Patients' perceptions of factors that affect recovery from illness in hospital.

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PATIENTS' PERCEPTIONS OF FACTORS THAT AFFECT RECOVERY FROM ILLNESS IN HOSPITAL

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CHAPTER 1

INTRODUCTION

Topic Under Investigation

This study set out to explore the multidimensional phenomenon of recovery. The setting was a district general hospital and a nearby community hospital in Wales. The definition of recovery was 'recovery from illness while in hospital'. This definition assumed that patients had been ill and required diagnosis and treatment that could not be provided by their own general practitioner. Recovery was regarded as the process of getting better, regaining good health and/or becoming medically fit for discharge from hospital.

Recovery would appear to be a poorly understood phenomenon. Patients with the same physical characteristics, such as age and gender, do not necessarily recover at the same rate despite apparently having the same care/treatment while in hospital. Nurses have a key role in helping patients to recover from illness and it was therefore considered important that factors that help patients recover should be identified with a view to improving the quality of nursing care received by patients in hospital.

A mixed method approach was used to collect data. Qualitative data were collected using interviews and focus groups. Examination of these data identified themes patients perceived to be important to help with recovery. These themes were categorised into factors or dimensions of recovery. This resulted in development of an instrument which was administered as part of a cross sectional survey to a convenient sample of hospital patients. Construct validity of the instrument was checked with exploratory factor analysis.

Statement of Purpose and Research Questions

The main aim of this study was to ask and establish what patients perceived would help them to recover from severe illness. Having established factors that patients perceived could help with their recovery, it was considered appropriate to establish if these perceived needs were met during patients' stay in hospital.

A secondary aim of the research was to help nurses and other professionals have a greater understanding of what patients perceive to be important. This could help them to be more attuned to patients' needs when undertaking a nursing assessment and when planning care. Understanding patients' needs could also help to check the appropriateness of the model of nursing used by nurses in this study.

The research questions for this study were:

1. What factors do adult patients perceive could help them recover from severe illness?
2. Does care given in hospital meet perceived needs of patients to help them with recovery?
3. Are perceptions of older people (over 60) with regards to recovery different from other age groups?
4. Is there any evidence that older people do not have their needs met as effectively as other age groups?
5. Do patients perceive that it is important to collaborate with nurses and other professionals and to be partners in care?

A Review of Related Literature

The search strategy for this review included the Cochrane Library, MEDLINE, EMBASE and CINAHL. A broad search was undertaken using online databases. Search limits included, the English Language and years 1980-2008. Key words used included combinations of: 'recovery'; 'nursing'; 'nursing models'; 'collaboration' and 'ageism'. A more in-depth description and justification of the search strategy can be found in Chapter 3.

This study is set, in the context of nursing practice, against a background of National Health Service (NHS) resource dilemmas. Pearson and Littlejohns (2007) reported that NHS organisations are incurring mounting deficits, while Williams, Bryn and McIver (2007) wrote of limits being set on services provided. Hospital beds are an expensive use of NHS resources and there is a current issue of capacity (Welsh Assembly Government, 2005). The National Institute for

Health and Clinical Excellence was established in 1999 with the aim of promoting clinical excellence and effective use of resources. Benefits of clinically effective healthcare treatments have been well documented but effects of more individual and holistic approaches to recovery are less well reported.

Over the past 10 years there has been an increasing drive for health professionals to work in partnership with patients (Welsh Assembly Government, 2006). This includes patients becoming more involved and responsible for their own health care (Degeling, Close and Degeling, 2006). While there is much evidence to suggest that patients should take responsibility to work with professionals to aid their recovery, Waterworth and Luker (1990) asserted that not all patients want to take on this responsibility. This study aimed to examine if patients did want to collaborate with nurses and other health care professionals and be partners in their own care.

While patients themselves may not wish to take on responsibility for their own recovery, responsibility for helping patients to recover from illness clearly lies with nurses (Henderson, 1960). There is, however, an issue of whether nursing theory, particularly with regard to models of nursing care, is appropriate to guide nursing practice in the 21st century. The Nursing and Midwifery Council (2008) states that provision of information and nurse/patient collaboration is a duty of care for nurses. There is evidence that this does not always happen. Provision of information is a complex process that must be tailored to individual patients' needs (Smith and Lilies, 2007). This requires that nurses get to know their patients (Henderson, Van Eps, Pearson, James, Henderson and Osborne, 2007) but bureaucratic demands including resources and financial constraints limit the ability of nurses to practice closeness with patients (Maben, Latter and MacLeod Clark, 2006).

With regard to understanding the phenomenon recovery, there is much evidence about physical aspects of patient recovery, for example; recovery from anaesthetic or natural regeneration and recovery of heart cells following a heart attack (Dorn, 2007). However there is less evidence about recovery in its broadest sense, i.e. the more human aspects of recovery from illness rather than a clinical recovery which is measurable by signs and symptoms.

The role of nursing is to ensure that individual needs of each patient are holistically met. This is particularly with regard to older patients who may be more vulnerable in a hospital environment. Literature suggests that ageism exists in the NHS (Davey and Ross, 2003; Robertson, 2002) This exploration of recovery, therefore, ensured that perceptions of older people were included and also set out to establish if the care received by older patients was different from other age groups. While the National Service Framework for Older People (Department of Health, 2001; Welsh Assembly Government, 2006) stressed that that older people should not be disadvantaged because of age, there is evidence that ageist discrimination occurs. There are reports that older people have lesser care because of negative attitudes towards them (Tong and Walsh, 2000) and that their nutritional needs are not met (Brownie, 2006).

Theoretical Framework

The theoretical framework for this study is recovery. The first phase of the study used qualitative research and an inductive approach was adopted with the aim of developing concepts and theories from data. The multidimensional concept of recovery is poorly understood. It was anticipated that exploring and defining this phenomenon through patients' perspectives would result in development of a conceptual framework for recovery that could be used by others.

With regard to nursing, the theory that this study has been based upon is the work of (Henderson, 1960; Roper, Logan and Tierny, 1980; Heath and Law,1982). These nurse theorists identified components of nursing that are universal and are considered basic or core elements of nursing care. The importance of their work, with regard to nursing contribution to patient recovery, is discussed in detail and its relevance to current nursing theory and practice. In particular, the role of nurses in providing patients with information and nurse/patient collaboration is examined.

Set against a background of ageism in the NHS, findings from this study will add to the body of knowledge regarding care received by older people from the perspective of older people.

Significance of the Study

This study was undertaken at a time of financial constraint of public funds and an acknowledged demand for sufficient hospital beds to meet the needs of patients requiring hospitalisation. It is, therefore, important both for individuals and for society as a whole, that patients are enabled to recover as quickly as possible from illness.

Improvements in medicine and technology have resulted in people living longer, with older people frequently requiring hospital admissions. There is however evidence of ageism in the NHS so that perceptions of older age groups and the care that they receive in hospital deserves further exploration.

With regard to the implications of this study for nursing theory and practice, this study will add to the body of nursing knowledge regarding recovery and how nurses can help patients recover from illness. It will also examine current nursing practice and care received as self reported by patients and thus identify deficits in practice that need to be addressed. While nurses are obliged to collaborate with patients, there is a gap in the literature regarding whether patients want the responsibility that this brings; findings from this study will help to address this.

Chapter Summary

This chapter has set the context and defined the phenomenon that has been explored in this study. It has highlighted gaps in current knowledge and provided justification for further research to be undertaken. The next chapter (Chapter 2) now takes a broad look at literature before the remainder of the literature review focuses specifically on recovery and the role of nurses in helping patients with this process.

CHAPTER 2

BACKGROUND AND SIGNIFICANCE OF PROBLEM

Overview of Chapter

There are many reasons why it is important for patients in hospital to recover as quickly as possible from a severe episode of illness. These reasons range from financial, political and social, to individual and personal. Chapter 2 takes a broad review of literature regarding the importance of recovery in a hospital setting and thus sets a context for this study.

Firstly resource dilemmas in the National Health Service (NHS) are examined to clarify why a speedy recovery from illness in hospital is important. This leads to discussion regarding the importance of recovery to patients and of providing clinically effective care and treatment. We then look at literature regarding working in partnership with patients and the potential for patients to be more involved in their care and recovery.

As large consumers of health services, views of older people are important. There are reports that older vulnerable patients do not always receive the treatment and care that is their right, in order that they have maximum opportunity to recover. This could possibly be due to existence of ageism and the issue is explored.

When considering recovery from illness, it has been well documented that nurses are key contributors to this process. This chapter briefly covers utilisation of models of nursing with regard to appropriateness of their use in the 21st century. The issue of nursing models is further pursued in Chapter 4. To conclude this chapter, a summary and a clear statement of purpose for this research are given.

National Health Service Resource Dilemmas

The National Health Service was founded in 1946 with a vision of providing a comprehensive health service for all including diagnosis and treatment of illness. Since the NHS was established, it has been well used and has perhaps become a victim of its own success. A service that was designed to secure improvements in physical and mental health of people has resulted in people living longer. This in turn has put more demand on the service. Maynard, Bloor and Freemantle (2004) highlighted that there has been substantial growth in the health service budget over the prevailing years but it will soon enter into a period of relatively flat funding. This view was endorsed by Pearson and Littlejohns (2007) who reported that many NHS organisations are incurring mounting deficits.

The United Kingdom has a population of circa 60 million and has been identified as one of the most densely populated countries in Europe (Nazarko, 2002). The number of older people in the UK is increasing and this is accompanied by a decreasing birth rate. An increased demand on health services has occurred because of declining health which often accompanies ageing (Welsh Assembly Government, 2004). This view is however being challenged. There is evidence that indicates that age alone is not the only factor to be considered and that proximity to death has a larger impact on health care costs (Seshamani, 2004).

There are many issues to be considered when looking at increased demand on health services, the greatest of which is probably advances in technology. Advances in medical science make it possible to treat more diseases but now involve setting limits on services that can be provided (Williams, Bryan and McIver, 2007). In addition public expectation has increased as people become more aware of what is possible and available via media and internet communications. Coast (2004), noted that society's health values may not be in line with some of the resource decisions being made.

Increased demand on health services has implications for both policy makers and citizens. Public money pays for most health services and there is an expectation that governments will spend this money wisely and continue to provide all services required. *The NHS Plan* (Department of Health, 2000) recognised the importance of increased investment in the health service and a programme of reform was proposed. Consequently in March 2001 Derek Wanless was asked to undertake a review of the health service in the UK. His interim report highlighted how far the UK had fallen behind other countries in health outcomes. Wanless (Department of Health, 2002) reported that the UK government had achieved less than other countries because it had spent less and not spent resources well.

The Wanless Report (Department of Health, 2002) had significant political implications. It identified that total spending at time of writing the report was expected to be around £68 billion. The report projected that this expenditure would need to rise between £158 billion and £184 billion by 2022-23. Wanless argued that success in delivering high quality services was not only dependent on there being adequate resources, but on those resources being used to maximum effect.

Hospital beds are an expensive and significant use of NHS resources. Treating people in hospital is not just a financial issue; it concerns patients who want to recover as quickly as possible, to be home with their families and wanting to live as normal a life as possible. Ways in which hospital beds have been used has changed over time. The introduction of the *NHS and Community Care Act* (1990) aimed to provide more long term care in people's own homes rather than in hospitals. Patients are now discharged home from hospital as soon as possible in order to prevent complications associated with hospitalisation, for example hospital acquired infections.

Hospital beds are now used predominately for acutely ill patients prior to an early discharge to their own homes or care in the community. Changes in the use of beds should have led to less demand but there remains an issue of capacity. This has been identified by the Welsh Assembly Government (2005) as a 'mismatch' between supply and demand. The current demand on health services makes it essential that patients' recovery is not delayed and that they do not remain in hospital due to inappropriate or ineffective care or treatment. The growth of evidence based practice has supported the provision of effective healthcare.

Clinically Effective Outcomes of Care

The concept of recovery from illness is closely linked to clinical effectiveness. Clinical effectiveness involves doing the right thing to patients at the right time and that treatment and care must be evidence based. It is difficult to judge what is clinically and cost effective. These judgements are complex and have become increasingly more difficult as the pace of medical advances has increased. The National Institute for Clinical Excellence (NICE) was established in 1999 (since renamed as the National Institute for Health and Clinical Excellence). The purpose of establishing this organisation was to provide guidance to health professionals and patients in England and Wales. The aim was to promote clinical excellence and effective use of resources (Rawlins,1999; Williams,Bryan and McIvor, 2007).

NICE has primarily been concerned with effectiveness of treatments; the focus of its work has predominately been on new technologies, usually new drugs (Horton, 1999). There is, however, a growing acknowledgement, that introduction of new drugs alone is not sufficient to meet the demands on the health care system. For example, the Welsh Assembly Government document *Designed for Life* (Welsh Assembly Government, 2005) highlighted the importance of managing chronic (long term) conditions in order to achieve an effective and efficient health and social care service in Wales. When a patient has a chronic condition, health professionals focus on medical management of the condition and that the right drugs are prescribed. However helping people to cope with the effect of their illness is also important. This includes encouraging self management and independence, and working in partnership with patients (Draus, Walblay, Barraco and Hall, 2002; Cretin, Shortell and Keeler, 2004).

With regard to national health strategies, it is clear that the Welsh Assembly Government takes its responsibility seriously, by its commitment to improve both the health and health care for people in Wales. However, funding does not usually accompany introduction of national strategies. Also, when governments and ministers change, so does strategic direction. As a result, many strategies never come to fruition whilst health care professionals continue to provide the best care possible to patients within the resources available to them.

National Strategies for Working in Partnership with Patients

Over the past 10 years there has been an increasing drive for health care professionals to do more than just treat or care for patients. This drive has been focussed upon forging partnerships with patients. Initially the document *Signposts* was published (Welsh Assembly Government, 2001). This document provided information to National Health Service organisations regarding how to engage with members of the public. Subsequently *Signposts Two: Putting Public and Patient Involvement into Practice in Wales* was published (Welsh Assembly Government, 2006). This second version of Signposts sought greater patient engagement which included the need to give patients more information.

National strategic policies issued since this time have highlighted the need not just for patients to have information but for them to become equal partners in their own care. The document *Designed for Life* (Welsh Assembly Government, 2005) set out a strategic framework for establishment of a world class health and social care service. It identified that the promotion of independence and service user involvement is key to this goal. The Welsh Assembly Government also published *Making the Connections* (Welsh Assembly Government, 2004) which identified the need to design and operate services around service users.

It is now a requirement that all National Health Service organisations recognise and have policies in place to ensure public and patient involvement (Welsh Assembly Government, 2003). There is, however, no assurance against a tick box tokenistic attitude to their application rather than a drive for improved services for patients. As with all policies there can be no assumptions that they are working well or are financed sufficiently (or at all). In addition, these policies may be contradictory and there may be problems for managers and staff who are expected to implement them. For example, while there is a government directive that service users must be consulted about changes to service provision, this does not necessarily mean that these views will be taken on board.

The recently introduced *Health Care Standards for Wales* (Welsh Assembly Government, 2005), required that standards for all health service provision are monitored through the eyes of the users of those services. There appears to be great difficulty in achieving this as there are uncertainties and tensions regarding how organisations can engage with service users in a way that is representative of a local population (Florin and Dixon, 2004; Waite and Nolte, 2006).

Despite these tensions, in England, foundation trusts have promoted social ownership of hospitals instead of state ownership whereby staff and citizens have a role in the governance of these organisations (Department of Health, 2004). These plans are not without problems; Lewis and Hinton (2008) reported on issues with accountability that needed to be resolved, when they undertook a King's Fund study in an NHS foundation trust. They also found that governors perceived that they had not influenced the decisions of the trust. There was, however, increased involvement of the public in general activities. This example illustrates that citizens may want to have a say in running their hospitals and planning their health services. This does not mean that they want to be involved in making decisions about their own health, which is a more personal and individual matter.

Current national health strategies assume that each individual will accept some responsibility for looking after their health by working in partnership with health care professionals. It should, however, not be assumed that patients wish to take part in this collaboration, especially if they do not think that it will change anything. Waterworth and Luker (1990) discussed the contradiction of asserting that patients have a right to become involved in decision making about their care. Patients may not want to take on this responsibility. Research undertaken by Waterworth and Luker (1990) identified that patients appeared to think that 'toeing the line' was the best approach when in hospital and that this suggested a balance of power on the side of the professional.

A balance of power may be affected by the way that patients regard themselves and by the way that they are spoken to by professionals. Marinker (1997) described patients' health beliefs as an impediment, which must be overcome. Marinker inferred criticism against patients by his comments and illustrated the need for patients to have easily digestible information available to them. This could help them understand how they can participate in decisions about their treatment and care. Patients may be reluctant participants in an alien environment but this could change in an environment in which they feel more at ease. For example, a hospital ward where the culture is aimed at achieving an equal partnership between patients and staff could foster patient participation.

Bytheway (2001) wrote about the importance of partnerships with patients. He described the concept of concordance as an aid to patient/professional interface. Concordance is an agreement, reached after negotiation between a patient and a health care professional, that respects beliefs and wishes of the patient. Although reciprocal, this is an alliance in which the health care professional recognises the primacy of patient's decisions regarding all recommended care/treatment. Gaining people's views can only be justified if professionals respect and give due consideration to this information.

Bytheway (2001) also suggested that routine is an important factor that needs to be considered if patient compliance to a regimen is to be achieved. He noted that there is a high diversity of daily routines in later life, between 'getting up and going to bed' and recommended that this need to be taken account of. The place of routine in recovery or the maintenance of a sustainable health status has not been fully explored but understanding importance of the daily routine of life should be examined further. Bytheway's work centered on patient compliance with medication taking in a home environment but the importance of routine to patients could potentially affect other aspects of recovery.

Liaising with users was not sufficient for Degeling, Close and Degeling (2006), who advocated that patients and service users should not just be given information but should be full partners in their own care. This includes being co-producers (with health professionals) in their own care plan. The focus here is that patients should not be recipients of care and treatment but should work with professionals to both prevent and recover from illness. This puts the onus on patients to be responsible for maintaining their own health and for getting better (recovering) from illness. While there is much 'top down' evidence which suggests that patients should take responsibility to work with professionals to aid their recovery (Welsh Assembly Government, 2005; Rogers, Kennedy, Nelson and Robinson, 2005; Singh and Ham, 2006; Nursing and Midwifery Council, 2008), there appears to be a gap in the literature regarding whether patients are prepared to accept this role of helping themselves.

A philosophy of self help demands that patients are able to help themselves or are thought to be able to help themselves. It also requires that patients are given sufficient information upon which to base decisions. In the case of older people there is evidence to suggest health professionals assume that older people have diminished cognitive function (Pudelek, 2002). As a result, it is possible that older people are not always given information that they require. They could thus be denied their rights in relation to participation and choice.

Ageism in the Health Service

The National Service Framework for Older People in England (Department of Health, 2001) put forward new standards to tackle age discrimination in both health and social services. This framework required that NHS services are provided regardless of age, on the basis of clinical need alone and that poor unresponsive insensitive discriminatory services are eradicated. An objective of the National Service Framework was to eliminate age discrimination, provide person centred care, promote older peoples' health and independence and fit services around peoples' needs based on evidence of effectiveness.

As with all national policies, the *National Service Framework for Older People* (Department of Health, 2001; Welsh Assembly Government, 2006) will only be as effective as the people who are introducing it at ground level. Local champions have been nominated to drive this process forward and monitoring returns are required by the Welsh Assembly Government to monitor implementation. However, this framework is extensive and the objective to eliminate age discrimination is just one of many.

The degree to which age discrimination occurs is difficult to assess. Davey and Ross (2003) attempted to do this by exploring staff views of old age and health care. They undertook an audit at Wirral Hospital aimed for a target population of 5000 staff members. The response rate to a questionnaire was relatively low at 27% (N=1343) but was a reasonable sample. The majority of respondents thought that older people were not disadvantaged. There was, however, also evidence of negative attitudes held and displayed, and inequalities in essential nursing care (Wirral Hospital NHS Trust, 2003).

Davey and Ross (2003) defined age discrimination as the treatment of individuals which denies opportunity, participation or benefit on grounds of old age. Direct discrimination would apply if someone were denied access to a service of treatment because of their age. Indirect discrimination can also occur, for example, if care or treatment does not take account of the needs of an individual. This could result in them being disproportionally disadvantaged. Davey and Ross (2003) pointed out that the NSF identified that older people should have specialist help if required in hospital. Patients should be treated with respect and care and treatment should be provided by staff that have appropriate skills, but this was not always happening.

There continues to be debate regarding what constitutes age discrimination or ageism. Arguments are put forward to justify age-based approaches to care, however it is not easy to judge the merits of such arguments. In general it would appear that perceptions of older people are influenced by their appearance and behaviour rather than their actual age. For example a 65 year old individual with severe dementia and/or poor mobility may be perceived as being old while a 75 year old individual with sharp mental alertness and good mobility might not. Loewy (2005) pointed out that statistics are only useful as guidelines and do not tell you anything about the individual patient in front of you. Chronological age does not always reflect capabilities of all patients in a particular age group.

Older people have been identified as major consumers of care but there is evidence to suggest that they do not usually complain about care they receive (Robinson, 2002). People aged 65 and over comprise about 16% of the general population but occupy two-thirds of hospital beds (Department of Health, 2000). They are also reported to account for 25-30% of NHS expenditure on medication and account for 45% of all prescribed items (National Pharmaceutical Society, 1997). According to Tinker (1996) older people make more use of hospital services than younger people. They are, however, less likely to find dissatisfaction (or perhaps to articulate dissatisfaction) with services than younger users and are generally satisfied with whatever services they are provided (Department of Health 2000).

Robinson (2002) found that there is a substantial body of evidence that older people experience age discrimination in health care. At the time of her report, Robinson headed a team at the King's Fund and was working to improve policy and practice affecting older people and their carers. She pointed out that prior to the introduction of the *National Service Framework for Older People* (Department of Health, 2001), the Labour government acknowledged the existence of systematic age discrimination in health and promised action to remedy this situation. This is concerning when considering recovery of patients in hospital. Older vulnerable patients could be denied high quality care if discrimination continues to occur.

Further work commissioned by the King's Fund involved Levenson, Jeyasingham and Joule (2005), who undertook seven focus groups in London. Eighty four people in total took part in this study. Respondents were primarily in their 50's and the aim of the study was to find out expectations of the next generation of older people. A number of different aspects were raised and discussed. Participants perceived that ageism and discrimination impeded access to good quality services. They felt that ageism was common and gave many examples of older people themselves being ageist. They also thought that a positive staff attitude, having choice, having information and being listened to were important. People at these focus groups felt that there was lack of respect and value of older people. Levenson et al.'s (2005) study revealed a consensus that there was a need to think about older people as individuals, not just to think about chronological age.

This view was also supported by Alliance for Aging Research (2005) that suggested that ageism becomes unconsciously a part of the thinking of older patients themselves and their families. Although an American organisation and possibly reflecting cultural differences, Alliance for Aging Research, concurs with British literature which suggests that ageism is a problem in the delivery of health services.

Butler (1975) described ageism as the systematic stereotyping of and discrimination against people simply because of their age. Wade (2001) wrote of persistence and perpetuation with regard to ageist attitudes which is reinforced by failing to ensure that health care professionals have specialist training in caring for older people. Bytheway, Ward, Holland and Peace (2007) found that stereotypes and prejudices continue to be translated into discriminatory practice.

With regard to negative discrimination, there are many examples where older people are treated less favourably, for example, the imposition of age limits for surgical and medical interventions (Dudley and Burns, 1992; Whelan, 1998; Little, 1999; Age Concern, 2000). There have also been claims that older people are less likely to be offered the best treatment for cancer (Turner, 1999). Terms such as 'had a good innings' have been reported by Glozier, Groom and Prince (2004), with a common tendency to consider many serious conditions in older people as a natural part of getting older.

While there are examples in the health service of direct discrimination occurring with regard to age limits for treatments and screening programmes, indirect discrimination is less obvious and often goes unnoticed. Robinson (2002) considered that the current drive at a national level to shorten lengths of stay in hospital has an adverse affect on older patients who take longer to recover from illness or surgery. This indirect discrimination can result in patients being discharged before they are completely recovered putting older patients, living alone, particularly at risk.

With regard to clinical decision making Dudley and Burns (1992), writing on the influence of age on policies for admission to coronary care units, found that 20 per cent of cardiac care units in the UK operated upper age limits and that there were age related policies with regard to thombolysis in 40 per cent of units. Worryingly, Grant (2000) found that older people were treated less favourably in Accident and Emergency departments; they were less likely to receive the most appropriate treatment and were more likely to die. This study took account of differences in co-morbidity and frailty. There are other examples of how age affects clinical decisions: Loewy (2005) wrote of the irrational inequality of hesitating before using a diagnostic MRI scan on 90 year old patients even when they are fully alert and enjoining life; New and Mays (1997) found that, with regard to treatment for renal failure, older people were less likely to be accepted; Hughes and Griffiths 1996 wrote that older people may have to wait longer for some forms of heart surgery.

It would appear that age per se is not a clinical factor in all instances. As long as older people require technical intervention and care in an acute setting; such actions appears to be justified and valued. There is evidence, however, that when this technical medical intervention has been completed, there is less attention paid to the changing needs of older people in an acute setting leading to their increased dependency and delayed discharges from hospital (Wade, 2001).

The quality of care received by older patients is reflected in the attitude and behaviour of staff providing their care. There is evidence that staff do not like caring for elderly patients and that they are patronising in the way they communicate with them (Lookinland and Anson, 1995). In some cases it has been reported that staff fail to ensure that basic needs such as nutrition and hygiene are met (Health Advisory Service, 2000).

Courtney, Tong and Walsh (2000) highlighted that with increased life expectancy, there are an increasing number of older patients utilising acute hospital beds. When examining research on positive and negative attitudes of nurses towards older people, they found many negative attitudes reflecting ageist stereotypes. In an acute setting (that did not specialise in caring for older patients) they found patients experienced reduced independence. They also found that older patients had limited opportunity to make decisions and had increased probability of developing complications.

It is not, however, only older age groups that are affected by discriminatory practice. While negative age discrimination is given much attention, there are also instances where positive age discrimination takes place. Literature relating to ageism has usually been found to be negative, illustrating how patients are disadvantaged because of their age. In contrast Glozier, Groom and Prince (2004) provided evidence of positive ageism in prioritisation for elective orthopaedic surgery. Their research included 230 participants who were followed for two and a half years. Contrary to their expectations they found that patients' psychological distress was not associated with being classified as an urgent case. In a multivariate model, age was the only factor that showed an independent effect of increasing the chances of being considered urgent.

There are other instances where positive discrimination with regard to older people appears to be commonly accepted, for example, free eye tests for people over 60. It must, however, be noted that positive discrimination for any age group, for example benefiting older people, inevitably leads to discrimination against younger or other age groups in the same circumstances.

The existence (or not) of ageism is a difficult concept to quantify. However, the evidence above appears to confirm that it is present in the health service and it could possibly have a detrimental affect on patients recovering from illness. There are an increasing number of older people being cared for on hospital wards and it is therefore likely that they will encounter ageism when they are in hospital. To ensure that the needs of older patients and indeed all age groups are met, it is important that nursing care maximises each individual patient's opportunity for recovery. We shall therefore next briefly examine whether the models of nursing used to guide provision of care are appropriate.

Models of Nursing Appropriate for 21st Century

This study is set in the context of examining current nursing practice. There is an implicit assumption here that practice can always be improved. This quest for improved quality of nursing care is not new and was the basis for development of models of nursing care. Roper, Logan and Tierney published their model of nursing in 1980 (Roper et al. 1980). This was with a purpose of moving towards treatment of patients as individuals rather than carrying out tasks and following hospital routine. Salvage (2006) described Roper, Logan and Tierney's model as a new way of thinking, groundbreaking and moving from a biomedical thinking to an independent and individualised approach.

Not everyone believes that nursing models and nursing theory are helpful to nursing practice. The place of models of nursing is being increasingly questioned (Wimpenny, 2002; Littlejohn, 2002; Salvage, 2006). Littlejohn (2002) argued that nursing models and theories are confusing and contribute to disillusionment at the heart of nursing. He concluded that whilst nursing assessments need some guiding framework there is evidence to suggest that the validity of nursing models and nursing theories must be questioned.

Roper et al. (1980, 1985) intended their 12 activities of daily living to provide a clear structure to nurses and a rationale for their care. Wimpenny (2002) reported that limited evidence is available on implementation of models of nursing and claimed that models of nursing have lost the challenge that they once provided to the nursing profession. Wimpenny's research explored the meaning of models of nursing to nurses. His work identified problems with relationships between theoretical models and practice. He concluded that in the 21st century, the relevance of models of nursing is based on divergent and ambivalent views and asked, are models moving from being extant to extinct?

While undertaking this literature review, a search for the term 'models of nursing' revealed many articles and much debate prior to year 2000, with a comparative paucity of publications after that date. This could be interpreted as meaning that models of nursing are now so well embedded into the process of nursing that they are implicit in everything a nurse does and therefore need no mentioning. Conversely, it could be interpreted that models of nursing are not perceived to be as important today as they previously were. Fawcett (2003) reported that some nurses considered conceptual models to be dinosaurs and irrelevant to contemporary nursing and research.

Fawcett (2003) in a guest editorial for the Journal of Advanced Nursing warned that nurses are adopting conceptual models of other disciplines to guide their practice. She noted that nurses are discarding the activity of bed baths and utilising nursing models and she voiced concern that this is contributing to extinction of nursing as a discipline. Fawcett went on to forcefully put the case that the disciplinary status of nursing rests upon conceptual models of nursing. She argued that without such a foundation nurses would have no right to be recognised by fellow professionals or to practice autonomously. Fawcett (2003) concluded this editorial by calling nurses to become champions of nursing discipline specific knowledge in order for the discipline of nursing to survive. It must be noted that this line of reasoning is focussed on nurses rather than patients and what is best for patients.

In the 21st century it is evident that the role of nurses must change because of changing political and cultural environments in which they work. If we are looking to provide best outcomes (recovery) for patients, nurses should do what is best for patients. There are varying views regarding the effectiveness of using theoretical models to direct nursing care. There is also debate around whether nurses should be purists and maintain a nursing model that projects that there is a unique function of nurses; or whether they should work towards a model of care that puts nurses in the context of a multi-professional team. Models of nursing have been criticised, but there appears to be few better suggestions being put forward to ensure that patients have a consistent quality of care wherever they are nursed. Perhaps it is not models that have become outdated but rather how models are applied in the 21st century.

On NHS hospital wards, nursing assessments are based on a model of nursing care that has been agreed by the service provider organisation. While there remains debate regarding the use of nursing models, there appears to be little disagreement regarding the importance of a good nursing assessment. This enables the nursing team to work together and with others to provide best care for patients. An assessment is usually based on a model of care. Some models may lend themselves to providing a better nursing assessment framework than others but there is a danger that, whatever model is followed, nurses may miss some vital patient perceived need simply because patients are not specifically asked, what needs they have. If nurses want to know what patients think will help them recover from illness, patients should be asked rather than assume that a pre-set nursing document will capture all their needs. The purpose of undertaking this study was to explore patients' perceptions so that these needs could be identified and addressed. As this study is about patient recovery, there is a need to delve more specifically into how models of nursing may or may not help this phenomenon. This will be discussed in more detail in Chapter 4.

Purpose of the Study

The prime aim of this study was to ask and establish what patients perceived would help them to recover from severe illness. The age profile of people in hospital is changing as there becomes an increased demand for healthcare by older people. The needs of older people may be different from younger people. Older patients in hospital are sometimes more frail, need more support and take longer to recover than younger people. When looking at recovery of people in hospital it was therefore considered important to establish perceptions of older patients with regard to recovery and whether older people had different perceptions from other adult age groups. It was anticipated that this comparison would reveal differences, which may help provide a greater understanding of the process of recovery in different age groups. For the purpose of this study, older people were taken to be those aged 60 and older.

A secondary aim of the research was to help nurses and other professionals have a greater understanding of what patients perceive to be important. This could help them to be more attuned to patients' needs when undertaking a nursing assessment and when planning care. It was anticipated that this study will contribute to exiting nursing knowledge, by examining current literature and by publishing results from this research. Having established factors that patients perceived could help with their recovery a second phase of this study was to find out if these perceived needs were met during patients' stay in hospital.

Summary of Chapter

This chapter has taken a broad overview of literature with a view to justifying a need to undertake this study. The domain of enquiry is about patient recovery in a hospital setting. Literature has supported that it is important for patients to recover quickly from an acute episode of illness and to be discharged from hospital. This releases much needed hospital beds for other ill patients. Resource dilemmas in the NH have been identified and the need to use existing resources well, this includes use made of hospital beds. A need to provide clinically effective care and treatment has also been discussed as this not only ensures that patients get the best care possible but also that their recovery is not delayed unnecessarily.

National strategic documents have shown how the government perceives that it is important for health care professionals to work in partnership with service users. There is, however, some evidence that patients may not want to collaborate or to be partners in care. This has supported the need to explore further whether patients want to collaborate with health professionals and to what degree?

This study is set within the context of ageism possibly existing in the NHS. There is evidence that there are negative attitudes that reflect ageist stereotypes that could influence nursing practice regarding older persons' quality of care. There is a need to further explore the extent to which ageism affects nursing care. There is also a need to develop and utilise a research instrument that includes a patient focus on care, particularly older patients.

This chapter has concluded with a description of the prime aims of this study, these aims are seen to be justified by the literature. When recovery is impeded or delayed there are significant consequences both at a national and individual level.

Understanding the process of recovery, particularly from a patient's perspective, would be beneficial.

CHAPTER 3

RECOVERY

Overview of Chapter

After taking a broad view of the background to this study in Chapter 2, it was confirmed that good recovery from illness is not only important to individual patients and their families, it is also of importance to society as a whole and to governments who have responsibility to ensure that citizens have their heath needs met as effectively as possible. This chapter (Chapter 3) now narrows the search to examine the process of recovery in more depth. Because this is a dual method study, there are two components to this section of the literature review and this is explained. Then a generalised view of recovery is discussed prior to examining more specific aspects of this multi-dimensional phenomenon.

This chapter concludes by highlighting the important contribution that nurses make to the process of recovery. Three key nursing documents by: Virginia Henderson (1960); Roper et al. (1980) and Heath and Law (1982) are briefly examined and attention is drawn to their relevance to this study.

Details of Search Strategy

It became necessary to conduct the literature search in two stages. An initial search with regard to the topic recovery produced much about the clinical physiological aspect of recovery, for example, physical recovery from injury and tissue damage. Little was revealed about what patients felt could help with recovery from illness or about what action could be taken to help patients recover. In qualitative research it is not unusual to find a relatively small body of previous work because of the nature of the questions asked and that in some instances, the topic is poorly understood (Polit and Hungler, 1999). With regard to recovery, some aspects of this phenomenon are well understood and there is research to support this understanding. A review of this predominately quantitative work is discussed in the first section of this chapter.

There are other aspects of recovery that are poorly understood. However, after completing the qualitative phase of this research, there were many themes identified by respondents as important to help patients recover from illness in hospital. These themes had not been previously identified via the literature search. Stage two of the literature search was subsequently conducted using the themes identified by respondents as search words/terms. Because recovery is such a multidimensional phenomenon, it was understandable that a literature search would reveal little until additional dimensions of recovery were introduced into the search process. Fruitful search words/terms were not available until the qualitative phase of the research had been completed. In this instance, therefore, it was necessary to use the results of qualitative data collection for a further literature search. Both stages of the literature search comprised of a broad search of online databases. Ovid (www.ovid.com) was the main search engine used. This was accessed using local university online catalogue services and also included the Open University facility, 'Open Research Online' (oro.open.ac.uk). In addition Welsh Assembly Government and Department of Health publications were obtained electronically for relevant policies and strategies in order to set the context of the research in today's NHS.

Subsequently citation lists of relevant studies were pursued for other research studies and articles. Cochrane reviews were also accessed (www.cochrane.org). The electronic data bases predominately used were: the Cumulative Index to Nursing and Allied Health Literature (CINAHL); Medical Literature On-Line (MEDLINE) and Exerpta Medica database (EMBASE). Search words/terms used for both stages of the literature search can be seen in Appendix I.

What is Known About Recovery

In the context of this study, recovery is taken to mean getting better after an illness. The definition of recovery varies between those involved in providing care. For many health care professionals and managers, 'outcomes' appears to be a more frequently used term, 'survival' is a term used by others. Physiological recovery was a term used by Ely *et al.* (2002) when looking at the recovery rate of older people following mechanical ventilation. Similarly, recovery of the heart following a cardiac episode is seen solely as a physiological process. Literature referring to such physiological aspects of recovery, lend themselves to quantitative data collection and analysis, e.g. the recovery of the heart after exercise (measured by a return to normal pulse rate). However, the phenomenon of recovery from patients' perspective has received little attention.

Gross and Battie (2005) undertook a study where recovery was indicated when patients were able to return to work. Their study attempted to predict recovery times following multidisciplinary rehabilitation for low back pain. They found that, not surprisingly, the number of pre-admission healthcare visits was the most robust indicator of delayed recovery. It would be expected that fitter individuals with fewer health problems would recovery more quickly. Gross and Battie's (2005) study highlighted individuality of recovering patients and the difficulties in generalising results. Perhaps this study would have revealed more about the recovery process if patients rather than professionals had had opportunity to suggest their own recovery indicators.

Healthcare intervention is aimed at helping patients to recover. Some patients do better than others as a result of this intervention. Koller, Lorenz and Wagner (2000) and Kalauokalani, Cherkin, Sherman, Koepsell and Deyo (2001) suggested that patients expectations and perceptions influence treatment outcomes. Metcalfe and Klaber Moffett (2005) also explored this area in some depth. Working in the field of physiotherapy, Metcalfe and Klaber Moffett's (2005) research project explored patients' expectations of benefits from physiotherapy. The first stage of the research presented findings from baseline data collected before treatment began. The second stage of the research presented follow-up data collected on discharge and was aimed at testing the hypothesis that 'expectations of benefits is positively correlated with outcome'. Baseline data comprised 285 respondents and follow-up data was provided by 239 respondents. Statistical tests included test for normality of distribution of the data plus appropriate parametric and non-parametric tests to calculate relationships.

Regression analysis was also used to determine the amount of variation attributable to each baseline variable.

Results illustrated that expectations were shown to be related to: change in functional disability (P<0.001), perceived improvement (P<0.001) and change in health status (P<0.004). The study concluded that patient expectations influenced outcomes of physiotherapy interventions and that if expectations can be altered then treatment outcomes can be enhanced. The conclusion went on to state that this had implications for physiotherapy practice and education particularly with regard to communication and education of patients about the aims and benefits of physiotherapy.

Although this study appeared to have quite rigorous design, there could be an issue about what was actually being measured. It was not clear if it was patient expectations or motivation which were being measured. It might be reasonable to suggest that patients' expectations are based on what they are motivated to achieve combined with what they are informed about or know is possible for them to achieve. Although this study indicated relationships between a number of variables, it was not possible to show which variable in particular caused most of the variable in recovery (the dependent variable).

It is well documented that psychological factors are influential on the outcome of physiotherapy treatment (Partridge and Johnson, 1989; Burton, Tillotson, Main and Hollis, 1994). The Mecalfe and Klaber Moffett (2005) study highlighted factors of patient motivation, good communication and working in partnership with patients which helped to benefit patient outcomes. Quantifying how exactly these factors improve outcomes and benefit recovery requires further research which needs to take into account individual patient experience.

Although human bodies are naturally programmed to repair and recover following illness or injury, patients need additional help when their injury or illness becomes more serious than can be self managed. An example of this is myocardial repair (repair of heart tissues) following a heart attack. Early reperfusion therapy, whereby drugs restore a blood flow to the heart within hours after a heart attack, has transformed this disease. Natural regeneration and recovery of heart cells then takes place (Dorn, 2007). This example shows that the body repairs and recovers itself but this process can be significantly enhanced by treatments and drugs administered by doctors and nurses.

The importance of a multi-disciplinary approach is becoming widely recognised (Braunwald, 2002; Major, 2007). A recent example of teamwork is the new approach to surgical care currently being introduced at University College London Hospitals NHS Foundation (Major, 2007). The aim of this ongoing study is to significantly reduce recovery time from surgery. It combines better pre-operative assessment, intra-operative monitoring and post-operative observation. The programme, developed by colorectal surgeons, is undertaking continuous audit of every patient and results will shortly be published. This type of study illustrates the medical ethos of recovery being measurable by signs and symptoms and scientific monitoring and observation.

Work undertaken by Heaver, Kaye, Lin and King (2003) provided another example of using the criteria of biological functioning, relative to the expectations of normal functioning, as a means of measuring recovery. Their research compared recovery from anaesthesia when two different anaesthetic drugs were used. Results of differences between the two drugs were measurable via vital signs and other quantitative measurements and data were subject to statistical analysis. The conclusion was that complete recovery was difficult to measure as patients were distracted by pain, nausea and mental distress which is more difficult to quantify.

Griffiths and Jones (1999) suggested that the recovery process can differ and was generally more protracted when patients are extremely ill. They noted that little had been published on detailed clinical recovery and that problems associated with recovery from critical illness could last for months or years, i.e. until patients were fully recovered. The study described how patients felt that the recovery phase of their critical illness was the most stressful period and that presence of social support increased tolerance to this stressful situation and had a beneficial effect. Activity was also important to recovery but was not always feasible due to severity of illness.

Griffiths and Jones (1999) also explored the usefulness of providing information on recovery. They stressed that simply giving patients a discharge booklet outlining possible problems was insufficient. Despite using such a booklet, 25% of patients attending a follow up clinic after being in intensive care indicated a high level of anxiety two months post discharge. Griffiths and Jones's (1999) study highlighted the importance of information to patients on the timescale of their recovery including practical advice on rehabilitation, exercise and nutrition. The individuality of patients was considered particularly important and the need to promote patients' responsibility in their own recovery.

Examples above illustrate that some treatment outcomes with regard to recovery are well documented, albeit from a clinical rather than an individual patient perspective. NICE now routinely reviews treatments with a view to recommending best practice primarily for medical interventions. The Cochrane database is also widely used as a resource for those who wish to obtain critical evaluations of research that has been undertaken. The Cochrane database was used in this study to undertake a search for literature regarding recovery. It was of note that the majority of articles in this database were found to be written by clinical researchers with a focus on clinical outcomes of medication and treatment rather than on individual patients' points of view.

Looking at differences between individuals as a result of the disease process, Sibbrit, Byles and Regan (2007) undertook a six year longitudinal study with regard to women's health. This Australian study included 12,432 women aged 70 – 75. Findings identified variables that could be associated with functional decline. Those who experienced decline in health were more likely to have pre-existing conditions, use more medication and have a higher health care use at the start of the study. Individuals' own rating of satisfaction with their physical ability was also a strong predictor of subsequent decline. Findings of this study would suggest that baseline health status and self perception of physical ability would contribute to resistance to decline with age. Perhaps resistance to decline is on a continuum with capacity to recovery and the revelation of factors affecting both scenarios could possibly be common.

Paterson, Govindasamy, Vidmar, Cunningham and Koval (2004) also identified that while individuals may be of similar chronological age, there are some individuals who are vulnerable to physical decline and others who appear resistant to decline in physical function. This can be compared to patients who are ill in hospital. Some patients get better more quickly than others for no obvious reason. These relatively unexplored reasons do not fit well with a biomedical model upon which much of the research on recovery is centred.

The biomedical model of care has been described as a rational activity based on scientific knowledge. Medical care is seen as a way of conquering and curing disease and thus aiding recovery. This model is however focussed on disease rather than the whole person (Walmsley, Northedge and Warner, 2005). Typical examples of the achievements of this model are antibiotics, anaesthetics, analgesia and surgical developments, particularly transplants. While the biomedical model has produced great success in relation to clinical outcomes that are measurable by improved clinical signs and symptoms, there would appear to be other factors involved in patient recovery in a hospital environment. The biomedical model does not explain why some patients recover more quickly than others following medical intervention.

Watson and Northedge (2008) described a modern hospital as a laboratory of medical science where medical intervention can be provided in laboratory like conditions and bodily functions are systematically observed. Individuals who are seriously ill are usually admitted to such an environment for diagnosis or treatment. Shilling (2002) highlighted that a state of illness is not regarded as the sick person's fault but when a person becomes ill, accepting a 'sick role' incorporates an expectation that people will seek help from a 'technically competent' health professional and also cooperate in the process of recovery.

The point at which patients recognise signs of illness and acknowledge these to themselves is the point at which they enter into the 'sick role'. The point at which they are able to leave this role is dependent on different and individual multi-dimensional factors. One of these must be that they want to recover as opposed to gaining some benefit from remaining 'sick'. Adopting a 'sick role' in hospital can, however, present patients with difficulties. Faulkner and Aveyard, (2002) argued that healthcare professionals have different expectations to patients regarding the role that patients should adopt in hospital. They point out that it is an obligation of patients to unquestioningly comply with health professionals, which is in conflict with the emphasis on encouraging patients to participate in their own care.

This review, to date, has shown the complexity of the process of recovery and that it is affected by physical factors but also by many individual human factors that are difficult to quantify. The next section attempts to explore these factors further.

Factors Perceived by Respondents to Affect Recovery

This section of the review is a result of literature searches undertaken on themes identified by respondents in the qualitative phase of this study. Categorization of themes and factors is fully explained in Chapter 7, the quantitative method section. As there was sparse information on the term 'recovery' (other than clinical trials described previously), each separate theme and factor to emerge from the qualitative data were entered as key words in the literature search. It was hoped that this would provide more information on recovery and thus enable more comprehensive comparison in the discussion chapter between existing knowledge and findings from this study. **Table 1** below lists the 20 themes and five factors/dimensions, representing the concept of recovery that emerged from the qualitative data, these are now discussed.

Table 1, Concept of Recovery

Factors/Dimensions of Recovery	Themes
Therapeutic intervention	Medication Plenty of rest Being made comfortable Keeping active
Core elements of care	Going to the toilet Washing and dressing Eating and drinking Being safely looked after
Collaboration	Maintaining a routine Being included in plans Being asked opinion Having good information
Social Interaction	Staff talking to patients Seeing friends and family Happy staff Having support at home
Motivation	Made to feel of value Being given confidence Given hope Looking forward to going home

Medication

Medication has already been identified in this review as important to recovery. However, there are other aspects of medication that deserve attention. While prescribing and administering of medication is generally regarded as an important aspect of treatment for patients in hospital, it is also known that the adverse effect of medication, drug errors and drug related illness are important causes of morbidity and can also cause distress to patients (Jordan, Tunnicliffe and Sykes, 2002).

Another important consideration with regard to medication identified by Barber, Parsons and Clifford (2004) was non adherence to medication regimes. Patient compliance has a strong association with collaboration. If recovery is to be achieved and maintained, especially after discharge, it is important that patients have a good understanding of why it is necessary to take the medication and to have information regarding expected side effects. Nurses have a key role in providing this type of information to patients. Saxton (2006) highlighted the importance of equipping nurses with skills necessary to support medicine management with regard to continued recovery of patients post discharge.

Plenty of Rest

Henderson (1960) stressed the importance of rest and sleep and the impact that stress and tension has on this phenomenon. She put the onus on nurses to ensure removal of irritants to sleep, particularly noise and other irritating stimuli. The importance of sleep was also recognised by Roper et al. (1980) and Heath and Law (1982). Sleeplessness was found to be distressing to patients by Duxbury (1994). Hogg (1998) highlighted the importance of staff finding appropriate solutions to the problem. Southwell and Wistow (1995) and Reid (2001) also reinforced the importance of sleep. The most common problem in hospital was found to be patients not getting enough sleep because they are disturbed by ward activities and routines.

Being Made Comfortable

Comfort was a key theme identified by respondents in this study as important to recovery. Little in the literature refers specifically to comfort; Henderson (1960) linked it briefly to ‘maintaining desirable positions’. Other authors have linked ensuring comfort with alleviating pain and have written about the importance of ensuring that patients are given the opportunity to express discomfort or pain (Mann and Redwood, 2000; Field and Adams, 2001). Howard (2001) highlighted the need to take all possible action to respond to any comfort or distress that patients are in.

Keeping Active

Henderson (1960) described helping patients to keep active as an component of nursing care. Roper et al. (1980) and Heath and Law (1982), supported Henderson's views regarding the need to help patients with mobility. Keeping patients mobile has additional benefits, for example, avoidance of pressure sores is helped by patient movement and activity (Gould, James, Tarpey, Kelly, Pattison and Fox, 2000; NICE, 2001). Helping patients to keep active is also an important aspect of maintaining patient independence which can have a motivating affect with regard to recovery (Faulkner, 2001; Lothian and Philp, 2001; Dent, 2002).

Going to the Toilet

Maintaining continence whilst in hospital can be particularly difficult for older patients and those who suffer from immobility. When patients are ill or confined to bed, this can cause great embarrassment and is often linked to social taboo. Being able to go to, or be taken to, a toilet whilst in hospital is therefore very important. Dowse and Mackender (2000) stressed the importance of ensuring that patients have access to a means of notifying staff of their needs. There could also an issue here of delayed recovery, patients become distressed and suffer reduced morale if they are unable to get to the toilet in time.

Henderson (1960), Roper et al. (1980) and Heath and Law (1982) noted that, similar to eating, elimination is closely tied up with emotion and stress and anxiety of being in hospital. While having enough to eat and drink and being able to go to the toilet are factors that patients would relate to while being in hospital, there are more complex factors involved here that perhaps patients would know little about. This concerns whether patients have sufficient and appropriate fluid intake and whether their fluid balance of intake and output is within a normal range. Any deviance could be symptomatic of complications associated with the illness, hence delayed recovery.

Washing and Dressing

Cleanliness is not only associated with clothing but also with being well groomed, maintaining dignity and self respect. Henderson (1960) spent more time writing about this than any other of the components of nursing. She included: bathing, shaving, hair washing, nail trimming, hair brushing and mouth care as essential. Roper et al. (1980) wrote of the importance of 'cleansing and dressing', while Heath and Law (1982) referred to meeting patients' hygiene needs. Whiller and Cooper (2000) and Ford, McCormack, Wills and Dewing (2000) also highlighted this aspect of nursing.

The importance of mouth care was reinforced by Rattenbury, Mooney and Bowen (1999) who pointed out that oral health is necessary for eating and drinking. Neglect of oral care can lead to infection and this also links with ensuring comfort. This point of view was also supported by Griffiths (2002).

Henderson noted (in 1960) than many aspects of nursing care had been passed to relatively untrained nursing personnel, particularly with regard to cleanliness and toileting. She wrote of the loss to the professional nurse of being deprived of hours with patients: talking, listening, observing and reassuring patients whilst bathing them. She stated how helping patients with their toilet gave the opportunity for natural spontaneous conversation that would help with patient assessment. This view was also identified by Fawcett (2003) who believed that if nurses give up bathing patients (to others) then they give up their professionalism. It is interesting that two highly profiled nurse theorists and leaders should forcefully write that bathing and toileting patients is so important to nurses, yet these are the tasks that have been given (away) to non registered nurses. These feelings are built upon the premise that the only way to get close to patients is to be undertaking intimate tasks. There appears also, to be a view, that only during these intimate moments can nurses really understand patients' individual needs.

It could well be that intimate times are the only times that professional nurses give their precious time to patients without feeling guilty that they should be doing several other simultaneous tasks. From a safety point of view, when dependent patients are being bathed or toileted they do need undivided attention/supervision and therefore there is an opportunity and time to talk privately (behind closed privacy doors). The question must be raised, whether this patient revelation that is said to occur in such situations benefits nurses or patients the most. If ongoing patient assessment is important to recovery, it would not be unreasonable for nurses in the context of collaboration, to take time in privacy, to sit with patients (without the bath or toilet) and talk about issues that are of concern to the patient.

Eating and Dinking

With regard to nutrition, Brownie, (2006) found in particular that older patients are at risk of nutritional deficiency as a result of hospitalisation and that chronic illness, medication and social factors also compound this problem. Brantervik, Jacobsson, Grimby, Wallen, and Bosaeus, (2005), also wrote of older hospitalised patients being at risk of malnutrition and regarded it as a major risk factor for delayed recovery and complications.

Importance of nutrition was also emphasised by Bond (1998), with regard to recovery from illness and healing of wounds. Patients should be offered a choice with regard to food and drink that meet their nutritional and personal needs. Where patients are unable to eat and/or drink unaided they should receive help and encouragement (Steele, 1998; Horan and Coad, 2000; Welsh Assembly Government, 2002).

Henderson (1960) pointed out that nurses are with patients day and night and that they are best placed to help patients to eat and drink. She also highlighted that eating should be socially pleasant and that if it is not, patients' dietary intake might be less than required. Nurses are responsible for assessing and ensuring the adequacy of food intake, Henderson described 'to eat when hungry' as a basic human freedom. Roper et al. (1980) and Heath and Law (1982) also supported a need for nurses to ensure that patients' nutritional needs are met.

Being Safely Looked After

Henderson (1960), Roper et al. (1980) and Heath and Law (1982) related this component of nursing care to protection of patients including danger from other patients and from infection. This also included danger from falls or other physical dangers. There was not at that time implementation of Risk Management Standards (Welsh Assembly Government and Welsh Risk Pool, 2002). Over intervening years, the principle of protecting patients from harm has remained the same, with perhaps more emphasis today, on prevention of treatment errors. There now appears to be a continual quest for improving patient safety (NICE, 2001; National Patient Safety Agency, 2001; Pennels, 2001 and Mitchell, 2002).

Collaboration

For the purpose of this study, collaboration is taken to mean all aspects of working in partnership with patients and their family with regard to health care. This includes, providing information, involving patients in decision making and generally encouraging full involvement and participation from patients.

Much has been written about the need and desirability of health care professionals collaborating with patients, this has been discussed in Chapter 2. Unfortunately, the quantity and quality of literature regarding how patient participation takes place is limited. Tutton and Ager (2003) described an action research project that took place over 18 months exploring views of patients and staff with regard to how older people could take part in their care. As a result of this study four themes were identified: facilitation, partnership, understanding the person and emotional work. These themes were used to provide a framework that could be used by staff to understand practicalities of undertaking participation in practice.

Tutton and Ager's (2003) study identified that over a period of time some staff values changed and staff began to view patients as autonomous. Staff found that by changing use of language and behaviour they could create opportunities for patients to take part in their own care. By reflection and as a result of the 'action' phase of this project, staff found that partnership must incorporate values of respect and trust.

These values of respect and trust provided the basis for negotiating daily care plans with an aim of balancing staff duty of care for patients with wishes of patients themselves. This study was about enabling patients to participate in their own care. However, the focus of this study was upon nurses and helping them to think differently about how they cared for patients. A limitation of the study was clearly identified by the author, namely: the difficulty in making changes in a ward environment where resources are limited for education and that there is insufficient research available with regard to patients' views and creating opportunities for them to be involved in their own care.

While it would appear that Tutton and Ager's (2003) action research project was successful in changing views of staff regarding patient participation, this would be as expected during an 18 month facilitated project which included reflective practice for nurses involved. It is of note, however, that during this 18 month period only nine patients were interviewed in phase 1 of the study and nine patients in phase 4. In contrast nurses had total involvement with the project via focus groups, interviews, reflective practice, discussion groups and an away day.

While changing views and attitudes amongst nursing staff is considered to be important, it has also been thought that patient education could be beneficial. McDonald, Green and Hetrick (2004) undertook a systematic review to determine whether preoperative education improved postoperative outcomes and patient recovery. A number of significant postoperative outcomes were identified which could be monitored such as anxiety, pain, mobility, length of stay and incidence of deep vein thrombosis. Randomised trials of preoperative education were included.

Data were independently assessed by two reviewers. Weighted mean difference and 95% confidence intervals were used for combined continuous outcomes. Nine studies met the inclusion criteria involving 782 patients. It was concluded overall that there is little evidence to support use of pre-operative education over and above standard care. However, three studies showed that people with education before surgery were less anxious, whilst two others found that anxiety was the same. The authors concluded that future research should try to establish which people need education before surgery. This review illustrated that people are individuals and what works well for one does not necessarily work for another. It would appear therefore that understanding the person is an important precursor to successfully providing information to patients. It must be noted that the outcomes monitored in McDonald et al.'s (2004) study were clinically focussed rather than outcomes that were patient generated.

While it appears difficult to quantify how much education benefits patients, provision of information and inclusion in decision making seems to be important to patients. Mayor (2005), reporting on a survey of 1713 stroke patients, stated that specialist wards resulted in better recovery rates. In stroke units it was reported that five per cent of patients did not receive help with their mobility compared to 16% on non specialist wards. The survey also indicated that patients wanted to take part in decisions about their care. Just over half the respondents wanted to be more involved with decisions about their treatment, but this was not always achieved. Twenty-one per cent said that the purpose of their medication was not explained to them.

Smith and Lilies (2007) undertook a comparative descriptive study to explore information needs of patients prior to discharge from hospital. Participants perceived that information regarding medication, complications and symptoms plus other illness related concerns were important. With regard to medication, Simpson (2007) found that from a nurse education perspective, encouraging patients to describe and share their experience of illness or taking medication could help to inform students and thus improve patients care.

Improving patient care was also the purpose of the Department of Health report on privacy and dignity in hospitals (Department of Health 2007). This report was principally aimed at finding out what patients thought about mixed sex accommodation. While the focus of the study was about privacy and dignity associated with mixed sex accommodation, privacy and dignity was rarely mentioned spontaneously by patients in open discussion. When asked to chose three items from 12 features that made patients feel they were treated with privacy and dignity, more people chose ‘a clean hospital’ (58%) than any other factor. This was followed by ‘being kept informed about what was going on’ (43%) and having ‘medical staff to explain procedures fully’ (40%). Issues relating to privacy and dignity appeared in this survey to be thought less important to patients than was perceived by the Department of Health. Having ‘thoughtful and courteous staff’ (21%) and ‘decent food’ (18%) was marginally considered to be more important than ‘being in a single sex ward’ (17%).

With regard to the nurses’ roles, Henderson (1960) identified a need for nurses to help patients to understand themselves, to alter conditions that are contributing to illness and to accept conditions that cannot be changed. Henderson (1960) saw helping patients to learn, quite clearly as the role of nurses. She stressed the need for patients to help to plan their care and believed the more initiative taken by patients; the more successful the plan of care would be executed.

Social Interaction

Fundamentals of Care (Welsh Assembly Government, 2003) identified a need for the wishes of family, relatives and friends to be taken into account (although the first responsibility is to respect the wishes of patients). This government paper highlighted the importance of patients being able to receive visitors within reasonable hours but that this should be sensitive to the needs of others. It also recommended that patients are supported with verbal and written communication if separated from friends and family and that they should be put in touch with a visiting service from voluntary organisations if required. Priestley (1999) discussed the difficulties of meeting the needs of visitors to intensive care units, while Hupcey (2001) also wrote about the particular need for social support for critically ill patients in intensive care. Lack of social interaction has been found to have a detrimental affect on patients in hospital as described by Ward (2000b) who wrote about reducing psychological affect of isolation when patients have to be isolated because of infection. It should, however, not be assumed that all patients want visitors; this can be particularly difficult for palliative care patients (Thomas, 2001).

Motivation

Metcalfe and Klaber Moffett's (2005) study indicated that motivation (amongst other factors) helped to benefit patient outcomes. Bruckbauer and Ward (1993) looked at the influence of positive attitudes to recovery. McHarg (2007) considered that patients' mental attitude can affect recovery from illness or help patients cope with life threatening conditions. In the field of mental health, Song and Jason (2005) and Hadlow and Deacon (2007) also linked motivation with recovery.

Status of Review on Recovery

A review should aim to contain high level evidence gained through research. However, Glaser and Straus (1967) and Morse (1991) highlighted that qualitative research can be used to generate theory and it is therefore not always appropriate that each phase of the research is guided by existing theory. Evidence is not always available especially when undertaking qualitative research or exploring areas where little is known. In this study an attempt has been made to gather as much information as possible regarding recovery of patients following illness. Where research papers have been found, they have been cited but weaker sources of evidence, such as relevant expert opinion, have also been used to build up information regarding this subject. Unfortunately, there was little evidence relating to how patients themselves view the phenomenon of recovery. A gap in the literature thus provides a purpose for this study.

With regard to the status of evidence, there are three papers which have consistently been cited in this review. Although not research papers they are important to nursing and relevant to this study. The justification for focusing on these three theoretical nursing models is because the second stage of the literature review consistently led back to these sources. In addition, these models were the framework for nursing care in the setting that this study took place. It must be noted that this research took place in the context of general nursing in the United Kingdom. It would not be unreasonable to assume that other models could be more appropriate when exploring recovery in other countries and for example in the context of paediatric or mental health nursing.

In 1960 the International Council of Nurses secured the help of Virginia Henderson, to prepare the publication *Basic Principles of Nursing Care* (Henderson 1960). Her paper outlined activities of which basic nursing is composed. These activities have also been called the fundamentals of nursing. Henderson's intent was to describe the care that any person requires. She linked this care directly to the purpose of helping patients to recover as illustrated by the following quote:

> *"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible".*
>
> Henderson (1960) page 4

This study set out to explore patients' perception regarding what helps them recover from illness. The twenty main themes that respondents identified were all aspects of nursing care. This suggests that what nurses do is important to recovery. Subsequent to publication of *Basic Principles of Nursing Care*, two other publications influenced the way that nursing care in Britain was undertaken. These are *The Elements of Nursing* (Roper et al., 1980) and *Nursing Process: What is it?* (Heath and Law,1982).

Around 1980, there was a move in Britain to change from biomedical thinking, to a more individualised approach to patient care. Roper, Logan and Teirney published their model of nursing in 1980. Their first textbook titled the *Elements of Nursing* aimed to capture the 'elusive core of nursing' (Salvage 2006). Roper et al.'s (1980) model is made up of 12 'activities of living'. These are shown in **Table 2** where it can be seen that they resemble closely the 14 components of nursing care described by Henderson, on which their work was based.

Following on from the publication of Roper et al.'s (1980) 'activities of nursing', the nursing process was introduced in Britain in 1982. Health and Law (1982) wrote a short booklet *Nursing Process what is it*? The Nursing Process was and remains a logical and systematic approach to nursing care. Heath and Law (1982) also outlined that patients should be involved in their own care: this would enable retention of independence and control. They wrote that better relationships should be built between nurses and patients and that the patient's family should be included. Heath and Law's work signalled an important change of direction in nursing away from a medical model of care to care that was intended to be focussed upon patients and their families.

The framework put forward by Heath and Law (1982) was also based upon Henderson's (1960) edition of *Basic Principals of Nursing Care*, however Heath and Law list 12 components of nursing care rather than the 14 components identified in the Henderson's 1960 version. **Table 2** shows the comparison between Henderson's 14 components of nursing care and the 12 components put forward by Roper et al. (1980) and Heath and Law (1982).

It can be seen that the lists of components (elements, principles or basics) of nursing care are similar. The majority of items in these lists were also identified by respondents in the qualitative phase of this study as being important to recovery. The notable exceptions (not identified by respondents) were 'respiration/breathing' and 'body temperature' which are important aspects of nursing (and recovery) but relate to clinical signs and symptoms which are not necessarily considered important by patients. The above three papers have particular resonance with this study as the majority of components of nursing care identified by these authors were also themes identified by respondents in this study as being important to recovery. In addition, the hospitals where this study took place uses Roper et al.'s (1980) model of nursing care as the basis of the nursing assessment documentation and Heath and Law's (1982) nursing process.

Table 2 Components of Nursing Care

Henderson (1960)	Roper, Logan and Tierney (1980)	Heath and Law (1982)
1. Respiration	1. Breathing	1. Respiration
2. Eating & drinking	2. Safe environment	2. Nutrition
3. Elimination	3. Communicating	3. Elimination
4. Moving	4. Eating & drinking	4. Sleep
5. Rest & Sleep	5. Eliminating	5. Body temperature
6. Dressing	6. Cleansing &dressing	6. Mobility
7. Body temperature	7. Body temperature	7. Communication
8. Keeping clean	8. Working & playing	8. Hygiene
9. Avoid danger	9. Mobilising	9. Safety
10. Communication	10. Sleeping	10. Spiritual needs
11. Practice religion	11. Expressing sexuality	11. Educational needs
12. Work	12. Dying	12. Social needs
13. Recreation		
14. Learning		

Chapter Summary

The body has a natural capacity to repair and recover but this can be enhanced by medication, treatments and nursing care. Recovery has been shown to be a multi-dimensional phenomenon comprising social and psychological aspects as well as physical aspects. The complexity of how patients recover from illness has illustrated that patients need to be treated as individuals.

Most research undertaken with regard to recovery has been written by the medical profession or clinical researchers, this has included reporting results of clinical interventions based on a biomedical rather than a holistic model of care. The biomedical model has many successes, including beneficial outcomes from modern treatments. Medical/clinical recovery is measured by signs and symptoms that show patients' observations have returned to a normal range. This does not take account of the psychological or social aspects of recovery that could affect when a patient believes themselves to be recovered and are thus able to discard a sick role that they have adopted for the period of their illness.

A number of studies have shown that some patients do better than others following healthcare intervention, this could be because of differences in patients' expectations. Individual response to psychosocial factors such as motivation, compliance and an understanding of their condition also appears to affect recovery.

Working in partnership with patients was shown to benefit patient outcomes but there is evidence that giving patients written information is insufficient. Greater attention needs to be paid to reinforcing information and working more closely with patients. A criticism of some of these studies was that measurement outcomes were clinically driven rather than being decided by patients. There is also insufficient research available regarding patients views on recovery and on creating opportunities for them to be more involved in their own care.

The second half of this chapter focussed on themes and factors identified as important to recovery by respondents in the qualitative phase of this study. Results of a search on these themes revealed information on the importance of nursing intervention in helping patients to recover. The final section of this review highlighted the work of Henderson (1960), Roper et al. (1980) and Heath and Law (1982). Their work has particular resonance with this study and the way in which nurses can help patients to recover from illness. The next chapter (Chapter 4) continues with discussion about the importance of nursing by examining the role of nurses in helping patients to recover in a hospital setting.

CHAPTER 4

THE ROLE OF NURSES IN HELPING PATIENTS RECOVER IN A HOSPITAL SETTING

Overview of Chapter

This chapter is the final section of the literature review. In Chapter 2 we looked at the broader picture and examined literature which illustrated the importance of helping people to recover as quickly as possible from a severe illness. Chapter 3 then went on to look in more detail at factors that affect recovery. Chapter 4 now explores the literature with regard the role of nurses in helping patients recover in a hospital setting. This includes examination of the contribution of nursing knowledge, models of care and nurse/patient collaboration. The final section of this chapter then provides a summary of the entire literature review and concludes with a re-affirmation of the general aim of the study and how this aim will be achieved.

The Contribution of Nursing Knowledge to Patient Recovery

Nursing care of patients in hospital requires nurses to exercise their nursing knowledge in order to promote patient recovery. Chapter 3 focussed on Henderson's (1960) *Basic Principles of Nursing Care* and the model of nursing developed by (Roper. et al 1980), referred to as *Elements of Nursing* (also known as activities of daily living) and Heath and Law's (1982) Nursing *Process: What is it?.* These papers contributed to nursing knowledge; they described core fundamental components of nursing care that are transferable to any setting where nursing is carried out. Nurses continue to search for this essence of nursing.

More recently, Zarzycka and Slusarska (2007) examined 324 Polish nurses' perceptions. They used a survey questionnaire designed to measure the essence of nursing care. Findings show that these nurses considered the essence of nursing care to include: providing basic care as well as communicating, supporting, helping, assisting, accompanying and managing. It was suggested by

Zanotti (1997) that the essence and role of nursing is very much related to nursing knowledge.

Scott (2007) also stressed the significance between the essence and role of nursing and the relationship with nursing knowledge, suggesting that this relationship defines the professional status of the discipline of nursing and determines the relative emphasis given to practice development, theory and research. This view was also taken by Thompson & Watson (2006).

Mantzoukas and Jasper (2008) examined types of knowledge used when guiding care of hospital patients. Their work will now be examined in a little more detail as it has particular relevance with regard to the ward type environment for this research study on recovery. They undertook a secondary qualitative analysis of data gathered five years previously from 18 registered nurses employed on four different medical wards. Their findings were that five types of nursing knowledge were used by nurses in practice. These were personal practice knowledge, procedural knowledge, theoretical knowledge, ward cultural knowledge and reflexive knowledge.

Mantzoukas and Jasper (2008) concluded that the knowledge base from which nurses in their study appeared to work was reflexive knowledge. This knowledge being partly an amalgamation of the other four types of knowledge, which they identified. Reflexive knowledge enabled nurses to react to situations based on their previous experience. Mantzoukas & Jasper (2008) also stressed that the culture within which nurses work has an affect on how they practice.

With regard to Mantzoukas & Jasper's (2008) conclusions, they equated the features of theoretical knowledge and personal practical knowledge with Carper's (1978) concepts of empirical knowledge and personal knowledge. They suggested that procedural knowledge, ward cultural knowledge and reflexive knowledge relate to how nurses bring together their sources of knowledge in the practice situation.

Mantzoukas & Jasper (2008) described three distinct periods whereby common characteristics of nursing knowledge can be identified over time from the 19th century until today. They believed that the essence of nursing knowledge has evolved; first this consisted of abiding to a distinctive set of rules. They then described the second period in the development of nursing with the development of theories and a body knowledge as described by Meleis (1997) and Fawcett (1993). The final period in the development of nursing, Mantzoukas & Jasper (2008) believed, is an attempt to 'debunk' previous theories and for nurses to interrogate previous methods of knowledge production and for each practitioner to develop an enquiring attitude. This line of reasoning does not entail discarding all previous knowledge but to be critical.

It is interesting that Mantzoukàs & Jasper (2008) considered that nursing knowledge has evolved and grown in this way and yet they acknowledged that it is unclear how these different types of knowledge are put into practice and how they affect the care of patients in hospital. Certainly the period they described, which commenced in the 1950's, linked into the time period when Henderson (1960) described the fundamentals of nurse care (see Chapter 3, p39).

The work of Henderson (1960) and others (Carper, 1978 and Benner, 1984), subsequently became the basis of knowledge upon which nursing is currently practiced. Whilst there is much room for further expansion of this argument, time prohibits this here, other than to say that there appears to be an essence of nursing (which refers to fundamental aspects of nursing care/practice) and an essence of nursing knowledge, which refers to the accumulating body of nursing knowledge over the years.

There is an assumption that today practicing nurses are critical about the knowledge they use (Nursing & Midwifery Council, 2008). Perhaps reflexive knowledge is therefore the most appropriate knowledge base to work from. Knowledge does not however always transfer itself into practice. Indeed there are those who believe there is a wide knowledge practice gap (Scott, 2007). There is also a perceived gap with regard to the use of nursing models in clinical practice (Salvage, 2006).

This must in turn raise the issue of whether models currently in use are best suited to achieving patient recovery in a hospital environment. Whilst this section of the literature review is predominately about nurses' contribution to patients' recovery in hospital, it must not be forgotten that nurses provide care in the context of a multi-disciplinary team. Some time will therefore be spent considering models in general, before looking in more detail at nursing models.

Models for Health Care

As this study was ward based in an acute District General Hospital, all patients were admitted under the care of a doctor. This is usually for diagnosis and treatment. It could however be argued that the reason patients are admitted to hospital, is because they are unable to manage the symptoms and/or effects of their illness at home and therefore need hospitalised nursing care. Rationale for this argument is that most diagnostic tests and medical consultations take a very small proportion of a 24 hour day and if it were not essential that patients have nursing care they could be treated at outpatients or by their own GP.

Patients in hospital need varying degrees of nursing care. This is during the period that they are not able to independently carry out their basic activities of daily living. Whilst predominately needing nursing care, patients are admitted to a hospital under the care of a medical consultant. Patients however need more than physical care, the role of the family is important and the contribution from a range of disciplines is often required (Biswas, 1993; Walmsley, Northledge and Warner, 2005; Watson and Northledge, 2008).

The medical model of care has been criticised for not being holistic. Chapman (1990) agreed that such criticism may well be justified and suggested that developing an elitist nursing profession is not helpful to patients. Hardy (1986) questioned whether professions have served the public well by utilising models. This view was endorsed by Cronenwett (1983) who concluded in a research study that the nursing models and definitions used in the study, implied that a medical model approach was used by nurses. Cronenwett queried the effectiveness of any model whereby problems are defined solely by helpers (nurses). Clarke (1982) stressed the importance of having an independent identity for nursing and not seeing nursing as a collection of tasks initiated by doctor, thus perpetuating the medical model of care.

This is not, however, just an issue of whether a medical or nursing or therapist model is best. Models reflect the things that are done to patients. Doctors diagnose and provide a plan of treatment, nurses assess patients' total needs and put an appropriate plan in place. Similarly with therapists and any other members of a multi-professional team who have input into an individual patient's care. The models ascribed by individual disciplines in the team will reflect the tasks they have to undertake to return a patient back to optimum health. Each model will exhibit underlying assumptions. The important issue here is that this elitist quest for different and unique models should not distract from the purpose of all disciplines, namely to focus on and do what is most appropriate for patients.

Although nurse practitioners who are experienced may not require a model or a framework with which to give good nursing care, a collective approach helps to prevent discontinuous care and helps to maintain an agreed approach to care (Jones, 1999; Garbett, 1996). It is also important to clarify the aims and outcomes of care agreed by the multidisciplinary team. Whilst there is a danger of being considered reductionist by using models, pathways or protocols to guide care there is a need for a system, highlighted by Garbett (1996), to identify what is required by professionals for patients' care. It is therefore appropriate to explore the use of nursing models further.

The Relevance of Nursing Models Today

Some writers consider that the terms 'model' and 'theory' are synonymous. Newman (1979) wrote that this lack of precision is not appropriate to a discipline that is concerned with being more scientific and suggests that the terms are so vague that they have little meaning. Newman was writing at a time when these terms were relatively new but this ambiguity has persisted through the years. For example Chapman (1990) when writing about nursing models volunteered that the term 'nursing model' is any set of concepts that he called a model in his writing. Melius (1997) also picked up this uncertainty and informed that frameworks, models and theories have been used interchangeably and freely and can refer to any conceptualisation of nursing reality. Melius continued that an example of a model is when the study of one system is based on the study of another and can be said to be modelled after it.

Kershaw and Salvage compiled their first papers on nursing models in 1985 (Kershaw and Salvage, 1986). They noted that an interest was accelerating in relating theories to practice and that this was a novelty in Britain at that time. They wrote that nurses should not feel guilty about not using a nursing model and stressed that many other approaches to nursing practice could be justified. They wrote that the experience of nurses introducing change found that it should be regarded as a process rather than a product. The process of examining and defining values and examining current practice provides a fresh focus of practice interest. This opens up channels of communication and could bring associated benefits to both nurses and patients.

For the purpose of this research study, a model is regarded as a system that is modelled or based upon another theoretical system. There are many models of nursing care in the literature and nursing care at the practice level is often based on (modelled after) these, for example Rogers (1970) and Roy (1984). It must be noted that both Rogers' and Roy's models specified underlying assumptions that are needed to be taken on board before adopting their models. Assumptions being regarded as statements assumed to be true without proof (Melius, 1997). Rogers identified five underlying assumptions and Roy identified eight. As with any conceptual model, it is argued that underlying assumptions are particularly relevant when undertaking ward based nursing. It is not just a case of which model is used but how it is used and the underlying philosophy of how care is delivered in that particular area. The model of nursing care used on wards where this study took place was based on Roper et al.'s (1980) 'Elements of Nursing' or 'activities of daily living'.

As identified in Chapter 3, Roper, Logan and Tierney published their model of nursing in 1980 (Roper et al., 1980). This was with a purpose of moving towards treatment of patients as individuals rather than carrying out tasks and following hospital routine. However, the extensive adoption of theoretical models in the nursing profession has been reported to be of concern. Hardy (1986) noted there was little resistance to this 'blanket adoption' in 1986.

Clarke (1982) believed that however poor and inadequate a model might be it identifies nursing as having a distinct identity of its own and is different from similar activities. This stance was supported by Chapman (1990) who argued that the case for developing and using nursing models rests on the assumption that the practice of nursing care ought not to be based on theories from other disciplines. He continued that 'borrowing' theories is not consistent with the development of a unique nursing science as the basis of an independent profession.

It could be argued that in a hospital ward environment, the use of a model may or may not be important to maintain nurses' identity. What perhaps is more important (and questionable) is whether having a defined model of care in place is important to patients. McAllister (2007a) asked the question 'Does nursing really matter?' She then went on to argue that if the answer is yes, then so do nursing models. McAllister (2007a) believed that nursing has a unique identity although she acknowledged that it shares its borders with other disciplines. Because of this believed uniqueness McAllister has contributed to the development of a different model of nursing called 'solution-focused nursing'.

As editor of the publication 'Solution Focused Nursing' she has joined other like minded academics from Australia, Britain and America to put forward a new and different model of nursing which focuses on solutions rather than problems. This patient focused approach to care puts the person not the problem at the centre of enquiry. The model is based on collaboration between nurses and their patients. The nurse's role is more than care of ill patients but also a proactive approach towards adaptation and recovery.

McAllister (2007b) described transitions as being choices that patients need to make. She believed that the role of the nurse is to explain these choices to patients so that they are able to make informed decisions and she described this process as facilitative, participatory and respectful. The work of the nurse in this situation is to interpret complex health information into a format that patients are able to understand.

This model would appear to be more patient focussed and it certainly stresses the importance of nurse/patient collaboration. Implementation of this model however assumes that time is available for nurse/patient participation. Undoubtedly there are certain essential tasks required of nurses in a hospital ward environment. These are reflected in Roper et al.'s (1980) activities of daily living which guide what nurses need to 'do' for patients.

Jones (1994) commented that nurses have neglected theory and have become obsessed with 'doing'. This has resulted in no commonly accepted model of nursing. Perhaps it has also resulted in a lack of innovation in developing new models to suit patients' contemporary needs. It is suggested that the development of such models should include patients and also members of the multi-disciplinary team. Hunt (1983) also recognised that most patients receive health care from a team of more than one type of health care profession. This implies that the team is working to a common goal dependent upon the individual needs of each patient.

Hunt (1983) pointed out that one individual may have a lack of knowledge or experience but that interrelated workers in a team can eliminate these deficits. Jones (1994) asserted that each discipline will have a model in their 'heads' when working and that allows individuals to function effectively in the multidisciplinary team. Jones suggested that nurses' inability to become equal members of a multidisciplinary team may be partly solved by them agreeing a practical model and making this clear to the other disciplines. This argument was also made by Pearson (1986) who claimed that the contribution of nurses will not be valued or their expertise understood if they are unable to establish their distinct role within the team.

The problem with both Jones and Pearson's argument is that this assumes that practising nurses (as opposed to nurse theorists) understand their model of care and are able to explain it to others. This assumption appears however not to be justified in all cases as there is evidence in Chapter 2 that it is questionable whether some nurses actually understand the term ‘model’ which would make it difficult to explain to others. Pearson’s (1986) and Jones’s (1994) argument also assumes that each member of the multidisciplinary team does not know what other members do which is highly unlikely in a professional team who work together on a regular basis. There may, however, be an area of uncertainty regarding the philosophy behind how people carry out their professional duties and how those philosophies fit together.

There is also an assumption here that each distinct discipline has its own unique model of care that is transferable in any situation. The probability is, that whilst certain basic fundamentals are always present, the model of care must be adapted to adopt the cultural beliefs of both staff and patients and the context in which care is carried out. Certainly if nursing has so many models which are not understood by nurses, there will be difficulty in transferring this information to others and there appears to be little evidence whether it matters to patients.

Jones (1999) claimed that nursing models are not integral to patient care and suggested that they are an unnecessary academic exercise that increases nurses’ workload. She described protocols, standards and pathways as being able to guide the expectations of purchasers and providers of healthcare as well as patients. These are able to quantify the material and human resources needed to deliver care. As a result they may be considered reductionist rather than holistic. Jones (1999) suggested that this reflected the current status of health care provision. She noted that the concept of holism being central to nursing models is not apparent in the current health care system.

Walsh (1994) highlighted that effective assessment is necessary if individualised patient care is being practiced and that nursing models give a rational structure to this process. He stated that if a careful assessment is not undertaken then professional care cannot be delivered. Walsh however acknowledged the time that a well documented assessment takes and cited this as a possible reason that the nursing process didn’t work; he also blamed poorly designed documentation.

From a simplistic perspective, it could be argued that nursing entails the physical, psychological and social care of patients with regard to the fundamentals of care articulated by Henderson (1960) and endorsed by Roper et al.'s (1980) activities of daily living. Models appear to be in use in most clinical settings, often they are prescribed by managers or nurse theorists rather than ward based nurses themselves. This could explain Jones's (1999) belief that the value of nursing models is not shared by all.

A model can perhaps best be described as an 'aide memoire' for nurses which enables them to have a template for patient assessment. This helps to provide a systematic and logical approach to assessing what each patient requires. Although not an overarching aim of this study, it will be interesting to see if the model of nursing used by the wards in this study: which is Roper et al.'s (1980) activities of daily living; reflect the care given to patients in this study. It will also be interesting to see whether the nursing staff on the ward will want to revise the model and/or any assumptions underlying that model, after results of the research have been disseminated.

If one accepts the above reasoning then a model should accommodate all patients' needs. This will include the need for information. The need for patient information and the role of the nurse in providing this was acknowledged by Henderson (1960). However, the importance of ensuring that each patient has sufficient information for their needs seems to have been given less importance over the intervening years. It is relatively recently that the need to provide patients with more information has come to the fore.

From a nursing perspective it is perhaps of particular note that the most recently issued 'code' (of professional practice) for nurses and midwives (Nursing and Midwifery Council, May 2008) has a specific section dedicated to collaboration (with those in your care). The wording of this code is particularly interesting whereby each item of the code is preceded by the term 'you must'. This clearly indicates that provision of information and collaboration is not an option but a duty of care in the year 2008.

Nurse/Patient Collaboration

A vital component of nurse/patient collaboration is the provision of information. Ensuring that patients' information needs are met has taken on more prominence in recent years (as discussed in Chapter 2.) From a nursing perspective however the need for patient information is not new. Henderson (1960) identified that helping a patient to learn is a fundamental principle of nursing care but studies undertaken in the 1960's drew attention to deficits on the part of health care professionals to satisfy patients teaching needs.

Cartwright (1964) writing about hospital care highlighted that patients did not think that the information they received in hospital was sufficient. It was also thought to be contradictory and confusing. This point of view was also endorsed by Duff and Hollingshead (1968). Simonds (1979) made the point clear that 'teaching' and 'patient education' are different. Teaching refers to the imparting of information whilst education is a process whereby patients' behaviour is influenced. This in turn produces a change in not only knowledge but in attitude and skills. These are required in order to improve and maintain health.

Sechrist, also in (1979) stressed that patient education is an important aspect of total patient care. Patients require information relating to their health care in order for them to regain their health and prevent further episodes of illness. Price (1984) considered patient education an essential component of the rehabilitation process whilst Carter (1994), believed that it is essential that information presented to patients is understandable and is individualised.

Dodge (1969) identified the importance of patients getting information that meets their particular needs especially as patients in hospital are usually under stressful conditions. Lauer, Murphy and Powers (1982) highlighted a difference between patients' and nurses' perceptions of learning needs. This was reinforced by the findings of Tilly, Gregor and Thiessen (1987), who also undertook a comparison of nurse and patient perceptions with regard to information and found differing views.

Henderson, Van Eps, Pearson, James, Henderson and Osborne (2007) highlighted the importance of nurses developing meaningful relationships with patients but recognised that increased workloads and staffing levels makes this difficult. Provision of relevant and appropriate information is a complex process. It involves developing a relationship of trust with individual patients. It would appear that patients feel ‘cared for’ when this type of relationship develops. A difficulty however, arises when time constraints prevent this nurse/patient interaction and more physical aspects of care are then prioritised before relationship development.

Dingman, Williams, Fosbinder and Warnick (1999) advocated implementing a caring model to improve patient satisfaction. They identified certain caring acts including providing patients with information, treating them with respect and showing concern. McCance, McKenna and Bloore (1997) identified four critical attributes of caring: ‘serious attention’; ‘concern’; ‘providing for’ and ‘getting to know’. Savage (1995) believed that physical presence helps with the establishment of rapport that assists ‘getting to know’ patients in a hospital setting.

With regard to nurse/patient collaboration, Caris-Verhallen, de Gruijter, Kerkstra and Bensing (1999) stressed the need for effective communication such as paying attention and providing appropriate feedback. Bassett (2002) however, wrote that competency in the performance of tasks and physical skills is highly regarded by patients. This point of view is in contrast to nurses who frequently rate humanistic behaviour as more important (Savage, 1995).

Collaboration is perceived to be important but this takes time and this is not helped by the current trend for increased health care demands. Maben, Latter, and MacLeod (2006) wrote about the theory practice gap and the work conflict that this presents to newly-qualified nurses. They continued that bureaucratic demands including resource and financial constraints limit the ability to practice closeness with patients. As a result the relationship basis of nursing has difficulty in being developed sufficiency for nurses to anticipate patient needs. This view was also supported by Fingeld-Connett (2007) who stressed that the working environment must allow the process of caring to occur.

Lumby and England (2000) undertook an Australian study and found that nursing staff's ability to deliver services dependently and accurately was perceived to be most important to patients. Staff willingness to help patients and provide a prompt service was perceived to be the second most important feature. The importance of nurses being responsive to patients needs has been well documented. When examining patients' expectations of health care, nurse responsiveness has been found to contribute significantly to patients' feeling of wellbeing regarding their care and also their feeling of safety (Irurita, 1999; Middleton and Lumby, 1999).

The research undertaken by Henderson et al. (2007) included nurse/patient observation. It was observed that patients' immediate needs were mostly attended to in a timely manner. These included hygiene, nourishment, mobilising and pain relief. Trends however emerged, from the questionnaires in this study, that indicated that the length of time nurses took to answer the bell and availability of nursing staff when you needed them scored poorly with patients. It was reported that patients appreciated that nurses could not always spend time with them due to their organisational demands. However, patients still thought that nurses should be available when requested. The findings of this study also suggested that patients believed nurses demonstrated that they were caring when they responded to specific requests.

The overall conclusion of Henderson et al.'s (2007) study was that nurses need to spend more time communicating with patients, particularly providing them with information about what to expect from the nursing ward routines. It is also important that nurses provide information regarding times when the nurses will talk to patients about their conditions. It was suggested that nurses need to balance their organisational duties and paperwork in order to give sufficient time to patients. There was, however, acknowledgement in this paper that increased workload and organisational demands are at conflict with the delivery of patients care. Henderson et al.'s (2007) comments about increased workload can be seen to be supported by other literature (Walsh, 1994; Maben, Latter and Macleod, 2006), however, Henderson et al.'s (2007) results must be viewed with caution.

Whilst the academic standing of the researchers is high, the response rate from the questionnaire was 24% (31 respondents).

Despite a deficit of hard evidence regarding the effectiveness of how patients are provided with information, much is written regarding nurse/patient interaction Johnson and Smith (2006). Three main areas were identified by Fosbinder (1994). These are: getting to know you, translating and expert compassion. Getting to know you includes being friendly, having humour and personal sharing of information. Translating includes instruction and teaching, informing and explaining. Expert compassion includes having a genuine concern for the patient.

Ideally one would like to believe that all of these facets of nurse/patient interaction are present in every nursing situation but the reality is that they may come second to more core elements of patient care described by Roper et al. (1980) and discussed in Chapter 3. This leaves a deficit regarding provision of information and also the more complex process of achieving nurse/patient collaboration in a hospital ward environment.

Collaboration and involvement of patients in their care has been a key theme throughout this study. As previously discussed there seems to be barriers to this happening. Tee, Lathlean, Herbert, Coldham, East and Johnson (2007) reported on a study aimed at increasing patient participation in clinical decisions. They found many factors which inhibited participation including staff using a paternalistic approach especially where diagnosis became the principle basis of clinical decisions. In contrast factors enhancing occurrence of participation included staff respecting and recognising user ‘expertise’ about their own illness.

The need for greater partnership between nurses and patients has been seen to reflect a change of view from decisions based on professional values to reflect the values of patients (Woodbridge and Fulford, 2003). There is a general aim in several countries to increase patient and public involvement in service design and service delivery with a view to greater transparency of public services. Getting the public involved in the democratic process of service evaluation is also important and helps to reduce inequalities in health and promote citizenship (Rose, 2002; Happell, Pinikahana and Roper, 2002).

Woodbridge and Fulford (2003) believed that whilst models may differ in their theoretical stance, they share a common focus to practice clinical decision making based on evidence, sound reasoning and transparency. Roycroft-Malone (2004), however, noted that there is variation on the value placed on different sources of evidence and went on to conclude that nurses need to be aware that their beliefs about evidence can influence their decision making. This could also include whether or not they decide to include patients in their decision making process. Rycroft-Malone advocated a framework for decision making that uses the patients experience as a 'strand' of the evidence to be considered when making decisions.

Tee et al. (2007) however pointed out that evidence derived from patients is qualitative whilst 'best' evidence is derived from quantitative methods. One could argue however that as each patient is an individual (albeit with similarities within disease groups) qualitative rather than quantitative evidence is more pertinent to that individual. Tee et al. (2207) found in their study using 17 participants that there were universal factors that should be displayed by professionals in the process of collaborative decision making. There are genuineness, kindness, civility and respect. As with all small studies, the results are not necessarily transferable, however these types of qualities are usually regarded to be an essential component with regard to the duty of care of nurses.

Perhaps while in hospital, nurses and other members of the Multidisciplinary team feel that it is 'their territory'. It is documented that patients may feel apprehensive and powerless when in the alien environment of a hospital ward (Dodge, 1969). Professionals may think that they do not need to consult patients because doctor or nurse knows best and indeed some patients may feel this way too (Waterworth and Luker, 1990). However, when patients are preparing for discharge, this is an area that professionals have less knowledge and therefore start to adopt a more participative approach with patients. Good communication has been cited as an essential component of participation between healthcare professionals and patients with regard to discharge planning (Olsen and Wagner, 2000; Carroll and Dowling, 2007).

While there is currently a focus on patient involvement this could possibly put patients in an uncomfortable and compromised situation, especially if they feel that they are in the presence of experts and think that their contribution about themselves is unimportant. This was found in a study by Efraimsson, Sandman and Rasmussen (2006) whereby patients felt uncomfortable due to their perceived lack of knowledge.

Communication is consistently cited as a vital component of person to person interaction be it health professional to patient or between members of a multidisciplinary team. Efraimsson et al. (2006) found that the term 'communication' is often used so loosely that it does not define what is to be communicated e.g.:

- Information to patients about what will happen to them
- Information about their illness
- Information to their family
- Listening to the patient and acting upon
- Collaborating with the patient and enabling active participation.

The Nursing & Midwifery Council (Nursing and Midwifery Council, 2008) describe giving of information under the heading of 'Collaborate with those in your care' and state:

> *"You must share with people, in a way they can understand, the information they want to know about their health".*
>
> (Nursing and Midwifery Council, 2008, p.3)

The NMC also highlights the importance of information under the heading 'Treat people as individuals' and state:

> *"You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support".*
>
> (Nursing and Midwifery Council, 2008, p.2)

With regard to collaboration, also included in the Nursing and Midwifery Council 2008 code, is the directive that nurses must: listen to people in their care; support people in caring for themselves; recognise the contribution that people make themselves to their own care and make arrangements to meet peoples' communication needs. All of which assumes that people want to have this level of involvement in their own care. As people are individuals with differing perspectives, this may not be the case.

In a small study, Waterworth and Luker (1990) questioned whether patients wanted to be involved in decision making regarding their care. In their study, using grounded theory as the method, they held in-depth interviews with 12 patients. Their findings suggested that some patients were more concerned with doing what was right and pleasing the nurse than they were in participating in decisions about their care. From a patient's perspective being involved could increase their feeling of self worth. However Waterworth and Luker's findings were that patients were not keen to participate in decision making and just wanted to 'stay out of trouble'. Waterworth and Luker's (1990) views, written in 1990, may not hold true today as patients' perceptions change over time as do cultural norms. Their study also had limitations of not being generalisable; this is an area therefore that deserves further investigation.

Writing in 1993, Kenny (1993) agued that nurses still need a set of explicit concepts to help guide their practice. He identified key ingredients that are relevant over the years and helpful to nurses in planning delivering and evaluating care. These ingredients are: individuality, holism, patient/nurse collaboration and patient/family education. The key point perhaps to bear in mind here is that each patient is an individual and will have individual and perhaps unique information needs. Nurses therefore have to respond individually to these needs and in setting individual patient goals with regard to them.

Ekman, Schaufelberger, Kjellgren, Swedberg and Granger (2007) defined the concept of concordance as mutual goal setting. In a study consisting of 56 respondents they set out to explore patient information needs with regard to prescribed medication. Patients who attended heart failure clinic completed a questionnaire: 'Satisfaction about Information about Medicines Scale', at their first and last visit. Patients' scores indicated more satisfaction with their information level at the final visit compared to the first visit.

Interestingly, seven nurses who also took part in the programme rated patients to be appropriately informed at their final visit whilst patients reported a need for more information. Unfortunately, the small number of respondents again casts doubts on generalisability. In this study specially trained nurses discussed medication taking with each patient. Both verbal and written information were also given. This included what the medication was for, the effects, side effects and how it worked. Patients' individual questions were also answered. The scale used for this study was a standard instrument and Cronbach's alpha determined that internal consistency varied between 0.86 and 0.91 for each of the sub scales.

Most variation between nurse and patients was with regard to 'action and usage of medication'. Here nurses perceived patients to be more satisfied than the patients' scores illustrated ($P<0.000$). The nurses scored patients' information needs to be non-existent or low at their final visit whilst patients still perceived that they had a need for more information. Possible reasons for this divergence of perceptions were explored and it was concluded that a possible reason might be that nurses may be unsure of the answers to some patients' questions and therefore may respond in a general or vague manner. Ekman et al. (2007) concluded that patients must feel that they have been satisfactorily informed.

There appears to be a difficulty in patients being able to express their information needs. While patients may report satisfaction with levels of communication with health care professionals, at the same time they want greater involvement in treatment decisions and with information but they fail to express these needs (Gray, Rofail, Allen and Newbury, 2005; Riegel, Moser, Powell, Rector and Havranek, 2006). One could argue, however, that all communication is a two way process and that staff fail to help patients express their needs or as described earlier; time and resource prohibit effective communication. The attitude that staff adopt could also adversely affect patient lines of communication.

There is evidence that attitudes adopted by nurses towards patients could possibly have a significant effect on patients' recovery. For example with regard to cancer patients, O'Baugh, Wilkes, Luke and George (2008) concluded in a qualitative descriptive study, that a positive attitude by nurses can assist with the success of patient treatment. This supported the work of Koopmeiners, Post-White and Gutknecht (1997) who found that nurses can influence patients' perceptions regarding hope. Valliot (1970) and Herth (1990) also found that nurses behaviour can inspire and strengthen patients hope as they usually have most contact with patients.

Whilst it can be seen that the role of nurses is to encourage patents to recover, it must be remembered that both nurses and patients are individuals with possibly different meanings associated with having a positive attitude. O'Baugh et al.'s (2008) study included just eight respondents and there is no indication that their work can be generalised. They even found difficulty in defining the concept 'positive attitude' because it means different things to different individuals. Worryingly, in this study by O'Baugh et al. (2008), nurses labelled some patients as taking on a 'sick role,' showing no consideration of any underlying factors that might affect patients' motivation. O'Baugh et al. (2008) concluded that nurses should support patients' ability to express hope and be positive but this must be based on patients' values and beliefs rather than the nurses.

Staff attitude can also include how cheerful and friendly staff are with patients. It has been suggested that humour may moderate the effects of stress (Martin, 2006) however McCreaddie and Wiggins (2008) reported that nurses believe that humour should be used with caution. Whilst cheerful staff could have a positive affect on patients; proactively motivating patients could also have an impact on their recovery as identified by Brodie, Inoue and Shaw (2008), who found that motivational interviewing was beneficial when used in a randomised controlled trial. Results of their study indicated that participants with chronic heart failure achieved a general trend of improvement in self efficiency and motivational scores ($p<0.05$). Again, however, this is an individual situation as it could be quite wrong to motivate patients in some other situations. It is therefore important that nurses discuss patients' needs with regard to interventions that would be appropriate for the individuals concerned.

It can be seen that honesty and openness must play a part in this nurse/patients interaction. Nurses can have a major influence on how patients feel in hospital because they are with them day and night. It would be quite inappropriate of nurses to adopt a positive attitude to patients' illness and to foster false hope when a patient is unlikely to recover. This view is supported by Rittenberg (1995) who argued that it is wrong to force patients to adopt a positive mental attitude as this could prevent then facing the reality of their illness. De Reave (1997) also supported this and wrote that patients, with cancer, for example, suffer moral and psychological pressure to think positively about their illness. Again the point is reiterated that what is right for one individual is possibly not right for others. This supports overall findings of the literature review; that with regard to recovery of patients, each patient is an individual and there is a challenge for nurses to meet these individual needs.

Summary and Conclusion of the Literature Review

In conclusion the literature supports that the speedy recovery of patients in hospital is important, this area therefore deserves further examination. Chapters 2, 3 and 4 focussed on a review which provided a background and gave justification for this study. When examining the process of recovery, much has been researched with regard to clinical medically focussed recovery from illness. There is however an apparent gap in literature with regard to more holistic factors that could affect recovery, this will be pursued.

There is also evidence of ageism existing in the NHS and this too deserves further exploration. When looking at recovery of people in hospital it was considered important to include establishing perceptions of older patients with regard to recovery and if older people received a lesser standard of care than other adult age groups.

As the purpose of nursing is to help with patient recovery, examining ways in which nurses can achieve this effectively will contribute to nursing knowledge and improved care for patients. This line of reasoning assumes that if nurses have knowledge, they will apply it in their practice. There is, however, evidence to suggest that this is not the case and that a theory practice gap exists. Time in this study will therefore be devoted to examining how well nurses meet patients' perceived needs.

The literature makes it quite clear that there is an expectation of health care professionals to provide patients with information. In particular as a component of their 'code of conduct' nurse must take active steps to collaborate with patients, and share with them any information patients want or need to know about their health. Whilst there is much evidence and there are government directives that patients should be enabled to collaborate in their care, there is also poor and dated evidence that they may not want to be involved. There must be a question here whether it is only the government and theorists that believe patents should be involved. There is a gap in the literature of good evidence to suggest the actual degree of involvement that patients want and this will be explored in this study.

Reaffirmation of the Aim of the Study and How These Aims Will be Achieved

The main aim of this study was to ask and establish what patients perceived would help them to recover from severe illness. Having established factors that patients perceive could help with their recovery, it was considered appropriate to establish if these perceived needs were met during patients' stay in hospital.

A secondary aim of the research was to help nurses and other professionals have a greater understanding of what patients perceive to be important. This could help them to be more attuned to patients' needs when undertaking a nursing assessment and when planning care. Understanding patients' needs could also help to check the appropriateness of the model of nursing used by nurses in this study.

The research questions for this study were:

1. What factors: do adult patients perceive could help them recover from severe illness?
2. Does care given in hospital meet perceived needs of patients to help them with recovery?

3. Are perceptions of older people (over 60) with regards to recovery different from other age groups?
4. Is there any evidence that older people do not have their needs met as effectively as other age groups?
5. Do patients perceive that it is important to collaborate with nurses and other professionals and to be partners in care?

An attempt to realise the aims of this study and answer the above research questions is described in following chapters.

CHAPTER 5

METHOD SECTION (QUALITATIVE)

Overview of Chapter

This study used mixed methods to collect data, namely: interviews and focus groups and a questionnaire. The first phase of the study, phase one, was intended to investigate respondents' perceptions of factors regarding recovery from an illness and was therefore largely designed to produce qualitative data. Phase two was intended to investigate how many people agreed with the findings from phase one and therefore would produce quantitative data. Research design for phase two is provided in Chapter 7. A description of the research design for phase one is now given; this includes discussion regarding the use of mixed methods and strengths and weaknesses of design.

Target population, sample and description of the setting is also provided. There is a discussion of ethical issues that were considered in the study including issues regarding informed consent and the measures taken to ensure that patients' rights were upheld. This is followed by a description of data collection before going on to describe how the data were analysed; an explanation of the thematic content analysis of the qualitative elements of the study is also included. The method section is concluded with discussion of validity and reliability.

Methodology

In describing the design of this study, it is considered appropriate to spend some time discussing the paradigms behind the chosen methodology in order to justify why this was used. In this study both qualitative and quantitative methods of data collection have been utilised. It is acknowledged that there is a dichotomy between qualitative and quantitative data, however, there is increased acceptance of methodological pluralism (Parahoo, 2006).

The purpose of this study was to find out what factors help patients recover from illness, from patients' perspectives. Literature suggests that this is an area where little is known, there was, therefore, a need to explore and delve into the phenomenon of recovery with an open mind. A strength of qualitative research is its potential to gain a greater insight into a phenomenon by gaining a rich wealth of information. This type of research has traditionally been used by anthropologists to gain a greater understanding of mankind.

Mitchell and Cody (1993) suggested that if nurses want to expand nursing knowledge then interpreting findings from a borrowed theory will not help to advance the discipline of nursing. Leveine (1998) however took the view that the rich reservoir to be found in the knowledge base of other disciplines can contribute to an understanding of human life. Also that trying to capture the wholeness of an individual can help to understand the tasks required of nurses. For the purpose of this study, the stance is taken that nursing is a social activity. It is further argued that when enquiring into the nursing contribution to patient recovery, borrowed theory is regarded as a valuable contribution to the understanding of this phenomenon.

Purists have argued that qualitative and quantitative research studies represent two incompatible paradigms. Rossman and Wilson (1985) noted that it is also a matter of different ontologies. This is in contrast to Polit and Hungler (1999) who argued that some areas of enquiry can be enriched by the blending of methods. This was supported by Connelly, Bott, Hoffart and Taunton (1997) who found that multi-method research aided theory building and that triangulation resulted in a more complete understanding by eliciting new dimensions. Rosswurm, Dent, Armstrong-Persily, Woodburn and Davis (1996) also used multi-method research to good effect, for exploring how cultural influences affected illness experiences.

Method

The research design used was a mixed method; findings from the qualitative phase one were subsequently used as a basis for the quantitative method used in the second phase. This method was successfully described by Green and Caracelli (1997). For the qualitative phase of this study, interviews and focus groups were undertaken, to collect the required information. Interview data were collected from individual respondents using focused semi-structured interviews. All interviews were recorded using a discrete tape recorder and tapes subsequently transcribed. Pilot interviews were undertaken before commencement of actual data collection in order to ensure familiarity with the resources.

Similarly for the focus groups, all sessions were taped and subsequently transcribed. Focus group discussion was channeled towards factors that help recovery of patients while in hospital. Pilot focus groups were undertaken to gain practice in the use of the equipment and to test the enquiry in a group setting.

Qualitative methods allow the collection of rich data which could give valuable information regarding factors that affect recovery. It is acknowledged, however, that data will comprise individual perceptions that may not be generalised to a population. Results could also be considered subjective (Polit and Hungler 1999). In order to offset this criticism, great attention was paid to ensuring the trustworthiness of this section of the study as recommended by Rudestam and Newton (1992). This trustworthiness was based on utilisation of member checks and a robust audit trail. Member checks were used as a method of validating the credibility of the data via post interview discussions with informants.

The importance of logistic considerations as described by Lincoln and Guba (1985) was taken on board when planning the method for this study. It would have been difficult to set up additional meetings with the same participants. A debriefing discussion therefore took place immediately after each interview and focus group. This debriefing consisted of checking with participants and reaching agreement with them on the main issues that had been revealed during interviews and group work.

The content of the taped recordings of each meeting was subsequently transcribed which enabled systematic collection of data. This allowed two other people (other than the researcher) to draw conclusions about the data which contributed to the audit trail.

Description of Setting

Settings for both phases of this study were the same: a district general hospital and a nearby community hospital in Wales. In-patient services provided at the district general hospital included: general medicine; general surgery; orthopaedics; elderly care; oncology and palliative care; and gynaecology. Care provided in the community hospital was mainly for older people. The county in which this hospital is set has a varied population. There is a mixture of affluence and urban/industrial areas of social deprivation.

With regard to overall population health; deaths are a key indicator because they provide an indication of general health within communities. In the county where this research took place deaths, from all causes for all ages 2001 – 2003, were within the average range for Wales. However, it was noted that unemployment and death from road traffic accidents were higher than the Wales average. Life expectancy at birth for males was within the Wales average at 76 years; life expectancy at birth for women was within the Wales average at 80.5 years (Health Information & Intelligence Team, 2006).

Identification of the Population and Sample

The overall purpose of this study was to explore patients' perceptions regarding factors that help with recovery from illness but during the qualitative phase of this study, a wider stakeholder group was utilised. Not only patients but other health care professionals' views were elicited. The rationale for this was that patients may not always talk about things that they take for granted and therefore might not identify these issues as important. However, on a daily basis, other health care professionals observe patients recovering from illness and could beneficially contribute to this area of enquiry.

Patton (1990) identified discrete strategies within theoretical sampling. These were helpful when considering the optimum sample plan for this study. The purpose in developing the sampling plan was to specifically meet the demands of the enquiry in hand. Two of Patton's strategies have been used; these are maximum variation sampling and homogonous sampling. Maximum variation sampling is a method whereby the participants are purposely selected in order to provide diverse views and perspectives. This is in contrast to homogonous sampling which aims to reduce variation whereby interviews can be conducted with groups of similar individuals.

For the interviews, enrolment included participants who represented different views and perspectives as described by Patton with regard to maximum variation sampling (1990). These participants included patients, nurses, a physiotherapist, an occupational therapist, and health care support workers. In addition homogonous sampling was also employed in the study so that focus groups and group interviews of patients groups, medical staff groups and nurse groups could be utilised. The aim in selecting the homogonous samples was to reduce variation and allow focused inquiry in order to understand a particular phenomenon (recovery). One of the benefits of using homogenous samples was that it opened up the opportunity of group interviewing with groups of similar individuals.

It is argued that this ‘mixed strategy’ was appropriate to ensure maximum coverage of the issues being explored by gaining both individual different views and group views. Developing a strategy that met the needs of the inquiry was considered to be important as advocated by Mason (1998).

Sample Size

The population were patients who had recent experience of being in hospital plus health care staff who had experience of caring for people either in hospital or in other care settings. All participants were from one county in Wales. There was no exclusion criteria other than that participants were willing and able to participate. The gender of the participants was pre-selected in order to have a balance of male and female perspectives where possible.

Time available for data collection was also a consideration. Polit and Hungler (1999) suggested a sample of 10 might be appropriate for phenomenological studies whilst grounded theory or ethnographic studies could involve 20 to 40 people. In this instance a sample of around 70 was aimed for and was considered sufficient for qualitative content analysis.

In total for maximum variation sampling, 16 individual in-depth interviews were planned. For homogonous sampling 8 focus groups were planned to take place involving a total of more than 50 participants in total. It was anticipated that the sample plan would allow a rich source of information to be gathered and that 'data saturation' as described by Polit and Hungler (1999) should be reached by completion of the data collection. Data saturation is achieved when no new information is generated and a state of redundancy reached. Sampling plan is shown in **Table 3.**

Table 3 Sampling Plan Using Theoretical Purposeful Sampling

Sampling Strategy	**Purposeful Selection of Information Rich Participants**	**Type of Participant**	**Number of Participants**
Homogenous Sampling	Focus groups of 2-10 participants aimed at focusing enquiry eliciting views of groups of similar individuals	Female patients x 2 groups Male patients x 2 groups Senior nurses Ward nurses Medical staff Health care support workers	16 10 9 4 10 2 **51 Total**
Maximum Variation Sampling	Individual participants with a range of diverse views and perspectives	Male Patients Female Patients Males nurses Female nurses Physiotherapist Occupational therapist Health care support workers	4 4 1 3 1 1 2 **16 Total**
Total numbers to be recruited			All participants = **67 Total**

Selection Procedure for Recruiting the Subjects

Although obtaining a purposeful sample, with regard to the type of respondents, was planned for the qualitative phase of this research, it was acknowledged that the actual sample would depend on who was available and willing to take part; given the work commitments of staff. **Table 3** identified participants considered to be suitable but with the caveat that this plan could change if respondents were not available. The sample was therefore a convenient sample.

This study was designed to explore patients' perceptions regarding recovery but the qualitative phase of the study also sought the views of nurses and other health care professionals. This was considered appropriate in order to gain as many perspectives as possible. It was reasoned that health care professionals had experience and knowledge of helping patients to recover and could therefore contribute to the understanding of this poorly understood multidimensional phenomenon.

Patients were recruited from a variety of adult wards; including medical, surgical and rehabilitation, thus providing diverse patient experiences. Recruitment was predominately organised by ward sisters. There were no pre-selection of individual wards, rather patients who were available and willing to participate before being discharged. The high throughput of patients in a short time presented difficulties because as soon as a patient started to recover their discharge became imminent. Focus groups and interviews, therefore, had to be set up and undertaken as quickly as possible.

The age range of patients who took part was purposefully varied in order to reflect the age range of patients on wards. This was 56 per cent of patients being over 60 years old. Patients on rehabilitation wards were, however, predominately in the age group 70 – 80+. The rehabilitation ward included in this study was at the community hospital. This was because structural alterations were being undertaken on the rehabilitation ward in the main hospital. All wards that participated in the study used Roper et al.'s (1980) nursing model and Heath and Law's (1982) nursing process as the basis of their nursing documentation and to guide the nursing care given to patients.

Having defined the participants required, recruitment of interview subjects was undertaken by asking individuals if they were willing to participate. If they met the subject list on the sampling plan and were available within the timescale for data collection, they were considered to be appropriate. The inclusion criteria for patients was that they should have been admitted to hospital for medical diagnosis and/or treatment and were in the process of recovering from the acute phase of their illness. The exclusion criteria for patients was that no patients should take part if they were under 18 years old (therefore not adults) or if they were too ill or distressed to participate. The inclusion criteria for staff was that they met the requirements of the sampling plan and were current staff employees of the trust. There was no exclusion criteria for staff.

Strengths and Weaknesses of Sampling Method

For individual interviews, maximum variation sampling was utilised. Individuals from different professional groups were selected with diverse views and perceptions. A strength of this method is that it is useful for obtaining and documenting the scope of the phenomenon in question (recovery from illness). It can also assist with establishment of varied patterns whereby the views of informants can be seen to be emerging into themes.

Polit and Hungler (1999) considered that it is important, with qualitative sampling strategies, that the researcher should have a solid base of knowledge with regard to the setting in which the research is taking place. In this instance, I had been a nurse manager who had worked in this particular setting for five years. However, at the time the research was undertaken, I had changed my role. Knowing the right people to approach in the various wards and departments where the interviews and focus groups took place, was particularly beneficial. It is acknowledged however that knowing some of the participants might have affected the quality of data.

With regard to the group interviews, homogenous sampling was used. This can deliberately reduce variation so that a more focused enquiry can take place. This enabled me to gain a better understanding regarding the perceptions of a particular group of people. The benefit of this method was that the people were a fairly homogenous group and therefore a comfortable group dynamic was readily obtained. From a convenience and time economy perspective, focus group interviews allowed the collection of more information within a given timescale.

The disadvantage of focus group work was that some people could possibly feel uncomfortable in expressing their views in front of others. To minimise this problem, it was helpful that I had over 20 years experience in focus group work as a moderator. I was thus able to help ensure that all participants had an opportunity to express their views. The above methods of sampling had many benefits whereby a rich source of information about the phenomenon of recovery was uncovered. However, it must be acknowledged from the onset that I was a part of this process and therefore the impact of influence and bias was taken into consideration.

With regard to the sample size shown in **Table 3,** the disadvantage of qualitative data collection is the time constraint which prevents interviewing of large numbers of respondents. The data are therefore unlikely to be representative of a population and results will not be generalisable. It was for this reason that this study was conducted in 2 phases: a qualitative phase in order to gather rich information regarding perceptions, and a quantitative phase whereby the questionnaire developed from qualitative phase allowed the generalisability of the study to be increased.

Details of Data Collection

For the qualitative phase, interviews and focus groups were undertaken in a range of venues within the county. The majority of individual staff interviews were undertaken in the workplace with the permission of managers, in a private office with dedicated time set aside. Patient interviews were taken at the bedside or if patients were mobile, in a comfortable private room. Focus groups for patients were undertaken wherever there was a convenient room that was able to comfortably seat a group of people. Other focus groups were undertaken at pre-arranged meeting venues. All interviews and focus groups were undertaken in areas that were quiet, comfortable and with pre-arranged dedicated time set aside.

In two instances existing group meetings were utilised by prior arrangement and a focus group was undertaken under an agenda item. The rationale for this was that staff time and availability was limited. However, regular monthly meetings already existed for senior nurses, and doctors also had weekly meetings scheduled. Utilising these meetings was the only practical way that focus groups for senior nurses and doctors could be arranged and that a guaranteed number of respondents would be available.

In the senior nurses' meeting, regular business was undertaken and then one and a half hours was scheduled for the focus group. Respondents at this meeting comprised of senior nurses and senior sisters representing each area in the trust. The doctors met weekly, usually to discuss items of clinical interest. When this focus group meeting took place, the meeting was dedicated to a clinical audit presentation followed by the focus group. Respondents at the doctors' meeting comprised consultants from all specialties in addition to more junior medical staff. On both occasions participants were relaxed and communicative and willing to spend time. This might not have been the case if these focus group meetings had been squeezed into a normal busy day.

Ethical Considerations

Nursing research, in particular, is likely to use people as study participants and it is essential that the rights of these people are protected. The principle of beneficence (do no harm) was, therefore, adopted when planning and undertaking this study. This section of the Method Chapter is focused on the qualitative phase of the study; consideration of the ethical issues pertaining to this type of qualitative enquiry are now addressed. Ethical issues relating to the quantitative phase of this study are considered in Chapter 7.

Qualitative enquiry can be more intrusive and personal whereby privileged information is directly shared between participants and the researcher. Care was therefore taken to ensure that the participants' human rights were protected.

Because of the extra sensitivity involved in face-to-face contact with participants in the qualitative phase of this study, Munhall's (1998) principle was adopted that:

> *" therapeutic imperative of nursing (advocacy) takes precedent over the research imperative (advancing knowledge) if conflict develops".*
>
> *Munhall (1998) p151*

In respecting people's human dignity one must accept that people have a right to voluntarily make informed decisions whether they want to participate in a study. Participants cannot however make such decisions without being provided with the information to enable informed decision making. Polit and Hungler (1999) described this process as 'full disclosure' whereby the researcher fully discloses that nature of the study to each participant.

In this study all participants were given full information regarding the study and were treated in a respectful and courteous manner at all times. They were also assured of confidentiality and anonymity. In addition the following steps were taken to protect participants:

* Patients were not identifiable by name but by number, gender and the ward they were from, for example: 'Patient 1, female, medical ward'
* ID numbers or real names were not used in any part of the study.
* All tape recordings and transcripts of interviews were seen by three people only: the researcher, the transcript typist and a third person used to collaborate identification of themes. The typist and the third person read the scripts but had no information regarding identity of individuals. The third person was a professional person and, in common with the typist, was made aware of their responsibilities and bound by rules of confidentiality with regard to this study.
* No identifiable information was entered into computer files. All data was held on a password protected computer, in a locked place. This information will be destroyed within five years after completion of the study.
* The majority of information gathered was reported in the aggregate and therefore individuals were not identifiable. Where actual quotes by

individuals have been used, identity of individuals was protected as no real names or person identifiable information were used.

While this study has the potential to benefit patients, the risks to participants were considered at all times. All participants agreed to take part in the study by prior arrangement. All were provided with an information sheet and consent form at the time of recruitment and asked to sign a consent form when they arrived at the interview/focus group. This was after the information sheet had been discussed with them and they had an opportunity to ask any questions regarding the research study. All respondents except medical staff signed consent forms. This group argued that their presence at the focus group illustrated their consent and the focus group went ahead.

A tape recorder was used for all focus groups and individual interviews. All participants were asked at the start of the interview if they were happy to have the interview recorded. Participants were encouraged to ask if there was any clarification needed regarding the content of the information sheet. They were assured of anonymity and confidentiality and that no information given could be attributed to them.

At focus group meetings respondents were asked to state what ward they were from/what area they worked in prior to speaking. It was explained this would help identify speakers and thus names would not be required. With regard to confidentiality at group meetings, staff were reminded of the need to maintain confidentiality about any sensitive discussions that may arise about patients. Patients were also informed that it would not be appropriate to discuss any confidential information about other patients, either during or after the focus group.

It would appear that there were no disadvantages to participants in undertaking this study and many benefits to be realised for future patients if the results of the study are acted upon. Patient participants, in particular, might have felt compromised by being asked to take part but they were assured that participation was entirely voluntary and that their care and treatment in hospital would not be disadvantaged if they decided not to participate. All patients were asked beforehand by their ward sister if they would be willing to participate.

Gaining Ethical Approval

Ethical approval was obtained from the regional ethics committee prior to commencement of the study. The usual COREC proforma was completed which contained comprehensive coverage of the ethical considerations that needed to be addressed before ethical approval could be considered. The focus of this process was:

* To ensure that participants were given sufficient information to allow them to make a decision whether to participate;
* That they were assured of anonymity and confidentiality;
* Participants involvement was entirely voluntary and that care would not be compromised in any way if they took part or indeed decided not to take part;
* The safe storage of data was also covered.

I attended the Ethics Committee when the study was presented for approval and there was constructive criticism of the submission which I was asked to take on board. These comments were with regard to the user-friendliness of the patient information leaflet and issues regarding the questionnaire and its distribution. The committee subsequently approved that the study should go ahead with the caveat that the information leaflet should be re-worded as suggested and that the final copy of the questionnaire should be sent to the committee for approval before distribution. The committee also required confirmation that the way the questionnaires were distributed would ensure that patients' rights were protected. This required that questionnaires or other correspondence should not be posted unsolicited to patients' homes All of these alterations to the proposal were made and returned to the committee who then gave final approval of the study prior to its commencement.

Operationalisation of Concepts

Operationalisation of concepts is a process of translating research concepts into measurable phenomenon (Polit & Beck 2006). At the commencement of this study there was a need to provide an operational definition of the concept being explored (recovery from illness) and to specify operations that needed to be performed to collect required information. Polit and Hungler (1999) noted that, prior to gathering information, qualitative researchers do not usually define in detail concepts that they are exploring. The rationale for this is that researchers are seeking meanings of these concepts and want these meanings to be defined by people being studied.

In this study however it was considered important to define terms that would be used with participants so that conceptualisation of the concept of 'recovery' was clear to others and they knew what was meant when interviewed. My conceptualisation of the dependent variable (recovery) was held throughout the study. The independent variables were those things that affect recovery. My conceptualisation of recovery was: 'recovery from illness whilst in hospital'. This definition assumed that patients had been ill and required diagnosis and treatment that could not be provided by their own general practitioner. Recovery was regarded as the process of getting better, becoming well, regaining good health and/or becoming medically fit for discharge from hospital.

For both the interviews and focus groups participants were asked to say what things they thought helped with recovery from illness. Participants then answered through experience and recall of being a patient, or experience and recall of observing others recovering from illness. In some instances, participants needed to be re-directed to focus specifically on the area being explored. Interviews and focus groups continued until all issues had been exhausted.

Description of the Data Collection

Data collection for the qualitative phase of this study was undertaken over a period of nine months. This included both one-to-one interviews and focus groups of up to ten individuals at a time; see sampling plan (**Table 3**). This plan was affected by availability and time constraints of respondents. An hour and a half per interview was scheduled and it was generally found that this gave sufficient time for:

- a briefing with respondent/s about processes,
- actual data gathering,
- finally, a member check and debriefing.

All interviews and focus groups were conducted in accordance with the topic guide (See Appendix II); they were taped and subsequently transcribed. For individual interviews, notes were taken to augment the tapes. In addition, for focus groups, notes were also taken by an independent observer. All participants were given an opportunity to contribute and shy people were encouraged to engage with discussion regarding the topic area. Throughout the sessions, in addition to free conversation, one participant at a time was asked their views, using such phrases as: “what do you think?” and “in your experience has this been the case?” This then generated more discussion and additional issues were introduced.

Member checks were also undertaken. This consisted of paraphrasing back to respondents and discussing key issues that they had identified as important factors that helped with recovery. Member checking is regarded as an appropriate method of validating the quality of qualitative data through discussions and debriefings with participants (Polit & Beck, 2006; Rudestam & Newton, 1992). The checking process and note taking also helped considerably when data were analysed as it gave an indication and extra information that data were being interpreted accurately. Although an indicative time limit was set for interviews and focus groups, sessions were brought to a natural end when no new themes were raised relating to recovery. Data collection was completed when as many as possible participants and groups had been interviewed in accordance with the sample plan. An audit trail process was set up whereby checking took place: when each interview was undertaken, when transcription had been completed and when each transcript had been coded. General comments were also written with regard how each interview went.

Towards the end of the data sampling stage; saturation was achieved when data were being repeated during the interviews. Saturation is considered to be achieved when discovered information is repeated. Confirmation of previously collected data also occurs whereby new data reveals redundant information (Morse, 1991; Polit & Hungler 1999; Streubert & Carpenter, 1999). (Polit and Hungler, 1999) described a process of saturation whereby repetition is recognised and the addition of new participants confirms existing findings rather than adding new information. It is noted however, that Morse (1991) believed data saturation cannot be achieved and that if a different group of participants were interviewed at another time, new data might be generated. This seems a reasonable stance as it is possible that different participants could generate new data.

When this research was undertaken, by the time all participants had been interviewed, a state of data saturation appeared to have been reached. However, it can be further argued that all research data, both qualitative and quantitative has the potential to change over time. For example people's beliefs and perceptions change and also more traditional empirical data such as life expectancy or birth rates. It can be concluded, therefore, that research data can only be said to be representative of the moment in time that it is undertaken.

Description of Data Analysis

The main aim when undertaking analysis of data was to organise and to gain meaning from the data. Polit and Beck (2006) acknowledged that when analysing and summarising qualitative data, there are no universal rules that apply. Data analysis for this study was, however, undertaken in a methodical and rigorous way. Readers of this work will not know if thematic patterns in the data were accurately captured but member checking, audit trails and investigator triangulation enhanced the trustworthiness of the study, this offers some reassurance. Lincoln and Guba (1985) highlighted the importance of making sense of data in order to lead to a maximum understanding of the phenomenon under investigation. In this study there was a systematic search for an understanding of the recovery process.

Grounded Theory was the research tradition that analysis of qualitative components of this study was based upon. Accordingly the style chosen, as being most suitable for the analysis strategy, was an editing analysis style as described by Crabtree and Miller (1999). Making sense of data was accomplished by inductive analysis as described by Feldman (1998). The process used as the basis of the inductive analysis was to utilise two sub-processes: unitizing and categorizing as described by Rudestam & Newton (1992). In the first sub-process (unitizing), information was coded into units of data isolated from text. In the second sub-process (categorizing) items of data that had similar meaning were sorted into themes.

Eventually a stage was reached where the number of themes reached a saturation point. A 'constant comparison method' described by Glaser and Strauss (1967) was used. Themes were continually revised, modified and amended until all data were placed into an appropriate theme and any new items did not reveal further information.

When analysing, each transcript was read line by line. A highlighter pen was used to mark each sentence or phrase that directly related to the question: "what in your experience have you found helpful to the process of recovery from illness?" Replies such as "well I suppose there are many things that help patients" were not highlighted but "it's important to access the toilet" was included. The rationale for this approach was that the aim of the study was to isolate factors that were tangible and respondents perceived could actually help with recovery. Whilst much of the data was interesting and could have been analysed in greater depth, it was important to keep focused on the research questions and not to wander away from the overall aims of the study. Whole sentences, not just isolated words or phrases, were highlighted because this helped to conceptualise meaning underpinning words. This precursor to the actual content analysis reduced data into a more manageable package for further analysis.

To reassure myself that I had highlighted all significant items, each transcript was read though independently by two other people. A proforma was drawn up and attached to each transcript. This allowed a systematic record to be maintained (an audit trail). Each transcript therefore had a record of: 1st reader, 2nd reader, 3rd reader, plus a record of any additional issues highlighted by different readers.

Elements present in one interview or focus group were compared with those elements identified in others. In this way commonalities were identified until all sources had been compared. The concept of 'fit' is described by Glaser and Strauss (1967) whereby the researcher establishes to which theme the data belongs. Polit and Beck (2006) warn, however, that data must not be forced to fit a theme or distorted in any way to achieve a 'fit'.

Coding of Data

Coding for this research was aimed at conceptualising the data into codes and themes. For this study three levels of open codes were used. Level one codes were derived directly from the transcripts, using participant's own words verbatim where possible. As the constant comparison between scripts took place, these level one codes were collapsed into level 2 codes which were broader themes. Finally level 2 codes were collapsed into level 3 codes or theoretical constructs. Two other people, involved in the coding of the data, helped to ensure intercoder reliability. This being the degree to which coders operating independently assign same codes to variables, as advised by Polit and Beck (2006).

This type of data reduction is more easily managed in quantitative research but naturalistic data reduction is less well developed (Lincoln & Guba 1985). There is a wide variation in methods used for undertaking qualitative research and this often requires researchers to develop their own methods (appropriate to the study in hand) for analysing data and for presenting results (Rudestam and Newton 1992; Crabtree and Miller, 1999). In this study the research process was primarily conducted in accordance with the writings of Rudestam and Newton (1992) and Polit and Beck (2006) where suitable and practical.

Data Management

Analysis commenced by organising data, the main task was to develop a method for classifying and indexing the data. It was also necessary to be able to access data without having repeatedly to re-read transcripts. A reductionist approach was adopted, whereby data was converted into smaller more manageable retrievable files, this was helpful. My editing was checked by two other people to help ensure that all relevant sections were retained, all non-relevant sections were discarded. Polit and Beck (2006) advised developing a category scheme and then to code data into these categories, It was found, however, not practical to develop a category template before analysing the data because themes were not predetermined but rather emerged from data itself. There are computer programs for managing qualitative data but in this instance conceptual files were developed whereby I created a computerised database file for each theme. All relevant data was then cut and pasted into files relating to each theme; content was then retrievable when required.

The transcribed focus groups and interviews were read several times prior to commencing the process of unitizing. Data was examined to find what Manns and Chad (2001) described as 'units of information' from the transcripts that included words, phrases, and even sentences. Units of information from the unitizing process were collated and then provisionally further grouped into themes where this data related to similar information. The file folder was easily retrieved with a view to looking for themes and patterns.

When all themes/categories had been extracted from the data, quasi statistics were used. Polit and Hungler (1999) point out that while frequencies in qualitative data cannot be interpreted in the same way that frequencies generated by quantitative studies, they can be useful. In this study tabulation was made of the frequency that each theme was supported by the data (see **Table 4**, Chapter 6, p91).

For example a respondent at a focus group commented that they thought "having good information is important". That was counted as one frequency for the theme ‘having good information’. Another respondent at the same focus group said “Yes, I think that is important too”; that was two frequency counts for the theme ‘having good information’. Another respondent at interview said “I think it is very important to know what is happening to me”. That was then accumulated to a frequency count of three for this theme (because ‘knowing what is happening’ had previously been grouped into the theme ‘having good information’). However, when one respondent spoke for several minutes about ‘having good information’ and repeated the word ‘information’ several times; that was only be counted as one frequency.

Data Quality and Trustworthiness

Reliability and validity are acknowledged criteria for evaluating the rigor of quantitative data (Parahoo, 2006; Polit and Beck, 2006). These measures cannot be meaningfully applied to qualitative data such as interviews. Therefore, other means of verifying the quality of data were sought. There has been much controversy regarding criteria for assessing truth value of qualitative data and difficulty in agreeing universally accepted criteria (Polit & Beck, 2006). This has been attributed, by Whittemore, Chase, and Mandle (2001), to tensions between a desire for rigor and a desire for creativity.

The main aim for this qualitative phase of the study was that data should reflect the true state of human experience with regard to the recovery process. It is appreciated that absence of information regarding data quality makes it difficult for others to come to conclusions about the believability of findings. Therefore, in this section of the method chapter, time has been devoted to demonstrating that rigour has been taken to ensure data quality.

Four criteria have been suggested for establishing trustworthiness of qualitative data. These are: credibility, dependability, confirmability and transferability (Lincoln and Guba ,1985).

Credibility

Credibility refers to interpretations of data and confidence in the truth of data. In this study care has been taken with a view to ensuring that believability is enhanced and that credibility is demonstrated.

In order to demonstrate credibility, i.e. the production of credible data and interpretations, Lincoln and Guba (1985) described and recommended the following techniques when undertaking evaluation of qualitative studies:

- prolonged engagement and persistent observation;
- triangulation;
- external checks;
- peer debriefing and member checks;
- searching for disconfirming evidence;
- researcher credibility.

Techniques advocated by Lincoln and Guba (1985), were applied to this study in order to enhance data quality, evidence of this is provided below.

Prolonged Engagement and Persistent Observation

Prolonged engagement refers to allowing sufficient time during data collection to build up an understanding of the culture under study. Persistent observation refers to researcher's focus on issues relevant to the phenomena being studied.

I spent a considerable amount of time on this study and immersed myself in the topic area prior to the data collection stage. This consisted of sitting and talking to individual patients and staff members and also groups of people about what it was like being in hospital as a patient and also about what it was like, for members of staff, to care for patients. I also held large groups sessions with up to 20 individuals at a time talking about the forthcoming study and how it best be approached.

Prior to commencement of the formal data collection I undertook two individual and two focus group pilot interviews to check for language and terminology differences. In total approximately 18 months was spent on the preparation, data collection, and coding of data. The data collection included undertaking 16 individual interviews and conducting 8 focus groups.

With regard to persistent observation, I had worked in this setting for five years prior to undertaking the study and had focused specifically on observing how some patients, especially older patients, appeared to recover quicker than others. I argue that these types of persistent activities increased the likelihood of producing credible data and interpretations, as advocated by Lincoln and Guba (1985).

Triangulation

Triangulation was also used to enhance credibility. Denzin (1989) recommended 'data source triangulation' and 'investigator triangulation' to overcome bias that can occur with single method and single observer studies. Data source triangulation was achieved by interviewing diverse key informants about the same topic. The sampling plan **(Table 3)** illustrates the range of informants who participated in the study. These included: patients, nurses of all grades, senior and junior doctors, health care assistants, and therapists. Using multiple data sources in the study helped to provide a more complete and varied picture of the phenomenon under investigation.

Investigator triangulation was also a key feature of this work whereby more than one person was involved with the collection, analysis and interpretation of data. During data collection, all focus groups were attended by a project secretary who observed, took field notes and also typed up all transcripts. She subsequently checked all transcripts after I had coded them, looking for significant words or phrases I had failed to highlight. A third person subsequently trawled all scripts again to ensure that there were no omissions.

Interpretation of data was undertaken by myself, but again this was checked by two other people and omissions or different ways of interpreting data were highlighted and discussed until consensus was reached. The aim was to distinguish true information from information with errors.

External Checks and Member Checks

Member checks are an important aid to help establish credibility with qualitative data (Lincoln and Guba, 1985). This can mean simply soliciting informants' views regarding preliminary finding and interpretations. In this study, member checking was carried out informally as data were being collected. Immediately after each interview or focus group session, I repeated back to respondents my understanding of the points they had raised. This gave them opportunity to correct me if I had misinterpreted the essence of what they had said.

After data had been analysed I then discussed my findings with respondents. Unfortunately, this was not possible with all of the respondents in the study but I was able to undertake formal member checking with eight respondents. It is noted that member checking is not recommended by all qualitative researchers. For example Giorgi (1989) has argued that member checking exceeds the role of informants. I found, however, that it proved useful for this type of study which was simply about asking respondents to recall things they felt could help with recovery and to check that I had recorded and interpreted their views correctly.

Searching for Disconfirming Evidence

Polit and Beck (2006) described how data credibility can be enhanced by undertaking a systematic search for data that discredits existing findings. People with conflicting viewpoints have been found to strengthen a description of a phenomenon. A search for disconfirming evidence was facilitated by the prolonged engagement and peer debriefings that took place in this study. That there was purposeful sampling of respondents, who had contrasting views, also helped to root out different perspectives that would contrast with one another. Certainly it became apparent when analysing data that views and language of patients differed from those of professional carers.

Researcher Credibility

Researcher credibility was considered by Patton (1990) to be an important aspect with regard to qualitative studies. Research reports should contain information about the researcher and whether any personal or professional issues could have affected data collection and interpretation. In this study I collected the data; therefore my training, qualifications and experience are important in order for the reader to have confidence in data.

My personal resume is: that I have over 20 years experience of working as a nurse in a health care setting. During that time I have been a field worker and also undertaken both qualitative and quantitative research studies. These studies provided me with relevant experience and skills. Work I have previously undertaken includes: *A comparative study of patients and nurses perceptions of nursing care* (Bowen, 1993); *Improving Service Delivery through User Feedback* (Bowen, 1994) and *GP's Perceptions of factors that affect emergency admission to hospital* (Bowen, 1999). My academic studies have run parallel to my nursing career for the past 20 years. In this time I have acquired three degrees, two of which were at master's level. All degrees included undertaking research that was supervised by a university.

In previous working posts as a nurse, I have taken a lead in setting standards and undertaking audit which has included experience of interviewing people individually and in groups. I have had training and experience in writing factual reports. I need to declare that I had a professional connection to the community under study and to the topic. Prior to commencing this study I worked for five years as a nurse director for the NHS trust involved in the study. My key objectives in this post included obtaining patient feedback and improving quality of care that patients received whilst in hospital. I have a particular interest in nursing care of older people.

I appreciate that as a senior nurse, I may have affected the way that staff members answered my questions and gave their views during the study. They may well have said what they thought they should do, rather than what they actually did, in practice. However, I was not testing their knowledge or practice but simply gaining their views. At the time of the study I had no direct or indirect management role over any of the participants. I acknowledge however that my seniority in the organisation may have been an advantage in getting people released from their workplace to be interviewed. I also had easy access to patients.

Dependability

The dependability of data was tested by having an external person to scrutinise and review all data and all supporting documents. This included full reports of analysis of each interview, including 1st and 2nd level coding, discussion notes and notes on constant comparison findings. A frequency table showing how many times each concept was raised was also available. This is shown in the qualitative results chapter. Where differences in codes or categories emerged, a consensus was reached following discussion.

Confirmability

Confimability links closely with dependability and is concerned with the objectivity and neutrality of the data. Polit and Beck (2006) described how enquiry audits can be used to help confirm both dependability and confirmability of data. In this study an audit trail was kept throughout. This included records of raw material, field notes, data reduction and analysis products. A decision trail record was also kept which documented decisions for categorising data.

Transferability

Lincoln and Guba (1985) highlighted the importance of a researcher providing sufficient descriptive data for readers to evaluate whether the data could be applicable in other contexts, i.e. whether findings from the data could be transferred to other groups or other settings. In this study, a wealth of data are available and is provided to enable others to make a judgment regarding this.

However, variation in perceptions both amongst patients and between patients and professionals would make it difficult to say whether results were generalisable. The findings of phase one revealed what people thought. The next phase of the study, the survey, will help to establish how many people feel the same way about each of the issues identified.

Overall Comments Regarding Data Quality

It can be seen from the above that rigour was applied to ensuring data quality and interpretation. All interviews and focus groups were recorded and then transcribed so the scripts remain a true account of what was said. Frequency with which certain words or phrases were repeated was also documented. However, meanings behind the words, and the way that I interpreted words may or may not represent the truth. Whilst I believe myself to be objective, and have had a great deal of experience in gathering and interpreting data, I could possibly have some biases which manifested themselves in attitude or gestures. These could then have affected the way that respondents answered my questions and probes.

I have interpreted what I believe to be a true representation regarding what people think about factors (things) that help people recover from illness. My perspective was endorsed by member checks, and by two other persons reviewing my work. I believe that my interpretation of the data highlighted sufficient features to allow the results that I present to be a recognisable picture. However, other people could have depicted different pictures from the available data, just as different artists might paint very different pictures of the same subject. The test of my interpretation is whether it is recognisable to others. Informal feedback of preliminary results that I have given to professionals and individual patients, tentatively suggests that I have captured true data and interpretations.

Chapter Summary

Chapter 5 has provided a record of the method used for the qualitative phase of this mixed method study. Justification for the research design has been given and a description of the model used. Details have also been given of the population and sample (patients and staff in a hospital setting) and sample size (67 participants). Strengths and weaknesses of the sampling method have been discussed including steps taken to minimise bias. Time has also been taken to fully discuss the ethical considerations that were taken into account. A detailed description of data collection and analysis has been given and great attention paid to ensuring data quality and trustworthiness.

This phase of the study was time consuming but rewarding. Interviews and focus groups went well and I obtained sufficient appropriate data for analysis. I felt that this was sound base on which to proceed to the quantitative phase of the study. The next chapter (Chapter 6) presents results of this qualitative phase prior to providing a description of the method of quantitative phase in Chapter 7.

CHAPTER 6

QUALITATIVE RESULTS

Chapter Overview

Chapter six presents results of the qualitative phase of this study. Data were generated via 16 individual interviews and eight focus groups. Data collection focused on establishing factors that help patients recover from illness. Respondents for this phase of the study were selected from both patients and staff in order to obtain a wide variety of perspectives.

Initially, a description of the sample is given prior to identification of key themes extracted from the data. Some general observations are then made and themes grouped into five distinct factors or dimensions of recovery. Findings from this phase of the research are then presented around main themes to emerge from the data. Direct quotes made by respondents have been used to illustrate importance of these themes. Similarities and differences between patients and staff views are illustrated and commented upon; however, in-depth discussion of these results are presented fully in Chapter 9.

Description of Sample

The sampling plan has been previously discussed in the qualitative methods chapter (Chapter 5; see **Table 3,** p70). However, as this was a convenience sample, numbers of participants in the focus groups were not finally confirmed until group meetings took place. Overall, there was good participation from a variety of respondents with regard to gender and age. In total, 67 respondents took part comprising 34 patients and 33 staff. The age of the participants ranged from 30-90 years old (patients) and 20-60 years old (staff) with a normal distribution of ages for both groups.

Identification of Themes

There were clearly recognisable recurring themes to emerge from analysis of qualitative data. Quasi statistics were applied to help extract the most frequently occurring themes, as described in Chapter 5. As a result 20 themes were identified. **Table 4** illustrates the frequency that patients raised these themes in comparison with staff. It can be seen that generally both patients and staff thought these themes important to recovery but there were some variations in the strength of the importance between the two groups.

Table 4 Frequency That Themes Were Raised by Patients and Staff

Theme	Frequency Talked about by Patients N = 33	Frequency talked about by staff N = 34	Total N=67
Having good information	113 times by 32 patients	17 times by 14 staff	130
Being included in plans	55 times by 26 patients	59 times by 25 staff	114
Being safely looked after	34 times by 23 patients	66 times by 29 staff	100
Looking forward to home	89 times by 29 patients	16 times by 10 staff	105
Being asked opinion	48 times by 26 patients	35 times by 21 staff	83
Maintaining a routine	38 times by 25 patients	44 times by 23 staff	82
Plenty of rest	59 times by 29 patients	9 times by 7 staff	68
Keeping active	37 times by 26 patients	29 times by 23 staff	66
Going to the toilet	38 times by 30 patients	27 times by 21 staff	65
Staff talking to patients	25 times by 23 patients	24 times by 20 staff	49
Eating and drinking	12 times by 11 patients	30 times by 22 staff	42
Made to feel of value	30 times by 23 patients	22 times by 17 staff	52
Medication	17 times by 17 patients	20 times by 18 staff	37
Being given confidence	20 times by 16 patients	16 times by 13 staff	36
Washing and dressing	5 times by 3 patients	28 times by 26 staff	33
Seeing friends and family	10 times by 9 patients	18 times by 16 staff	28
Happy staff	9 times by 8 patients	17 times by 12 staff	26
Having support at home	20 times by 16 patients	0	20
Being made comfortable	23 times by 21 patients	0	23
Given hope	10 times by 7 patients	4 times by 4 staff	14

General Observations

It was apparent after conducting the first few interviews; there were two distinct perceptions of some of the topic areas. Perceptions of patients were different from staff. Whilst the focus of the study was recovery, it was apparent that in this instance, the phenomenon was also closely linked to the overall culture and language relating to care in a hospital setting. Patients used different terminology to staff; they referred to being looked after rather than being cared for. They did not use terms such as: 'holistic', 'fundamentals of care' or 'quality of life', whereas staff did. There were two notable areas raised by patients that were not mentioned at all by staff. These were: 'support at home when discharged' and 'being made comfortable'.

In contrast staff identified areas they considered important, while patients did not. Some of these were linked to the way they worked on wards. For example, staff talked about 'teams and teamwork', 'involving other agencies' and 'environment of care'. It was also apparent that staff felt that patients needed certain things to be considered while patients did not speak in these terms at all; for example, 'continuity', 'psychological needs' and 'reassurance'.

Staff also spoke about a 'medical model of care' and appeared to pay great importance to assessment of patients' needs and goals. They also spoke of rehabilitation and patient education and raised issues relating to elderly patients and ageism. While patients did not use the term 'medical model of care' they mentioned issues relating to this, for example, the importance of medication. In all staff interviews and focus groups, there was a noticeable assumption by staff that many patients recovering would be elderly people. Staff illustrated this by speaking about recovery needs particular to older patients. This is perhaps explained because there are a high percentage of older people (over 60 years old) admitted to hospital.

Staff and patients saw different ways of expressing phenomena or rather how they viewed phenomena. For example 'time' was often raised as an issue by staff as they felt that they didn't have time to do the things that they should be doing for patients. Time prevented them from providing care that they felt they should. In contrast, patients did not use the term 'time' in the same way. Rather they saw staff as being so busy that they could not do everything for them that they would like.

Dependency and independence were also concepts viewed differently by staff and patients. Staff spoke about facilitating independence in patients and did not talk of dependency. Patients in contrast expressed that they did not want to be dependent on nursing staff. They appeared, however, not to make the link between not depending on staff and being independent. With exception of the above differences between patients and staff, there was, on the whole, a convergence of views regarding what could help patients recover from illness.

National Health Service (NHS) Culture and Language

The above general observations highlighted the differences in nomenclature, culture and language between hospital staff and patients. Mantzoukas and Jasper (2008) described this as ward cultural knowledge which is staff familiarisation with written and unwritten norms and rules that apply in hospital. It is argued that this type of knowledge adds to the barriers to communication between staff and patients and reaffirms the medical model whereby health professional have more knowledge than patients thus putting patients at a disadvantage. It could be seen that often patients and staff had different perceptions and understanding of the same phenomenon. This reaffirmed the rationale for undertaking this study which helped to expose these differences. The study has also explored patients' perceptions in order to find out what they wanted to help them recover; in a language used by patients and therefore more likely to be understood by patients.

Factors Affecting Recovery

Identified themes were further grouped under five headings which aimed to correspond to distinct factors which make up the multi-dimensional concept of recovery. The way in which themes were grouped into factors is explained in detail in Chapter 7. These factors are: therapeutic intervention; core elements of care; collaboration; social interaction and motivation (see **Table 5).**

Table 5 Concept of Recovery

Factors/Dimensions of Recovery	Themes
Therapeutic intervention	Medication Plenty of enough rest Being made comfortable Keeping active
Core elements of care	Going to the toilet Washing and dressing Eating and drinking Being safely looked after
Collaboration	Maintaining a routine Being included in plans Being asked opinion Having good information
Social Interaction	Staff talking to patients Seeing friends and family Happy staff Having support at home
Motivation	Made to feel of value Being given confidence Given hope Looking forward to going home

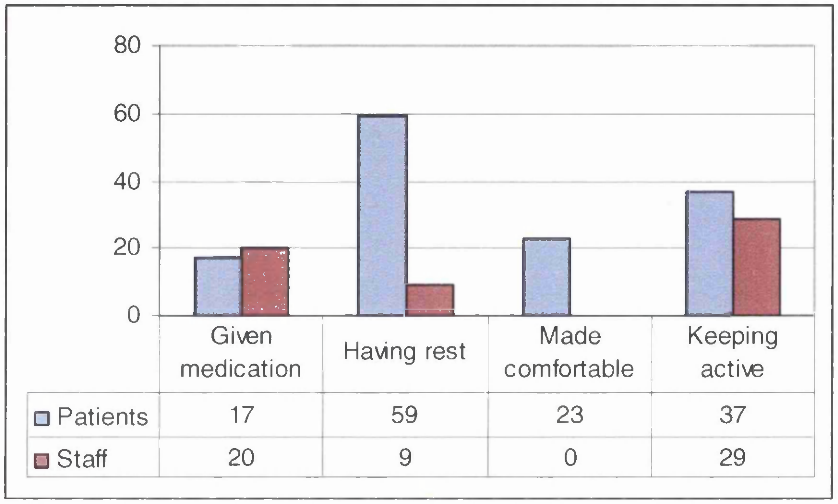
Presentation of Results

Findings have been arranged around major themes to emerge from the data, as suggested by Polit and Beck (2006) for presentation of qualitative results. Direct quotes have been used to illustrate important points. In order to aid an understanding of this research and its setting, a list of the participants who have been quoted is provided in Appendix III. All respondents who have been interviewed have been given pseudonyms to maintain respondent anonymity. Details of type of ward on which patients were cared for/staff worked and ages have also been given, where known. Diagrams have been provided in order to summarise an overall conceptualisation of how respondents perceived the phenomenon recovery. Each of the five factors of recovery are presented in turn, starting with 'therapeutic intervention'

Therapeutic Intervention

This factor of recovery comprised of four themes relating to: medication; rest; comfort and keeping active. Each of these themes is reported upon individually. **Figure 1** illustrates the frequency that each of these themes were mentioned by patients and by staff.

Figure 1 Themes that Make Up the Factor Therapeutic Intervention



	Given medication	Having rest	Made comfortable	Keeping active
▢ Patients	17	59	23	37
▨ Staff	20	9	0	29

Medication

Both patients and staff perceived medication to be a key component of recovery. This theme was raised 17 times by patients and 20 times by staff. Staff also linked medication to the term 'medical model of care'. Paula, a female staff nurse from a surgical ward commented:

> They are seen to be God or the person with all the knowledge. That's how some people perceive consultants. Then that's the medical model, a lot of people will trust it but not everyone. My partner's mother had bowel cancer and wasn't interested in chemotherapy or radiotherapy. She was quite happy to look at alternative treatments to help her but equally was of the opinion that what ever would happen, would happen. But she had a lot of negative responses from medical consultants for wanting to go down that route. She just didn't trust the consultant's route although a lot of people will completely put all their trust in them".
>
> (Interview)

Examination of data indicated that illness and recovery were considered to be in stages: first get over the illness and then start to recover. Medical staff seemed to think of recovery differently from either patients or nursing staff. They saw recovery in terms of recovery from anaesthetic or recovery of muscles after trauma. Consultants in geriatric medicine, however, looked upon recovery from a more holistic perspective and closely linked recovery with rehabilitation back to a patient's normal lifestyle. Patients stated a particular reliance on doctors especially if they had chronic illnesses. An older female patient from a rehabilitation ward stated:

> "Last year my appointment (to see the consultant) was cancelled. I cried all morning. I was so disappointed and upset that I just lost all hope of getting better".
>
> (Focus group)

Many patients related their medication to doctors, who prescribed medication and therefore were seen as key to their comfort. Tom, a 52 year old patient on a medical ward stated:

> "I have one tablet from the doctor for the pain and one to help me sleep. I don't think I would sleep otherwise".
>
> (Interview)

There appeared to be differences of opinions between staff members regarding the role of medication in recovery. Jordan, a health care support worker from a rehabilitation ward stated:

> "I think medication has got a big part, yes. And obviously then you look at supporting people and making them feel better, but I don't think people who feel better recover any quicker than people who don't. It's the medication that makes the difference".
>
> (Interview with two respondents)

This view was in contrast to Leslie, another health care support worker, from a rehabilitation ward, at the same focus group who stated:

> "I would say that medication has definitely got a big part, but just as big a part as well, is the support that comes when medication is sorted".
>
> (Interview with two respondents)

There was an obvious difference of opinion between these two health care support workers. One participant seemed to have great faith in the medical model whereby the intervention of a doctor, preferably a consultant was a key factor that helped people recover. In contrast, the second participant thought that while medical intervention and medication were important, she also thought that support (described as giving help and assistance) played just as big a part in helping people to recover. This second view was endorsed by others who regarded doctors as not really supporting patients. A senior ward sister stated:

> "They (doctors) just see the medical problem, the doctor doesn't see them 95% of the time, they don't think about social issues. They don't think the cat, the dog, the knees, the carer and everything that is involved in that. They just see bed, medically fit, go. Medically fit doesn't necessarily mean they're fit for discharge or that they are sufficiently recovered".
>
> (Focus group)

Again there were contrasting views from patients. Susan, a 38 year old patient from a surgical ward had a positive view of doctors:

> "Yes the consultants and such made me feel, they took a personal interest in me, not just the illness. They might have thought, 'oh no. there's nothing wrong with me', so for them to get to know me helped me deal with the illness that was mine".
>
> (Interview)

While another recollection from Linda, a staff nurse from a rehabilitation ward was:

> "You must have seen the doctors do it on ward rounds, they talk to their team and they are not talking to their patient and the clear message that they give to the patient is I am not very interested in you as a person".
>
> (Interview)

It can be seen that in some instances the medical model of care appeared to be regarded negatively and in contrast to holistic or individual care which many of the nurses considered to be the most appropriate type of care. Despite an apparent disapproval of a 'medical model', it was acknowledged that patients need to be diagnosed and that medication was an important aspect during an acute phase of an illness, followed by continued medication during a recovery process.

Getting Plenty of Rest

Rest was the third most frequently raised factor identified by patients, (first and second were 'having information' and 'looking forward to going home', respectively). Whilst patients considered rest to be important, staff appeared to think it was less important. This theme was raised 59 times by patients and nine times by staff. Patients felt that rest was important during an acute phase of an illness and also during recovery when they felt particularly tired. It was evident that ward routine in hospital was not conducive to patients getting their rest and staff did not seem to appreciate this perceived need.

It appeared that visiting time could be very disruptive to patients trying to sleep during daytime, perhaps after being disturbed by ward activity all night long. Nurses getting patients out of bed early in the morning was also viewed negatively as illustrated by a female patient from a surgical ward:

> "To recover I feel you need to have your sleep and I wasn't getting the sleep I needed to recover because there was just so much ongoing noise day and night and even through the night you could hear staff at the nurses station talking. They were talking about holidays and it was quite loud, and it may be part of their working day but I was trying to get to sleep. I found that was just a major hindrance to recovery, then come the morning when the lights just went on, I felt absolutely shattered. Then to suddenly be forced out of bed I felt absolutely exhausted and I am a lot younger than a lot of people on the ward".
>
> (Focus group)

This view was endorsed by Tom, a 52 year old patient from a medical ward:

> "Patients should be allowed to rest when they are ill. Not for the entire stay, but maybe for the first few nights or couple of nights. Just to help them build up their strength. So they got the strength to tolerate all the comings and goings".
>
> (Interview)

In contrast to patients, rest was not deemed to be as important to some staff with regard to recovery. As one male senior nurse stated:

> "Resting on the bed makes your muscles weak".
>
> (Focus group)

This gave a contrasting perception, of rest being both good and bad for patients, depending on circumstances and on individual point of view.

Being Made Comfortable

This was closely linked to getting enough rest and was an issue raised 23 times by patients. Staff respondents on the other hand did not raise this issue at all, again showing a contrasting view. Being made comfortable was viewed positively by patients and whether or not it happened would appear to depend upon staff on duty. This was clearly illustrated by Dorothy, an 82 year old patient from a rehabilitation ward:

> "She would ask did they want to go to the toilet, did you need this or that, and it was the same every night. It meant a lot to patients because we knew when she came on duty; we would be comfortable for the night. She would help us to the toilet and make sure we had a drink of water. She would make us comfortable and put our bedclothes straight and would help us from the chair into bed or back out. Would we like to stay in the armchair or would we like to get back to bed? That made a difference, made a huge difference".
>
> (Interview)

While making someone comfortable was not a term that staff respondents used, patients repeatedly said things like "they cannot make me more comfortable than what I am". Comfortable was also associated with being home. "It's more comfortable at home".

Helped to Keep Active

This is the last theme grouped under the factor 'therapeutic intervention'. Keeping active following illness was perceived to be an important factor by both patients and staff respondents, with frequencies of 37 and 29 respectively. Several terms were merged together here during coding as physical activity was referred to in different ways by both patients and staff. Patients saw recovery, getting better or regaining their health, as getting back to be able to do the same things that they did before their illness. For example, housework, paid work, mobilising around their own home, going out with family/socialising.

There was anecdotal evidence from staff; of patients not being able to go home (be discharged) because, while they had recovered from their illness, they had become too frail to safely walk on their own as a result of hospitalisation. A female patient from a rehabilitation ward stated:

> "I've been here for 5 weeks and haven't walked yet. I couldn't possibly be at home because I can't walk. What's going to happen I don't know but I can't walk, I can't do anything. I can't even lift this because it is so heavy. I don't want to fall down again, that's the worst thing".
>
> (Focus group)

A male hospital medical consultant, Dr Jackson, also felt that keeping active was an important step in the recovery process:

> "Sometimes, patients who suffer from dementia will have the ability to get up and walk as they have no fear. For those patients who do not suffer dementia, there is often a lack of confidence and a presence of fear to get up and walk. It is very important that people are helped to keep active or they will loose their confidence altogether and will have less chance of a successful recovery".
>
> (Focus group)

And from a female patient on a medical ward:

> "I know I can't go home until I can walk because I wouldn't be able to manage at home. My husband's no good, I need to look after him".
>
> (Focus group)

While overall, both staff and patients perceived that keeping active was important, there was also a feeling expressed that older patients were sometimes viewed from an ageist perspective, even by patients themselves, as this quote from a female nurse from the rehabilitation ward shows:

> "Older people feel ageist about themselves. They don't believe or understand that they can get better as they get older. Just because you're old doesn't mean you have to stop being active and independent. A lot of people say' well I'm 94' but that doesn't matter, If you can still do things for yourself then why shouldn't you. I think a lot of that comes from families. I think for elderly people, they become so wrapped up in trying to protect them that they don't actually help them. They just take away some of their ability".
>
> (Focus group)

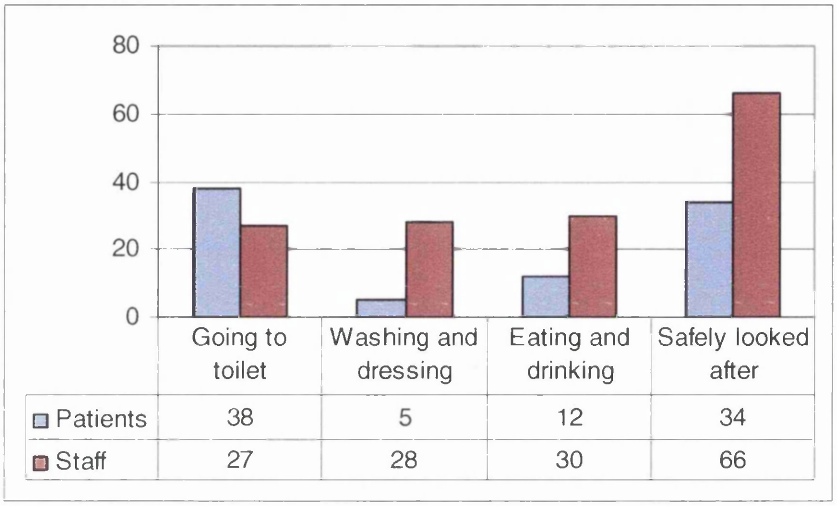
The above examples seemed to indicate that regaining a normal level of activity was considered to be a key component of the recovery process. Some patients used the term 'rehabilitation' when taking about physical activity; rehabilitation was a term used frequently by staff. Other patients spoke of being helped to walk and keeping active. The next section of these findings reports other examples of patients being helped with activities during their recovery of health.

Core Elements of Care

This factor of recovery comprised of four themes relating to: 'being helped to go to the toilet'; 'being helped to wash and dress'; 'being given enough to eat and drink' and 'being safely looked after'. It became apparent that patients regarded being given help and support, for these core elements of care was perceived to be an important factor in the recovery process.

Data suggested that these core elements of care were closely linked to concepts of dependency and being independent. It was apparent that patients wanted to perform these tasks independently, as they would do if they were not ill. Respondents appeared to perceive a continuum with illness and dependency at one end and wellness and independence at the other. Each of the themes of core elements of care are now reported upon. **Figure 2** illustrates the frequency that each of these themes was mentioned by patients and by staff.

Figure 2 Themes that Make Up the Factor Core Elements of Care



Being Helped to go to the Toilet

Being helped to the toilet was considered to be important by both patients and staff respondents who raised this theme 38 and 27 times respectively. While helping patients to go to the toilet seemed to be a normal nursing task to staff respondents, it also had emotional consequences for some patients.

For example, Sharon, a therapist from a medical ward relayed the following circumstances relating to a patient:

> “The first words that she said to me were I am unhappy, I am anxious and I am in anguish. The thing that she was unhappy, anxious and in anguish about was that she couldn’t access the toilet, and because she couldn’t access the toilet, she was afraid to take the laxatives, and because she couldn’t take the laxatives, she was constipated. Because she was constipated, she couldn’t eat and because she felt so utterly wretched she’d stopped going to bed. She had stopped getting undressed and this sort of thing unravelled. It was like having a big ball of wool”.
>
> (Interview)

Being unable to use a toilet independently was regarded by many patients as being the "worst part of being in hospital". It was apparent that being incontinent because of illness or temporary reduced mobility caused distress to patients. One gentleman in particular relayed to me how humiliated he felt when he became incontinent of faeces. This was not just because he had profuse diarrhoea that he was unable to control; predominately it was the attitude of one staff member who completely demoralised him and he said made him feel "life wasn't worth living".

This apparent distress was also raised by another patient, on this occasion, a female patient from surgical ward:

> "It was awful; you would have Mrs. Jones in the other bed calling for a nurse for two hours sometimes. It was distressing for her because she didn't want to have an accident. She didn't want to be seen as being incontinent. She had enough troubles of her own with the ops she'd been through".
>
> (Focus group)

Nursing staff acknowledged there was a difficulty in ensuring that patients were able to access a toilet when needed. This appeared to be because of time constraints as illustrated by a comment from Jean, a health care support worker from a surgical ward:

> "They've got the indignity of being incontinent when they don't really need to be because, y'know it's only a matter of someone getting there to help them".
>
> (Interview)

There was however a tension between taking a patient to the toilet in a wheelchair and helping them to walk there themselves. John, a staff nurse on a medical ward commented:

> "Once we put people in a wheelchair to go to the toilet they are not able to walk to the toilet on their own".
>
> (Interview)

This nurse appeared to be concerned that patients should not become dependent on the nursing staff and explained that helping patients to help themselves was much more time consuming. Patients, in particular, related going to the toilet with a lack of independence, for example Dorothy, an 82 year old patient from a rehabilitation ward explained:

> "From my point of view, I can't speak for others but from my point of view its very frustrating having to ask everybody to do everything for you especially if you need to go to the toilet in the middle of the night and you have to ring the bell. I don't like asking, I try to hang on, but they are very nice about it".
>
> (Interview)

Being Helped to Wash and Dress

Washing and dressing patients were combined into one theme because so often, both staff and patients spoke of them together at the same time. This was probably because of the task oriented way that the hospital wards were organised with washing and dressing patients being considered a key responsibility of staff on a morning shift. Washing and Dressing was raised just 5 times by patients but 28 times by staff. This could have indicated that patients did not think that it was as important to their recovery as other nursing tasks. Staff on the other hand talked about washing, dressing, toileting and feeding staff as a basic need. One female staff nurse from a medical ward commented:

> "Nurses are trained in what is needed for basic care. You know, washing and dressing, feeding and making sure they've got water".
>
> (Focus group)

The relative importance of washing and dressing was, however, raised by Jordon, a health care support worker from a rehabilitation ward who said:

> "Helping patients to recover is about tending to their needs, washing is a need but not always the most important".
>
> (Interview with two respondents)

Similarly a senior male nurse from a medical ward explained:

> "Nurses help with washing but I think nurses need to think differently. A typical example of meeting need is a guy we had in the other week. Once we

> established that he wasn't going to get better, all he wanted was to have a little service in the chapel so we facilitated this. He was pretty well chuffed when his wife came in and it was all set up. He did not want anything else. He wasn't bothered about anything else".
>
> (Focus group)

While few patient respondents talked about washing and dressing, this was perhaps because they assumed that it was a task that nurses would carry out and therefore needed no mention. There was, however, evidence that the way in which this task was carried out was positively perceived by patients, as Sharon, a therapist from the medical ward reported:

> "A few weeks ago I was washing a ladies feet and she said to me, 'I'm so glad I've got one of you old ones'. I said to her, well I am not sure how to take that, what do you mean? She replied, 'oh I can tell by looking at you, you've got no degree but you know how to dry between my toes' ".
>
> (Interview)

Being Given Enough to Eat and Drink

Similar to the theme 'being helped to wash and dress', the theme 'being given enough to eat and drink' was raised more frequently by staff than by patients. Patients talked about this on 12 occasions compared to staff who raised this theme 30 times.

Patients were aware that nutrition received through food and drink could aid the recovery process by providing the body with nutrients for healing to take place, as Susan, a 38 year old patient from a surgical ward illustrated.

> "Nutrition is important, I was in hospital with a spinal injury and I knew that having the right food would help my body to heal, so I ate even when I didn't like the food".
>
> (Interview)

The issue of patients not liking the food was also raised by nursing staff who thought that having the food they liked and wanted, could help patients with their recovery. This however, was not always possible due to restrictions on what was available. Sometimes all patients 'fancied' was bread and butter but this was never on the menu.

The ability of patients being able to eat and drink independently was also considered by staff to be helpful to their recovery because it made patients feel better. This was illustrated by some debate amongst health care support workers from a rehabilitation ward, whereby Leslie said:

> "Like if someone had a stroke well then they would need help with holding a spoon. It's important for them to use a spoon or to hold a fork. If someone is able to feed themselves, it helps their well being which makes them feel better".
>
> (Interview with two respondents)

A contrasting view from Jordon was:

> "But that doesn't make them any better does it? It doesn't help them, that's just coming to terms and dealing with their problems its not improving their well being".
>
> (Interview with two respondents)

And this was answered by Leslie:

> "Well I would think it is, somebody being able to feed themselves, they feel better for being able to do that".
>
> (Interview with two respondents)

Betty, a 65 year old female patient on a medical ward supported this view:

> "It's important for people to be able to feed themselves so their food should be near to them. I felt that this was giving me some control".
>
> (Interview)

As shown by this patient, being able to feed herself gave her independence and control over what was happening to her in hospital. However, the experience of a male staff nurse on a rehabilitation ward illustrated that perhaps not all patients are so eager to maintain their independence:

> ".....but I've also looked after people who are recovering from illness and are quite capable of their own independence and they basically don't want to be independent, they want to be looked after, they've given up their independence. A lot of people give up and then they don't get better".
> (Focus group)

In general, themes that make up this factor of recovery were very much linked to patient's ability to do things for themselves or if they are unable to do for themselves then they were forced to be dependent on staff. This comment by Tom, a 52 year old patient from a medical ward illustrated this:

> "Well I think when you are ill there are three aspects of control. There is what you can do for yourself so you have full control. Then there are some things you need help with and that's partial control. Then there are the things you can't help yourself with and that's when they have control".
> (Interview)

Being Safely Looked After

Patient safety was considered to be important by both patients and staff, although staff raised this aspect of care more frequently. Patients raised this theme 34 times compared to staff who raised it 66 times. There were several issues that were spoken about during interviews that were incorporated into this theme. Staff thought differently about safety than patients and linked safety with risk management, clinical governance and ensuring that no harm came to patients as a result of being in hospital. Staff thought that well trained knowledgeable staff contributed to patient safety. They also conveyed a sense; that safety not so much helped people recover but a lack of safety prevented them from recovering, as one female senior nurse pointed out:

> "The main thing we worry about is that no harm comes to patients, this isn't just because of litigation, it's because to recover, patients need to get the best care possible with no adverse events hindering their recovery. Things like contracting MRSA certainly keep patients in hospital longer and can set their recovery back weeks or even months".
> (Focus group)

From a patient's perspective being safely looked after meant having knowledgeable staff but also feeling safe at a vulnerable time as the following comment from Mike, a 76 year old patient from a rehabilitation ward illustrated:

> "It's good to have nurses looking after you who know what they are doing. It's difficult to move patients sometimes to go to the toilet and to have a wash. You need to know that you are in safe hands".
>
> (Interview)

There was also an issue of feeling safe and secure within a hospital ward. For several patients this was their first time in hospital and female patients in particular raised the issue of feeling safe. This was illustrated by an older female patient from a rehabilitation ward:

> "When I was first admitted to hospital, I felt quite vulnerable at that moment and I didn't feel safe where I was. I wanted to be left somewhere quiet, to be left alone but the ward was so busy, so much going on, so many strangers".
>
> (Focus group)

Similar comments came from Joy, a 46 year old patient from a surgical ward:

> "Sometimes I felt threatened when I was really really ill and all I wanted to do was to sleep. I felt threatened because I was on a ward with three or four other people that were quite vocal, very loud, screaming, shouting all the time. You never knew what they were going to do next. I was so ill and vulnerable because I couldn't, if they'd come over to me, I wouldn't have been able to defend myself. Obviously the nursing staff are so busy, they can't be there all the time".
>
> (Interview)

However, not everyone felt like this as this comment by an older female patient on the rehabilitation ward illustrated:

> "It's nice here and I feel safe".
>
> (Focus group)

Collaboration

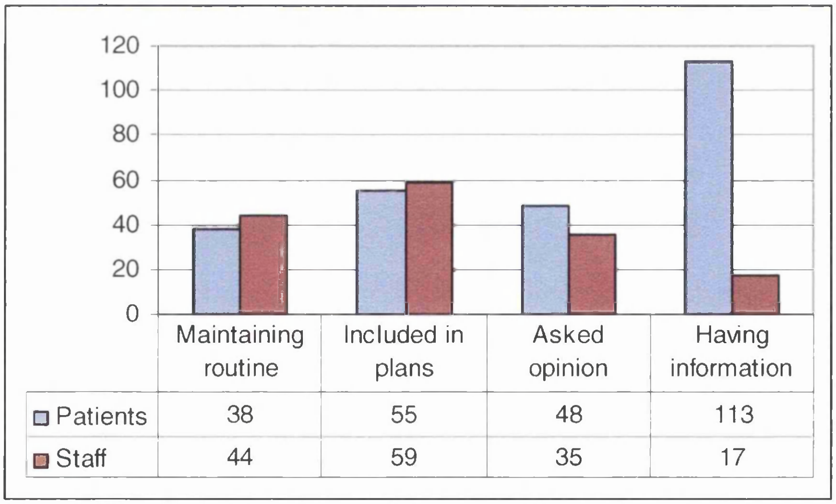
This factor of recovery comprised of four themes relating to: 'maintaining usual routine'; 'being included in plans'; 'patients being asked their opinion' and 'having good information'. Patients found these themes to be of varying importance but did not use the term 'collaboration'. Staff actually used the term collaboration; the term was defined by a senior sister from a rehabilitation ward:

> "With true collaboration you have partnership and you have good communication with the patient. But sometimes the patient will see the nurse as someone in authority and that relationship will not be collaborative, they will act in the role that they are expected to act in".
>
> (Focus group)

This quote illustrated the complexity of the nurse/patients interaction with particular respect to the factor collaboration.

Themes which make up the factor collaboration are now reported upon. **Figure 3** illustrates the frequency that each of these themes was mentioned by patients and by staff.

Figure 3 Themes that Make Up the Factor Collaboration



Maintaining Routine

The theme 'routine' was raised 38 times by patients and 44 times by staff. Routine was described by respondents as something that was very personal and individual for patients and could be related to normality or their usual lifestyle. Recovery was perceived by both staff and patients as getting back to a state of good health whereby a normal lifestyle could be resumed. For example a male nurse volunteered: "helping them to do what they normally do helps them to get better"; while a female patient stated "getting back to normal routine is helpful".

There was, however, an apparent feeling amongst some patients that routine in hospital meant 'hospital routine' rather than individual routine. The word 'regimentation' was also used, for example Peter, a 68 year old patient from a medical ward stated:

> "It's a sort of regimented thing. I mean if you don't want your dinner at half past twelve in a hospital, what do you do, you end up with no dinner".
>
> (Interview)

This point of view was also echoed by Alan, a 35 year old patient from a surgical ward:

> "I get up at home, after breakfast, go to the toilet, get myself washed. I don't get up as early at home as I do here; that's not getting out of bed, its being woken up. But here you just fit in with whatever they do; well it's a question of having to".
>
> (Interview)

Generally patients appeared to perceive that routine was important to their recovery or rather regaining routine was a marker of recovery. However, patients seemed to consider that maintaining their usual routine could not be expected in hospital; rather an enforced routine would be applied, as illustrated by a male patient on a medical ward:

> "Routine is important especially in hospital because you need to know where you fit in. It's about control over my life. In hospital it's an enforced routine sometimes but it's important to get back into your own routine. Illness throws routines out anyway so there is a need to re-establish some order in your life".
>
> (Focus group)

Nursing staff, in particular, considered it important to have routine with regard to mealtimes. Linda, a staff nurse from a rehabilitation ward said:

> "Routine regarding meals is important but many older people neglect themselves at home so coming into hospital is good, in that way they have regular meals and medication".
>
> (Interview)

Nurses also appreciated that routine or rather being out of routine could have a negative affect on patients. This was illustrated by a comment from Paula, a nurse from a surgical ward.

> "People need to be treated as individuals. Some people are morning people and some people are night people. If you try to wake a night person at 6.30 in the morning to get them up because that's what you think their routine should be, they're not going to respond".
>
> (Interview)

While a female staff nurse, working on a rehabilitation unit, said:

> "I work with patients to help them re-establish their routine because I find that comforting. If you have a young child, one of the first things you do as a mum is to establish a routine isn't it, and a routine is comforting. I think it's comforting for each of us at any stage of our life, when things become unsettled, that's always true of illness a routine builds confidence and lessens anxiety".
>
> (Focus group)

This point of view was reinforced by Paula, a staff nurse from a surgical ward:

> "Even in a strange environment, people prefer to know what's going to happen, or what's going to happen next. They want to know what the routine of the day is, what time they will expect to get a drink, or what time they will expect somebody to come around and see them. Its being able to prepare for what's going to happen next isn't it?"
>
> (Focus group)

In particular nursing staff on the rehabilitation ward thought that it was important to keep patients' individual routines if possible especially with older people "who like to have their routine".

Being Included in Plans

Both staff and patients raised the importance of being included in plans, with patients raising it 55 times and staff 59 times. Care planning for patients was seen by nurses as an essential component of the process of nursing and indeed the process of recovery. Care planning was not the same, however, as including patients in the care planning process. There appeared to be a 'doing to' approach to care planning rather than a 'doing with patients' approach. This was illustrated by the comments of a female senior nurse from a medical ward:

> "I think we tend to take control; there are plenty of complaints coming in that show we should be catering for them as individuals".
>
> (Focus group)

This point of view was reinforced by a sister from a rehabilitation ward, who stated:

> "Well it's about negotiation isn't it; it's about trying to get negotiation and manipulation, trying to get them to achieve the goal that you want them to agree".
>
> (Focus group)

The use of the word manipulation was interesting here and seemed to relay a paternalistic, professionals know best, rather than a partnership approach to care. This was clearly illustrated by another senior nurse from a medical ward:

> "Health care professionals know better about actual conditions probably but not about the individuals themselves. You have to get them to agree with their plans. I wouldn't dream of telling a patient when they had to get up, that's up to them. But if a patient is telling me that it's better for her if her leg is down and I know having done the tests that patient's leg needs to be up, then I will do everything, even if its against what the patient really wants, to get her leg up. I feel that is justified, unless they want their leg amputated".
>
> (Focus group)

This paternalistic approach was not apparent with all staff. Some nurses and therapists saw the benefit of working together with patients. This was shown by the comments from Jackie, a therapist from the rehabilitation unit:

> "It's not only important for us to be able to identify their needs, it is also important for that patient for us to have a better understanding of where their

> strengths and weakness lie. We need to be able to know what they can do and what they can't do".
>
> (Interview)

There was an appreciation that illness doesn't just affect patients, but the whole family. Working with the family was therefore cited as being beneficial. However some staff appeared to be of the view that patients were not always willing to help themselves. Bob, a health care support worker from a medical ward stated:

> "Assertive people do become very much involved in their own care and other people just want you to do it all for them".
>
> (Interview)

This point of view was endorsed by Shirley, a staff nurse from a medical ward:

> "We need to set goals with people to get them better but sometimes it seems that they just want to depend on services rather than take on responsibility themselves. I think it's sometimes about educating people. They sometimes think oh well if carers are doing it for me, I don't have to worry".
>
> (Interview)

Some patients did express that they thought that professionals knew best and that they were happy to follow any plan or regime that was decided for them. There were others, for example, a female patient from a surgical ward, who wanted to be included in any decisions about her treatment and care:

> "I am not saying they don't know what they are doing but they don't always get it right in my experience. I want to know exactly what is going to happen to me and to be involved in any decisions that are made. I feel more comfortable with that, less frightened of being in hospital".
>
> (Interview)

Patients Being Asked Their Opinion

There were a variety of similar issues that were combined into this theme. These included being involved in decision making and being asked to make choices. This theme was raised 48 times by patients, slightly more than the number of times raised by staff, which was 35 times. It was apparent that there were different times in the recovery process that patients thought it was appropriate for them to be more involved. There was strong agreement that during the acute phase of an illness, patients felt vulnerable and just wanted professionals to make them feel better. At this time they felt too ill to be able to take on the responsibility of making any decisions, as illustrated by this female patient who had been on a surgical ward:

> "I think that generations coming on after us will have different expectations. But even then having recently encountered the health service, because you've got this fear, this anxiety about what might be wrong, you still, and you know I felt myself saying, just tell me what I need to do here. There is that vulnerability, no matter how in control you feel in other scenarios, when it's your own health there is definitely something that puts you in that vulnerable position".
>
> (Focus group)

This was reinforced by another female patient who had recently been on a surgical ward:

> "When you are really ill you don't want to be asked your opinion or asked to make choices, you just want someone to care for you".
>
> (Focus group)

Even in these circumstances, though, it was apparent that there were some things that were unacceptable, as the same female patient also said:

> "I didn't like having a young lad wash me down; I think that I should have been given the option to have a female carer".
>
> (Focus group)

This patient obviously felt that she could not express her preferences regarding who should care for her, probably because she felt so ill. There is a possibility that patients are particularly disadvantaged at times of vulnerability and perhaps nurses should therefore ensure that what happens to patients is not against their wishes or cultural norms. This point of view was also implied by Betty, a 65 year old patient from a medical ward:

> "I think it's important that people are able to express themselves and what they would prefer, rather than just accept what's put to them by a professional".
>
> (Interview)

A male patient from a medical ward reinforced this point of view:

> "I know that patients rely on the medical profession to inform them about their treatment but it would be really helpful if patients were asked their opinion more, especially with regard to their being involved and included in the decision making".
>
> (Focus group)

But again not all patients agreed as shown by an older male patient from a rehabilitation ward, who said:

> "Do as you are told, that's what helps you to recover. Do as you are told and the quicker you go home".
>
> (Focus group)

Nursing staff, however, saw a benefit in obtaining patients' opinions on what would help them to recovery as illustrated by this comment by a staff nurse from a rehabilitation ward:

> "It's about getting a patient's opinion on what will work and reaching an agreement, negotiating how you care for that patient. If they don't want to do something, then they won't, especially when they go home, because you are not in control of their lives for 24 hours a day".
>
> (Focus group)

This point of view was reinforced by another female staff nurse from a surgical ward:

> "Younger patients feel that they have more rights. They are quite vocal and they know what they want and I think we have to go with them, because otherwise we would just end up with conflict and you don't get anywhere".
>
> (Focus group)

Other nurses felt that it was their responsibility to change a patient's opinion if it was in their best interests, as this quote by a female staff nurse from a medical ward illustrates:

> "It's like, if it's only one medication that a patient can take that will improve their situation and they said 'well I don't want to take it'; you have got to talk to them to change that opinion. If they still don't want to take it, then that's fine as long as you've given the information".
>
> (Focus group)

This last comment illustrates the importance of giving patients information, which is the next theme to be explored.

Patients Having Good Information

Having Good Information was the theme raised most frequently by patients, who raised it 113 times as important to recovery. In contrast staff raised the issue of information just 17 times. Analysis of data indicated that there were different types of information that were perceived to be important to patients. These types of information related to what was about to happen to patients, either clinically or with regard to other general aspects of their care. There was also a difference in perceptions of older patients who appeared to be resigned to waiting until they were told something rather than asking about what they wanted to know. This was illustrated by comments from a female surgical patient:

> "When I was getting better, I would ask what was happening but there were people there who wouldn't ask. You could imagine them shrinking away, shrinking back, because they wouldn't ask and the only time they had a voice was when their family came in and if they had a son or daughter who would ask for them".
>
> (Focus group)

This was in contrast to the views of younger patients as the following quote by Joy, a 46 year old patient from a surgical ward shows:

> "Again it's an individual thing isn't it? Some people would just quite happily be told this is what is going to make you better, this is what we are going to do and they'll have the trust in that person to do those things and have the belief that they will get better. Whereas I want to be more proactive and get all the information for myself and not just rely on one consultant".
>
> (Interview)

A male patient from a medical ward reinforced this point of view:

> "People look up stuff on the internet now about their illness. They want more information. Sometimes you know doctors can't help because they give jargonistic explanations which you don't understand. So I have researched myself to find out, and also tried to relate to someone else who has got the illness".
>
> (Focus group)

It wasn't just clinical information that patients wanted. Information needs were sometimes quite general but important to people and needed to be given in a timely manner as illustrated by a female patient from a surgical ward, who said:

> "Come the time that I was to be discharged, it was up to me to make arrangements about how I was going to get home. I knew that I wasn't fully recovered at that time. They were the things that were concerning me because although I had a husband there who was running around doing everything, he didn't know where to go to make different arrangements and we were quite capable of asking and did keep asking. Whereas some people who see a professional they won't question them, they won't ask, they just sit there and worry. This could impede their recovery because they've taken on this extra worry and stress about what they will do when they go home and who will make the arrangements. We need a person we can bring in to explain things to us to take that worry and those fears away".
>
> (Focus group)

Having worries and concerns about what was happening was echoed by a female patient from a rehabilitation ward who had been in hospital five months and was obviously not being kept informed regarding her progress. She found this quite upsetting:

> "I find it quite frustrating not knowing what might happen next, for example I did not know until this minute that my consultant was away. I wish I knew more. Its four times my appointment has been cancelled and I don't know what is going to happen. The nurses tell us everything we need to know if they know it. Last time my appointment was cancelled, I cried all morning, I know that I can't heal any quicker but I would like to know".
>
> (Focus group)

Information was not only seen to be important to patients, it was also considered to be vital for the functioning of the multi disciplinary team as illustrated here by a female staff nurse from a rehabilitation ward:

> "We are in a very privileged position being able to talk to patients but what is important is transferring that information to other members of the team. I think people want less people involved with them but with more knowledge about them".
>
> (Focus group)

Additional Observations about the Factor 'Collaboration'

This section on the factor 'collaboration', has shown many comments were generated, illustrating varying points of view. There appeared however to be a general consensus that it should not be assumed that all patients wanted to take on responsibility for their own recovery especially when they were feeling very ill. This was illustrated by comments by a female patient from a medical ward:

> "Maybe its not the time is it when you are actually ill, with an episode of illness? I think the worries and the anxieties; it's mostly at a stage when you're so happy for someone else to take the control for you. You just cannot deal with it when you are physically unwell; it's almost well I can't think about that. I can't think about going home or worrying about things, because I'm just too ill to worry about it".
>
> (Focus group)

The amount of involvement and information needed after the acute phase of their illness seemed largely to depend upon individual patients. There was a general feeling in a group of senior nurses that the idea of collaboration or working in partnership with patients was to give staff information and knowledge that they needed to make decisions about patients' care. This appears to imply that nurses wanted information from patients but didn't necessarily see collaboration as a two way process whereby nurses proactively work in partnership with patients helping them to make their own decisions regarding care and treatment. There is also an issue regarding the extent of responsibility really wanted by patients; as a senior sister from a medical ward said:

> "I think we may be in danger of making too many assumptions about it".
>
> (Focus group)

Nursing staff also commented on different stages in a patients illness and pointed out that they were perhaps more likely to focus solely on managing the patients illness, particularly the acute phase of an illness. This perhaps suggested that these nurses were using a medical model of care, as illustrated by the following comment by a staff nurse from a medical ward:

> "They come in acutely unwell and we are very good at dealing with that, but once they start recovering I think we forget to go back and think what are their psychological needs, their social needs, their information needs? I don't think we re-visit it".
>
> (Focus group)

It was apparent, however, that some nurses held a more holistic approach to patient care and indeed put emphasis on the importance of patients helping themselves to recover. This is illustrated by a quote by a staff nurse from a rehabilitation ward:

> "We stress from a very early stage that really you are only going to recover by your own efforts, we can only guide your efforts, we can't make you better.

> You can only make yourself better but we can work together with you and this is the way to do it......I know some nursing staff do things to patients rather than have them help themselves, it's quicker and it's easier. You know they (nurses) are not really useful to their (patients) recovery if they simply do things for them. They may be looking after them and they may be caring for them, but that's not necessarily contributing to their recovery".
>
> (Focus group)

There also appeared to be an assumption by some nursing staff that older patients would not necessarily expect to be involved in what was happening to them while in hospital as illustrated by this comment by Paula, a staff nurse from a surgical ward:

> "It's not something they (older people) actually think about. They don't expect do they, to actually be asked, well what do you think, and what do you actually want? They are just so grateful for their health care because it's free. They were brought up on the doctor is God and the nurse knows best and they don't really, I think, expect to be involved and asked well what do you actually want from your care?"
>
> (Interview)

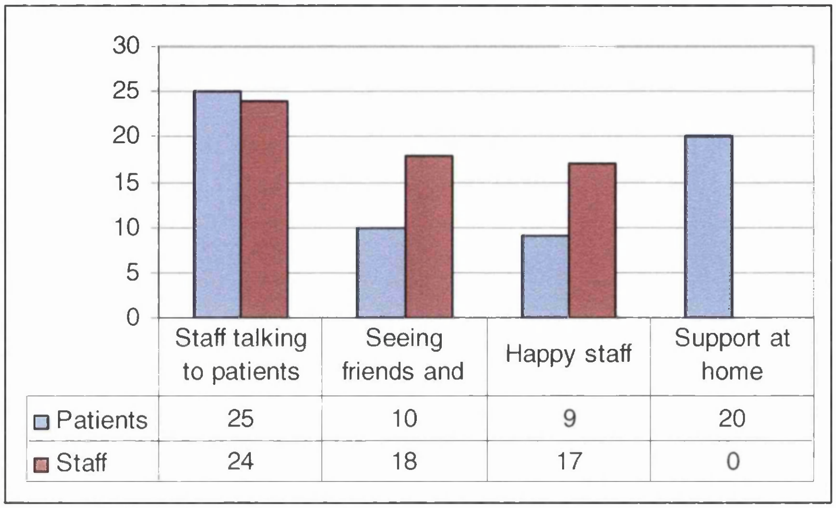
This view that a patient's age affected their expectations was also raised by a female student nurse:

> "Some people don't want to know what's happening; they are quite prepared to put themselves into someone else's hands. I think it depends on age doesn't it – like bringing my parents into hospital appointments and things, they'll just sit there and be told. They don't really ask many questions. Whereas when I go, I ask more questions and I feel I have right to ask. When I take them, I feel comfortable at asking a question that perhaps they wouldn't. They would just put their trust over, thinking the professionals know best. I think it's just the way that times were or how they have grown up".
>
> (Focus group)

Social Interaction

This factor of recovery comprised of four themes relating to: 'staff talking to patients'; 'seeing friends and family'; 'happy staff' and 'having support at home'. Each of these themes is now reported upon. **Figure 4** illustrates the frequency with which each of these themes were mentioned by patients and by staff.

Figure 4 Themes that Make Up the Factor Social Interaction



	Staff talking to patients	Seeing friends and	Happy staff	Support at home
🟦 Patients	25	10	9	20
🟥 Staff	24	18	17	0

Staff Talking to Patients

Staff taking time to talk to patients was brought up by both patients and staff. This theme seemed to be viewed similarly with regard to importance, with patients raising it 25 times and staff 24 times. There appeared to be tensions with staff who considered talking to patients to be important but felt that they didn't always have enough time to do this. Patients on the other hand perceived staff taking time to talk to them as exhibiting friendliness, making them feel less apprehensive. This was illustrated by the following quote by a male patient from a rehabilitation ward:

> "Sometimes I can't tell the difference between the nurses, therapists and carers but it doesn't matter to me, what I want is to feel comfortable with being in hospital and not afraid to be here. Having people take time to talk to me helps to make me feel more at ease in a strange place".
>
> (Focus group)

This point of view was reinforced by a female patient, also from a rehabilitation ward:

> "It was good to have someone to talk to, someone to make you feel important, to say how was your day today Gwen?"
>
> (Focus group)

Patients also saw the benefit of patients feeling that they could talk freely to staff. This was shown by a female patient from a surgical ward who recalled an incident regarding her relative:

> "My aunt only went into hospital when she was desperately ill, but she never felt she had anyone to talk to, she never got used to anybody that she felt she could tell 'you know I've got this profuse diarrhoea'. She tended to see to herself and keep out of trouble, be a good patient as opposed to a nuisance that was always ringing the bell and needing support".
>
> (Focus group)

The way in which staff spoke to patients was also relevant as this linked to the attitude with which staff approached patients, as shown by the following quote by Linda, a staff nurse from a rehabilitation ward:

> "I think it's about the way they talk to people. Time is a big issue, if you don't value someone, you rush them, you don't talk to them when they need you to. As daft as it seems calling them by their right name is important".
>
> (Interview)

The issue of a lack time to talk came up frequently by staff as shown by comments by Sharon, a therapist from a medical ward:

> "There are times I must admit that I didn't ask the question because I hadn't got time to hear the answer...... I really work at getting that face on that says when I get to a patient, 'I have got time for you', even if inside, I'm thinking, 'oh I do hope it's not going to be long because I've got so much to do' ".
>
> (Interview)

Having time to educate patients was also an issue raise by a female senior nurse:

> "For me personally, it isn't about wanting to be a technocrat because that's never really interested me, but its about having the time to stop, to talk, and to be able to educate patients about what you know, teach as you go along on your day to day".
>
> (Focus group)

Talking to patients was seen as a way of getting to know patients as shown by this comment by Jean, a health care support worker from a surgical ward:

> "Nurses need to talk to patients. It's very important to listen and talk to the person. You need to know the whole person, their family, their home, what is important to them".
>
> (Interview)

As with other themes derived from the data, comments were made regarding specific needs of elderly patients. This was highlighted by Linda, a nurse from a rehabilitation ward:

> "Elderly people need the greatest support. They are not used to the system as they have not grown up with it and they feel a burden. If the nurses don't talk to them, they won't ask. Then those things get lost like the assistant who could walk them to the toilet or help with their teeth. Those things get lost if you haven't got that rapport".
>
> (Interview)

With older patients in particular, it was also considered important to maintain their communication skills as illustrated by a comment from a female nurse from a rehabilitation ward:

> "It's about trying to bring people out isn't it, to keep them alert and to keep their social skills up. You need somebody sometimes to draw that out so that they have the confidence to talk to people again".
>
> (Focus group)

This point of view was reinforced by Linda, a nurse from the rehabilitation ward:

> "Recovery is a very social thing. Once an elderly person starts to improve, once you start to get better you need people that they can talk to and relate to. In the old days of day rooms where people used to go for their meals, it was a very social event and we've lost that".
>
> (Interview)

Seeing Friends and Family

This theme was raised by both patients and staff but not as frequently by patients as some of the other themes perceived important to recovery. Patients raised this issue 10 times with staff raising it 18 times. 'Seeing friends and family' was generally related to the visiting times on wards. Again there appeared to be phases in a patient's illness when they were less able to cope with external stressors. Thus the occurrence of having many visitors at a time when people felt very unwell was not welcome. This theme can be seen to be linked closely to patients getting enough rest as illustrated by a comment by Susan, a 38 year old patient from a surgical ward:

> "I was on a ward with other patients and had not long come from theatre, my husband only visited me for a short time because he knew I just wanted to sleep but at visiting time, the whole ward was invaded by people. They were all talking loudly and moving chairs. They were even talking to me, I just didn't want it".
>
> (Interview)

This view was endorsed by Peter, a 68 year old patient from a medical ward, who said:

> "When I was really ill, I just didn't feel like any visitors at all, I just wanted to be quiet, not to have to make any effort".
>
> (Interview)

Not all patients, however, thought that visiting by friends and family was a bad thing, rather that it made them feel better as shown by this older female patient from a rehabilitation ward who was well on the way to recovery and looking forward to going home:

> "I miss my family so much in hospital; they are the only ones who understand how I feel. I get so low being in here. At weekends my daughter brings my grandchildren in to see me, that cheers me up".
>
> (Interview)

As well as from patients, there were contrasting views from staff with regard to visiting. Many nurses thought that visiting rules should be strictly adhered to with set times and only two visitors to each bed, although this appeared difficult to enforce as identified by Paula, a staff nurse from a surgical ward:

> "It's difficult to control visiting; they (visitors) are queuing up outside the door until we let them in. They think that because we have visiting time for two hours, that they should stay all the time. It's just too much for patients when they are ill".
>
> (Interview)

There were other staff, however that thought that visiting time could be beneficial as it gave them an opportunity to talk to relatives. This is shown by comments of a female sister from a rehabilitation ward:

> "I like visiting times because it gives us a bit of a break. You don't get many bells going off and it gives us the opportunity to talk to the family to see what the home situation is like. You can soon tell if the family want them home".
>
> (Focus group)

Happy Staff

The subject of happy staff was raised by patients and staff but not as frequently as many of the other themes. Patients raised this issue nine times and staff 17 times. This theme is closely linked to staff talking to patients. There was a general feeling from both patients and staff that happy staff made everyone feel better and was something that should be promoted. A female patient from a surgical ward made this point:

> "It makes a big difference if the staff are happy. One lady in particular when she came on she would go around. She was a cheerful person and she would talk to people and she got to know in that short space of time, she got to know about the individual. She would go straight to patients and talk to them about something they had in common and that person would chat to them".
>
> (Focus group)

This point of view was reinforced by Betty, a 65 year old patient from a medical ward, who said:

> "I really like the domestics on the ward who bring our meals and chat with us. A person in a red dress in the morning who gives you your meal, who doesn't smile or look at you in the morning when she gives you your meal, can put you off for the entire day".
>
> (Interview)

Happy staff also included general attitudes of staff. While pleasant smiling staff were consider to cheer people up and portray a friendly kindly attitude, there were also times when inappropriate jovial behaviour was considered inappropriate, as illustrated by a female patient from a medical ward:

> "This one nurse laughed over the patients about what had happened last night, how she'd gone out and got drunk and was sick. I was in danger of being sick myself that morning and had been warned that I would have to have tubes put down if I was sick again. I found the thought of this very distressing and I didn't like listening to this nurse talking about how she had been sick the night before".
>
> (Focus group)

A female ward sister from a medical ward felt that appropriate laughter was important for both patients and staff because she believed this resulted in good staff morale and better care for patients, she said:

> "It's important to have happy staff; I like to make patients laugh because I think it improves their quality of life.......you can't train a person to be a nice person though".
>
> (Focus group)

Having Support at Home

This theme is the last comprising the factor 'social interaction'. Knowing that there would be someone at home to provide both care and support was raised 20 times by patients. This was in stark contrast to staff who did not raise this issue at all. It appeared that some patients were almost afraid to go home as they would be on their own. Others despite living with family were also concerned that they might not be able to manage. It is possible that some of this apprehension was because patients felt that they were not fully recovered before the staff started talking about discharge. This is illustrated by comments made by a female patient from a medical ward:

> "I think maybe some reassurance along the way, that if and when patients are discharged from hospital and they are going home, that they are not on their own. Some older people are afraid to go home. I want to go home, but I think how am I going to manage? I will need ongoing help until I am on my feet basically. After that hopefully I will be able to get out to meet my friends".
>
> (Focus group)

An older male patient from a rehabilitation ward thought that support at home could come from a variety of sources:

> "I think support at home is important; this could be from family but also from self help groups and the district nurses".
>
> (Focus group)

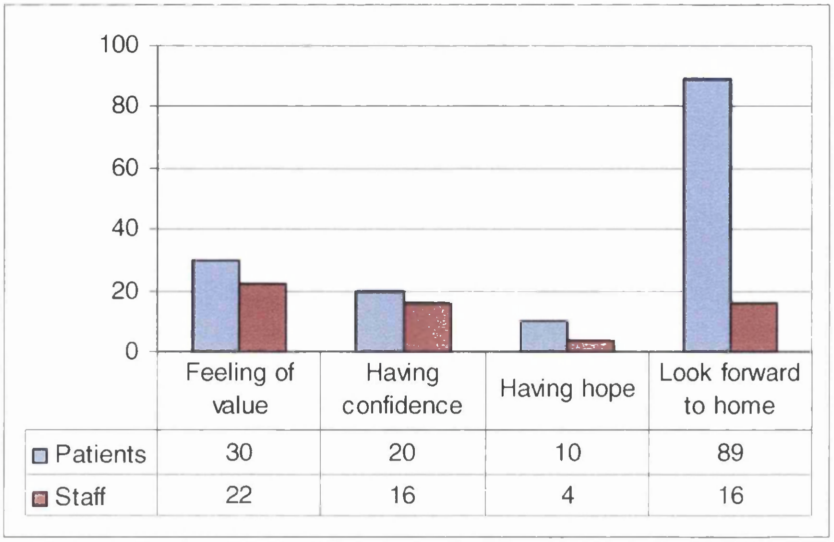
When asked what support meant he said:

> "Helping people deal or come to terms with their problems by helping them in any way really".
>
> (Focus group)

Motivation

Motivation is the final factor of recovery. It comprised of four themes relating to: 'feeling of value'; 'having confidence'; 'having hope' and 'looking forward to going home'. Each of theme is now reported upon. **Figure 5** illustrates the frequency with which each of these themes were mentioned by patients and staff.

Figure 5 Themes that Make Up the Factor Motivation



Feeling of Value

This theme was raised by both patients and staff, with patients raising this issue 30 times and staff 22 times. There was a general perspective from staff that helping people to maintain independence and enabling them to recover and go home helped to increase patients' feeling of self worth. The importance of self worth is illustrated by Tom, a 52 year old patient from a medical ward:

> "When you're feeling a bit rough and you ask to go to the toilet and they bring you a commode, then you end up sitting there for 40 minutes because nobody comes back to you to fetch you, you're not going to feel worth anything".
>
> (Interview)

There was also an issue raised that suggested that some patients who had lost their independence may feel that they were a burden as illustrated by the comments of a senior nurse:

> "I think one of the contributing factors of recovery is their psychological well-being; they have to feel their worth. They have to feel cared for and wanted, they don't want to feel they are a burden to anybody".
>
> (Focus group)

A female staff nurse from a rehabilitation ward observed that, in particular, she found that older patients seemed to value themselves less than younger patients; she felt that this was because they felt that they could no longer contribute to their family:

> "I find that older people don't value themselves because they have come to the end of their life".
>
> (Focus group)

Having Confidence

Having confidence was raised both by patients and by staff. Patients raised this issue 20 times and staff raised it 16 times. Mostly this confidence related to a stage in recovery when the acute phase of the illness was over. Patients then had to regain their ability to become more independent and to prepare themselves for going home. There appeared to be doubts in some patients' minds that they would be able to cope at home as comments by a female patient from the rehabilitation ward shows:

> "I would not want to be here permanently, we certainly want to go home but we can't as we are. I don't think I could cope as I am anyway".
>
> (Focus group)

This fear was clearly acknowledged by Jackie, a therapist from the rehabilitation ward, who said:

> "We need to take away fear from people. Confidence is about knowing that you can do something. When you are talking about walking, it's a fear of falling that takes away confidence. If they have had several falls, that's exacerbated. Confidence is about adapting your abilities to manage things as you are now".
>
> (Interview)

Nursing staff also saw the need to reassure patients and to build up their confidence so that they could manage at home when discharged, as this comment by a female nurse from a medical ward shows:

> "I think you need to build up their confidence. It's about having the confidence to do things that they were able to do before they got ill".
>
> (Focus group)

Encouraged to Have Hope

This theme scored quite low for patients and even less for staff. Patients raised the issue of having hope 10 times with staff raising it just four times. It must be acknowledged, that whilst this study was an exploration of factors that affect recovery, there are many patients who will never completely recover. This situation then presents a dilemma to both staff and patients who need to refocus on what can be positively achieved. It was evident that staff from rehabilitation and cancer wards thought of recovery in a different light to staff from other wards as illustrated by comments from Sharon, a therapist from the rehabilitation ward:

> "Recovery isn't necessarily going back to a stage before they were ill but it's still a recovery. There is still something to be gained......we keep reinforcing that things can improve. Even if they can't return to a job, they can be useful in their own society".
>
> (Interview)

There appeared to be something spiritual about the theme hope especially with regard to patients who were unlikely ever to recover completely. A comment from a nurse working on a cancer ward illustrated this:

> "I used to be quite afraid of talking with people who wouldn't get better, because how could I talk about hope when the thing that was most in their heart was something they were never going to have. For this lady her hope is that her life is going to improve, she is going to re-establish her sleep pattern, she is going to regain her appetite. Now this lady hasn't got a long time to live but the rest of her days can be better".
>
> (Focus group)

The issue of managing unrealistic hope was also raised by a nurse from the rehabilitation ward:

> "Well I think everybody has to have a positive aspect to the way they are feeling at the moment. We've got to put that into people to say, yes I am going to get better, things are going to improve but its got to be a realistic one, its not fair to raise people's hopes if they are unrealistic".
>
> (Focus group)

Jackie, a therapist from the rehabilitation ward, however, took a slightly different approach to raising patients' hope:

> "I don't set them unrealistic goals, that would be raising their hope too much but I don't necessarily squash their unrealistic goals of recovery at an early stage. It's a gradual process where they realise for themselves that things aren't happening but you can still put the positive to them what they can do".
>
> (Focus group)

This somewhat paternalistic approach may, however, be justified as it was apparent that maintaining hope was very difficult for patients when they felt really unwell, as illustrated by Joy, a 46 year old patient from a surgical ward:

> "I thought gosh, how on earth do people manage to keep their hope up, y'know, to keep going basically to help keep up their strength. I thought I couldn't do it but I kept saying to myself, my goodness, I've got to get better".
>
> (Interview)

This seemed to illustrate that hope was closely linked to being motivated, to not giving up and to maintaining the will to recover as a comment by a female staff nurse from a medical ward shows:

> "I think hope fits in with motivation which is very important in relation to having the will to recover.........people need to have hope, they must not give up. They can then go on to recover enough to go home".
>
> (Focus group)

Looking Forward To Going Home

Apart from ‘having good information’, which was raised 113 times, ‘looking forward to going home’ was one of the most frequently raised themes by patients. It was raised 84 times by patients but only 11 times by staff. At interviews and focus groups, comments relating to home were often made by patients; “everybody likes being at home” and “there is no place like home”.

This strong motivator was highly regarded for a number of reasons. For some patients, they greatly missed their families and also worried about them. For example Peter, a 68 year old patient from a medical ward said:

> “I miss my family; it’s not the same as home. As I said to someone the other day it is a wonderful hospital but is not the same as being at home”.
>
> (Interview)

This was especially the case with younger patients who felt their role was to look after their family as a male patient from a surgical ward shows:

> “At my age I think I need to get better to get home to support my family and friends but if I was elderly, I would probably have a different view then because I wouldn’t be supporting my family, they would be supporting me I would imagine”.
>
> (Focus group)

Getting home to ‘look after’ was also a sentiment extended to pets at home whereby patients worried if they were ‘all-right’. This is illustrated by the comments of Bob, a health care support worker from a medical ward:

> “They worry about things like their dog at home without them; this gives them something to fight for, to get better”.
>
> (Interview)

Indeed patients often became emotional when they spoke of home. One female patient from a rehabilitation ward who had been in hospital several months cried as she explained:

> "I had to ask my husband what my kitchen looked like because I couldn't remember".
>
> (Focus group)

Chapter Summary

Chapter 6 has presented findings from the qualitative phase of the study. Respondents' words have been used wherever possible to illustrate an accurate a picture regarding how they felt about the phenomenon recovery. This has been a lengthy chapter because as many quotes as possible pertaining to themes have been included. The rationale for this was that selecting quotes to illustrate just one point of view could give a different overall perspective to the reader regarding how these people felt. Results have been presented based on the five factors of recovery that emerged from the themes identified by respondents. These were: 'therapeutic intervention'; 'core elements of care'; 'collaboration'; 'social interaction' and 'motivation'.

This chapter has highlighted the different perspectives of staff and patients. Staff appear to have their own culture and language that could put patients at a disadvantage in an alien environment. Having information regarding their illness appeared to be very important to patients but less so to staff. Patients raised this issue 113 times as important to recovery. In contrast, staff raised the issue of information just 17 times. A lack of information made patients feel disadvantaged; with the professionals in control. There were examples where patients described being extremely distressed when information was not forthcoming.

In particular there was a perception that older patients were particularly disadvantaged here as they appeared to be resigned to waiting until they were told something. It was suggested that they would not ask if something was bothering them, they would just put their trust in professionals thinking that they know best. This was attributed to how they have grown up; there were even suggestions that older people do not value themselves because they have come to the end of their life.

Having information is a component of the factor collaboration, which entails more that just having information. It involves health professionals and patients working in partnership towards patients' recovery. Collaboration requires patients to take on-board some responsibility for their own recovery. Data revealed that while there were some aspects of collaboration that were perceived to be very important to patients, for example provision of information; there were other aspects that appear to be influenced by how well patients feel.

It was apparent that patients felt very vulnerable when in hospital. There was evidence that one patient received care in such a way that it was against her wishes or cultural norms but because she felt vulnerable she did not protest. Patients felt they were capable of making decisions in every day life but when it came to their own health there was evidence that they felt differently. A contributing factor here was their particular feeling of vulnerability when they felt very ill. At these times, they felt incapable of making decisions. There was strong agreement that during the acute phase of an illness, patients felt they just wanted professionals to make them feel better. Illness and recovery were considered to be in stages: first get over the illness and then start to recover.

When the acute phase of illness was over, it would appear that some patients did want more involvement However, data suggested that there appeared to be a 'doing to' approach to care planning rather than a 'doing with patients' with a 'professionals know best', rather than a partnership approach to care. This resulted in some patients acting in the role that they are expected to act in; while some nurses appeared to adopt a medical model of care that was based on treating acute physical illness rather than adopting a holistic approach.

The second most important theme identified from data was 'looking forward to going home'; this links with the factor 'motivation'. It was raised 84 times by patients but only 11 times by staff. Having someone at home to provide care and support was also perceived to be important by patients who raised this issue 20 times. This was in stark contrast to staff who did not raise the issue at all. Evidence suggested that home was perceived by patients to be important while they were in hospital but a patient's home was not felt to be important by nursing staff. This could possibly be because staff only viewed patients in the role of a patient rather than a person with a home.

Another contrast between patients' and staff views, was in relation to patients getting enough rest. This was regarded as the third most important theme identified by patients, while staff appeared to think it was less important. Having too many visitors at a time when people felt very unwell was identified as being unwelcome to patients. This theme can be seen to be linked closely to patients getting enough rest. Again there was evidence of patient distress and a feeling that recovery could be impeded if patients did not get the rest they felt they needed.

Some of the core elements of nursing care were regarded to be of varying importance. However, 'having help to go to the toilet' appeared to be another area that incurred emotional consequences for some patients. Being unable to use a toilet independently was regarded by many patients as being the "worst part of being in hospital".

Contrasting views described above, illustrate one of the main criticisms of qualitative research whereby the views of one person represent a true account of how they view the world but are not necessarily generalisable. In this instance contrasting views from both patients and staff have illustrated the important point; that each person is an individual. It could be argued that it is this individuality that makes people human. The qualitative phase of this study highlighted how important it is to recognise that each patient is an individual and the only way of finding out their individual views, is to ask them. While this study has identified that each patient is different, there is some consensus about what helps with their recovery.

20 themes have been listed as being perceived important to recovery (see **Table 4**). This table has been based on themes raised most frequently by respondents. There were also issues that were raised by respondents that have not been identified as themes in their own right and this deserves further discussion. For example 'feeling vulnerable' was raised by patients on two occasions in the context of their physical safety. It has been coded into the theme 'being safely looked after'. However 'feeling vulnerable' may not only relate to physical vulnerability but psychological and emotional vulnerability also.

Similarly patients raised the issue of 'anxiety', 'feeling worried' and 'feeling in control'. The issue of hospital infection was raise just once by a nurse and was coded under 'being safely looked after'. The fact that these issues were raised infrequently during data collection cannot be considered to mean that these issues are unimportant. To explore their perceived importance would require further in-depth interviews with respondents specifically being asked their perceptions regarding how these concepts affect recovery. Unfortunately it was not within the scope of this study to have done this but would potentially be a rich source of information for further research.

The discussion above illustrates the complexity of the phenomenon recovery. Reducing data to just 20 themes has made the concept of recovery simpler to visualise and has aided understanding. It has also enabled the production of a user friendly questionnaire. However it must be acknowledged that recovery is a complex phenomenon and that a greater understanding will only be achieved through further enquiry. The second phase of this study, detailed in Chapter 7, goes on to test generalisability of these results through use of a survey used to collect cross-sectional data from a larger sample.

CHAPTER 7
METHOD (QUANTITATIVE)

Overview of Chapter

This chapter describes development and administration of a questionnaire which was used for data collection in the quantitative phase of the study. The instrument was developed from data generated in Phase 1 (the qualitative phase) of the study. The main purpose of developing a questionnaire was to further explore the concept of recovery and to establish whether results from the qualitative phase could be generalised to a more representative sample from the population of patients recovering from ill health after an admission to hospital.

It is acknowledged that development and testing a new questionnaire is a significant and time consuming task. In particular, validating an instrument in terms of construct validity can be difficult (Rudestam and Newton, 1992; Polit and Beck, 2006). This chapter therefore focuses on exploring the construct validity of the instrument by the use of exploratory factor analysis (EFA).

The structure of this chapter provides details of the method used to collect data so that research questions could be answered. It describes design of this phase of the study, a description of the sample and provides a detailed explanation of how the instrument used to collect the data was developed and tested.

Sample

Sample comprised adult patients (over 18 years old) who had been recently discharged after an in-patient stay in hospital. Settings for both phases of this study were the same: a district general hospital and a nearby community hospital (see Chapter 5, p71). It is appreciated that there is no way of ensuring a representative sample unless information is obtained from the entire population. For this study the entire population over a three month period was targeted, however, the actual sample obtained depended entirely on people distributing questionnaires and on respondents, many of whom declined to take part.

Sample size aimed for was 250 respondents. This would give sufficient data for exploratory factor analysis to be undertaken on the new research instrument (see Chapter 8, p161). While a larger sample could have increased the reliability of the factors emerging from the analysis, practical considerations of time and resource constraints did not allow this. In total 600 questionnaires were distributed over three months. Initially it was planned for this to occur over a six week period but it was necessary to extend the distribution period until an acceptable number of responses were returned.

When selecting the sample for the quantitative phase of this study an overriding consideration was the degree that the sample would be representative of all hospital patients. Consideration was also given to avoiding sampling bias. This can occur by systematic over representation or under presentation of some sections of the population. Polit and Hungler (1999) advised that it is helpful to compare sample characteristics with population characteristics in order to identify biases. Information was therefore obtained from the NHS trust regarding the age and gender of all in-patients discharged from hospital in the year that the research was undertaken. This enabled some comparison to be made between sample and population characteristics. As all patients were included in the sample it was anticipated that they would differ in socio economic characteristics thus reflecting perceptions and experiences of different socio economic classes.

Operationalisation of Concepts

Operationalisation of concepts has been discussed previously in the methods chapter for the qualitative phase of this study. In this quantitative phase, themes identified in the first phase of the study have been translated into variables that comprise items of a questionnaire. For clarity, the questionnaire will hereafter be referred to as the 'instrument' and variables will be referred to as 'items'.

Further exploration of the phenomenon of recovery continued into the quantitative phase of the study. The conceptualisation of recovery remained the same, that is, recovery from illness whilst in hospital. This definition assumed that patients had been seriously ill and needed diagnostic tests and treatments that could not be provided by their own general practitioner. Recovery was regarded as the process of getting better, or becoming well, thus regaining improved health and becoming medically fit for discharge from hospital. Results obtained from this phase of the study enabled the following research questions to be addressed:

1. To what extent do responses from the quantitative phase support results from the qualitative phase of the study, regarding factors perceived by adult patients to help them recover from severe illness?
2. Of the 20 items perceived to help with recovery, which do patients consider to be most important?
3. Does care given in hospital meet perceived needs of patients to help them with their recovery?
4. Are perceptions of older people (over 60) with regards to recovery different from other age groups?
5. Is there any evidence that older people do not have their needs met, with regard to recovery, as effectively as other age groups?
6. Do patients perceive that it is important to their recovery to collaborate with nurses and other professionals and to be partners in care?

Development of a Research Instrument

Content of the instrument was based on 20 themes that emerged from the qualitative phase of this study. These were developed into questions or items that comprised the main body of the study. For example 'going to the toilet' was identified as a theme. This was turned into a question regarding the importance of patients being given help to go to the toilet when they needed to.

There are multiple dimensions to the phenomenon recovery. In developing the instrument, the intention was to capture each of these dimensions on a separate scale. Hence the 20 items were categorised into five separate sub-scales, each reflecting a different factor/dimension of recovery (see **Table 6**).

Table 6 Concept of Recovery

Factors/Dimensions of Recovery	Items/Themes
Sub -scale Therapeutic intervention (SPSS name: **intvent**)	Medication Plenty of rest Being made comfortable Keeping active
Sub -scale Core elements of care (SPSS name: **corecare**)	Going to the toilet Washing and dressing Eating and drinking Being safely looked after
Sub -scale Collaboration (SPSS name: **collab**)	Maintaining a routine Being included in plans Being asked opinion Having good information
Sub -scale Social Interaction (SPSS name: **social**)	Staff talking to patients Seeing friends and family Happy staff Having support at home
Sub -scale Motivation (SPSS name: **motive**)	Made to feel of value Being given confidence Given hope Looking forward to going home

Identification of the factors/dimensions of recovery, which formed the sub-scales of the instrument, was made prior to data analysis. A difficulty here is that different researchers could have read different concepts into the 20 items resulting in different groupings of the items and thus identification of different factors/dimensions. Action was taken to minimise this problem by involving two other sources of independent opinion (a member of the hospital research team and a senior nurse) in the process of identifying factors/dimensions of recovery. Subsequently, exploratory factor analysis was used to verify appropriateness of these groupings and is discussed below.

Steps for developing an instrument were in accordance with Polit and Hungler's (1999) and Polit and Beck's (2006) advice. When a first draft had been finalised it was discussed critically with the research department in the hospital in which this study took place. Independent opinion was also sought from the research department regarding appropriateness of questions. Wording for each item was given much thought in order for questions to be as unambiguous as possible, having the same meaning to whoever read them.

The document was then checked for grammatical errors and spelling mistakes. Pre-tests highlighted several areas where improvements could be made with regard to wording and layout. In addition, meetings were held with ward staff who provided further suggestions with regard to layout and user friendliness of the instrument. These meetings with staff also helped to make them feel involved with the research that was about to take place on their wards.

Measurement Characteristics of Instrument

The instrument is comprised of a mixture of categorical (nominal/ordinal) and continuous (interval/ratio) data items (see full version of questionnaire in Appendix IV). It consists of four distinct sections which have different characteristics. Detail regarding each of these sections is now described.

Section 1 Demographical Details

This section comprises six items relating to: gender; age band; whether or not there was a partner at home and/or a pet; what ward respondents were on and length of stay in hospital.

Section 2 Patients' Perceptions

Sections 2 and 3 contain the main body of the instrument. Section 2 was designed to capture patients' perceptions regarding factors that help recovery from illness when in hospital. It consists of a 20 item scale comprising five sub-scales of four items each.

A five point Likert scale was used to measure extent that respondents agreed or disagreed with each statement. Scoring criteria are shown in **Figure 6**.

Figure 6 Scoring Criteria for Likert Scale

1 = Definitely True
2 = Mostly True
3 = Not Sure
4 = Mostly False
5 = Definitely False

Note - missing data were coded 0

It is acknowledged that scales comprising odd options allow respondents to choose the middle point (Polit and Beck, 2006; Scott and Mazhindu, 2006). However, in this instance it was decided to use five point scales. It was reasoned that using even scales may force some individuals to make a choice that they do not agree with when they are genuinely neutral.

Section 3 Patients' Experience

This section aimed to capture patients' experience of whether items perceived to help with recovery, and listed in Section 2, actually happened to them whilst in hospital. Similar to Section 2, it consists of a 20 item scale comprising five sub-scales of four items each. The layout and scoring for this third section of the instruments replicates that of Section 2. This was done purposefully in order that these two sections could be compared during analysis. The 20 items asked in Section 3 are simply rephrased versions of Section 2 questions. Each question is preceded by: "When I was in hospital recently:" An example of a question following this was "When I was in hospital recently: I was given good information about my illness".

Section 4 Identification of Perceived Most Important Items

This section of the instrument simply lists all 20 items identified as important to recovery and patients were asked: "out of the list below: please select the five things that you think most important to help patients recover from illness when they are in hospital". Respondents were asked to list five out of 20 items rather than rate perceived most important items. The reason for this was because in pre-tests of the instrument respondents found this to be the easiest way of responding. Where respondents are asked to make several choices, Polit and Beck (2006) suggested that it is appropriate to treat each item as a separate question. Items were therefore coded as 20 separate dichotomous items, with code 1 signifying a yes response and code 2 signifying a no response. The total frequency of occurrence of all selected items was then used as a score to show the relative perceived importance of each of the 20 items.

Reliability

As this study included development of a new research instrument it was important to ensure internal consistency (degree to which the sub-scales of the instrument were measuring the same attribute). Scales in the instrument were designed to measure dimensions of recovery. They were composed of sets of items which were intended to measure these dimensions and nothing else. Cronbach's alpha was used to test reliability; the correlation coefficient so generated ranged between 0 and 1. Higher values indicate a higher degree of internal consistency. The cut-off point varies, Bryman and Cramer (1999) suggested that a coefficient greater than 0.8 should be aimed for but 0.7 might be sufficient in some circumstances. Polit and Beck (2006) reported that there is no standard for an acceptable reliability coefficient but coefficients of 0.8 or greater are desirable. Scott and Mazhindu (2006) also advocated 0.8 as indicating a high level of internal consistency. A cut-off point of 0.7 was deemed acceptable for scales in this instrument, as it was in a developmental stage.

Twenty items were used to measure patients' perceptions regarding recovery (Section 2 of instrument). These items formed five subscales which were considered to reflect different factors/dimensions of recovery (see **Table 6**). Similarly 20 items were used to measure whether care perceived to be important to recovery, was received (Section 3 of instrument). These items also formed five subscales. Results of Cronbach's reliability for the sub-scales are shown below in **Table 7.**

Table 7 Reliability of Instrument Sub-Scales N = 249

Scale	Alpha
(Section 2 of instrument)	
Therapeutic intervention	0.52
Core elements of Care	0.67
Collaboration	0.79
Social Interaction	0.61
Motivation	0.78
(Section 3 of instrument)	
Therapeutic intervention	0.76
Core elements of Care	0.75
Collaboration	0.87
Social Interaction	0.66
Motivation	0.82

Computing New Variables

There are five scales which make up the concept of recovery. New variables were computed in SPSS to generate these five scales. Variables: 'therapeutic intervention (intvent)', 'core elements of care (corecare)', 'collaboration (collab)', 'social interaction (social)' and 'motivation (motiv)' were thus created (see **Table 6**). This involved summing scores of existing variables to create new variables. It can be argued (Bryman and Cramer, 1999) that this process transforms ordinal data into interval data which permits parametric analysis. Reliability of the newly computed variables for Section 2 of the instrument was $\alpha = 0.71$, whilst reliability of the new variables for Section 3 of the instrument was $\alpha = 0.80$ (when all items were tested together).

Validity

The issue of validity in a newly developed instrument was difficult to ascertain at this early stage and will be developed over time as the questionnaire becomes more widely used and refined. Steps were taken, however, to ensure both content and construct validity in the given circumstances. Recovery can be envisaged as a construct comprising of many dimensions. In order to develop the new instrument, conceptualisation of the construct of recovery was obtained by gaining views from patients who had recently recovered or were in the process of recovery. Views were also obtained from staff who had first hand knowledge and experience of caring for patients during their recovery. This was in accordance with Polit and Hungler's (1999) advice; that when developing new instruments, a thorough conceptualisation of the construct of interest is required in order to capture the domain of enquiry. Content validity was considered to be of importance and was enhanced by incorporating the results of qualitative enquiry into items in the scales of the new instrument (Frank-Stromborg, 1988). It must be noted that whilst both patient and staff views were sought in the qualitative phase of this study; the research instrument was patient specific and thus only administered to patients. Staff views were sought in the qualitative phase of the study in order to fully capture the construct under investigation; however, a separate instrument would need to be developed for staff. Time and resource restrictions prohibited this for the purpose of this study.

In addition to content validity, it was important that construct validity was given consideration. This entailed establishing whether the abstract concept being explored was being adequately measured by the new instrument. Construct validation can be undertaken by using a statistical procedure called exploratory factor analysis. This is a process that identifies clusters of items that go together as unified concepts; these are then referred to as factors (Polit and Beck, 2006). Results of exploratory factor analysis are reported at the beginning of the results chapter (**Chapter 8**).

Reliability and Validity of Section 4 of the Instrument

There was more uncertainty about the reliability and validity of the last scale in the instrument (Section 4) where patients were asked to select five from 20 items. While each of these 20 items had been used previously and shown to have internal consistency when used in Section 2 of the questionnaire, it was difficult to know whether respondents would consistently choose the same five from 20 items over time and on different occasions. The way in which the items were arranged on the scale may have made a difference. For example respondents may have been more likely to chose items at the top of the scale and then have used their five choices before they got to the bottom of the scale. As this instrument was in a developmental stage, this approach to getting patients to prioritise items would need to be tested further. Results must therefore be viewed in the light of this uncertainty.

Other Qualities of the Instrument

In addition to reliability and validity, other qualities of the instrument were given consideration, namely: objectivity, unidimensionality, reactivity and simplicity. With regard to objectivity, the instrument was administered in the same way to each respondent with written instructions for completion. The measuring tool was unidimensional because it had been designed to allow the production of separate scores for the unified factors that were identified (Polit and Hungler, 1999). In addition the instrument was designed to be used without affecting the attribute (recovery) that was being measured. Finally design of the instrument was kept as simple as possible. This helped to reduce risks of errors caused by administration of complicated measures. While great attention was paid to development of a good measuring tool, there were several areas where design of the instrument could be improved.

Design Error of the Instrument

When designing the questionnaire there were many issues that were considered. Piloting the instrument revealed issues that had not been thought of. While there were several pre-tests with small groups of three to six respondents at a time, a design error manifested itself when a larger sample was used. In the scale for 'core elements of care', one item asked if respondents 'received assistance with going to the toilet'. Another asked respondents if they 'received assistance with washing and dressing'. In the design phase no account was taken that some patients would be completely independent in hospital and therefore not need this assistance. Respondents had no option to record not applicable and therefore did not answer these questions. They did, however, in all instances, explain their reason or non-responses in the comment section on the questionnaire.

Sampling error was another form of error that was considered in designing this study. As sampling error decreases as the sample size increases, it was considered that a sample of around 250 would enable statistical techniques to take account of this type of error. It was planned to obtain a sample that was representative of the population being studied. In this instance the aim was to give a questionnaire to every patient on discharge. It was acknowledged, however, that by using this method, the sample would only be representative of the population of patients who are the type of people who complete questionnaires. Unfortunately, the method of data collection allowed no possibility to contact non-responders, whereby a reminder could have been sent (see ethical considerations, in procedure section). Consistency of the measurement tool was considered at the design stage. All questionnaire packs were given out with the same instruction to respondents. In addition to the instrument, a covering letter and an information sheet were provided (see Questionnaire, Appendix IV).

Care was taken to minimise both systematic and random measurement errors. Data cleansing and verification were carried out in order to eliminate data entry inaccuracies. Random errors were minimised by triple checking of the data entry. As there were in excess of 21,000 items, this took some time. There were 13 occasions where there were errors in data entry and these were eliminated at the second and third checking procedure.

Items perceived to be important to recovery from illness were identified from the qualitative phase of the study. The instrument was developed to test if these items were also perceived to be important to a larger sample. There was a need to know whether the instrument was valid as a measurement tool, i.e. was it really measuring what it intended? With regard to reliability, Cronbach's reliability coefficient appeared to indicate an acceptable internal reliability. Polit and Hungler (1999), however, reported that researchers almost always work with fallible measures, and this needs to be borne in mind. We also needed to know if results would be the same if the test was repeated. This will however only be achieved over time when the questionnaire is tested on further samples. Rudestam and Newton (1992) warned that the reliability of an instrument is dependent on the characteristics of a population and will not necessarily achieve the same level of reliability when used in a different population. As previously stated, there are many problems associated with developing a new instrument. This should not, however, stop development of such tools if the outcome enhances patient care. There is just a need to be aware of shortcomings of a new instrument and to interpret results in the light of these.

Pre-testing the Questionnaire

Having developed a research instrument it was essential that it should be subject to rigorous pre-testing. This is recommended by Polit and Beck (2006) in order for the instrument to be evaluated and if necessary refined. The instrument consists of 51 items which required completion. It was important to determine the length of time to administer the instrument and whether respondents would feel this to be too much of a burden. The main aim of the pre-tests was to establish if any part of the instrument was difficult to read or understand and to remove any ambiguity.

A total of five small pre-tests consisting of three to six respondents in each pilot, was undertaken. As a result refinements were made to the instrument. These included minor changes to the wording of some items and redesigning the layout of the instrument to improve presentation and facilitate completion. Improvements included allowing extra space for respondents to make additional comments which encouraged provision of helpful and interesting comments from patients.

Procedure

This section on procedure covers ethical considerations and a description of how the instrument was administered.

Ethical Considerations

Ethical issues have been considered previously in the qualitative methods section where gaining ethical approval for this study was described in detail (Chapter 5, p77). With regard to distribution of the questionnaire pack, all patients were verbally informed that completion was entirely voluntary and that patients would not be able to be identified. There was also a written assurance to patients in the letter attached to the instrument, that all information would remain entirely confidential (see Appendix IV). The accompanying information sheet assured patients that participation was entirely voluntary and that they would not be disadvantaged in any way if they decided not to take part.

The main concern of the ethics committee was that patients should not have questionnaires posted unsolicited to their homes. This concern was addressed by handing patients a questionnaire immediately prior to discharge, thus there was no fear of unwanted intrusion. The instruction to all wards that took part, was that all patients should be given the opportunity to take part in the study, unless it was known by staff that the patients would be going home to die (as often can be the case with palliative patients).

The final recommendation by the ethics committee was that the respondent information sheet should be more detailed. This was amended accordingly. All requested changes were confirmed by the ethics committee and a revised version of the information sheet and the instrument itself was approved by them before distribution took place.

Having initiated distribution of questionnaire packs, I was aware that analysing data could reveal that some respondents may have received an unacceptably poor standard of care in hospital. To cover this eventuality, respondents were advised in the information sheet that if they felt their nursing needs had not been met whilst in hospital, they should write their concerns in the comments box provided. If there had been an occasion when analysing the questionnaires, that I had been concerned that respondents care had been compromised, I would have reported this to the Trust. As questionnaires were anonymised, I would not have broken any patient confidentiality. There was an issue with regard to noise on wards and lack of sleep that some patients were experiencing. This issue came up repeatedly and I passed on the information to the head of quality for the Trust. The matter was then brought to the attention of staff immediately and appropriate action taken. There was just one occasion when a questionnaire contained a signed and addressed letter to me with details of a genuine complaint from one of the respondents. Fortunately, this respondent also advised me that a letter had been sent to the chief executive of the trust. I knew that this would be dealt with appropriately through formal complaint channels.

Distribution

Permission for access to patients was via the trust's Research and Development Committee, followed by written permission from the director of nursing on behalf of the trust board. Distribution was undertaken by ward staff on each ward, under supervision of the ward sister. As stated previously, the Local Ethics Committee would not approve of questionnaires being sent to patients' homes post discharge. This meant that another means of distribution had to be found. Following discussion with the NHS trust where the study was taking place, it was decided that the most practical method for distribution was for ward nursing staff to hand a questionnaire pack to patients at the point of their discharge. Patients then took these packs home with them and were thus under no obligation to complete them and send them back in the pre-paid addressed envelope.

Ward staff were encouraged to hand questionnaires to patients while informing them that these were completely anonymous and confidential. Staff were also asked to reinforce with patients that the focus of the questionnaires was to improve the way in which people are helped to recover from illness. With regard to staff training and information on questionnaire distribution, a meeting was held which was attended by ward sisters or deputies from each ward. A presentation was given to them regarding the origin and purpose of the study. Content of the questionnaire was also discussed in depth and minor changes were made to the content of the patient letter as a result of ward sister input. District nursing sisters also attended this presentation and volunteered to encourage patients at home to complete and return the questionnaires.

Decisions regarding how many questionnaire packs to send to each ward was based on annual throughput of patients through each ward. There were 10 wards/clinical areas in total that took part in the study. The only ward that was not included was paediatrics because it was considered to be a specialised area with regard to obtaining patient feedback. Each of the 10 wards/clinical areas that took part were distributed a batch of questionnaire packs that was proportional in number to their patient throughput. Each questionnaire pack consisted of a questionnaire booklet comprising nine pages and a prepaid addressed envelope. The first page was a letter inviting patients to take part in the research, whilst the second page provided information about taking part and gave a contact number for patients who required further information. The remaining seven pages comprised the instrument itself (see Appendix IV).

Strengths and Weaknesses of Distribution Method

The strength of the sampling method was that it was intended to be a sample that was representative of the population. By handing a questionnaire pack to everyone who was discharged from hospital it was anticipated that all patients would be given an opportunity to take part in the study. There was no coding or numbering on the instrument to identify individual patients but they were asked to state which ward they had been on whilst in hospital. This was at the request of the trust who were interested in obtaining results for individual wards.

From a weakness perspective the main source of error in distribution was human error. While questionnaire packs were distributed to all wards in accordance with a proportional plan, there was no absolute assurance that all questionnaires were handed to all patients on discharge Some wards had good return rates while others were quite poor. It was apparent that some wards were more conscientious at handing out packs than others. It was noted that the best return rates appeared to come from wards where the sisters had a keen interest in research. This seemed to suggest that these staff had been pro-active in handing out packs and encouraging patients to complete.

Despite a varying rate of returns from different wards an overall sample of 249 (42%) was achieved. Polit and Beck (2006) advised that the larger the sample, the more likely it is to be representative of the population and that larger samples result in less sampling error. This view was supported by Parahoo (2006).

Data Analysis

Analysis of data was divided into three main sections, each being treated differently. These sections were: 'demographic data', 'main body of the instrument' and 'selection of most important items'. Demographic data provided statistics that described characteristics of the sample.

The main body of the instrument consists of two discrete sections, each comprising of 20 items scales which were measured using Likert scales. While Likert scales provide ordinal level data, there is an argument that they can be regarded as interval data (Bryman and Cramer, 1999; Polit and Beck, 2006) and could, therefore, utilise parametric tests. However, a criterion for use of parametric tests is that distribution of scores is normal. In this instance this was not the case as seen in **Table 8**, which shows measures of central tendency with regard to data in the main body of the instrument (recovery factors questionnaire).

Table 8. Measures of Central Tendency for Recovery Factors Questionnaire

		Therapeutic Intervention	Core Elements of Care	Collaboration	Social Interaction	Motivation
N	Valid	249	249	249	249	249
	Missing	0	0	0	0	0
Mean		4.65	4.58	5.12	4.76	4.53
Median		4.00	4.00	4.00	4.00	4.00
Mode		4.00	4.00	4.00	4.00	4.00
Std. Deviation		1.06	1.30	1.84	1.25	1.10
Skewness		2.21	2.58	1.79	1.96	2.34
Std. Error of Skewness		.15	.15	.15	.15	.15
Kurtosis		6.84	10.41	2.59	3.76	5.05
Std. Error of Kurtosis		.31	.31	.31	.31	.31

Note: Average scores for each of the five factors are shown.

It was not unexpected that data pertaining to these scales were skewed illustrating that most people were in strong agreement with the questions. The main purpose of the quantitative phase of this study was to establish if a larger population confirmed the results of the qualitative phase. **Table 8** shows that except for 'collaboration', both skewness and kurtosis exceeds 1.96; the distribution can therefore be said to differ significantly from normal (Scott and Mazhindu, 2006). Maltby, Day and Williams (2007) further suggested that with regard to skewness, any statistic above 1.00 indicates that distribution is skewed. The range for each item was 4 – 20.

Selection of statistical tests was based on data distribution and research questions that needed to be answered. The study was not designed to test a hypothesis but rather to explore multi-dimensional concepts of recovery. As illustrated above, data in the recovery factors questionnaire can be seen to be a non-normal distribution and therefore non parametric tests were used for data analysis. Thus, for example, it was considered appropriate to use a Spearman's rho correlation in accordance with Maltby, Day and Williams (2007) guidelines for analysis of two independent continuous type variables. A Kruskal-Wallis H test was used to examine significant differences between different age groups with regard to patients' perceptions of how important they considered the five factors of recovery. A Kruskal-Wallis H test was also used to examine significant differences between different age groups and care received.

CHAPTER 8

QUANTITATIVE RESULTS

Overview of Chapter

This chapter reports results of the quantitative phase of the study. Initially results of exploratory factor analysis are reported. This statistical procedure was undertaken in order to confirm construct validity of the new instrument. This helped establish whether the abstract multidimensional concept of recovery was being adequately measured. This section is then followed by sections reporting results of descriptive and inferential statistics. Analysis looks at relationships between variables and differences between groups. Finally, data regarding patients' comments are also included to augment results obtained from quantitative data analysis. Data were analysed to answer the following research questions:

1. To what extent do responses from the quantitative phase, support results from the qualitative phase of the study, regarding factors perceived by adult patients to help them recover from severe illness?
2. Of the 20 items perceived to help with recovery, which do patients consider to be most important?
3. Does care received in hospital meet perceived needs of patients to help them with recovery?
4. Are perceptions of older people (over 60) with regards to recovery different from other age groups?
5. Is there any evidence that older people do not have their needs met, with regard to recovery, as effectively as other age groups?
6. Do patients perceive that it is important to their recovery to collaborate with nurses and other professionals and to be partners in care?

Results of Exploratory Factor Analysis

Bryman and Cramer (1999) pointed out that in order for factor analysis to be undertaken reliably, it is important that a sufficient sample is used, with an absolute minimum of five participants per item. There were 20 items in the instrument and 249 respondents took part. This would also comply with Gorsuch's (1983) recommendation that an absolute minimum of not less than 100 individuals per analysis is required. Factor analysis was undertaken using SPSS (Release 13). Initially a correlation matrix was computed for the 20 items which made up five sub-scales of the instrument. Undertaking a correlation matrix was recommended by Bryman and Cramer (1999) who advised that if there were no significant correlations between items, they would be unrelated. It would therefore not be expected that they would form one or several factors and conducting a factor analysis would not fruitful. The correlation matrix for the 20 items and their significance levels were examined. The majority of items were significantly and positively correlated at less than the 0.05 level indicating that they may form one or more factors.

The next step was to perform exploratory factor analysis (EFA). Principal axis factoring was used and factors were then rotated to maximise loadings of items and increase identification of factors. Oblique rotation was then undertaken, as described by Bryman and Cramer (1999.)

Bryman and Cramer (1999) suggested that items that correlate less than 0.3 can be omitted as they account for a small portion of the variance and are therefore less important. There were, however, no loadings less than 0.3 in this analysis. An alternative criteria was therefore used (again suggested by Bryman and Cramer, 1999), whereby no item correlated higher with more than one factor. The structure matrix can be seen in **Table 9**, which shows that seven factors were identified.

Identification of dimensions (factors) of recovery was made prior to data analysis. These scales were subjectively put together in a 'common sense' manner in what appeared to be a reasonable fit of characteristics that went together to form a dimension or factor. Undertaking exploratory factor analysis aimed to determine which of the 20 items went together to constitute a factor and which were unrelated. As a result, the process helped to confirm construct validity of scales and sub-scales used in the questionnaire. Differences between factors identified in the questionnaire and those derived as a result of the exploratory factor analysis are highlighted and commented upon. Items with the highest loadings were noted.

Table 9 Structure Matrix for Factor Analysis

Item	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Helped to have confidence	.718						
Encouraged to have hope	.718						
Made to feel of value	.718						
Look forward to going home	.566						
Help to wash and dress		.836					
Help to go to the toilet		.770					
Asked opinion			-.872				
Given good information			-.732				
Enough to eat and drink		.432	**-.635**				
Included in all plans			-.572				
Help to maintain routine			-.569				
Cared for by happy staff				.903			
Staff talk to patients				.483			
Able to see friends and family				.421			
Have support when go home				.516	**.568**		
Given regular medication					.525		
Keep as active as possible					.524		
Safely looked after						.664	
Made comfortable as possible							.794
Able to get plenty of rest							.436

Note: Extraction Method: Principle Axis Factoring
Rotation Method : Oblimin with Kaiser Normalization

Results of exploratory factor analysis are now discussed. Comparisons are made between dimensions (factors) initially subjectively categorised from the 20 items (as depicted in sub-scales, see **Table 6,** p145), and those factors subsequently derived from exploratory factor analysis.

Sub-scale 1 - Therapeutic Intervention
(Factor 5 and Factor 7 in Table 9)

This 4 item sub-scale was categorised as 'therapeutic intervention'. Items from 'therapeutic intervention' appeared in two factors which suggests that these items make up two factors rather than one (see **Table 10**). Reliability for the therapeutic intervention scale was α = .52 and is the least reliable of the scales in the instrument. The item 'Have support when go home' also loaded on factor 5, which would appear to have nothing in common with the other items in factor 5. For ease of cross referencing each item is numbered in the order that they appear in the instrument (see **Table 6**, p145).

Table 10. Therapeutic Interventions - Sub-scale 1 (N = 249)

Items	**Loadings**
1. Given regular prescribed medication **(Factor 5)**	.53
4. Helped to keep as active as possible **(Factor 5)**	.52
3. Made to feel as comfortable as possible **(Factor 7)**	.79
2. Able to get plenty of rest **(Factor 7)**	.44

Sub-scale 2 - Core Elements of Care
(Factor 2 in Table 9)

This 4 item sub-scale was categorised as 'core elements of care'. Two items loaded highly on this factor, with item 7 having a lower loading (see **Table 11**). Item 8 did not have a loading with regard to 'core elements of care' but was identified as a separate factor (factor 6 in **Table 9**). Reliability for this scale was reasonable with α = .67.

Table 11. Core Elements of Care - Sub-scale 2 (N = 249)

Items	**Loadings**
6. Help to wash and dress	.84
5. Help to go to the toilet	.78
7. Enough to eat and drink	.43
8. Safely looked after - **this appears to be a separate item that does not fit in 'core elements of care'**	**.66**

Sub-scale 3 - Collaboration

(Factor 3 in Table 9)

This 4 item sub-scale was categorised 'collaboration'. Two items (11 and 12), loaded highly on this factor with items 9 and 10 loading less (see **Table 12**). There was good reliability for this scale (α = .78). It is noted that 'enough to eat and drink' was also loaded onto factor 3 (in **Table 9**) at -.64. It is not clear why this is so.

Table 12. Collaboration - Sub-scale 3 (N = 249)

Items	**Loadings**
9. Help to maintain routine	-.57
10. Included in all plans	-.57
11. Asked opinion	-.87
12. Given good information	-.73

Sub-scale 4 – Social Interaction

(Factor 4 in Table 9)

This 4 item factor was categorised 'Social Interaction'. Item 15 loaded highly on this factor at .90, with the three other items loading less strongly (see **Table 13**). Reliability for this scale is just below the level generally accepted as adequate (α = .61).

Table 13. Social Interaction – Sub-scale 4 (N = 249)

Items	Loadings
13. Staff talk to patients	.48
14. Able to see friends and family	.42
15. Cared for by happy staff	.90
16. Have support when go home	.52

Sub-scale 5 - Motivation
(Factor 1 in Table 9)

This 4 item sub-scale was categorised 'motivation'. Three items, loaded highly on this factor with item 20 loading less (see **Table 14**). There was good reliability for this scale ($\alpha = .78$).

Table 14. Motivation - Sub-scale 5 (N = 249)

Items	Loadings
17. Made to feel of value	.72
18. Helped to have confidence	.72
19. Encouraged to have hope	.72
20. Look forward to going home	.57

Results of exploratory factor analysis were encouraging for such a newly developed questionnaire. Exploratory factor analysis showed that items grouped together but that there was not an exact fit for all items within each dimension of recovery. It must be noted that categorisation was undertaken subjectively during the qualitative phase of instrument development. This subjective categorisation, however, appeared to closely resemble factors derived via exploratory factor analysis. The main difference being that of the five original factors, 'therapeutic intervention' was divided into two factors by exploratory factor analysis. This is illustrated by **Table 15,** which shows a comparison between five factors identified in the qualitative phase of study and seven factors identified via exploratory factor analysis.

Table 15 Different Methods of Categorising Dimensions of Recovery

Factors Reflecting Five Dimensions of Recovery (via subjective categorisation)	Factors Reflecting Seven Dimensions of Recovery (via Exploratory Factor Analysis)
Therapeutic intervention	Therapeutic Intervention Rest and Comfort
Core Elements of Care	Core Elements of Care Safety
Collaboration	Collaboration
Social Interaction	Social Interaction
Motivation	Motivation

Descriptive Statistics

Wards that Took Part

In total 10 different wards/clinical areas took part in the study (see **Table 16**).

Table 16 Wards That Took Part in the Study

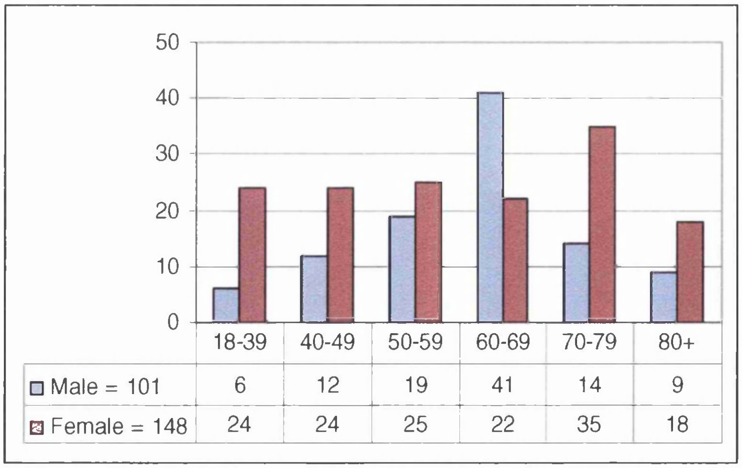
Ward Name	Nature of Ward	Completed Questionnaires Returned	Response Rate
Ward 1	Orthopaedics	26	37%
Ward 3	General Surgery	61	53%
Ward 4	Female Surgery	19	24%
Ward 7	Respiratory	24	35%
Ward 10	Oncology/Palliative Care	22	37%
Ward 12	General Medicine	16	31%
Maternity	Maternity	19	34%
Community	Rehabilitation	8	32%
Medical Admissions Unit	Medical Admissions	2	20%
Coronary unit	Cardiac	2	20%
Ward not indicated	Not Indicated	50	
Total		**249**	

Average response rate was just under 42%. There were three areas with lower response rates. These were the female surgery ward, medical admissions unit and coronary care. A likely reason why these rates were lower was because patients stayed in these areas less than 24 hours prior to being discharged home or being transferred to another ward. There were 50 completed questionnaires that had no ward indicated by respondents or had two or three wards indicated. This illustrated how patients were moved from admission wards to more general wards or patients were moved around the hospital when bed shortages occurred. Motivation of staff who distributed questionnaires could also have had an effect on the response rate. For example, the sister on the general surgery ward was highly supportive with regard to nursing research; this could have increased motivation of patients to return questionnaires. It is usual to increase response rates by sending two reminders to non-responders. Reminders were sent to the wards involved but patient address details were not available.

Characteristics of the Sample

The sample consisted of 249 respondents aged 18 and over, of whom 40% were male. Ages ranged from over 18 years old to 80+ years old with 44% of respondents being under 60 years old. Sample characteristics with regard to gender and age range can be seen in **Figure 7** which illustrates that there were more females than males in all groups except the 60-69 age group.

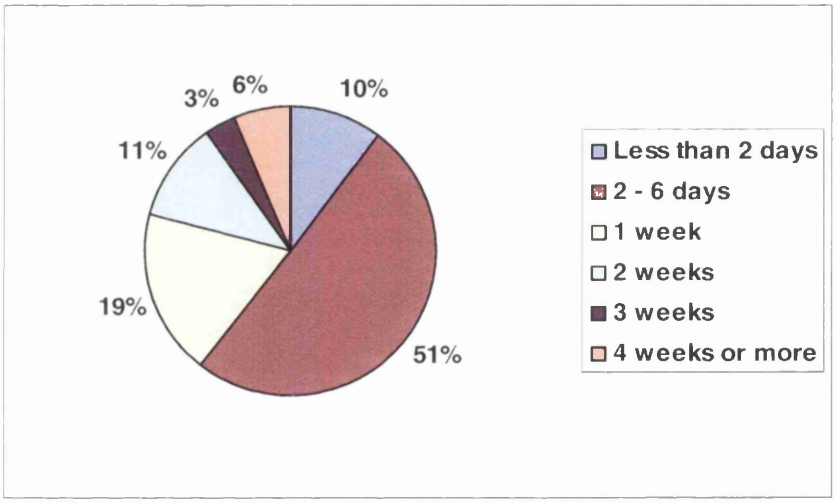
Figure 7. Age Range and Gender Cross Tabulation N = 249



	18-39	40-49	50-59	60-69	70-79	80+
▢ Male = 101	6	12	19	41	14	9
▨ Female = 148	24	24	25	22	35	18

Analysis showed that 18% of respondents lived alone; respondents who had pets totalled 100 (40%). Patients' length of stay in hospital varied from 'less than 2 days' to '4 weeks or more' (see **Figure 8**). It can be seen that 10% of patients stayed in hospital for less than two days. The majority (51%) of patients were in hospital two to six days. Remaining patients spent one week or more in hospital. A correlation between age and length of stay revealed a positive relationship (rho (247) =.401, p = .000). This indicated, not surprisingly, that patients in older age groups tend to stay in hospital longer. Of patients aged 60 and over, 56% stayed in hospital one week or more. This was in contrast to patients under 60, the majority of whom (81%) stayed less than one week.

Figure 8. Length of Patients' Stay in Hospital N = 249



Of 249 completed questionnaires, 37 (15%) were completed with the help of a friend or relative. Older patients (over 60) were more likely to have had help with this.

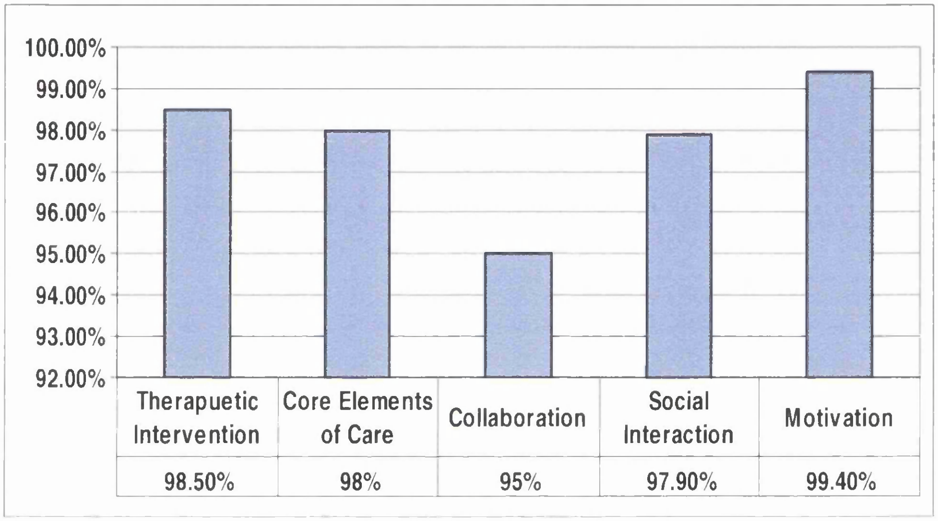
Inferential Statistics

This section now focuses on answering the research questions and results are presented under the headings of each research question.

To what extent do responses from the quantitative phase, support results from the qualitative phase of the study?

Chapter 7 (Quantitative Method Chapter) described how 20 items in the research instrument were categorised into five factors representing dimensions of recovery. These factors were confirmed by exploratory factor analysis, as described earlier in this chapter. **Figure 9** shows percentage of agreement that respondents perceived these factors to be important to recovery.

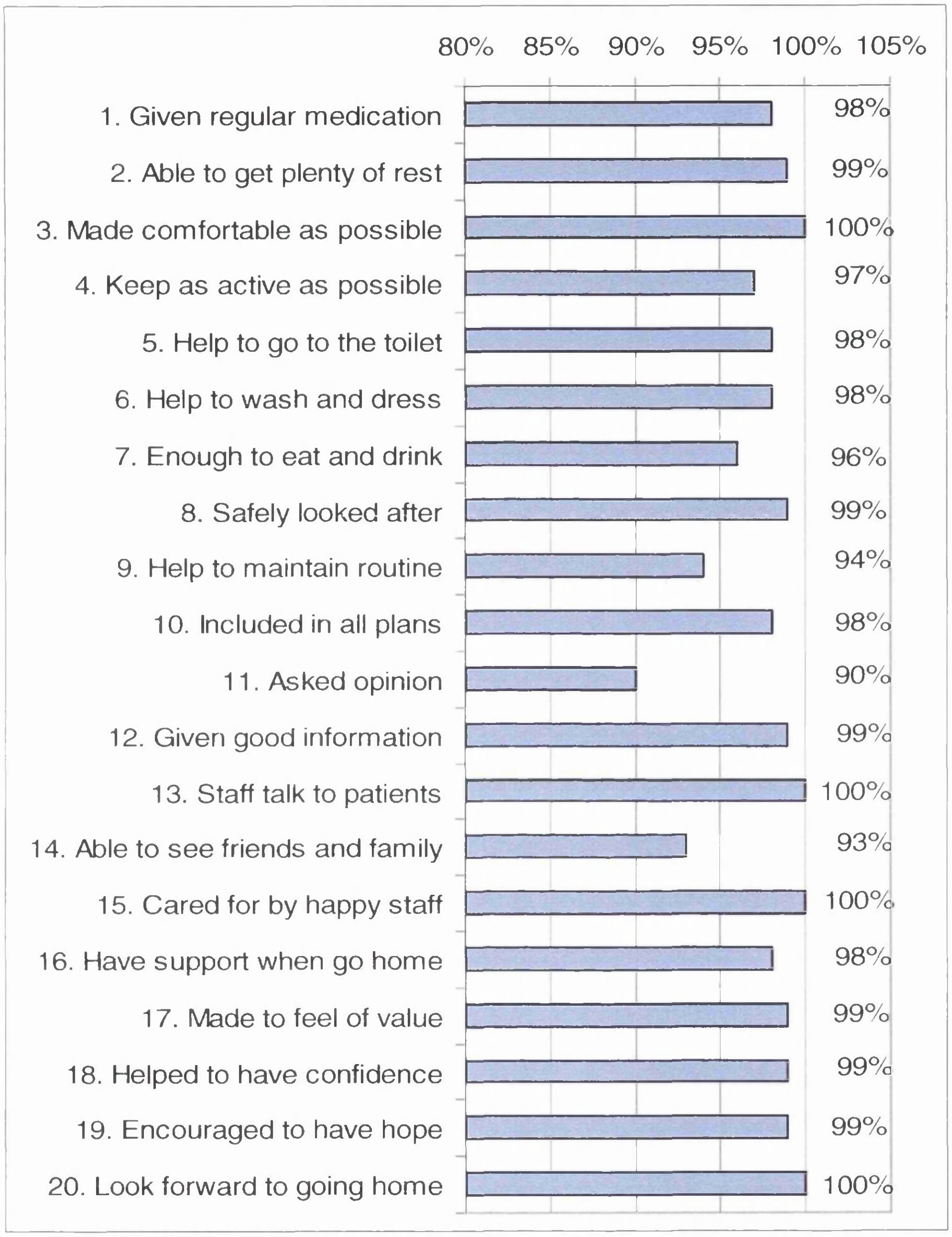
Figure 9 Factors Perceived to be Important to Recovery N = 249



Scores for each factors shown in **Figure 9** indicated strong agreement that these factors were perceived to be important to recovery. It was noted that the factor collaboration showed a lower score than other factors.

In order to explore these results in more detail an analysis was also undertaken for each item within the five factors of recovery. It was anticipated that these more detailed findings would be helpful to feedback to nursing staff to help them understand which elements of nursing care were perceived to be more important to patients. **Figure 10** shows the frequency of agreement that each of the items were perceived important to recovery.

Figure 10 Items/Themes Perceived to be Important to Recovery N = 249



Note: Items 1 - 4 = Factor Therapeutic Intervention
Items 5 - 8 = Factor Core Elements of Care
Items 9 - 12 = Factor Collaboration
Items 13 - 16 = Factor Social Intervention
Items 17 - 20 = Factor Motivation

Figure 10 illustrates that, overall, there was a strong agreement by respondents that each item in the instrument was perceived to be important to recovery. There was a slightly less strong agreement (90%) with regard to 'patients being asked their opinion'. With exceptions of 'being able to see friends and family' (93%) and 'being helped to maintain their routine' (94%), all other items achieved agreement of 96%, or more. The qualitative phase of this study identified that each of these items were perceived to be important. Findings from the quantitative phase confirmed that a larger sample also perceived these items to be important. Because level of agreement was so high between items further analysis was not necessary.

Of the 20 items perceived to help with recovery, which do patients consider to be most important?

From 20 items perceived to help with recovery, patients were asked to select five items they considered to be most important. The rationale here was to establish if patients thought that some items were more important than others. The frequency with which each of the factors was identified was totalled to provide the items which achieved the five highest scores. As there was a joint fifth rating, six items can be seen in **Figure 11.**

Figure 11 Perceived Most Important Factors – N = 249

‘Being given regular prescribed medication’ (162) was perceived to be the most important factor with regard to recovery. This was followed by, ‘having good information about your illness’ (121), ‘being safely looked after’ (119) and ‘being included in all plans’ (113). There were also two joint fifth places of ‘being cared for by happy staff’ (87) and ‘staff talking to patients’ (87).

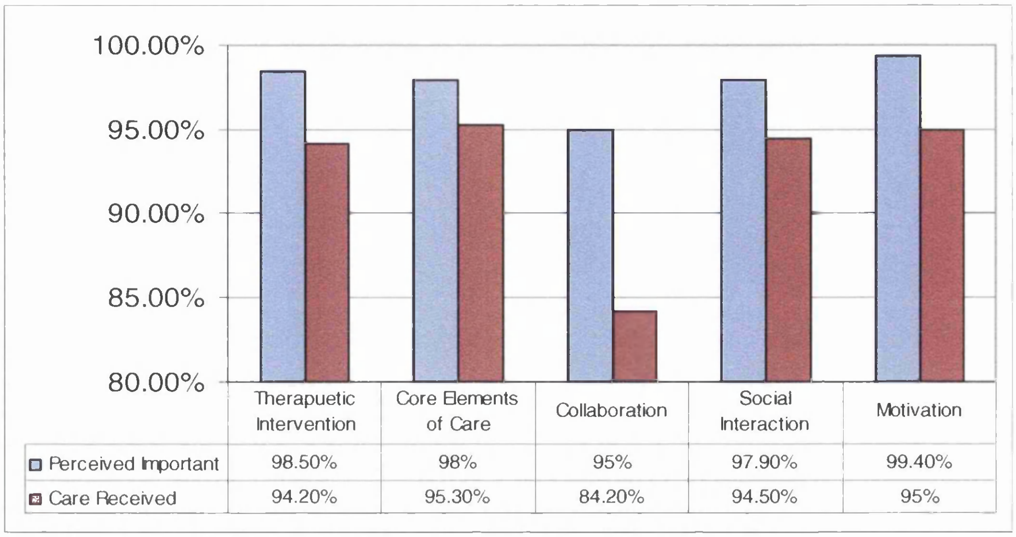
These results were interesting, each of the items in **Figure 11** scored 98% or over in section 1 of the questionnaire as indicated in **Figure 10**, illustrating strong agreement regarding importance of these items to recovery. However, respondents’ ranking changed slightly when they were asked to select the most important items rather than just agree whether or not these items were important to recovery.

Does care received in hospital meet perceived needs of patients to help them with their recovery?

In the main body of the instrument, patients were asked whether they agreed with 20 statements relating to what might help them recover from illness. They were subsequently asked whether they actually received the care that they perceived would help with their recovery. For example, first, patients were asked to indicate degree of agreement regarding whether or not they thought it important that patients should be given regular prescribed medication; they were then asked to indicate degree of agreement with the statement ‘I was given my prescribed medication regularly’. **Figure 12** shows a cross tabulation relating to the five factors: therapeutic intervention, core elements of care, collaboration, social interaction and motivation.

Apart from the factor ‘collaboration’ there was a 94% (or above) agreement that patients actually received the care that they perceived would help them with recovery. ‘Collaboration’ scored slightly less at 84%. These results would appear to suggest that generally patients in the study received the care that they perceived would help them with their recovery.

Figure 12 Relationship Between Factors Perceived Important to Recovery and Care Received N = 249

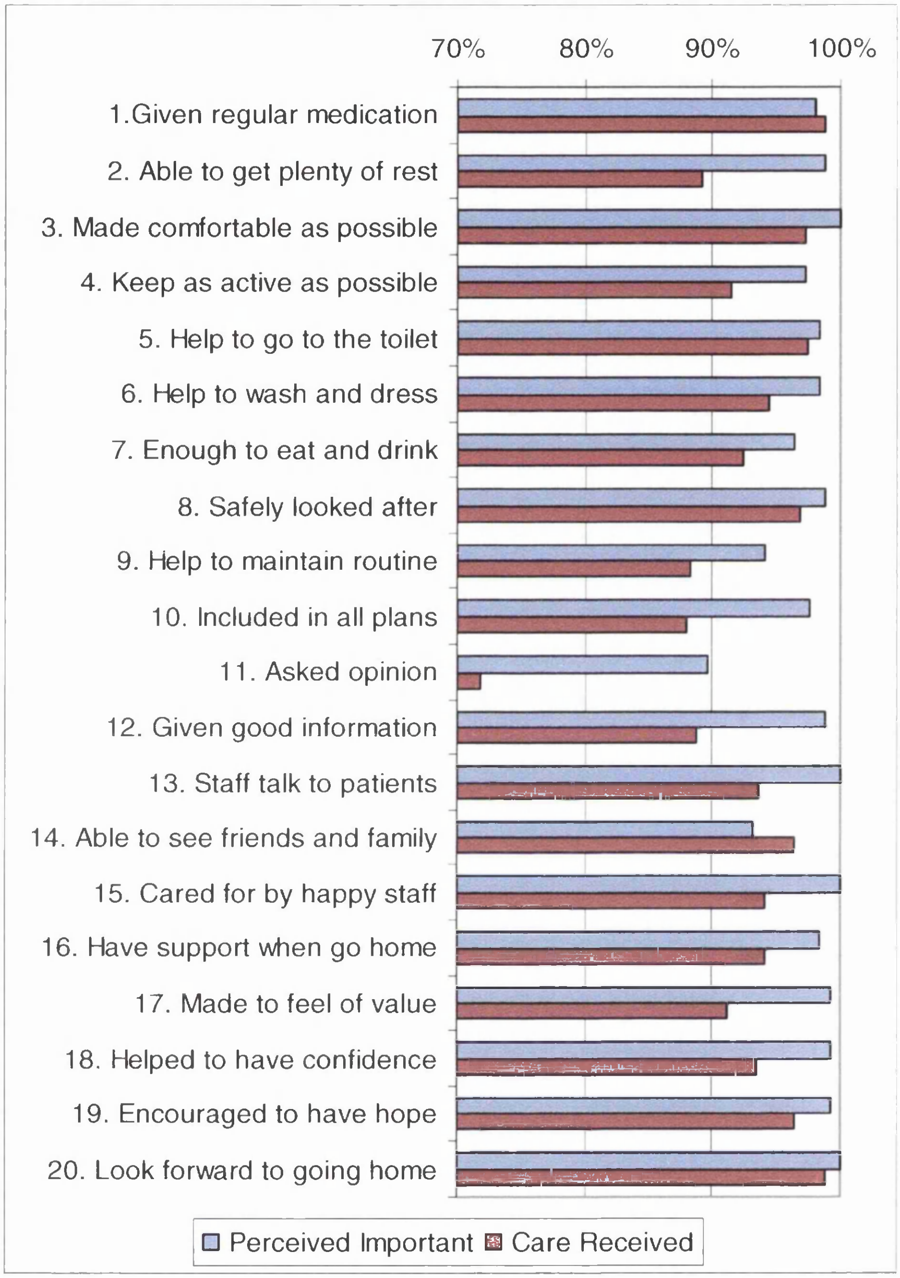


	Therapeutic Intervention	Core Elements of Care	Collaboration	Social Interaction	Motivation
☐ Perceived Important	98.50%	98%	95%	97.90%	99.40%
▨ Care Received	94.20%	95.30%	84.20%	94.50%	95%

In order to explore these results in more detail an analysis was undertaken of the relationship between each of the 20 items perceived to be important to recovery and patients recollection of whether this care was received (see **Figure 13**). Again the rationale for exploring these findings in further detail was so that more information would be available regarding elements of nursing care received. It was anticipated that this would help nursing staff to have more detailed information available regarding areas for further improvement. It would also enable further discussion in the final chapter regarding whether findings from this study supported current literature.

In the majority of cases, care that patients had identified as being important to recovery, was actually received (care received exceeded 90% for 15 of the 20 items). Those items which scored lower with regard to care received were: 'patients being asked their opinion' (72%), 'being included in plans' (88%), 'helped to maintain routine' (88%) and 'being given good information' (89%). These results clarify individual scores of items that make up the factor 'collaboration' (seen in **Figure 12** to score less highly than other factors of recovery with regard to care received). The other item which scored less than 90% was 'able to get plenty of rest' (89%). The issue of patients not getting enough rest was also supported by respondents' comments.

Figure 13 Relationship Between Items Perceived Important to Recovery and Patients' Perceptions of Care Received N = 249



Note: Items 1 - 4 = Factor Therapeutic Intervention
Items 5 - 8 = Factor Core Elements of Care
Items 9 - 12 = Factor Collaboration
Items 13 - 16 = Factor Social Intervention
Items 17 - 20 = Factor Motivation

With regard to medication, the most noticeable feature here was that care received (98.8%) marginally exceeded patients' perceptions of importance of items that help with recovery (98%). This seemed to imply that care received (administration of medication) exceeded patients' perceptions of what should happen. The other occasion where care received exceeded patients perception of what should happen, related to visiting of friends and family whereby care received scored 96.4% and patients' perceptions of items that help with recovery scores 93.2%. This appears to indicate that perhaps not all patients wanted to have visitors. This was supported by respondents' comments on this issue.

A Spearman's rho correlation was used to examine the relationship between patients perceptions of what would help with their recovery and care received. This relationship is illustrated in **Table 17.**

Table 17. Relationship Between Patient's Perceptions and Care Received

Paired Items	Spearman's rho Correlation
Given regular medication	rho (247) = .194, p = 0.002*
Able to get plenty of rest	rho (247) = .265, p = 0.000*
Made as comfortable as possible	rho (247) = .305, p = 0.000*
Keep as active as possible	rho (247) = .315, p = 0.000*
Help to go to toilet	rho (247) = .377, p = 0.000*
Help to wash and dress	rho (247) = .318, p = 0.000*
Enough to eat and drink	rho (247) = .439, p = 0.000*
Safely looked after	rho (247) = .397, p = 0.000*
Help to maintaining routine	rho (247) = .479, p = 0.000*
Included in all plans	rho (247) = .333, p = 0.000*
Asked opinion	rho (247) = .336, p = 0.000*
Given good information	rho (247) = .344, p = 0.000*
Staff talk to patients	rho (247) = .149, p = 0.019**
Able to see friends and family	rho (247) = .292, p = 0.000*
Cared for by happy staff	rho (247) = .327, p = 0.000*
Have support when go home	rho (247) = .357, p = 0.000*
Made to feel of value	rho (247) = .328, p = 0.000*
Helped have confidence	rho (247) = .399, p = 0.000*
Encouraged to have hope	rho (247) = .397, p = 0.000*
Look forward to home	rho (247) = .174, p = 0.006*

* Correlation is significant at the 0.01 level (2-tailed)

** Correlation is significant at the 0.05 level (2-tailed)

In this instance statistically significant and positive relationships were found between each of the 20 paired items. A pair of items consisted of one item asking whether it is important to have medication whilst the other item would ask if the patient actually received medication whilst in hospital. This relationship is illustrated in **Table 17**. All results were significant at the p < 0.01 level except for 'staff talk to patients' which was significant at the p < 0.05 level. These results suggest that care received by patients in hospital was in accordance with their perception of what should happen to help their recovery.

Are perceptions of older people (over 60) with regards to recovery different from other age groups?

A Kruskal-Wallis H test was used to examine significant differences between different age groups with regard to patients' perceptions of how important they considered the five factors of recovery. **Table 18** shows mean rank scores for different age groups were found to be statistically significant for the factors 'social interaction' and 'motivation' (p< .05).

Table 18 Mean Rank Scores of Age Group for Recovery Factors 'Social Interaction' and 'Motivation'

Factor	Age Range	N	Mean Rank	Respondents In agreement
Social Interaction **P = .034**	Under 40	30	111.70	100%
	40 – 49	36	140.10	92%
	50 – 59	44	148.00	98%
	60 – 69	63	117.83	100%
	70 -79	49	114.17	100%
	Over 80	27	118.56	100%
	Total	249		
Motivation **P = .019**	Under 40	30	111.67	99%
	40 – 49	36	114.29	100%
	50 – 59	44	128.88	99%
	60 – 69	63	127.17	100%
	70 -79	49	117.07	99%
	Over 80	27	157.11	96%
	Total	249		

There were some minor differences between age groups for the factors 'social interaction' and 'motivation. However, the level of agreement for all groups was so high' (minimum of 92% for social interaction and 96% for motivation), that no further analysis was appropriate and it would appear, from this sample, that perceptions of older people with regard to recovery are no different from those of other age groups.

Is there any evidence that older people do not have their needs met, with regard to recovery, as effectively as other age groups?

A Kruskal-Wallis H test was also used to examine significant differences between different age groups with regard to patients' self reported experience of whether they actually received the care that they considered important to recovery. There were differences in mean rank scores for different age groups in each of the factors: 'therapeutic intervention', 'core elements of care', 'social interaction' and 'motivation'. These scores were not, however, found to be statistically significant ($p > .05$). This seemed to indicate that there was no evidence that older people did not have their perceived needs met, with regard to these factors.

For the factor collaboration, there were variations in mean scores across age groups (see **Table 19**). It is noticeable however that the age group 80+ scored highest for the Kruskal-Wallis H test and lowest for reported care received. These findings were statistically significant at the $p < .05$ level.

Table 19 Mean Rank Scores of Age Group for Care Received - Recovery Factor 'Collaboration'

Factor	**Age Range**	**N**	**Mean Rank**	**Care received by respondents**
Collaboration **P= .018**	Under 40	30	139.98	63%
	40 – 49	36	131.64	67%
	50 – 59	44	129.85	75%
	60 – 69	63	100.91	86%
	70 -79	49	122.42	78%
	Over 80	27	152.48	59%
	Total	249		

These results could suggest that patients over 80 did not have as much opportunity as other age groups to collaborate in their care. As this is a new instrument, and the sample of 80+ year old respondents was just 27, these results are noted but must be viewed with caution. However, it must also be noted that of this age group 93% perceived collaboration to be important. This perhaps suggests that these patients wanted to engage in decision making about their care but were not enabled to do so. Results from the qualitative phase of this study suggested that older people are reluctant to ask questions. There was little in the data regarding whether patients distinguished between staff although one older male patient stated that he couldn't tell the difference between therapists nurses and carers and it did not matter to him as long as they took time to talk to him. .There was also evidence that doctors did not always communicate well with patients but there was contrasting evidence from one younger female patient that she had not found this to be the case. Perhaps the barriers to communication and collaboration are more pronounced with older patients due to a lack of time to engage with them.

Do patients perceive that it is important to their recovery to collaborate with nurses and other professionals and to be partners in care?

Findings relating to this research question have already been discussed and are illustrated **Figure 9**. This shows that 95% of respondents perceived that collaboration was important to recovery. However, as previously discussed, this score is lower than the other factors perceived to be important to recovery.

Patient Comments

In the main body of the research instrument (sections 2 and 3), patients were asked to indicate agreement or disagreement with items on each page. They also had opportunity to make comments relating to each factor of recovery, in a comments box provided on each page. The page layout of the questionnaire enabled these comments to be easily grouped under each item. This resulted in 116 individual comments being recorded from 65 of the 249 respondents. **Table 20** shows how many comments were made about each item in the instrument. It can be seen that 101 comments were specifically related to items in the instrument. Another 15 general comments were made complementing the staff on their hard work and saying how busy they were. Miles and Huberman (1994) highlighted the importance of providing a logical chain of evidence which incorporates displayed data and analytical text, thus allowing the reader to recreate the journey leading to conclusions. All information perceived to be important to this study has therefore been included. Data displayed in **Table 20** illustrates that respondents volunteered to add additional comments in support of their agreement or disagreement with statements made on the questionnaire.

Table 20 Respondents' Comments N = 249

Subject and Number of Comments Made	
Medication	3
Having plenty of rest	10
Being made comfortable	4
Keeping active	3
Going to the toilet	6
Washing and dressing	4
Eating and drinking	6
Being safely looked after	0
Maintaining a routine	9
Being included in plans	3
Being asked your opinion	1
Having good information	13
Staff talking to patients	6
Seeing friends and family	18
Happy staff	11
Having someone at home	0
Made to feel of value	1
Being given confidence	0
Having hope	0
Looking forward to going home	3
Total	**101**

Previously discussed findings illustrate that there was high level of agreement for statements made. Generally, comments made by respondents supported their decisions to agree with the statement. However, there were exceptions where patients wished to explain why they disagreed with the statements. These instances are noted below.

With regard to maintaining usual routine while in hospital, the following comments illustrate that these patients did not agree that their routines could be maintained while in hospital:

> "Maintaining their routine is an unreasonable demand by the patients; after all they are in hospital".

Another respondent commented:

> "It's not possible to keep to your own routine in any hospital".

With regard to having good information, the following comment indicates that information needs were not met:

> "I found lack of information terrible like waiting for a scan all day then told I would not have one. Ended up not knowing what was happening and upset and confused".

Another respondent commented:

> "I was kept in the dark. Instead of discussing it with me they would go out of the ward and discuss my case out of view. It left me wondering there was something more wrong with me than I had been told".

With regard to seeing friends and family, the following comments indicate disagreement that visiting of friends and family was helpful:

> "I feel some sort of restriction could be applied to how many visitors at any time to a bed as a hospital ward is no place for something that resembles a rugby scrum. It's unfair on both other patients and staff".

Another respondent commented:

> "I think friends and family should only be allowed to visit at visiting times unless it is absolutely urgent for them to visit at any other time".

Chapter Summary

This chapter initially provided details of exploratory factor analysis undertaken to test the construct validity of the new instrument. Information regarding both setting and sample for the quantitative phase of this study was then provided. A sample of 249 (42%) was achieved and findings from the quantitative phase of the study suggests support for findings from the qualitative phase. There was a high level of agreement by respondents that the factors and 20 items, identified in the qualitative phase of this study, were important to recovery. Of these 20 items, six were shown to appear more important to respondents than others, these were in relation to: medication; information; being safely looked after; being included in plans; happy staff and staff talking to patients.

With regard to the research question, whether care received in hospital met perceived needs of patients, there was strong indication that this was the case. There was no evidence that older patients (over 60) had different perceptions with regard to recovery from other age groups but there was evidence that generally older patients had their care needs met as effectively as other age groups. There was some evidence that patients over 80 years old did not have their needs met as effectively as other age groups with regard to collaboration; despite 93% of this age group indicating that they perceived that collaboration was important.

There was also evidence that all patient age groups perceived that it is important to their recovery to collaborate with nurses and other professionals and to be partners in care. These findings, however, must be viewed with caution because the instrument used is in a developmental stage.

Finally, data relating to comments made by respondents on the questionnaire have been briefly reported and help augment the quantitative data. The following discussion chapter (Chapter 9) continues with more comprehensive exploration of these results viewed in the context of current theory and literature and findings from the qualitative phase of this study.

CHAPTER 9

DISCUSSION

Overview

The final chapter of this study discusses findings from both qualitative and quantitative phases of this study. The chapter is structured around answering each of the research questions. Results are linked to existing literature and discussed in the context of existing knowledge. Implications of the study for current theory are also discussed and the work of Henderson (1960), Roper et al. (1980) and Heath and Law (1982) is noted. Limitations of the study are examined, in particular, those that may affect generalisability of results. The instrument used in the quantitative phase of the study remains in a developmental stage and this is borne in mind when considering results. Finally, recommendations for further research are made and implications of the study for nursing practice are considered prior to a final conclusion.

Significant Findings

Twenty themes were derived from qualitative data collected during the initial phase of the study. Data were collected via individual interviews and focus groups. Themes were subsequently categorised into five factors or dimensions of recovery: ‘therapeutic intervention’; ‘core elements of care’; ‘collaboration’; ‘social interaction’ and ‘motivation’. An instrument was developed from the themes and data for the quantitative phase of the study was collected via distribution of a recovery questionnaire. Respondents were asked to rate agreement with items perceived to be important to recovery and also to report whether care received was in accordance with these perceptions. It must be noted there was strong agreement that the items identified in the qualitative phase of the study were also perceived to be important by a larger sample in the quantitative phase. This strong agreement plus the small sample size within age groups made comparison between age groups difficult to assess; this is acknowledged. Respondents were also asked to select five from 20 items in the instrument that they considered most important. This resulted in a ranking of the six items perceived by patients to be most important.

Respondents included in the qualitative phase of the study comprised both patients and staff; data for the quantitative phase were collected only from patients. Results of this study are presented in order of the research questions, commencing with question 1, and focusing first on the recovery factor ‘therapeutic intervention’.

Question 1, what factors do adult patients perceive could help them recover from severe illness?

Therapeutic Intervention

This factor comprised: ‘having medication’; ‘having plenty of rest’; ‘being made comfortable’ and ‘keeping active’. Findings from qualitative data indicated that while ‘having medication’ and ‘keeping active’ were perceived to be important by patients and staff, ‘having plenty of rest’ was perceived to be more important to patients than to staff. The importance of rest and sleep to recovery was raised 59 times by patients and nine times by staff in the qualitative phase of this study, while there was also strong agreement of its importance in the quantitative phase. ‘Being made comfortable’ was also perceived to be important to patients but noticeably staff did not raise this as important to recovery. Data collected from the larger sample (i.e. the quantitative phase of the study) indicated that 98.5% of patients regarded therapeutic intervention as important to recovery and that all patients felt that being made comfortable was important to recovery.

These findings are in keeping with the literature on this topic. There is no doubt that drug and therapeutic intervention has transformed some diseases (Dorn, 2007). However, it is also known that adverse affects of medication are an important cause of morbidity (Jordan et al, 2002; Howard and Avery, 2004). It was noticeable that no issues were raised by respondents with regard to negative affects of medication; this could imply trust in the medical profession or that patients were simply unaware of potential adverse affects of treatment.

With regard to 'having plenty of rest', patients spoke in the context of both rest and sleep and there were direct quotes (collected in both qualitative and quantitative phases of data collection) which indicated patients felt that they do not get enough rest and sleep in hospital. Duxbury (1994) found that sleeplessness was distressing to patients which reflected the findings of this study. The problem of not getting enough sleep was acknowledged in the literature with the most common problem found to be due to disturbance of ward activities. Hogg (1998) highlighted the importance of finding solutions to this problem. The importance of sleep was reinforced by Southwell and Winstow (1995) and Reid (2001).

From a nursing perspective, ensuring rest and sleep was recognised by Henderson (1960) as a fundamental component of nursing. Rest has been consistently quoted in nursing documents as key to recovery following illness (Roper et al., 1980; Heath and Law, 1982; Welsh Assembly Government, 2003). Given that ensuring patients get rest and sleep is an important function of nurses, and that it is usually only nurses who are consistently present on a ward at night time, it is clear that this issue is a nursing responsibility. Patients in the study accepted that there are sick people on a ward at night who need to be attended to but there appears to be little explanation for banging, loud talking and laughing at night, as so distressingly described by patients, unless staff were unaware of the distress that this caused to patients.

Core Elements of Care

This factor comprised: 'being helped to the toilet', 'being helped to wash and dress'; 'having enough to eat and drink' and 'being safely looked after' (being safely looked after entailed having knowledgeable well trained staff looking after patients, ensuring that no harm came to them). Findings from qualitative data indicated that each of these aspects of 'core elements of care' was perceived important by both patients and staff. There were differences; patients perceived 'going to the toilet' as more important than staff, while staff perceived 'washing and dressing' and 'eating and drinking' as more important than patients.

Noticeably, staff also perceived 'being safely looked after' more important than patients. This item was raised 66 times by patients and 34 times by staff. In the quantitative phase of the study, 98% of the sample felt that 'core elements of care' were important, illustrating that the larger sample supported qualitative results. 'Being safely looked after' achieved the highest level of agreement (99%). Nursing literature also supported that these core components of nursing care are important (Henderson, 1960; Roper et al. 1980; Heath and Law, 1982; Welsh Assembly Government, 2003). Bond (1998) stressed the importance of nutrition with regard to recovery and also to wound healing.

The greater relative importance given by staff to patients being safely looked after, is possibly due to an increased emphasis in the National Health Service on clinical governance and risk management (Welsh Assembly Government, 2005). In addition, from a nursing practice perspective, the Nursing and Midwifery Council Code (2008) has a specific section on safety, although it uses the term 'protect' patients rather than safely look after them.

Collaboration

This factor comprised: 'maintaining routine'; 'being included in plans'; 'patients being asked their opinion'; and 'having good information'. Findings from qualitative data indicated that each of these aspects of the factor 'collaboration' was perceived important by both patients and staff. 'Having good information' was perceived by patients to be very important to recovery; patients raised this issue on 113 occasions in contrast to 17 times by staff. In the quantitative phase of the study, 95% of the sample felt that collaboration was important, illustrating that the larger sample supported qualitative results but the level of agreement for this factor was not as high as the other four factors of recovery. Having good information achieved the highest level of agreement (99%) within this factor. There were, however, two of the lowest levels of agreement for items in this factor which reduced the overall score for the factor 'collaboration'. These were for 'being helped to maintain a routine' and patients 'being asked their opinion', which achieved 94% and 90% respectively. The lower level of agreement for 'maintaining a routine' can perhaps be explained; as this quote (from a male patient on the surgical ward) inserted in the open ended comment box of the questionnaire illustrated:

> "Maintaining their routine is an unreasonable demand by the patients, after all they are in hospital".

Patients' perceptions of the hospital appeared to be that it was a regimented place that they were expected to fit into rather than having their individual needs met. This view was held despite the fact that when nursing assessments were undertaken for these patients, routine should have been discussed with patients with regard to their usual toileting and sleeping routines. In the literature, Bytheway (2001) advocated that routine needs to be taken into account particularly with medication. It is understandable, however, that in a hospital, it would not be possible for every patient to have their individual routines met, for example with regard to food and mealtimes. With this in mind, Henderson et al. (2007) suggested that it is important to provide patients with information regarding nursing ward routines. This would enable patients to have the security of a routine, albeit not their own.

Patients 'being asked their opinion', to make choices or being involved in decision-making achieved the lowest agreement of all items on the instrument. There appeared to be acquiescence by patients that they would do as they were told and that professionals know best. Patients recalled that when they were very ill, they just wanted professionals to take over because they felt incapable of making any decisions. There was also a feeling that staff had control because of patients' dependence at this time and also because staff had information that patients might not have.

With regard to the factor 'collaboration' there is wealth of literature supporting a move to a greater partnership between professionals and their individual patients. This is comprehensively covered in the literature review (Tutton and Ager, 2003; Simpson, 2007) but there are many barriers to this happening.

Literature supports the benefits of patients being more involved in their own care but this probably needs to be led more by professionals so that patients feel comfortable with being encouraged to be involved. Woodbridge and Fulford (2003) supported this move and wrote that there has already been a change of view from decisions based on professional values to reflect the values of patients. Not everyone, however, considered that patients input should be taken on board. Tee et al. (2007) pointed out that evidence concerning this is derived from qualitative studies and that more research is needed from larger samples of patients.

This is a valid point and it is anticipated that results from this study will support the need for more collaboration between patients and health professionals so that a mutual understanding and agreement is reached. Mayor's (2005) study of 1713 stroke patients showed that patients wanted to take part in decisions about their care, and staff respecting and recognising patients' 'expertise' about their own illness was likely to increase participation.

In both the qualitative and quantitative phases of this study, information was seen to be particularly important. It was raised 106 times in phase 1 of the study (more frequently than any other item) and 99% of the sample felt that information was important in phase 2 of the study. Qualitative data also illustrated how distressed patients could become; as this quote (from a female patient on the medical ward) inserted in the open ended comment box of the questionnaire illustrates:

> "I was kept in the dark. Instead of discussing it with me they would go out of the ward and discuss my case out of view. It left me wondering there was something more wrong with me than I had been told".

There were also comments from respondents in the qualitative phase of the study who described how information helps to take away worry and fears associated with being ill and being in hospital.

Social Interaction

This factor comprised: 'Staff taking time to talk to patients'; 'patients seeing friends and family'; 'happy staff' and 'having support when patients go home'. Findings from the qualitative data indicated that each of these aspects of the factor 'social interaction' was perceived important although to different degrees by patients and staff. 'Staff taking time to talk to patients' was perceived to be quite important to both groups of respondents, being raised 25 times by patients and 24 times by staff. The underlying issue here was 'time', with staff feeling that talking to patients was important but not always having time to do it. Having time to talk to patients was cited as a reason why staff liked bathing patients as this allowed them both time and privacy to talk (Henderson 1960; Fawcett, 2003). In the quantitative phase of the study all respondents agreed that this item was important.

'Seeing friends and family' and 'happy staff' were perceived important by both staff and patients but in both instances was considered more important by staff. There was less agreement by patients in the quantitative phase that 'seeing friends and family' was important (93%). There were many comments from patients in both phases of the study who regarded visiting as not always appropriate when patients were feeling ill. The Welsh Assembly Government (2003) recognised that there can be problems associated with visiting in hospital and recommended that patients should be able to have visitors within reasonable hours but consideration should be given to the needs of others.

With regard to 'happy staff', it was felt this was not only an indicator of good morale on the ward but it actually boosted staff morale especially when undertaking some of the more difficult and emotionally draining aspects of their role. Patients stated that having happy staff could make a difference to their entire day although it was also noted that inappropriate laughing was not appreciated when people are feeling ill.

The final theme in the 'social interaction' factor was 'having support at home'. This meant patients knowing that they would have someone to support them when they were discharged from hospital and wouldn't be left on their own.

Patients perceived this to be important and raised this issue 20 times yet staff did not raise this issue at all. In the quantitative results 98% of respondents agreed that 'having support at home' was important.

With regard to the literature for social interaction, Henderson et al. (2007) highlighted the importance of nurses developing meaningful relationships with patients while Savage (1995) wrote of the need for physical presence with patients in order to get to know them in a hospital setting. It is also documented that humor and friendliness is helpful especially creating a comfortable environment in the context of sharing information (Fosbinder, 1994; Johnson and Smith, 2006). Martin (2006) found that humour may moderate effects of stress, however McCreaddie and Wiggins (2008) reported that nurses believed that humour should be used with caution. This is supported by findings from qualitative data in this study, whereby poorly patients found laughter inappropriate, especially at night when they were trying to sleep.

Motivation

This final factor comprised: 'being made to feel of value'; 'being helped to have confidence'; 'having hope' and 'looking forward to going home'. In the qualitative data each of these aspects of the factor 'motivation' was raised by both patients and staff. It was noted that in all instances, patients perceived these issues to be more important than staff. This difference was particularly marked with regard to looking forward to going home, whereby patients raised this 89 times compared to staff who raised it 16 times. In the quantitative phase of the study, 99.4% of the sample felt that the factor 'motivation' was important, illustrating that the larger sample supported qualitative results. This factor was perceived to be slightly more important than the other recovery factors.

These findings linked well to the literature relating to motivation. For example; Brodie et al. (2008) reported that proactively motivating patients could have a beneficial impact on their recovery. It is also well documented that psychological factors influence the outcomes of physiotherapy treatment (Partridge and

Johnson, 1989; Burton et al., 1994). In particular, Metcalfe and Klaber Moffett (2005) found that motivation helped benefit patients' recovery outcomes.

However, there is also opinion that it is inappropriate for nurses to adopt a positive attitude and to foster false hopes when a patient is unlikely to recover (Rittenberg, 1995; De Reave, 1997). Nurses should support patients' ability to have hope and be positive but this should be based on patients' values and beliefs rather than nurses'. This illustrates the individuality of each patient and the need for nurses to get to know their patients well.

Items Perceived to be Most Important

Of the 20 items perceived to help with recovery, respondents selected five items that they perceived to be most important. 'Being given regular prescribed medication' was perceived to be the most important factor with regard to recovery. This was followed by, 'having good information about your illness', 'being safely looked after' and 'being included in all plans'. There were also two joint fifth places of 'being cared for by happy staff' and 'staff taking time to talk to patients'.

It is not unexpected that patients perceived medication to be so important. While the medical model of care might be criticised because it does not always incorporate a holistic approach to care, it is apparent that patients have 'faith' in the benefits of modern medicine. The interesting aspect of these results is that patients did not perceive the physical aspects of care (going to the toilet, washing and dressing or eating and drinking) to be as important as the more holistic factors of recovery: collaboration and social interaction. While nurses often appear to be concerned with doing physical tasks for patients, it would appear that patients perceive that staff getting to know patients and providing them with information is more important. These results could be unique to this particular sample of respondents so cannot be considered to be generalisable. However, the findings do reflect current literature, that medication has a beneficial affect on recovery but there are other psychosocial factors that need to be considered.

To conclude discussion of the first research question, the qualitative phase of this study identified 20 themes perceived to be important to recovery. These were seen to comprise five factors or dimensions of recovery. The quantitative phase of the study illustrated that these factors were also perceived to be important by a larger sample thus making the findings more generalisable. The literature supports these findings with regard to recovery and no disconfirming evidence has been found. The exceptions being medication whereby inappropriate use can be harmful to patients and that humour should be used with caution. Having established that all of these aspects of care were perceived to be important to patients while in hospital, the next section of this discussion explores whether this care was received by respondents.

Question 2, Does care given in hospital meet the perceived needs of patients to help them with their recovery?

The quantitative phase of this study set out to establish if a larger sample supported findings from the qualitative phase. It also aimed to establish if care that patients perceived as important to recovery was received by them when they were patients in hospital. There is much anecdotal evidence that care in hospitals today is not good particularly with regard to some more holistic aspects of care. Henderson et al. (2007) found that patients' immediate needs were mostly attended to in a timely manner, this included hygiene, nourishment, mobilising and pain relief. However, availability of nursing staff when needed scored poorly with patients. Walsh (1994) and Maben et al. (2006) highlighted that workload and organizational demands are at conflict with the delivery of nursing care.

Findings in this study, regarding whether patients received care they perceived could help with recovery, were very positive. For four of the factors of recovery: 'therapeutic intervention'; 'core elements of care'; 'social interaction' and 'motivation', 94% (or over) of the sample self-reported that they received the care that they perceived to be important to recovery. Noticeably the factor 'collaboration' achieved the lowest level of agreement that care was received (84.2%).

The lowest level of agreement that care was received within the factor 'collaboration' was 'patients being asked their opinion' (72%). This included being asked to make choices and participate in decision making. There is little in the literature to compare this result other than the study by Efraimsson et al. (2006) which indicated that patients felt uncomfortable participating in decisions about their care and treatment due to perceived lack of knowledge. Dodge (1969) noted that patients may feel powerless and apprehensive in an alien environment.

In this section relating to care received, there were two unexpected findings which must be noted. These were with regard to 'medication' and 'seeing friends and family'. For 'medication' care received (99%) marginally exceeded patients' perceptions of items that help with recovery (98%). This seemed to imply that care received (for administration of medication) slightly exceeded patients' expectations. The other occasion in this study where care received exceeded patients perception related to 'visiting of friends and family' which scored 96% and 93% respectively. For all other items, care received was lower than patients' perceptions of items that help with recovery.

A possible explanation for high nurse compliance with administration of medication is because staff could be disciplined if they do not administer medication as prescribed. It is considered a duty of care, under the Nursing and Midwifery Council code and an omission in practice that could ultimately result in loss of registration. A point that needs to be noted here is that if a nurse does not administer a patient's medication (without good reason) she/he would be liable for disciplinary action. However, if a nurse does not take an active part in collaborating with those in her/his care, it probably would not be regarded as an omission of care or render the nurse liable to disciplinary action. This is despite the fact that the responsibility of nurses to collaborate with patients is clearly defined in the Nursing and Midwifery Council code of conduct (Nursing and Midwifery Council, 2008).

With regard to 'seeing friends and family', it became apparent in both qualitative and quantitative phases of this study, that patients thought that while contact with friends and family was perceived to be important, visiting could also be disruptive and it prevented them getting the rest which they felt they needed when they were unwell. This is illustrated by a quote (from a male patient on the surgical ward) inserted in the open ended comment box of the questionnaire:

> "I think visiting times should be adhered to and are long enough When one feels ill, there is no escape from your own or other people's visitors who are unaware how you feel. One hour is fine any more can be stressful".

Findings appeared to illustrate that staff did not take steps to control visiting in order to allow a balance between ensuring that patients had support from family and friends, while also ensuring that patients received enough rest at a time when they may feel too ill to be sociable.

Question 3, Are perceptions of older people (over 60) with regards to recovery different from other age groups?

This study is set against a background of possible ageism and it was felt important to try to establish whether older patients had different perceptions about recovery that other age groups. Findings show that there were statistically significant differences amongst age groups for the factors 'social interaction' and 'motivation'. However the level of agreement was high (minimum of 92% for social interaction and 96% for motivation), indicating all factors were perceived important to recovery. In addition the number of respondents in each group was low, which did not provide sufficient evidence to suggest that perceptions of older people with regard to recovery was different from other age groups.

Little was found in the literature to support these findings. Most papers in relation to recovery have sought views of professionals rather than patients themselves. Levenson et al. (2005) undertook a study of older people but he used respondents in their 50's talking about the needs of older people (needs that they perceived that they would have when they were older). These respondents felt that a positive attitude was important but that does not mean that they would think the same when they were 70 or 80 years old. During the qualitative phase of this study there were many staff comments about the need to motivate patients with regard to rehabilitation. There were suggestions that older people sometimes give up because they no longer feel of value to society but these views were not from patients.

Question 4, Is there any evidence that older people do not have their needs met as effectively as other age groups?

With regard to differences amongst age groups for care received, of the five factors of recovery only 'collaboration' was found to have mean scores that were statistically significant ($p < .05$). These findings must be viewed positively as generally older age groups in this study appeared to have received the care that they perceived to be important to their recovery. This is in contrast to many of the findings of the literature review. For example the Health Advisory Service 2000 (1998) found that staff failed to ensure basic needs of nutrition and hygiene for older people. This was supported by Brantervik et al. (2005) and Brownie, (2006) who found that older people in particular do not have their nutritional needs met in hospital. Terms like 'had a good innings' were quoted by Glozier et al. (2004) indicating that older people may not be perceived to warrant the care and treatment given to other age groups. Courtney, Tong and Walsh (2000) also wrote that older people have lesser care because of the negative attitudes of nurses towards them. This literature was also supported by Robinson (2002) and Davey and Ross (2003).

For 'collaboration', the age group 80+ scored lowest for care received (59.3%). These findings appear to indicate that the over 80's age group were possibly disadvantaged in not having an opportunity to collaborate in their own care. There was a total of just 27 respondents in this age group and the research instrument has not been sufficiently tested. These findings are therefore noted but no conclusions drawn. However, it is also noted that Lookinland and Anson (1995) found that staff did not like caring for elderly patients and were patronising in the way they communicated with them. Courtney, Tong and Walsh (2000) found that older people had less opportunity to make decisions. There is, therefore, a possibility that some older people in this study did not feel that they were involved in their care as much as they would like. This must be viewed in the context that generally older age groups in this study appeared to have received the care that they perceived to be important to their recovery. Literature with regard to the care received by older people is not generally supported by findings of this study. However, with regard to 'collaboration', findings were supported by the literature.

Question 5. Do patients perceive that it is important to collaborate with nurses and other professionals and to be partners in care?

Findings suggest that generally patients in this study did perceive that it was important to collaborate with nurse and other professionals and to be partners in care. Of the 249 respondents who completed the recovery questionnaire, 95% thought that 'collaboration' was important. This score must however be viewed in the context that 'collaboration' did not score as highly as: 'therapeutic intervention'; 'core elements of care'; 'social interaction' or 'motivation'. Component items of 'collaboration' were: 'helping patients to maintain their usual routine'; 'including patients in all plans'; 'asking patients opinion' and 'giving patients good information'.

Of these items 'being given good information' was perceived to be very important (99%). It was noticeable that, in the qualitative phase of this study some patients appeared not to expect that they had a right to collaboration. This could be because respondents had a low expectation of their rights. It is possible that National Health Service patients are so used to being passive recipients of care that it will require a major change in the way that care is given before they will ask for their right to collaborate as assertively as they will ring the bell to ask for help with a physical need.

With regard to the literature relating to collaboration, this study supports the findings of Waterworth and Luker (1990) who found that some patients were not keen to participate in decision making and just wanted to please the nurse and stay out of trouble. Increasing the amount of patient participation in clinical decisions is difficult when staff have a paternalistic approach and when diagnosis becomes the principle basis of decision making (Tee et al., 2007). Dodge (1969) wrote that patients often feel powerless in the hospital environment. Findings from this study indicate that this situation still exists.

Collaboration and the provision of information is a defined duty of care in Britain (Nursing and Midwifery Council, 2008). It is also clear that collaboration brings the nurse/patient interaction to an individual level because every patient's needs are different. The degree that different patients want to collaborate will depend not only upon their physical but also their psychological, social and cultural differences. For example it was highlighted by respondents in the qualitative phase of this study that when patients were very ill, they just wanted the professionals to take over for them because they felt they were incapable of making any decisions for themselves. Collaboration needs to be assessed throughout a patient's stay in hospital and altered according to their capacity to participate. For this to happen nurses need to take time to get to know their patients (Johnson and Smith, 2006). Difficulties arise when time constraints prevent this nurse/patient interaction and the more physical aspects of care are prioritised.

Implications of the Study for Current Theory

Literature has suggested that nursing models are still required to guide nursing care (McAllister, 2007a). It is argued, however, that today's models of nursing care need to reflect patients' needs in 21st century. Perhaps it is not sufficient for models of nursing to have underlying assumptions because these are not explicit enough in the minds of practitioners. A model needs to provide clear guidance to staff who are using it, be generated by patients and staff and to be augmented by a culture that gives prominence to obtaining and acting upon patients' perceptions of their needs.

Nursing theory which has been used as a marker for this study has been the work of Henderson (1960), Roper et al. (1980) and Heath and Law (1982). These key publications have directed the way that nursing in Britain has been delivered for the past 26 years (and longer with regard to Henderson). These theorists proposed basic elements or components of nursing care fundamental to human need, when a person is not able to do these things unaided themselves. Their components of nursing care were very similar to each other. They were predominately focused upon physical care although communication, spiritual and social needs were also included.

Respondents in this study identified 20 component items of recovery. In a hospital environment, it is nurses who have responsibility for coordinating and ensuring that these activities are carried out. It follows therefore that these 20 component items of recovery could possibly be regarded as components of nursing care. These have been generated by patients in this study, in the 21st century, and consist of more than the 14 identified by Henderson in 1960 (12 by Roper et al., 1980 and 12 by Heath and Law, 1982). They include additional factors important to recovery. These are: 'collaboration', 'social interaction' and 'motivation'. In addition to the worth of the qualitative narratives gained in this study, the instrument developed as a result shows promise as a reliable tool to gain patients perceptions. After further testing and refinement of the instrument, results could possibly be generalised to larger samples. If this is achieved, then it would not be unreasonable to use these 20 components of recovery as a basis of a model of care generated by patients, to be used by patients.

Limitations of the Study

Despite a large time investment in analysis of transcripts from the qualitative interviews and focus groups, there is an issue of correct interpretation of data. I have interpreted what I believe to be a true representation regarding what factors respondents perceived could help people recover from illness. My perspective was endorsed by member checks, and by two other persons reviewing my work. I believe that my interpretation of the data highlighted features that allowed themes and factors of recovery to be isolated. However other people could have drawn different themes from the data. The test of the interpretation of data is whether it is recognisable to others. Informal feedback of preliminary results given to professionals and individual patients tentatively suggests accurate interpretations have been captured. It is acknowledged that respondents could tend to answer in a socially desirable way rather than providing honest answers. This could have occurred in the qualitative phase of the study with regards to nursing staff and was given consideration when interpreting results.

Time was also a delimiting aspect of the quantitative phase of this study. Despite lengthy development of an instrument including comprehensive pre-testing, this is still an instrument in a developmental stage. It needs further refinement and testing on larger samples so that it can be subject to further exploratory factor analysis. Further testing of the instrument then needs to take place before results can be generalised. While sample size, as a whole, was reasonable (249), much larger samples are needed to assess if there are significant differences amongst age groups. Another issue to be considered is whether representative samples were captured in each phase of the study as in both phases convenience samples were used. Respondents were, however, seen to be representative of the population of hospital patients with regard to gender and age.

Recommendations for Further Research

This study has explored the multi-dimensional phenomenon of recovery from patients' perspectives. Results are promising and have implications for nursing practice, which could improve the quality of care received by patients. There has already been interest in the findings and an eagerness to undertake additional investigation by the NHS trust involved in the study. Further research now needs to be undertaken with regard to development of the instrument and testing with larger and different samples in order to enhance validity and reliability. Larger samples will also enable differences between age groups to be explored.

In addition to further quantitative research, there are more qualitative explorations that could increase our understanding of the recovery process. Both patient and staff views were sought in the qualitative phase of this study in order to capture the construct under investigation (recovery). Very little emphasis, however, was placed on the role of staff other than nursing staff; thus investigation was defined to a limited area. It did not inquire about staff that patients had contact with and whether patients distinguish between nurses and other staff. This study has been conducted within the theoretical framework of nursing care and has therefore not really explored the great contribution that other health care professionals, for example doctors, therapist and carers make to the process of recovery. One respondent volunteered that he could not tell the difference between nurses, therapist and carers but that it did not matter because what he wanted was people to talk to him and make him feel at ease. We do not know if any other patients had the same perception. The role of professionals other than nurses needs further exploration both from the professionals' perspective and from patients' perspective; further qualitative research is required with regard to this.

Implications of this Study for Nursing Practice

Not unexpectedly, there are similarities between implications for current nursing theory and implications for nursing practice. The study has generated 20 items perceived to be important to recovery. These components of recovery can be regarded as components of nursing care. Overall findings have shown that these components or elements of nursing were identified to be important by both patients and staff, in the particular setting where the study took place. Results from the quantitative phase of the study illustrated that the components of recovery/nursing care identified in the qualitative phase of the study were also perceived to be important by a larger sample of patients. Importantly, in the majority of cases, care that patients had identified as being important to recovery was actually received. This suggests that Roper et al.'s (1980) model of nursing (with regard to activities of daily living), was actively used in the trust where this study took place. There were, however, items which scored lower with regard to care received. These were components of the recovery factor ‘collaboration’, namely: ‘patients being asked their opinion’ (72%), ‘being included in plans’ (88%), ‘helped to maintain routine’ (88%) and ‘being given good information’ (89%). These lower scores for care received with regard to ‘collaboration’ suggest that improvements can be made.

It is clear that collaboration is not a simple process. It not only requires professionals to reject a paternalistic approach to care but also requires that patients are given the confidence to assert their rights to being equal partners in healthcare and the process of recovery. This requires that the balance of power (based on knowledge and information) becomes equal between staff and patients through shared knowledge and information in a form that is easily understood by patients. While Henderson (1960) acknowledged the role of nurses in providing patients with information and helping them to learn about their own health care, it was not until 2008 that the Nursing and Midwifery Council gave a specific directive that it is a duty of care for nurses to collaborate with patients. It is clear that practising nurses must adhere to this directive.

The other item which scored less than 90% by patients in the quantitative phase of this study was ‘able to get plenty of rest’ (89%). The lower level of agreement with this item was reinforced by patient comments which illustrated how distressed patients can become if they do not get plenty of rest. Although well documented that this is important to patients and identified by Henderson in 1960 as a clear responsibility of nurses, it is apparent that this problem still exists and that nurses must take active steps to address this situation. Improving the quality of rest that patients are able to get in hospital should simply be a management issue, however, the fact that this issue has not been resolved over the years suggests that nurses are just not valuing patients’ perceptions and understanding their needs. Collaboration will mean spending more time with patients in order to get to know patients and to understand their individual needs, not only for rest and sleep but also for information and participation, where appropriate, in all aspects of their recovery. Henderson et al. (2007) stressed the importance of nurses developing meaningful relationships with patients but recognised that increased workload and staffing levels makes this difficult. Maben et al. (2006) wrote of the bureaucratic demands including resources and financial constraints which limit the ability of nurses to practice closeness with patients. These issues need to be addressed.

With regard to ageism, there was no significant evidence in this study that older patients did not have their needs met as effectively as other age groups. It was noted that of 27 respondents in the 80+ age group, only 59.3% self reported that their needs were met with regard to collaboration. It could be that this age group felt particularly uncomfortable and disadvantaged in the presence of experts, due to their perceived lack of knowledge, as described by Efraimsson et al. (2006). Comments by respondents also implied that older patients exhibited deference to perceived authority. It is suggested that extra nursing time should therefore be given to older patients, if appropriate, to address any imbalance in their ability to engage in mutual partnership with regard to their own care.

Final Conclusion

Aims of this study were to establish what patients perceived would help them with recovery and to help nurses and other professionals to have a greater understanding of what patients perceived to be important. Both qualitative and quantitative methods have been used in this study for data collection and these complementary methods have helped to give a good insight into the multidimensional phenomenon of recovery. This has enabled a theoretical framework depicting recovery to be developed. The aims of the study have been achieved and research questions addressed. Five factors or dimensions of recovery were identified: 'therapeutic intervention'; 'core elements of care'; 'collaboration'; 'social interaction' and 'motivation'. All were perceived to be important to patients with 'motivation' achieving a slightly higher level of agreement than the other four factors.

While nurse/patient collaboration was perceived to be important to both nurses and patients, there appeared to be barriers to this happening in practice. For this to be addressed, nurses need to get closer to patients, to be confident in their own knowledge and to adopt a culture of partnership with patients. Some patients, particularly older patients need to be enabled to exercise their rights of partnership. The responsibility of making this happen lies with nurses (as directed by Nursing and Midwifery Council, 2008), with patients themselves, with educationalists and most importantly with governments. The Welsh Assembly Government in Wales is proactively encouraging collaboration with patients but it is clear that additional resources need to be made available for this to happen.

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APPENDIX I

PATIENTS' PERCEPTION OF FACTORS THAT AFFECT RECOVERY FROM ILLNESS IN HOSPITAL

SEARCH STRATEGY FOR LITERATURE REVIEW

1ST Stage of Search

Search Words/Terms Used:

Recovery

- Patient recovery
- Patient recovery/Illness
- Patient recovery/NHS
- Patient recovery/NHS resources
- Patient recovery/Nursing
- Patient recovery/Older people
- Patient recovery/ Clinical effectiveness
- Patient recovery/Evidence based practice

Nursing

- Nursing /Patient recovery
- Nursing/Recovery of older people
- Nursing/Collaboration with patients
- Nursing/Partnership with patients

1^{ST} Stage of Search (continued)

Nursing Models

- Nursing models/Patient recovery
- Nursing models/Recovery of older people
- Nursing models/ Collaboration with patients
- Nursing models/Partnership with patients

Collaboration

- Collaboration/patients
- Collaboration with patients/NHS
- Partnership/patients
- Partnership with patients/NHS
- Patient involvement
- Nurse/patient collaboration

Ageism

- Ageism/NHS
- Ageism/Nursing care
- Ageism/Healthcare
- Ageism/Hospital
- Discrimination/Older patients

Second Stage of Search

(Undertaken after completion of qualitative phase of the study and using themes identifies by respondents as search words/terms)

Search Words/Terms Used:

- Medication/recovery
- Rest/recovery
- Sleep/recovery
- Comfortable/recovery
- Keeping active/recovery
- Keeping mobile/recovery
- Mobility/recovery
- Going to toilet/recovery
- Toileting/recovery
- Washing and dressing/recovery
- Washing/recovery
- Dressing/recovery
- Eating and drinking/recovery
- Eating/recovery
- Nutrition/recovery
- Drinking/recovery
- Safety/recovery
- Collaboration/recovery
- Information/recovery
- Social Interaction/recovery
- Socialisation/recovery
- Motivation/recovery

APPENDIX II

Patients' Perception of Factors That Affect Recovery From Illness in Hospital

Topic Guide

Each respondent to be provided with written information about the research prior to attendance at interview/focus group.

Prior to commencement of interview/focus group:

- Outline and discuss the purpose of the study; namely to find out things that help patients' recovery from illness, in order to make nurses and other health professionals more aware of the needs of patients they are caring for.
- Ask if anyone wants to ask questions about the research.
- Ensure that all participants have consented to take part.
- Explain that the results of the study will be published in order to share knowledge with others.
- Explain that no information will be published that identifies any participants.
- Explain (in staff focus groups) that, as usual, any confidential information about patients that might arise in discussion must remain confidential.
- Explain (in patient focus groups) that, in discussion, it will not be appropriate to talk about any personal information they know about other patients.
- Ask each respondent to state what ward they are from/area that they work prior to them speaking.

- Explain that this is entirely voluntary and that participants can stop the interview or leave the group at any time they wish.
- Explain that I would like to use a tape recorder and ask if anyone objects.
- Introduce person taking notes in focus group meetings.
- Clarify what I mean by recovery from illness in hospital, i.e. getting better, regaining improved health, becoming fit for discharge or well enough to go home.

Patients

Question: From your experience in hospital, what are the things that you think help you to recover?

Prompts:

What helps you to get better when you are ill in hospital?

Is there anything else you can think of?

Can you say a bit more about that?

What do you mean; can you explain a bit more?

What else do you think would help you or anyone else get better?

What do you think? (to respondents who have not spoken)

In you experience has this been the case?

Staff

Question: You have knowledge and experience of helping patients to recover from illness in hospital; what are the things that you think help them most with the process of recovery?

Prompts:

What have you found are the most important things to help with their recovery?

What else do you think is helpful?

Can you say a bit more about that?

What do you mean; can you explain a bit more?

What else do you think helps patients get better?

What do you think? (to respondents who have not spoken)

In you experience has this been the case?

At the end of data collection:

- List key points made by respondent/s and ask for confirmation (or disconfirmation) that their comments have been interpreted correctly regarding their perception/s about what helps patients recover from illness in hospital.

- Thank respondent/s for taking part

- Remind respondent/s of my contact details (also to be found on previously distributed information sheet) in case there are any additional comments they would like to make to me or, for focus groups, if there is anything more sensitive or confidential that they would like me to know about and is relevant to the research.

Appendix III
Details of Respondents Who Took Part in Interviews and Focus Groups

Method of data collection	Description of respondent and name if known	Type of ward on which patient cared for/staff member worked	Age
Interview	Joy - female patient	Surgical	46
	Susan - female patient	Surgical	38
	Dorothy - female patient	Rehabilitation	82
	Betty - female patient	Medical	65
	Tom - male patient	Medical	52
	Mike - male patient	Rehabilitation	76
	Peter - male patient	Medical	68
	Alan - male patient	Surgical	35
	Paula - female staff nurse	Surgical	20 - 60
	Linda - female staff nurse	Rehabilitation	20 - 60
	John - male staff nurse	Medical	20 - 60
	Shirley - female staff nurse	Medical	20 - 60
	Bob - male support worker	Medical	20 - 60
	Jordon - male support worker	Rehabilitation	20 - 60
	Leslie -female support worker	Rehabilitation	20 - 60
	Jean - female support worker	Surgical	20 - 60
	Sharon - female therapist	Medical	20 - 60
	Jackie - female therapist	Rehabilitation	20 - 60
Focus Group			
	4 Male patients	Medical and Surgical	Mixed ages
	6 Male patients	Rehabilitation	Older patients
	8 Female patients	Medical and Surgical	Mixed ages
	8 Female patients	Rehabilitation	Older patients
	4 Female ward nurses	Various wards	Mixed ages
	9 senior nurses and senior sisters	Various wards	Mixed ages
	10 Medical staff	Various wards/specialities	Mixed ages

NB All names are pseudonyms to protect the identity of respondents.
Older patients on the Rehabilitation ward were in the age band 70 – 80+ years

APPENDIX IV

RECOVERY QUESTIONNAIRE, PATIENT LETTER AND PATIENT INFORMATION SHEET

XXXXXXXXXXXXXXXXX

XXXXXX

XXXXXXXXXXXXXXXXX

Dear Patient,

Re Research Questionnaire

You have recently been a patient in XXXXXXXXX NHS Trust hospital and we hope that you have benefited from the treatment that you have received. We also hope that our professional team has helped with your recovery and that you feel better now than when you were admitted to hospital.

In order to improve the way in which we help people recover from illness, I would be grateful if you could take the time to complete the attached research questionnaire. The questionnaire has been developed by talking to many people throughout XXXXXXXXXX and asking their views. The aim of the research is to establish and gain a greater understanding of how people can be helped to recover from illness.

You can be assured that all information supplied to me will remain confidential and will only be used for the purpose of this research. The results of this survey will be fed back to hospital staff and will help us to improve the care we give. I enclose a pre-paid envelop for your reply, I also enclose an information sheet to tell you a little more about the research and to help you know what is expected of you.

Yours sincerely

Jenny Bowen
RGN, BA, MN, MBA
XXXXXXXXXXXXXXXXXXXXX

Title of Research: ***Gaining Patient's perceptions about factors that help them to recovery from illness***

Question **Who will carry out this research study?**
Answer I am a nurse working at XXXXXXXXXXXXXX am undertaking this research as part of an educational qualification for a Doctorate in Nursing Science.

Question **Tell me about the research ?**
Answer The purpose of this research is to find out factors (things) that help patients recover from illness. In order to do this many patients and health care professionals in XXXXXXXXXXXXX have already been asked their views and this information has helped me to develop the questionnaire. I now need to ask many more patients about the things that are important to them when they are in hospital. This will make the results of my research more valid and meaningful.

Question **How many patients will be asked to take part ?**
Answer In total 600 people will be asked to take part.

Question **How will this research benefit patients ?**
Answer The research will benefit future patients who come into hospital because nurses will be more aware of the needs of the patients that they are caring for. All nurses in the hospital will be made aware of the results of this research and this will give them a better understanding of how they can help people recover from their illness or after an operation.

Question **Do I have to take part in this research ?**
Answer No, if you do not want to or if you have not got the time, that is fine. Taking part is entirely voluntary and you will not be disadvantaged in any way if you decide not to.

Question **Will any personal information about me be given to anyone else ?**
Answer No you do not have to put your name on the questionnaire and you will not be able to be identified in any way.

Question **What if I feel that my nursing needs were not met when I was in hospital ?**
Answer Fill the questionnaire in by putting a tick in the boxes required and also write your concerns in the box provided for comments, explaining why you think your nursing needs were not met. This will help us to improve the care of future patients.

Question **How can I obtain more information about this research ?**
Answer Please contact me, contact details are below.

Jenny Bowen
Tel: XXXXXXXXXXXX
E-mail: XXXXXXXXXXXXXXXXXXX
Address:XXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXX

Firstly I would be grateful if you could complete the following information about yourself

1. Gender
(please tick one box)

Male ☐ Female ☐

---

2. Age Range
(please tick one box)

Under 40 years old ☐
40 – 49 years old ☐
50 – 59 years old ☐
60 – 69 years old ☐
70 – 79 years old ☐
Over 80 years old ☐

---

3. Who you live with
(please tick one box)

I live alone ☐
I live with another person or other people ☐

---

4. Do you have a pet at home ?
(please tick one box)

Yes ☐ No ☐

If you do have a pet please state what pet/s you have e.g. cat or dog etc. ☐

---

5. Ward

Please state which ward you were on when you were recently in hospital
(if you were on more than one ward,
please name the ward that you spent the most time on) ☐

---

6. Approximately how long were you in hospital ?
(tick one box)

Less than one week ☐
One week ☐
Two weeks ☐
Three weeks ☐
Four weeks ☐
More than four weeks ☐

recover from illness when they are in hospital

To help patients in hospital recover from illness it is Important that:

	Definitely True 1	Mostly True 2	Not Sure 3	Mostly False 4	Definitely False 5
7. Patients are given regular prescribed medication	☐	☐	☐	☐	☐
8. Patients are able to get plenty of rest if they feel that they need to	☐	☐	☐	☐	☐
9. Patients are made to feel as comfortable as possible, for example in their bed or chair	☐	☐	☐	☐	☐
10. Patients are helped to keep as active as possible, for example having exercise or being helped to walk about	☐	☐	☐	☐	☐

Now - do you agree with the following statements regarding your recent experience of being in hospital?

When I was in hospital recently:

	Definitely True 1	Mostly True 2	Not Sure 3	Mostly False 4	Definitely False 5
11. I was given my prescribed medication regularly	☐	☐	☐	☐	☐
12. I was able to get plenty of rest if I felt that I needed to	☐	☐	☐	☐	☐
13. I was made to feel as comfortable as possible, for example in my bed or chair	☐	☐	☐	☐	☐
14. I was helped to keep as active as possible, for example having some type of exercise or being helped to walk about	☐	☐	☐	☐	☐

Please add any further comments here or continue over the page if necessary

Please answer the following questions about what you think could help patients recover from illness when they are in hospital

To help patients in hospital recover from illness it is Important that:

	Definitely True 1	**Mostly True 2**	**Not Sure 3**	**Mostly False 4**	**Definitely False 5**
15. Patients are given help to go to the toilet when they need to	☐	☐	☐	☐	☐
16. Patients are helped to wash and/or dress themselves	☐	☐	☐	☐	☐
17. Patients are given enough to eat and/or drink	☐	☐	☐	☐	☐
18. Patients feel that they are being safely looked after	☐	☐	☐	☐	☐

Now - do you agree with the following statements regarding your recent experience of being in hospital?

When I was in hospital recently:

	Definitely True 1	**Mostly True 2**	**Not Sure 3**	**Mostly False 4**	**Definitely False 5**
19. I was helped to go to the toilet when I needed to	☐	☐	☐	☐	☐
20. I was helped to wash and/or dress myself	☐	☐	☐	☐	☐
21. I was given enough to eat and/or drink	☐	☐	☐	☐	☐
22. I felt that I was being safely looked after	☐	☐	☐	☐	☐

Please add any further comments here or continue over the page if necessary

recover from illness when they are in hospital

To help patients in hospital recover from illness it is Important that:

	Definitely True 1	Mostly True 2	Not Sure 3	Mostly False 4	Definitely False 5
23. Patients are helped to maintain their usual routine whilst in hospital	☐	☐	☐	☐	☐
24. Patients are included in all plans regarding their care and treatment	☐	☐	☐	☐	☐
25. Patients are asked their opinion about what should happen to them whilst in hospital	☐	☐	☐	☐	☐
26. Patients are given good information about their illness	☐	☐	☐	☐	☐

Now - do you agree with the following statements regarding your recent experience of being in hospital?

When I was in hospital recently:

	Definitely True 1	Mostly True 2	Not Sure 3	Mostly False 4	Definitely False 5
27. I was helped to maintain my usual routine whilst in hospital	☐	☐	☐	☐	☐
28. I was included in all plans regarding my care and treatment	☐	☐	☐	☐	☐
29. I was asked my opinion about what should happen to me whilst I was in hospital	☐	☐	☐	☐	☐
30. I was given good information about my illness	☐	☐	☐	☐	☐

Please add any further comments here or continue over the page if necessary

recover from illness when they are in hospital

To help patients in hospital recover from illness it is Important that:

	Definitely True 1	Mostly True 2	Not Sure 3	Mostly False 4	Definitely False 5
31. Staff take enough time to talk to patients	☐	☐	☐	☐	☐
32. Patients are able to see their friends or family as much as possible	☐	☐	☐	☐	☐
33. Patients are cared for by happy staff	☐	☐	☐	☐	☐
34. Patients know that they will have someone to help/support them when they go home from hospital	☐	☐	☐	☐	☐

Now - do you agree with the following statements regarding your recent experience of being in hospital?

When I was in hospital recently:

	Definitely True 1	Mostly True 2	Not Sure 3	Mostly False 4	Definitely False 5
35. The staff took enough time to talk to me	☐	☐	☐	☐	☐
36. I was able to see my friends or family as much as I wanted to	☐	☐	☐	☐	☐
37. I was cared for by happy staff	☐	☐	☐	☐	☐
38. I knew that there would be someone to help/support me when I went home from hospital	☐	☐	☐	☐	☐

Please add any further comments here or continue over the page if necessary

recover from illness when they are in hospital

To help patients in hospital recover from illness it is Important that:

	Definitely True 1	Mostly True 2	Not Sure 3	Mostly False 4	Definitely False 5
39. Patients are made to feel of value	☐	☐	☐	☐	☐
40. Patients are helped to have confidence to do things that they are nervous of doing by themselves	☐	☐	☐	☐	☐
41. Patients are encouraged to have hope that they will get better	☐	☐	☐	☐	☐
42. Patients are able to look forward to going home, for example to be with their family, friends or pets	☐	☐	☐	☐	☐

Now - do you agree with the following statements regarding your recent experience of being in hospital?

When I was in hospital recently:

	Definitely True 1	Mostly True 2	Not Sure 3	Mostly False 4	Definitely False
43. The staff made me feel of value	☐	☐	☐	☐	☐
44. I was helped to have confidence to do things that I was nervous of doing by myself	☐	☐	☐	☐	☐
45. I was encouraged to have hope that I would get better	☐	☐	☐	☐	☐
46. I was able to look forward to going home, for example to be with my friends, family or pets.	☐	☐	☐	☐	☐

Please add any further comments here or continue over the page if necessary

47. Now - out of the list below: please select the 5 things that you think most important to help patients recover from illness when they are in hospital.

Only tick 5 boxes in total

☐ Being given regular prescribed medication

☐ Being able to get plenty of rest if you feel you need to

☐ Being made to feel as comfortable as possible, for example in your bed or chair

☐ Being helped to keep as active as possible, for example being helped to walk

☐ Being given help to go to the toilet when you needed to

☐ Being helped to wash or dress yourself

☐ Having enough to eat and drink

☐ Feeling that you are safe and being looked after

☐ Being helped to maintain your usual routine whilst in hospital

☐ Being included in all plans regarding your care and treatment

☐ Being asked your opinion about what should happen to you

☐ Having good information about your illness and being told what will happen

☐ Staff taking time to talk to you

☐ Being able to see your friends and family as much as possible

☐ Being cared for by happy staff

☐ Knowing that you will have someone to support you when you go home from

☐ Being made to feel of value by staff

☐ Being given confidence to do things that you are nervous of doing by yourself

☐ Being given hope that you will get better

☐ Looking forward to going home to be with your family, friends or pets