attitude to activity. Glad to have someone take over initially however pacing includes co-operating

Overcoming generally centred on help and incentives from family – appreciated help however had to get on with it after help withdrawn – family pushing can equal achievement / others noticing provides incentives and reinforcement to succeed

Third category a) – connecting – raised some issues about connecting with professional staff – lack of information, not being involved /told about things – expected to be part of / participate

Third category b) – balancing – positive and negative – liberating / inhibiting e.g. walker; family – good to have encouraged/ pushed / cost time effort; physical function – someone to help / having to get on with it

Issues arising:

- Is co-operating a way of managing recovery – give away aspects initially (professional connection) accepts help until it dries up then has to decide what to do – what do I give up / change to regain a normalcy – what gets adjusted / adapted to suit the current situation
- Sees ageing as normal process therefore changes made with ageing are a normal process

Questions arising:

- Outlined some clarification of normalising: - normal is realising you're not what you were anymore; static points in life – home, meals / changes; redefine normal – changes anyway with age; adjustment; back to a normal place – what is the relevance of these as a main concern not a category for resolution process

#14 31/12/10	**Getting back to normal – to get going**

- **Main Concern - links to interviews: all previous**
- Similar to above #13: As with previous interviews and especially more recent injuries – getting home has preference also getting back to established routines
- Getting back to normal explicitly stated as important to achieve
-
- **Relationship to Concepts/Categories**:
- Mild dementia present therefore exploring processes were difficult. Word / phases were raised to see if these resonated with the person however difficult to determine if she was responding to word clues or stating her own thoughts
- Pacing, Connecting & Controlling raised
- **Issues arising:** Mild dementia noted – while explicit with main concern, determining processes less evident
- **Questions arising:** Assumption could be made that following a similar routine to others in the recovery journey (physically) – pacing would still be appropriate as would connecting – family, rest home residence and familiar things in her room. Controlling is difficult to establish however her discussion on current staff would underpin her relationships with healthcare personnel
- Have I made an assumption that fits the categories and selecting words that suit these?
- The interview was limited as responses from participant where not full and often affirming or negating questions I put to her therefore does this interview still have relevance and support the emerging categories?

Appendix 11: Memo on the main concern

Reconceptualise Main Concern ; Normalisation	Is normalisation a professional or public domain word/phrase? Are routines – evident in the majority of the interview data – hidden patterns of behaviours Therefore a participant would want to stabilise their routines – get back to doing what they were before. Is **Routinisation** the Main Concern? That is getting back to the routines associated with/normal life' even though some of these routines may be altered / adjusted to accommodate independence. Independence has to be self-defined by the participant not by others. Routines can be undertaken by the person or 'given to' others to achieve e.g. home help, careers Therefore to resolve the main concern routines have to be stabilised!!! A theory of **stabilising routine**. (descriptive term) Is stabilising a professional word as it conjures up fixation of the hip fracture, mobility aids for walking reducing risk etc. Are we looking at a typology of recovery – levels / degrees then would routines still be the main concern? However if routinisation remains the main concern what resolution process would achieve a return to this pattern of behaviour? Stabilising does not suggest movement back to – it seems a static / achieved or not word. There is an action in the words used by the participants - getting back to. This needs to be conceptualised as a concern – it is about journeys, trajectories, progression – however these words have professional overtones. Journeys: - excursion, expedition, jaunt, odyssey, outing, passage, peregrination, pilgrimage, progress, ramble, tour, travel, trek, trip, voyage, fare, fly, go, proceed, range, roam, rove, traverse, wander, wend Trajectory: - course, flight, flight path, line, path, route, track Progression: - advance, advancement, furtherance, gain, headway, movement forward, progress, chain, cycle, order, sequence, series, string, succession
	From interview data: Walking is central to recovery / independence Life is not geared around the fracture Living with chronicity – chronic, co-existing conditions – accepting slowing down Redefine normal as events / ageing occurs Being independent / Get over it / Fatigue / Mobility / activity Ageing – sudden realisation o post fracture; evidence of; weakening / Sameness / Routines Getting back to: - Getting mobile again Going out every day and getting into the real world - Normal Doing the same things as before - Routines Thinking there is nothing wrong with me - Familiarity To husband and way things used to be - Doing as much as I could Doing things by myself - Expectation of returning to normal My old routines - Just getting on with it Doing my own thing - Adjusted normal Get back home The event loses significance once walking is re-established

Appendix 12: Memo on pacing category

As the interviews progressed over 2009 the category – **Pacing:**

How does pacing act as a category (resolution process) at the end of 6 interviews.
 Concept – **PACING**- that is the shifting gears according to the stages of the recovery process
Initial – neutral at fracture and increasing the gear ratio from neutral – first up to fourth according to the restoration of function o and psychosocial functionality – Compare with literature here)
Issue – who controls the pace and are there ways the older adult can slow down or speed up the gear changes?
Professional expectations and timelines verses the perception of the stage (gear) the older adult has reached – Who finally shifts the gears? The professional or the older adult??
Need to find out how does Pacing relate to **OVERCOMING**? (Concept 2).
Is it important to achieve small steps along the recovery progression – i.e. overcoming pain or the injury or surgery – (*Archibald article useful here?*)
Overcoming the hospital experience to return home or just accepting the inevitable of having to go to hospital and staying in neutral until discharge?
Overcoming the obstacles of decreased function – mobility, transport, social activities, does this lead to **NORMALISING?**
Could this be **FINDING A WAY** instead of overcoming???
At this point overcoming / finding a way could sit beneath **Pacing as a Core Concept** if pacing is defined as the older adult resolution process to meet challenges, obstacles etc through "pacing oneself" to reach an ultimate goal of normalising.
NORMALISING – returning to prefracture status? – Professional view or person defined?? ?only socially as there are always functional changes, so normalising is the readapting of the life situation according to how the older adult paces oneself to reach this redefined normalised state?

---

19 April 2010

Also bringing in the thinking about the phased recovery approach and Pacing as a main concern or possibly the Core Category – i.e. Theory of Pacing.   (Notes/drawing in notebook.)
Thinking and writing on whiteboard started a drawing / discussion on a phased approach of change occurring in an older adult and how would that link into a changed phased pacing   ??Matrix?? How does this link together – not sure.

I have used the term 'normalising' as one way of doing this but normalising is... could be used in Pacing - you are normalising back therefore you are using your past to pace yourself in the present to manage your future
You do this according to what you can cope with
• Robinson used the word ' transitioning' – I don't know – possible as it is a good word – moving from one state to another state, adapting back
• Maybe be useful as you pace oneself according to one's past by using transitions
• Interviews – a lot discussed 'bringing forth their past' to make themselves who they are
 • More relevant to the longer duration participants – *would have to see if this is relevant to shorter term / fracture recovery not so long ago*
  Literature demonstrates there is a potential for a phased recovery
  What is the question??
• Hum – it is all professionally based and there is little participant perceptive.
• What theory comes out of this? I still think there is three categories –
o one that has not emerged as yet that relates to the acute phase – more interviews to discover this - ??? regaining
o overcoming
o normalising
• **A theory of phased pacing – a theory of pacing**
o Acute - regaining – physical **return** - ?? initial as what defines it – literature says it may be 4-6 months - safety a defining property
o Rehab – overcoming - using networks, physical and social functional **restoration**
o Long term – normalising – bringing forth the past to manage the present – traits, behaviours to **recover** – changes based on history
  Maybe this is a theory that occurs in phases
  Is this a theory of pacing? Then what is the main concern – changing gear – shifting
up or down accordingly??

Appendix 13: First grounded theory seminar overview of theory

Recovery in older adult's following hip fracture.   23 May 2011

MAIN CONCERN:	**RESOLUTION**: (Psychosocial Process)
Connection Which is about disconnection and re-connection to get back to normalisation and routines *Previous main concerns included - Normalisation or Routinisation* Descriptive: Main message in interviews – 'getting back to something – people, place, things, routines – Hidden patterns within participant data – of routines – physical, emotional, - a socio-cultural response to managing their fracture	Potential Theory of: *Negotiated Positioning* *Previous thoughts included: -Stabilising / Measuring / Pacing / Phasing / Re-engaging / self-organising* There are hints of adjusting, adapting within the data There are strong emphases on past values, beliefs and behaviours Levels or degrees evident in data

Sub-Process : **PACING** (Physical)	Sub-Process: **DELIBERATING** (Cognitive)	Sub-Process: **OVERCOMING** (Emotion/Psychological)
Pushing	Permissioning	Relying
Measuring	Spacing	Internalising
Judging	Easing back	Accepting
Balancing *Self & others*	Controlling/Choosing *Self & others*	*Self*

Key points:
– 14 interviews completed
– Getting back to something and routines appear to underpin the participants data
– Pacing was significant from the beginning along with Overcoming
– Main concern and resolution – are there professional / public influences here?

Questions:
1. Do I stay within the stated boundaries of the topic – older adults / hip fractures for selective sampling? I.e. have a general theory of recovery within an orthopaedic arena then re-apply for extended ethics
2. How do I recognise the main concern and resolution process? - To move forward I need to have these.

Appendix 14: Mill Valley workshop # 2 May 2012- Outline of theory

Theoretical code	Core Category	Categories	Properties	Indicators
BALANCING (Theoretical code) (This is action occurs constantly in the behaviour patterns of older adults recovering from hip fracture). Balancing is an action that provides balance for the older adult to achieve/maintain equilibrium. Equilibrium is this instance is the equalising of functioning and self-determination to achieve or keep a perceived normal state. *"Living in the present, using the past, to gauge the future"*	**RENORMALISING** (Theory of) "Getting back to normal" This is defined by the processes of regaining and reclaiming to get back to normal following an event that impacts the current normal state	**REGAINING** Is defined as the pacing, spacing and relying that is needed to get back to normal	**PACING** is the degree of activity restored, that is influenced by ageing, routines and measurement in returning to normal	*Activity:* function, changing levels, exercise, energy *Ageing:* pace of life, restrictions, natural, chronicity *Routines:* regimes, personal, social function, professional *Measures:* life events, restrictions, professional judgement comparison,
			SPACING is using symbols, security measures and role shifting to facilitate a return to normal	*Symbols:* messages, level of help, assistance, public/private *Security measures :* safety & hazards, creating distance, assistance requirements *Role shifting*: functionality, personal and social roles, formal and informal relationships
			RELYING is the degree of personal and additional support determining independence and the return to normal	*Personal:* values/beliefs, history, expectations, self-reliance *Additional supports*: personal, community, professional *Independence:* freedom, privacy, mobility
	Main Concern: NORMALISATION This is the prime issue of returning to a previous normal – to be able to do what they were doing before the fracture event	**RECLAIMING** Is defined as the permissioning, connecting and reconciling needed to get back to normal	**PERMISSIONING** is determining the level of involvement/influence developmental age, expectations and others have in returning to normal	*Developmental:* age-related, psychosocial, cultural, physiological *Expectations:* self, faith, participation *Others:* choice, levels, expertise
			CONNECTING is the degrees of personal, social, professional and environmental linking needed to return to normal	*Personal:* close, family, helpers *Environmental:* familiar things, home, public places *Social:* networks, community *Professional:* agencies, healthcare, knowing
			RECONCILING Is the attitude, adjustment and acceptance needed to resolve / facilitate a return to normal	*Attitude:* positiveness, mindset, expectations *Adjustment:* alterations, understanding, rationalising *Acceptance:* level, changing, progressive, new ways

Appendix 15: Copy of article attached to following pages:

Reprinted from the International Journal of Orthopaedic and Trauma Nursing, 15(1), 18-28, Healee, D.J., McCallin, A.M., & Jones, M. (2011), Older adult's recovery from hip fracture: A literature review, with permission from Elsevier.

Older adult's recovery from hip fracture: A literature review

David J. Healee RGN, MA (Doctoral Candidate, Nursing Lecturer) *,
Antoinette McCallin PhD (Director, National Centre for Interprofessional
Education and Collaborative Practice) [1], Marion Jones PhD (Associate
Professor and Associate Dean, Postgraduate) [2]

AUT University, Private Bag 92006, Auckland, New Zealand

Summary   This paper examines studies on older adult's recovering from hip fracture
and views these in relation to practice. A metasearch engine was used to access health
databases to identify studies relevant to recovery from hip fracture that occurs pre-
dominantly in the older adult. Three themes emerged: professional; quality of life,
and ageing status. Results suggest recovery has a predominant functional restorative
focus although recovery outcome is also influenced by physical function and psycho-
social factors. Results suggest that the patient-centric approach has been lost in the
drive for organisational efficiency has potentially driven care delivery, which has
emphasised safer interventions and improved programmes. This has reduced compli-
cations and shortened length of stay in hospital but the psychosocial factors that have
a long-term affect on recovery have been lost altogether. Investigating the patient-
centric approach to care for older adults recovering from hip fracture is required to
balance the organisational efficiency within healthcare systems. Mental health recov-
ery models may provide such a framework to review the patient focused approach.
© 2010 Published by Elsevier Ltd.

Editor Comments:
How many times have you had to bite your lip when someone mentions meeting targets? This article looks at both the physical and
psychological impact of proximal femoral fractures and demonstrates that recovery is a complex issue. The authors explore some of
these complexities whilst challenging a target orientated care delivery system that concentrates mainly on functional
restoration.   BS

* Corresponding author. Tel.: +64 9 921 9999x7642; fax: +64 9
921 9796.
   E-mail addresses: david.healee@aut.ac.nz (D.J. Healee),
antoinette.mccallin@aut.ac.nz (A. McCallin), marion.jones@
aut.ac.nz (M. Jones).
  [1] Tel.: +64 9 921 9999x7884; fax: +64 9 921 9796.
  [2] Tel.: +64 9 921 9999x7871; fax: +64 9 921 9706.

Introduction

One prime objective for clinicians is to have older
adults recover from hip fracture and regain func-
tional independence. Research knowledge about
recovery has increased in recent years. Recovery

knowledge includes research about physical conditions and mental health illness (Richmond et al., 2000; Williams et al., 2007; Zalon, 2004). Recovery from a physical condition describes physical restoration and functional return following a specific disease, injury or healthcare intervention.

In this paper literature about the older adult's recovery from hip fracture is reviewed. Surprisingly, while recovery is affected by physical, psychological and social influences, it is usually defined professionally (Jacobson and Greenley, 2001; Repper and Perkins, 2003; Roberts and Wolfson, 2006). Recovery in health is often determined by achieving predetermined criteria relative to a specific physical condition. For example, hip fracture recovery may be determined by an ability to mobilise post-fracture, as this function is indicative of achieving a previous state and denotes restoration of function.

The focus of restorative recovery based on disease or injury, highlights interventional treatments and is supported by evidenced-based medicine (Roberts and Wolfson, 2006). For example, cardiac, neurological, abdominal or orthopaedic conditions are assessed against fatigue, depression, or physiological changes that impact recovery (Barnason et al., 2008; Dowswell et al., 2000; Ely et al., 2002; Givens et al., 2008). The 'physical approach' to recovery emphasises the trajectory a condition should follow, allowing recovery to be measured against specific milestones of achievement (Dorsett, 1991; Halcomb and Davidson, 2005). Variables within the trajectory to be examined, explained and improvements made to treatment regimes recommended (Dorsett, 1991; Godfrey and Townsend, 2008; Halcomb and Davidson, 2005; Horan and Clague, 1999; Kearney, 1999).

Improving recovery for older adults is important, as the hip fracture rates increase in an ageing population (Chang et al., 2004; Ishizaki et al., 2004; Johnell and Kanis, 2004; Khasraghi et al., 2003; Stephenson et al., 2003). Improved anaesthetics, surgical techniques, and post-operative management, and functional rehabilitation programmes have enhanced recovery outcomes. Research is critical to support the principles of the Bone and Joint Decade (2000–2010). This paper reviews current research and gives direction for the future.

Method

Selected literature was examined to gain some insight into how recovery from hip fracture in older adults was perceived by healthcare professionals. Using a metasearching strategy, the term recovery was entered as a search parameter. Modifications included: older adult, elderly, illness/injury, hip fracture and fractured neck of femur. English titles and abstracts were reviewed. If the abstract met the search criteria, full text versions were reviewed. Approximately 90 articles were reviewed. Three themes emerged: professional focus, quality of life, and ageing status. Fig. 1 outlines the major themes from the literature reviewed.

The professional theme centred on interventional and predictive functionality associated with hip fracture recovery. A quality of life theme was related to change following hip fracture and included measurement, gender/culture and experience. An ageing status theme highlighted the age and co-morbidities factors related to older adults. Fig. 1 will be used as a structural guideline for discussing the literature.

Results

Professional focus

There is a strong professional emphasis on understanding how functional recovery is regained post-fracture. Professional understanding of functional restoration suggests that the aim of recovery is to restore the older adult to their fullest physical, mental and social capabilities (Maher et al., 2002; NZGG, 2003). Functional recovery outcomes were generally measured according to mobility, activities of daily living, dependence levels, transferring ability and self-care. Functionality research was grouped as follows. The first group examined definition and measurement of function and outcomes, reviewing achievable restoration levels. The second group explored healthcare interventions, professional and environmental factors that enhanced recovery. The third group focused on recovery prediction. Often the themes were intertwined.

According to Magaziner et al. (2000) defining functionality according to specific function is useful to determine recovery potential. Regaining physical function occurs in a sequential process which assists clinicians to evaluate recovery and disability prospects of older adults. The functional areas included: upper and lower extremities, physical and instrumental activities of daily living, gait and balance, social, cognitive, and affective function (Magaziner et al., 2000). In contrast, Zuckerman et al. (2000) measured recovery function and compared it to prefracture independence functioning. Their tool assessed basic and instrumental activities of daily living and mobility as potential
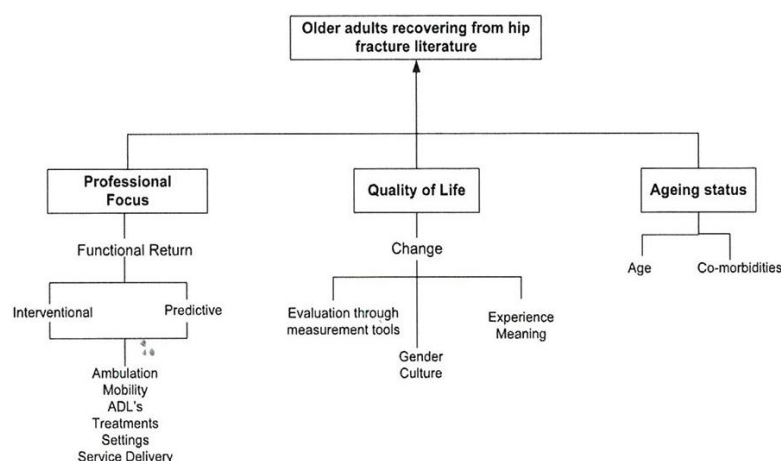
Fig. 1   Themes on recovery from hip fracture.

indicators of functional restoration following hip fracture (Zuckerman et al., 2000a,b). Eastwood et al. (2002) presented an alternative approach measuring functional outcomes in terms of locomotion, transfers, sphincter control and self-care.

Professionals have used functional return measures to help clinicians assess levels of function and use resources appropriately (Eastwood et al., 2002; Egol et al., 1997; Giaquinto et al., 2000; Guccione et al., 1996; Koot et al., 2000). Magaziner et al. (2003) compared hip fractured patients with community dwelling older adults where activities of daily living, walking, transferring and grooming were examined. Allowing for pre-existing conditions, age and functional limitations it was apparent that a permanent decline in function post-fracture is common. Lin and Chang (2004) also reported functional decline concluding that most patients did not return to prefracture status and significant recovery was completed at 3 months. Recovery was dependent on outdoor pre-walking ability prior to the fracture (Lin and Chang, 2004).

Interestingly, professional interventions such as surgery and treatments, nursing factors, physical therapy, co-ordination of care may improve functional recovery post-hip fracture. The type of prosthesis such as total hip joint replacement for instance, improves recovery (Mouzopoulos et al., 2008). Surgical intervention and functional recovery relationships have been evaluated to determine effectiveness of prostheses, techniques, and treatment decision-making (Lichtblau, 2002; NZGG, 2003; Siu et al., 2006; Tanaka et al., 2003). Koot et al. (2000) took a different approach examining functional and mobility recovery outcomes and reported that age, co-existing disease, general and

local complications were significant. Clearly, appropriate treatment minimises potential risks from complications.

Nursing factors that impact on hip fracture recovery focused on specific interventions that potentially enhance recovery prospects (Barangan, 1990). Nursing is well positioned to prevent or reduce complications post-fracture through improved assessment and interventions. Nurses though needed to understand the multiple factors such as age, gender, type of fracture repair, general medical condition, confusional state, depression and iatrogenic complications that also affect recovery (Barangan, 1990). Jagmin (1998) examined post-operative mental status, concluding that nurses should be aware that confusion is common in some older post-operative patients irrespective of their prior condition. Confusion compromises recovery (Jagmin, 1998). As patients often fell owing to post-operative confusion, Lappe (1998) suggested that nurses need a hip fracture awareness update to improve prevention practices. Titler et al. (2006) noted that the younger patient, admitted from home with a spouse to return to, had an improved chance of returning home, and which relevant nursing interventions impacted on discharge.

Professionally, targeted physical therapy improves recovery prospects for older adults posthip fracture. Tsauo et al. (2005) compared in-home physical therapy with standard in-hospital treatment. If physical therapy continued after discharge, full function was regained earlier with added quality of life benefits. However, this affected clinical practice and resources (Tsauo et al., 2005). Oldmeadow et al. (2006) compared

the effects of early mobilisation against delayed ambulation post-operatively. Early ambulation promoted functional recovery with an increased discharge rate to the home environment and reduced the need for higher level of care. Extra physiotherapy reduced functional impairments post-surgery (Oldmeadow et al., 2006).

Choong et al. (2000) compared standard treatment regimes with clinical pathway management. Clinical pathways decreased length of stay without increasing complication rates. Similar studies examined the implementation of the clinical pathway progression in service delivery (Fisher et al., 2006; Koval et al., 2004; Koval and Cooley, 2005; Morris and Zuckerman, 2002; Olsson et al., 2006; Roberts et al., 2004; Watters and Moran, 2006). These studies suggest that 'fast-tracking' older adults through the hip fracture process minimises potential complications, reduces length of stay and improves the likelihood of discharge to a suitable residence. Factors such as time from admission to surgical intervention, mobilisation and discharge are improved through reduced variance. However, the older adult experience of the process is not well explored in clinical pathways studies.

Another theme in the literature is that rehabilitation units improve recovery outcome. However, Jette et al. (1987) found there was no benefit to the outcomes of recovery when enhanced rehabilitation regimes were provided. The impact on mortality, discharge status, and level of recovery was not statistically significant to warrant increased rehabilitation programmes. Ganz et al. (2007) and Giaquinto et al. (2000) argue that the rehabilitation environment focuses on functionality, thus ensures appropriate interventions and resources are directed to support an individual's recovery. Overall, older adults rehabilitated in specific facilities generally improve so that type of environment seems beneficial too and suggests clinical best practice.

When professionals collaborate recovery outcomes improve (Lichtblau, 2002; Morris and Zuckerman, 2002). Professional collaboration affects the quality of care (Fisher et al., 2006; Koval and Zuckerman, 1994; Lichtblau, 2002; Morris and Zuckerman, 2002; NZGG, 2003; Siu et al., 2006; Watters and Moran, 2006). The complex nature of recovery suggests that healthcare staff focus on operative interventions, a collaborative approach to care, good psychosocial evaluation and social support to ensure recovery outcomes are maximised (Koval and Zuckerman, 1994).

The professional view of recovery suggests that predicting functional recovery is maximised if psychosocial, dependency, potential for mobilisation and activity factors are considered in recovery prediction. Social support networks may influence recovery as do physical symptoms post-fracture and surgery. Cummings et al. (1988) suggested that the greater the number of social supports prior to the hip injury the more likely complete recovery was possible. In addition, Mossey et al. (1989) argued that psychosocial factors affect recovery. Social connectedness, personality and self-rated health all impacted recovery prospects. While there may be a decline in physical function, psychosocial factors remained stable during recovery. However, Mossey et al. noted that depression post-surgery inhibited recovery and needed to be treated early by clinicians. Givens et al. (2008) recommended that the prevalence of depressive symptoms, cognitive impairment and delirium on functional recovery were measured using standard validated tools. Recovery declines with an increased decline in function associated with mood or cognitive disorders such as depression and confusion (Givens et al., 2008). As functional recovery peaks at approximately 6 months, social supports and psychosocial factors underpinning recovery become increasingly important (Magaziner et al., 1990).

If professionals can predict activity and mobilisation potential post-fracture, clinicians can plan therapy interventions to improve functional outcome and minimise complications. Magaziner et al. (1990) evaluated predictors for walking and activities of daily living noting optimal post-fracture mobilisation was reached at 6 months. Similar studies (Cree, 2004; Khasraghi et al., 2003; NZGG, 2003; Tanaka et al., 2003; Titler et al., 2006; Young et al., 1997) concluded that functional activity generally stabilised at approximately four to 6 months though multiple factors impacted on achieving a final functional outcome. Such factors included age of patient, type of fracture, underlying bone or physical condition, gender, race and socioeconomic factors. According to Ingemarsson et al. (2003) walking ability and activity at 1 year indicated factors such as physical aspects, pain and bone density, impacted on improved function and indicated walking and balance prospects for 1 year post-fracture. Knowledge about a patients prior walking habits and degree of independence supported the prediction (Ingemarsson et al., 2003). Assisting clinicians to minimise risk and maximise outcome potential through prediction supports quality of care delivery as well as influencing quality of life for the older adult.

Quality of life

Impact on an older adult's perceived life situation is evident if viewed through a 'quality of life' lens. This suggests that recovery from hip fracture is

affected by more than physical change. Quality of life is ''health status'' (van Balen et al., 2003, p. 507) that is measured in three dimensions. That is, functionally, psychologically and social health, determine a health related quality of life. Health related quality of life can be measured with assessment of functional changes and examined for psychosocial changes by exploring gender, culture, experience or meaning, all of which impact social health. This approach provides a broader measurement of recovery.

Changes in health related quality of life post-hip fracture may be related to actual or perceived functional differences which can be measured. The most common measure of quality of life is the Short Form-36 which has been used in hip fracture research from 2000. Functional measurement tools included: Barthel Index, Timed Up & Go, Berg Balance scale, Rehabilitation Activities scale, Nottingham Health Profile, COOP/WONCA, and the Cummings Hip scale. Hall et al. (2000), Peterson et al. (2002), and van Balen et al. (2003) combined such measurement tools with the SF-36 examining impacts of functional loss on quality of life. Patient reported outcome measures (PROMs) feature prominently in the UK. Two types of PROMs are presented. Firstly, are the standardised questionnaires the measure patient assessed information pre and post an elective procedure (Dawson et al., 2010). Secondly, is the combination of different types of evaluation tools to assess different perspectives on the outcomes of quality of life (Garratt et al., 2002; Greenhalgh et al., 2005; Ostendorf et al., 2004). For example, the combining of the SF-36, a disease specific evaluation tool and patient reported outcomes creates a wider perspective for determining overall outcome. These processes have identified specific interventions that could be relevant to older adult's recovery.

Validated assessment tools measuring non-physical aspects against functional factors may offer clinicians a quantifiable outcome about quality of life issues. The SF-36, reports a definitive decrease in physical function, role participation and social activities following hip fracture compared to control groups (Boonen et al., 2004; Hallberg et al., 2004; Randell et al., 2000; Shyu et al., 2004; Van Balen et al., 2001). This was evident irrespective of the time difference in the studies, from 3 months to 2 years. Clearly, perceived quality of life differences continue even though functional restoration had occurred. Apparently, non-physical factors impact recovery more than functional factors.

Gender and culture may impact on quality of life. Females have been thoroughly examined (Lofman et al., 2002; Norton et al., 1995; Sanders et al., 1999a,b). Interestingly, Pande et al. (2006) and Hawkes et al. (2006) examined the difference in recovery between males and females, noting that there is a higher mortality and morbidity potential for males following hip fracture although this was influenced by prefracture status. Cultural differences were evident in New Zealand in that Norton et al. (1995) noted that within Maori and Pacific Island groups hip fracture rates were lower compared to the Caucasian population. This was comparable to international incidence rates where the hip fracture occurred predominantly among white females. However, there were no studies noting differences between the cultural groups in New Zealand related to quality of life post-fracture. Kirk-Sanchez (2004) suggested distinctive cultural and psychological factors were relevant to quality of life in Cuban Americans. Premorbid limitations affecting quality of life post-fracture related to mental health illness, being male, in an older age group, or having a condition such as heart disease or diabetes (Kirk-Sanchez, 2004). Similar culture specific studies from Asian countries noted how hip fracture in an ageing population affected quality of life (Shyu et al., 2004; Tanaka et al., 2003; Tsauo et al., 2005). This 'cultural filter' adds a different dimension to the meaning of recovery. Mossey et al. (1989) observes that post-surgical depression, personality type, social connectedness and self-rated health status are significant for recovery. It was clear that the 'invisible' psychosocial factors were less visible in recovery. Determining which psychosocial factors influenced recovery is important for clinicians planning interventions.

Quality of life has been examined in relation to the experience of having a hip fracture (Archibald, 2003; Borkan et al., 1991; Hunt and Stein, 2004; Robinson, 1999; Ziden et al., 2008). According to Borkan et al. (1991) the meaning of the experience was threefold. First, was how the person explained the fracture, second, the sense of disability perceived, and third, futurity — how the individual perceived their future. Innovative for its time, Borkan, Quirk, and Sullivan's study suggested meaning could be applied to functional status as perceived by the older adult that not only impacted on recovery outcomes but also improved clinician understanding of the patient experience. In contrast, Robinson (1999) examined how behaviours promoted or inhibited recovery transition. Apparently prefracture adaptive behaviours were significant for recovery and good adaption techniques generally promoted recovery. Not surprisingly, poor adaptive behaviours inhibited recovery. If healthcare teams are aware of

242

these issues care planning and delivery could be enhanced.

Improving knowledge for clinicians impacts upon quality of life. Archibald's (2003) noted that there were four distinct phases in recovery — injury, pain, recovery, and disability. Understanding of these would improve nursing intervention planning, and minimise physical and psychological complications thus improving quality of life for the older adult. The hip facture experience was examined by Ziden et al. (2008) with people being interviewed soon after discharge from hospital. Findings suggest that multidimensional change impacts physically, socially and psychologically and this emphasises uncertainty about the future. Clinicians understanding of such changes to body function, self-perception and overall impact, may improve planning and delivery of care (Ziden et al., 2008).

Quality of life perceptions of hip fracture and recovery differ if injury is hypothetical. Hunt and Stein (2004) explored how 'well-elders' viewed potential injury. Expectations of recovery were generally optimistic as predictions were compared with their current life situation. Clearly, good attitudes prior to hip fracture potentially enhance recovery prospects (Hunt and Stein, 2004). With an ageing population and potential for increased hip fracture incident rates, knowledge about the multiple factors that influence recovery is important.

Ageing status

The third theme — ageing status — recognises that the age and health state of an older adult influences hip fracture recovery. There is an ageing population worldwide and an increase in older adults presenting with hip fracture (ACC, 2005; Chang et al., 2004; Gullberg et al., 1997; Ministry of Health, 2003). Older age is generally defined as 65 years and above (ACC, 2005; Ministry of Health, 2003, 2007; NZGG, 2003). According to Norton et al. (1995) and Kannus et al. (1996) the potential for hip fracture increases with advancing age especially in the over 85 year age group. However, the mean age of studies examining hip fracture tended towards the mid-seventies to mid-eighties age range. Conversely, a number of studies examined an older age group — 90 years and over. Many of the studies noted that pre-existing conditions affect recovery.

Being older at time of fracture means that recovery outcomes decline. Adults in their seventies and eighties had a poorer outcome following hip fracture (Kannus et al., 1996; Melton III,

1996; Young et al., 1997). A mean age of 83 years was noted as significant (van Balen et al., 2001) who also reported that seventy percent (70%) of participants with hip fracture had a co-existing condition. Titler et al. (2006) observed that age affected recovery and discharge destination, while Young et al. (1997) report an increased complexity in the older adult recovering from hip fracture.

However, age alone does not automatically reduce outcomes although it certainly influences treatment decisions. While rehabilitation programmes improved recovery, complications and co-morbidities are more common. For example, Shah et al. (2001) compared those who were 90 years plus with a younger age group, noting an increased risk of death, decreased functional return and longer length of hospital stay as significant issues in the older age group. Increased risks generally impacted negatively on basic activities for this age group. Tanaka et al. (2003) reported increased risks of non-ambulation and death in this age group but suggested specific surgical interventions may benefit this older age group. Anticipating complications following surgery on the very old can determine where relevant resources and interventions would be best utilised (Cree, 2004; Tanaka et al., 2003). Giaquinto et al. (2000) argue that very old people can have a favourable outcome after hip fracture.

Age impacts on recovery from any fracture but it is noticeably significant when there are co-existing conditions. For example, the *Older People's Health Chart Book* (2006) indicated that hospitalisation of older people from 75 years and above was most often from falls with unintentional injury (ACC, 2005; Ministry of Health, 2007). Falls are often a precursor to hip fracture (Chang et al., 2004; Kannus et al., 1996; Lappe, 1998; Norton et al., 1995; Sanders et al., 1999a). Many older adults have pre-existing conditions such as osteoporosis, although these people live successfully in the community if they are well managed (Chang et al., 2004; Ishizaki et al., 2004; Koval et al., 1996). However, co-existing conditions may require increased resources and an increase hospital stay. Examination of co-morbidities and their effect on recovery from hip fracture agree that the complex interplay of hip fracture treatments and co-existing conditions must be managed carefully, if the impact on recovery outcomes and the economic impacts on the health sector are to be minimised (Egol et al., 1997; Ishizaki et al., 2004; Khasraghi et al., 2003; Koot et al., 2000; Young et al., 1997).

Discussion

It was noticeable that the main emphasis in the literature was on functional restoration post-hip fracture. However, there was acknowledgement of ageing populations, increased healthcare service demand and improved physical and psychosocial understanding of hip fracture recovery. Several themes stood out: restoration of function; the need to improve co-ordinated care; and the need for the patient perspective of recovery. These are considered in relation to organisational efficiency and patient-focused care.

It is apparent that care is generalised to meet the needs of the healthcare organisation and professionals and is less responsive to the needs of the older adult. Organisationally, if care delivery is generalised strategic planning for potential incidence increases can be managed. This approach supports the need for economies of time, effort, finance and efficiency. Thus, the functional approach to hip fracture may provide safer physical recovery, standardised care delivery, reduced complications and a shorter length of hospital stay.

This pragmatic view explains how organisations and professionals manage in an environment in which the number of admissions often outstrips the available beds. In an attempt to minimise 'bed blocking' many older adults with hip fracture are 'fast tracked' through the acute episode. Surgery takes place, post-operative complications managed and the team co-ordinates care to mobilise the patient for discharge. The emphasis in the healthcare facility's interest is to have patients assessed, treated and discharged in a timely manner (Chang et al., 2004; Koval and Cooley, 2005; Olsson et al., 2006; Watters and Moran, 2006). Restoration of function in a fiscally tight environment potentially drives practice.

Therefore targeting interventions, programmes or resources for functional return or decline is important. Predictors of recovery are useful to recognise and manage complications that may delay recovery. Recognising predictors such as age, pre-existing conditions, complications post-surgery or prefracture activity along with specific tests such as ''Timed Up & Go'' (Ingemarsson et al., 2003) or the Rehabilitation Activity Profile (van Balen et al., 2003) are strong indictors of functional return especially with walking or activity. Developing patient reported outcome measures (PROMs) to sit alongside current validated tools such as the SF-36 and condition specific evaluators will provide another perspective to the data collection methods already in practice. Predicator and measurement research are important to support best practice

initiatives, reduce potential complications, decrease length of hospital stay and improve recovery outcomes overall.

Co-ordinated care is also important for hip fracture recovery. It was evident from the literature that co-ordinated care was medically led according to condition-treatment decisions made. The primary focus was on the fix-repair initiative with the other health care team members following up care delivery once surgery was completed (Lichtblau, 2002). Similarly medical lead care was the driver for improved outcomes when medical specialities provided co-care. For example, orthopaedic and geriatric specialties enhance care through medical 'collaborative' practice thereby improving injury related outcomes (Fisher et al., 2006). This condition-focused approach was very different to patient-centred care. However, moving older adults from acute care to specialised rehabilitation units is more common. This shifts care from a condition focus to meeting individual needs. However, the medical model of care dominates recovery processes and is seen in clinical pathways (Choong et al., 2000; Olsson et al., 2006; Roberts et al., 2004). Advocates of clinical pathways argue that this process benefits both patient and organisation by reducing in-hospital days and improving outcomes. Co-ordination of the multidisciplinary team through planning programmes or pathways focuses the professional to provide 'expert' care at designated times according to a preset approach to meet goals or criteria. Co-ordinated care improves efficiency of process. While acute care co-ordination is critical there is a need for comprehensive, co-ordinated and ongoing care that goes beyond the hospital period to ensure recovery is optimised (Morris and Zuckerman, 2002). Therefore, a professional understanding of recovery from hip fracture needs to be tempered with the post-discharge understanding of psychosocial recovery that is also important from the older adult's perspective.

In summary, an implicit taxonomy, a three staged approach to recovery is presented (Table 1). In the recovery taxonomy, phase one includes the acute or in-hospital phase. The emphasis is on physical recovery from injury and surgery. The older adult is mobile with walking aids, relatively independent to self-care albeit with assistance, and assessed as 'safe to discharge' from acute care. Phase two is the rehabilitation stage. This may occur at an institution or in a normal residence. Age is often relevant to this stage. The older the adult the more likely they will need specialty rehabilitation for functional strengthening. If the person is younger rehabilitation tends to be

Table 1   Hip fracture recovery taxonomy.

Phase	Physical location	Properties	Phase goal
Acute	In hospital episode	Stable pre and post-operatively Minimal complications Ambulated with mobility aids Self-care — grooming, meals, toileting Support network available	Survive injury and surgery and achieve a safe discharge from acute care
Rehabilitation	Rehabilitation facility or older adult's residence	Functional strengthening Managing co-existing conditions Adapting to environments	Return to prefracture status or to an adapted version
Enduring	Normal residence	Re-negotiating social networks, physical boundaries, environments and activities	To function as normal

home-based with outpatient or social/community input. The third phase is the enduring stage. There, older adults use their own previous health belief strategies to determine if and when they have recovered. Timeframes have not been added, as each phase varies according to external or internal factors impacting on the individual.

It is also essential that a patient focused approach to recovery be included in future research. Emphasising understanding and improving potential outcomes for the older adult were evident in most studies but less obvious was the patient perspective. Exploring the psychosocial aspects of older adults in the recovery journey was more noticeable even though it was usually linked to function. However, research about the meaning and experience of recovery was limited. Understanding the older adult's view of hip fracture recovery could help healthcare professionals with future planning and delivery of care (Archibald, 2003; Borkan and Quirk, 1992; Robinson, 1999; Ziden et al., 2008). The patient perspective is important to balance the functional approach with the phased recovery taxonomy (Table 1). In phase one, it could be assumed an older adult will 'adhere' to healthcare 'instructions' to 'get through' the hospital episode and return home but have minimal control during this. The personal goal to return home balances the need to physically recover with participation in discharge planning. To be discharged the older adult achieves criteria that determine physical recovery. However, how the individual internalises meeting those physical recovery objectives depends on many factors. Once physical function is returned if somewhat limited, the older adult, through phases two and three draws on previous experiences and knowledge to manage the non-physical aspects associated with the fracture and recovery. Robinson's (1999) work on transition

suggests older adults use previous behaviours that support their recovery while meeting health professional's expectations as did other studies (Archibald, 2003; Ziden et al., 2008). Archibald (2003), Borkan and Quirk (1992), Robinson (1999), and Ziden et al. (2008) examining the patient perspective all suggest that being cognizant of the older adult's role in recovery will not only improve the prospects of the individual, but will also develop care regimes that reflect those outcomes.

A pragmatic requirement for shorter hospital stays, minimal healthcare risk activities and more standardised approaches to care delivery, influences current models of care. The management of episodes of care to ensure functional restoration is emphasised. This means that older adults must mobilise safely with walking aids, be able to self-care and perform activities of daily living prior to discharge. This approach is problematic, as although functional recovery is assumed on discharge, psychosocial recovery may not have taken place or be in process. The initial in-hospital episode of recovery therefore provides a limited view of recovery, as it does not take into account patient transitions through acute, rehabilitation, and enduring recovery phases. Somehow the healthcare sector needs to balance effective patient-centred care with the efficiency required in today's health environment.

Conclusion

Organisational restructuring has emphasised clinical efficiency and the need to identify facts that promote a rapid recovery. This has produced a focus on restorative function. This was evident as 87% of the hip fracture literature reviewed was quantitative and medically lead. Something though

has been lost. While quality of life and ageing issues are better understood, health professionals need to understand the patient-centric perspective as well. Recovery is complex and must be balanced with broader pragmatic, economic, and patient-centred issues that impact recovery. The growing emphasis on patient reported outcomes sitting alongside standardised evaluation tools will enhance patient centred understanding and reflect improved clinical practice. The mental health recovery models were not evident in hip fracture studies but these models could provide a framework for examining recovery that goes beyond the current physical restorative model of care. The suggested taxonomy of recovery may also benefit the clinical arena once it is examined and validated. While clinician knowledge is gained through experience, studies on hip fracture recovery need to continue and ensure the patient's experience is included. It is critical therefore to develop nursing research in this area and develop nursing knowledge about recovery. This knowledge has the potential to improve recovery outcomes for the older adult, update clinicians' knowledge, and meets the intent of the Bone and Joint Decade, to improve the continuum of care for people with hip fracture through ongoing research.

References

ACC, 2005. Preventing injury from Falls: The National Strategy 2005–2015. Accident Compensation Corporation, New Zealand.

Archibald, G., 2003. Patients' experiences of hip fracture (Issues and innovation in nursing practice). Journal of Advanced Nursing 44 (4), 385–392.

Barangan, J.D., 1990. Factors that influence recovery from hip fracture during hospitalization. Orthopaedic Nursing 9 (5), 19–28.

Barnason, S., Zimmerman, L., Nieveen, J., Schulz, P., Miller, C., Hertzog, M., Rasmussen, D., 2008. Relationship between fatigue and early postoperative recovery outcomes over time in elderly patients undergoing coronary artery bypass graft surgery. Heart & Lung 37 (4), 245–256.

Boonen, S., Autier, P., Barette, M., Vanderschueren, D., Lips, P., Haentjens, P., 2004. Functional outcome and quality of life following hip fracture in elderly women: a prospective controlled study. Osteoporosis International 15, 87–94.

Borkan, J.M., Quirk, M., 1992. Expectations and outcomes after hip fracture among the elderly. International Journal of Aging and Human Development 34 (4), 339–350.

Borkan, J.M., Quirk, M., Sullivan, M., 1991. Finding meaning after the fall: injury narratives from elderly hip fracture patients. Social Science & Medicine 33 (8), 947–957.

Chang, K.P., Center, J.R., Nguyen, T.V., Eismen, J.A., 2004. Incidence of hip and other osteoporotic fractures in elderly men and women: Dubbo Osteoporosis Epidemiology Study. Journal of Bone & Mineral Research 19 (4), 532–536.

Choong, P.F.M., Langford, A.K., Dowsey, M.M., Santamaria, N.M., 2000. Clinical pathway for fractured neck of femur: a

prospective, controlled study. The Medical Journal of Australia 172, 423–426.

Cree, M.W., 2004. Hip fracture-related changes in health ratings of older patients with cognitive impairment. Aging & Mental Health 8 (6), 524–529.

Cummings, S.R., Phillips, S.L., Wheat, M.E., Black, D., Goosby, E., Wlodarczyk, D., Trafton, P., Jergesen, H., Winograd, C.H., Hulley, S.B., 1988. Recovery of function after hip fracture. The role of social supports. Journal of American Geriatric Society 36 (9), 801–806.

Dawson, J., Doll, H., Fitzpatrick, R., Jenkinson, C., Carr, A., 2010. Routine use of patient reported outcome measures in healthcare settings. British Medical Journal 340 (186), 464–467.

Dorsett, D., 1991. The trajectory of cancer recovery. Scholarly Inquiry for Nursing Practice 5 (3), 175–184.

Dowswell, G., Lawler, J., Dowswell, T., Young, J., Forster, A., Hearn, J., 2000. Investigating recovery from stroke: a qualitative study. Journal of Clinical Nursing 9, 507–515.

Eastwood, E.A., Magaziner, J., Wang, J., Silberzweig, S.B., Hannan, E.L., Strauss, E., Siu, A.L., 2002. Patients with hip fractures: subgroups and their outcomes. Journal of American Geriatric Society 50, 1240–1249.

Egol, K.A., Koval, K.J., Zuckerman, J.D., 1997. Functional recovery following hip fracture in the elderly. Journal of Orthopaedic Trauma 11 (8), 594–599.

Ely, E.W., Wheeler, A.P., Thompson, B.T., Ancukiewicz, M., Steinberg, K.P., Bernard, G.R., 2002. Recovery rate and prognosis in older persons who develop acute lung injury and the acute respiratory distress syndrome. Annuals of Internal Medicine 136 (1), 25–36.

Fisher, A., Davis, M., Rubenach, S., Sivakumaran, S., Smith, P., Budge, M., 2006. Outcomes for older patients with hip fractures: the impact of orthopaedic and geriatric cocare. Journal of Orthopaedic Trauma 20 (3), 172–180.

Ganz, S.B., Peterson, M.G.E., Russo, P.W., Guccione, A.A., 2007. Functional recovery after hip fracture in the subacute setting. Hospital for Special Surgery Journal 3, 50–57.

Garratt, A., Schmidt, L., Mackintosh, A., Fitzpatrick, R., 2002. Quality of life measurement: bibliographic study of patient assed health outcome measures. British Medical Journal 324 (7351), 1417–1422.

Giaquinto, S., Majolo, I., Roncacci, S., Sciarra, A., Vittoria, E., 2000. Very old people can have favorable outcome after hip fracture: 58 patients referred to rehabilitation. Archives of Gerontology and Geriatrics 31, 13–18.

Givens, J.L., Sanft, T.B., Marcantonio, E.R., 2008. Functional recovery after hip fracture: the combined effects of depressive symptoms, cognitive impairment, and delirium. Journal of American Geriatric Society 56, 1075–1079.

Godfrey, M., Townsend, J., 2008. Older people in transition from illness to health: trajectories of recovery. Qualitative Health Research 18 (7), 939–951.

Greenhalgh, J., Long, A.F., Flynn, R., 2005. The use of patient reported outcome measures in routine clinical practice: lack of impact or lack of theory?. Social Science & Medicine 60 833–843.

Guccione, A.A., Fagerson, T.L., Anderson, J.J., 1996. Regaining functional independence in the acute care setting following hip fracture. Physical Therapy 76 (8), 818–826.

Gullberg, B., Johnell, O., Kanis, J.A., 1997. World-wide projections for hip fracture. Osteoporosis International 7, 407–413.

Halcomb, E., Davidson, P., 2005. Using the trajectory framework to describe recovery from traumatic injury. Contemporary Nurse 19 (1–2), 232–241.

Hall, S.E., Goldswain, P.R.T., Williams, J.A., Criddle, R.A., Senior, J.A., 2000. Hip fracture outcomes: quality of life and

functional status in older adults living in the community. Australian New Zealand Journal of Medicine 30, 327—332.

Hallberg, I., Rosenqvist, A.M., Kartous, L., Lofman, O., Wahlstom, O., Toss, G., 2004. Health-related quality of life after osteoporotic fractures. Osteoporosis International 15, 834—841.

Hawkes, W.G., Wehren, L., Orwig, D., Hebel, J.R., Magaziner, J., 2006. Gender differences in functioning after hip fracture. Journal of Gerontology 61 (5), 495—499.

Horan, M., Clague, J., 1999. Injury in the aging: recovery and rehabilitation. British Medical Bulletin 55 (4), 895—909.

Hunt, M.G., Stein, C.H., 2004. Living life to the fullest: well elders' views of hip fracture. Ageing International 29 (2), 178—198.

Ingemarsson, A.H., Frandin, K., Mellstrom, D., Moller, M., 2003. Walking ability and activity level after hip fracture in the elderly — a follow-up. Journal of Rehabilitation Medicine 35 (2), 76—83.

Ishizaki, T., Imanaka, Y., Oh, E., Kuwabara, K., Hirose, M., Hayashida, K., Harada, Y., 2004. Association of hospital resource use with comorbidity status and patient age group among hip fracture patients in Japan. Health Policy 69, 179—187.

Jacobson, N., Greenley, D., 2001. What is recovery? A conceptual model and explication. Psychiatric Services 52 (4), 482—485.

Jagmin, M.G., 1998. Postoperative mental status in elderly hip surgery patients. Orthopaedic Nursing 17 (6), 32—42.

Jette, A.M., Harris, B.A., Cleary, P.D., Campion, E.W., 1987. Functional recovery after hip fracture. Archives of Physical Medicine & Rehabilitation 68 (10), 735—740.

Johnell, O., Kanis, J.A., 2004. An estimate of worldwide prevalence, mortality and disability associated with hip fracture. Osteoporosis International 15, 897—902.

Kannus, P., Parkkari, J., Sievanen, H., Heinonen, A., Vuori, I., Jarvinen, M., 1996. Epidemiology of hip fractures. Bone 18 (Suppl. 1), 57S—63S.

Kearney, M.H., 1999. Understanding Women's Recovery from Illness and Trauma. Sage Publications, Thousand Oaks, CA, pp. 13—37.

Khasraghi, F.A., Lee, E.J., Christmas, C., Wenz, J.F., 2003. The economic impact of medical complications in geriatric patients with hip fracture. Orthopaedics 26 (1), 49—54.

Kirk-Sanchez, N., 2004. Factors related to activity limitations in a group of Cuban Americans before and after hip fracture. Physical Therapy 84 (5), 408—418.

Koot, V.C.M., Peeters, P.H.M., de Jong, J.R., Clevers, G.J., van der Werken, C., 2000. Functional results after treatment of hip fractures: a multicentre, prospective study in 215 patients. European Journal of Surgery 166, 480—485.

Koval, K., Cooley, M., 2005. Clinical pathway after hip fracture. Disability & Rehabilitation 27 (18—19), 1053—1060.

Koval, K., Chen, A., Aharonoff, G., Egol, K., Zuckerman, J., 2004. Clinical pathway for hip fractures in the elderly: the Hospital for Joint Diseases experience. Clinical Orthopaedics and Related Research 425, 72—81.

Koval, K.J., Skovron, M.L., Polatsch, D., Aharonoff, G.B., Zuckerman, J.D., 1996. Dependency after hip fracture in geriatric patients: a study of predictive factors. Journal of Orthopaedic Trauma 10 (8), 531—535.

Koval, K.J., Zuckerman, J.D., 1994. Functional recovery after fracture of the hip. The Journal of Bone and Joint Surgery (American) 76-A (5), 751—758.

Lappe, J.M., 1998. Prevention of hip fractures: a nursing imperative. Orthopaedic Nursing 17 (3), 15—24.

Lichtblau, S., 2002. Treatment of hip fractures in the elderly — the decision process. The Mount Sinai Journal of Medicine 69 (4), 250—260.

Lin, P.C., Chang, S.Y., 2004. Functional recovery among elderly people one year after hip fracture surgery. Journal of Nursing Research 12 (1), 72—82.

Lofman, O., Berglund, K., Larsson, L., Toss, G., 2002. Changes in hip fracture epidemiology: redistribution between ages, genders and fracture types. Osteoporosis International 13 (1), 18—25.

Magaziner, J., Fredman, L., Hawkes, W., Hebel, J.R., Zimmerman, S., Orwig, D., Wehren, L., 2003. Changes in functional status attributable to hip fracture: a comparison of hip fracture patients to community-dwelling aged. American Journal of Epidemiology 157 (11), 1023—1031.

Magaziner, J., Hawkes, W., Hebel, J.R., Zimmerman, S.I., Fox, K.M., Dolan, M., Felsenthal, G., Kenzora, J., 2000. Recovery from hip fracture in eight areas of function. The Gerontological Society of America 55 (9), M498—M507.

Magaziner, J., Simonsick, E.M., Kashner, T.M., Hebel, J.R., Kenzora, J.E., 1990. Predictors of functional recovery one year following hospital discharge for hip fracture: a prospective study. Journal of Gerontology 45 (3), M101—M107.

Maher, A., Salmond, S.W., Pellino, T., 2002. Orthopaedic Nursing, third ed. W.B. Saunders, Philadelphia, pp. 1—26.

Melton III, L.J., 1996. Epidemiology of hip fractures: implications of the exponential increase with age. Bone 18 (Suppl. 3), 121S—125S.

Ministry of Health, 2003. Fracture of Neck of Femur Services in New Zealand Hospitals 1999/2000. Ministry of Health, Wellington, NZ. Retrieved from <http://www.moh.govt.nz>.

Ministry of Health, 2007. Older People's Health Chart Book 2006. Ministry of Health, Wellington, NZ. Retrieved from <http://www.moh.govt.nz>.

Morris, A., Zuckerman, J.D., 2002. National consensus conference on improving the continuum of care for patients with hip fracture. The Journal of Bone and Joint Surgery (American) 84, 670—674.

Mossey, J.M., Mutran, E., Knott, K., Craik, R., 1989. Determinants of recovery 12 months after hip fracture: the importance of psychosocial factors. American Journal of Public Health 79 (3), 279—286.

Mouzopoulos, G., Stamatakos, M., Arabatzi, H., Vasiliadis, G., Batanis, G., Tsembeli, A., Tzurbakis, M., Safioleas, M., 2008. The four-year functional result after displaced subcapital hip fracture treated with three different surgical options. International Orthopaedics 32, 367—373.

NZGG, 2003. Acute Management and Immediate Rehabilitation after Hip Fracture amongst People Aged 65 Years and Over. New Zealand Guidelines Group, Wellington, New Zealand.

Norton, R., Butler, M., Currie, R., Lee-Joe, T., Campbell, A.J., Reid, I.R., Gray, H., 1995. Hip fracture incidence among older people in Auckland: a population-based study. The New Zealand Medical Journal 108 (1010), 426—428.

Oldmeadow, L.B., Edwards, E.R., Kimmel, L.A., Kipen, E., Robertson, V.J., Bailey, M.J., 2006. No rest for the wounded: early ambulation after hip surgery accelerates recovery. ANZ Journal of Surgery 76, 607—611.

Olsson, L., Karlsson, J., Ekman, I., 2006. The integrated care pathway reduced the number of hospital days by half: a prospective comparative study of patients with acute hip fracture. Journal of Orthopaedic Surgery and Research 1 (3) (online publishing).

Ostendorf, M., van Stel, H.F., Buskens, E., Schrijvers, A.J.P., Marting, L.N., Verbout, A.J., Dhert, W.J.A., 2004. Patient reported outcome in total hip replacement. Journal of Bone and Joint Surgery 86 (6), 801—808.

Pande, I., Scott, D.L., O'Neill, T.W., Pritchard, C., Woolf, A.D., Davis, M.J., 2006. Quality of life, morbidity, and mortality

after low trauma hip fracture in men. Annuals of the Rheumatic Diseases 65, 87–92.

Peterson, M.G.E., Allegrante, J.P., Cornell, C.N., MacKenzie, C.R., Robbins, L., Horton, R., Ganz, S.B., Augurt, A., 2002. Measuring recovery after hip fracture using the SF-36 and Cummings scales. Osteoporosis International 13, 296–302.

Randell, A.G., Nguyen, T.V., Bhalerao, N., Silverman, S.L., Sambrook, P.N., Eisman, J.A., 2000. Deterioration in quality of life following hip fracture: a prospective study. Osteoporosis International 11, 460–466.

Repper, J., Perkins, R., 2003. Social Inclusion and Recovery: A Model for Mental Health Practice. Bailliere Tindall, London.

Richmond, T., Thompson, H., Deatrick, J., Kauder, D., 2000. Journey towards recovery following physical trauma. Journal of Advanced Nursing 32 (6), 1341–1347.

Roberts, C., Pickering, R., Onslow, E., Clancy, M., Powell, J., Roberts, A., Hughes, K., Coulson, D., Bray, J., 2004. The effectiveness of implementing a care pathway for femoral neck fracture in older adult people: a prospective controlled before and after study. Age and Ageing 33, 178–184.

Roberts, G., Wolfson, P., 2006. New directions in rehabilitation: learning from the recovery movement. In: Roberts, G., Davenport, S., Holloway, F., Tatton, T. (Eds.), Enabling Recovery: The Principles and Practice of Rehabilitation Psychiatry. Gaskell, London.

Robinson, S.B., 1999. Transitions in the lives of elderly women who have sustained hip fractures (Issues and Innovations in nursing practice). Journal of Advanced Nursing 30 (6), 1341–1348.

Sanders, K.M., Nicholson, G.C., Ugoni, A.M., Pasco, J.A., Seeman, E., Kotowisz, M.A., 1999a. Health burden of hip and other fractures in Australia beyond 2000: projections based on the Geelong osteoporosis study. The Medical Journal of Australia 170 (10), 467–470.

Sanders, K.M., Seeman, E., Ugoni, A.M., Pasco, J.A., Martin, T.J., Skoric, B., Nicolson, G.C., Kotowicz, M.A., 1999b. Age- and gender-specific rate of fractures in Australia: a population-based study. Osteoporosis International 10 (3), 240–247.

Shah, M.R., Aharonoff, G.B., Wolinsky, F.D., Zuckerman, J.D., Koval, K.J., 2001. Outcome after hip fracture in individuals ninety years of age and older. Journal of Orthopaedic Trauma 15 (1), 34–39.

Shyu, Y., Chen, M., Liang, J., Lu, J., Wu, C., Su, J., 2004. Changes in quality of life among elderly patients with hip fracture in Taiwan. Osteoporosis International 15, 95–102.

Siu, A.L., Boockvar, K.S., Penrod, J.D., Morrison, R.S., Halm, E.A., Litke, A., Silberzweig, S., Teresi, J., Ocepek-Welikson, K., Magaziner, J., 2006. Effect of inpatient quality of care on functional outcomes in patients with hip fracture. Medical Care 44 (9), 862–869.

Stephenson, S., Langley, J., Campbell, J., Gillespie, W., 2003. Upward trends in the incidence of neck of femur fractures in the elderly. The New Zealand Medical Journal 116 (1185), 665.

Tanaka, J., Tokimura, F., Seki, N., 2003. Outcomes of hip fracture surgery in patients aged >90 years. Orthopaedics 26 (1), 55–58.

Titler, M., Dochterman, J., Xie, X.-J., Kanak, M., Fei, Q., Picone, D.M., Shever, L., 2006. Nursing interventions and other factors associated with discharge disposition in older patients with hip fractures. Nursing Research 55 (4), 231–242.

Tsauo, J., Leu, W., Chen, Y., Yang, R., 2005. Effects on function and quality of life of postoperative home-based physical therapy for patients with hip fracture. Archives of Physical Medicine & Rehabilitation 86, 1953–1957.

Van Balen, R., Essink-Bot, M.L., Steyerberg, E.W., Cools, H.J.M., Habbema, J.D.F., 2003. Quality of life after hip fracture: a comparison of four health status measures in 208 patients. Disability & Rehabilitation 25 (10), 507–519.

Van Balen, R., Steyerberg, E.W., Polder, J.J., Ribbers, T.L., Habbema, J.D.F., Cools, H.J.M., 2001. Hip fracture in elderly patients: outcomes for function, quality of life, and type of residence. Clinical Orthopaedics and Related Research 390, 232–243.

Watters, C., Moran, W., 2006. Hip fractures- a joint effort. Orthopaedic Nursing 25 (3), 157–165.

Williams, A., Dunning, T., Manias, E., 2007. Continuity of care and general wellbeing of patients with comorbidities requiring joint replacement. Journal of Advanced Nursing 57 (3), 244–256.

Young, Y., Brant, L., German, P., Kenzora, J.E., Magaziner, J., 1997. A longitudinal examination of functional recovery among older people with subcapital hip fractures. Journal of American Geriatric Society 45 (3), 288–294.

Zalon, M.L., 2004. Correlates of recovery among older adults after major abdominal surgery. Nursing Research 53 (2), 99–106.

Ziden, L., Wenestam, C.-G., Hannsson-Scherman, M., 2008. A life-breaking event: early experiences of the consequences of a hip fracture for elderly people. Clinical Rehabilitation 22, 801–811.

Zuckerman, J.D., Koval, K.J., Aharonoff, G.B., Hiebert, R., Skovron, M.L., 2000a. A functional recovery score for elderly hip fracture patients: 1. Development. Journal of Orthopaedic Trauma 14 (1), 20–25.

Zuckerman, J.D., Koval, K.J., Aharonoff, G.B., Skovron, M.L., 2000b. A functional recovery score for elderly hip fracture patients: 11. Validity and Reliability. Journal of Orthopaedic Trauma 14 (1), 26–30.