



The chaotic journey: Recovering from hip fracture in a nursing home



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ABSTRACT

Purpose of the study: To understand the journey experienced by nursing home residents following hip fracture and impressions of an outreach rehabilitation program offered after their return home.

Design and methods: A qualitative investigation was undertaken in parallel with a randomised controlled trial investigating the efficacy and cost utility of providing a hospital outreach rehabilitation program for older nursing home residents who have recently returned from hospital following hip fracture. Family members and nursing home staff of 28 (out of the first 30) participants (14 from intervention and 14 from control) agreed to participate in interviews and focus groups to provide information and perceptions of each person's journey. NVivo 10 qualitative data analysis software package was used to identify major themes (via open, then axial and finally selective coding).

Results: Both family members and staff described nursing home residents with dementia as receiving poor post-operative care from hospital staff who seemed unfamiliar with dementia and delirium. Discharge from hospital soon after surgery (median 4.5 days) occurred with poor transfer of information. Difficulties with residents' emotions, pain management and commencing mobilisation seemed more prevalent within usual care group, whereas fewer overall problems were encountered by those with access to a geriatrician and additional therapy.

Implications: This research suggests that an integrated care pathway including the hospital stay and first weeks back at nursing homes should be developed. Performance indicators should include carer measures on the quality of the transfer, pain management measures in the first month and return to walking.

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1. Introduction

Hip fractures are a common and important cause of morbidity in nursing homes. There is a 10 fold increase in the risk of hip fractures amongst residents of nursing homes compared to age matched community dwelling older people (Choong, Langford, Dowsey, & Santamaria, 2000). Guidelines for the management of hip fracture promote provision of prompt surgery, early mobilisation, organised multidisciplinary health care teams and a team based rehabilitation approach to restoring function and mobility (NICE, 2011). While audits show that the timing of surgery and choice of orthopaedic fixation is unaffected by admission accommodation (Kerse et al., 2008; NICE, 2011) nursing home residents are often excluded from rehabilitation programs

(Kirchbaum, 2008). Patients frequently discharge from orthopaedic wards directly back to the nursing home on day 2 to day 7 post-surgery.

More than half of residents residing at Australian aged care facilities have a recorded diagnosis of dementia (AIHW, 2012). Studies report people with cognitive impairment, in particular, receive less support from clinicians (including physiotherapists) in the hip fracture recovery period, compared to other older people who suffer hip fractures (Hedman, Stromberg, Grafstrom, & Heikkila, 2011). This practice may be due to the belief that people with dementia do not have the potential to improve with rehabilitation. However there is evidence that people with dementia who fracture their hips can engage in rehabilitation (Uy, Kurrle, & Cameron, 2008).

As many people from nursing homes who fracture a hip are very frail and receiving end of life care, there is uncertainty about the cost effectiveness of rehabilitation models in this setting.

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Furthermore it is not clear how acceptable the approach is and so qualitative research is needed to provide a patient and family perspective on barriers to recovery and treatments (Mays & Pope, 2000). In this study, we sought formal and informal carers' perceptions about the experiences of patients from nursing homes following hip fracture repair to determine whether they perceived any shortcomings in the services provided and whether they had suggestions for improvement.

This qualitative sub-study was conducted in parallel to a randomised controlled trial (RCT) which was evaluating the efficacy and cost effectiveness of providing a 4 week rehabilitation program into nursing homes following residents' discharge from hospital post-surgery to repair a fractured neck of femur (SACRED – Southern Adelaide Co-ordinated Regional Hip and Debility Rehabilitation Programme ACTRN12612000112864). We recruited 240 older people in 3 hospitals in metropolitan Adelaide, South Australia who were admitted from nursing homes and were recovering from hip fracture surgery. Post operatively they were randomly allocated to receive a 4 week geriatric rehabilitation program (minimum 3 visits per week) or usual care. The primary and secondary outcome measures collected at 4 weeks and 12 months included quality of life, mobility, nutritional status and burden of care measures. Triangulation of data was supported with the addition of qualitative data collected in this current study to allow for a more comprehensive understanding of the research phenomena under investigation (Mays & Pope, 2000).

1.1. Purpose of study

To understand the journey experienced by nursing home residents following hip fracture and impressions of an outreach rehabilitation program offered after their return home.

2. Design and methods

This qualitative aspect of the study assumed that when attempting to understand the experience for nursing home residents following hip fracture, it was important to seek accounts from individuals who could reflect and verbalise their feelings and opinions. As most of the residents had significant cognitive impairment and were unable to engage in the interview process, their next of kin and nursing home staff were invited to provide information and perceptions of each person's journey. We attempted to understand the experience for residents who returned to "usual care" within the nursing home as well as those who received outreach rehabilitation within the nursing home.

2.1. Data collection

Prior to beginning data collection, approval to undertake this study was received from the Southern Adelaide Human Research Ethics Committee, South Australia.

We approached the next of kin and nursing home staff for the first 30 participants recruited to the RCT. Interviews with consenting family and focus groups with consenting staff were conducted on average 5 weeks after the resident returned to the nursing home from hospital. The twenty eight participants whose family and nursing home staff consented to be interviewed had suffered a recent hip fracture but had been walking and a resident in a nursing home prior to the fracture. They were discharged from hospital soon after surgery (median 4.5 days and range 2–19 days) and fourteen residents received usual care which included physiotherapy provided by the nursing home's staff and medical care provided by their usual general practitioner (GP). The remaining fourteen residents received outreach rehabilitation in

Table 1
Characteristics of all participants (n = 28).

	Allocation ^b	Pseudonym ^a	Gender ^c	Family interviewed ^d	Caring Staff interviewed ^d	Age	MMSE (out of 30) ^e
1	R	Mrs Gill	F	y	Y	86	2
2	U	Mrs Ireland	F	y	Y	93	7
3	U	Mrs Moyle	F	y	Y	89	0
4	U	Mrs Vickers	F	y	Y	84	1
5	R	Mrs Maxwell	F	y	y	93	15
6	U	Mrs Davids	F	y	y	89	1
7	R	Mr Williams	M	y	y	89	0
8	U	Mrs Allen	F	N	y	93	7
9	R	Mrs Gaffrey	F	y	y	84	25
10	U	Mr Ickley	M	y	y	70	20
11	R	Miss Rush	F	N	y	87	1
12	R	Mrs Carter	F	y	y	84	13
13	U	Mrs Engel	F	N	y	92	12
14	R	Mrs Harry	F	y	y	91	27
15	U	Mrs Gerrard	F	y	y	88	19
16	R	Mrs Roberts	F	y	y	93	14
17	R	Mrs Leigh	F	y	y	73	0
18	U	Mrs Lamb	F	y	y	88	9
19	R	Mrs Dodd	F	y	y	86	14
20	U	Mrs Smith	F	y	y	84	6
21	R	Mrs Edwards	F	y	y	81	13
22	U	Mrs Sunderland	F	y	y	94	16
23	U	Mr Jackson	M	y	y	82	16
24	U	Mr Roach	M	y	y	81	15
25	R	Mrs Night	F	y	y	89	20
26	R	Mrs Harrison	F	y	y	87	0
27	U	Mrs Edgecombe	F	y	y	97	3
28	R	Mrs Black	F	Y	Y	87	0

^a Pseudonyms provided to maintain confidentiality.

^b Allocation (R = rehabilitation, U = usual care).

^c Gender (F = female, M = male).

^d Family interviewed/Caring Staff interviewed (Y = yes, N = no).

^e MMSE: Severe cognitive impairment (0–17) n = 23; Mild-moderate cognitive impairment (18–23) n = 3; no cognitive impairment (24–30) n = 2 (Folstein et al., 1975).

addition to usual care. These residents received an average of 14 visits (range 8–17) over 4 weeks from the local hospital team including geriatrician, physiotherapist, and a dietician. The intervention included a medical assessment, review of medications and co-morbidities and physiotherapy focused on restoration of transfers and limited mobility. Experienced physiotherapists used positive motivational scripts to encourage engagement. When required rehabilitation nurses visited the facility. The physiotherapist worked with aged care staff to encourage a rehabilitation approach between formal therapy sessions. A formal meeting with families was held with the geriatrician within a fortnight to discuss progress and relevant issues.

Participants allocated to control received usual care in the nursing home. All three hospital sites had an orthogeriatrics service tasked with reviewing inpatients prior to discharge. On return to the nursing home, residents received medical care from a general practitioner and all nursing home sites had contracts with physiotherapists or occupational therapists.

Families were invited to meet with the interviewer at their home or at the residential care facility. Focus groups for staff were organised at the residential care facility where they worked. The mix of staff who attended the focus groups differed for each facility but typically consisted of registered and/or enrolled nurses and caring staff. On two occasions out of 28 focus groups, the residential care coordinator and facility physiotherapists attended. The questions for the interviews and focus groups covered three main topic areas: (1) What challenges were experienced following the resident's hip fracture (for resident, family and residential care staff)? (2) What part of the residents journey went well following their hip fracture? (3) What would have improved the journey? The interviewer asked further questions dependant on responses from participants and the participants were invited to raise new topics relevant to the enquiry. Interviews and focus groups were audiotaped and transcribed verbatim.

2.2. Data analysis

To ensure truth, value, credibility and dependability and ensure that all descriptions reported were accurate, each family participant and nursing home staff were provided with a summary of their interview to check before coding began (Krefting, 1991; Mays & Pope, 2000). Any discrepancies following member checking by the participants were altered ready for analysis.

Qualitative thematic analysis was undertaken with the assistance of NVivo 10 qualitative data analysis software package. Firstly, the transcripts of each interview and focus group underwent a preliminary analysis to identify the meaning in each unit of data for that person or group. As patterns emerged across the interviews and groups, data was pooled according to similar meanings, perceptions and feelings and the initial nodes were developed. In this way, subthemes began to emerge. Next the subthemes were combined to arrive at the major themes. At each phase of analysis the three researchers (MK, MC and RW) discussed the categories and grouped them into subthemes and then major themes until consensus was reached. The researchers were

confident that saturation had been reached when no new themes were emerging as the latter data sets were analysed.

3. Results

Of the twenty eight residents recruited to the trial, twenty six had cognitive impairment according to the Mini Mental Score Examination (MMSE) undertaken at entry to the trial (Folstein, Folstein, & McHugh, 1975). Twenty three participants had severe cognitive impairment (MMSE 0–17), three participants had mild-moderate cognitive impairment (18–23), and two people had normal cognitive ability. The majority of participants were older-old people with the median age of the group being 87.5 years (range 70–97 years) (see Table 1). The interviews were attended by one family member except on one occasion when 2 people from the same family attended. The interviews usually lasted 20–30 min. The focus groups varied in size with between 2 and 6 people attending. Focus groups lasted 10–45 min. All the interviews and focus groups except one were undertaken by the same experienced interviewer (MK). One interview was undertaken by an experienced clinical trial nurse.

Thematic analysis revealed key themes which highlight the different experiences for those receiving outreach rehabilitation in addition to usual care (see Table 2). The journey was chaotic for all individuals from time of fracture throughout their inpatient hospital stay. Following their return home, those who received outreach rehabilitation from the hospital after their return to the nursing home were reported to have a less stressful and more positive experience once home compared to those residents who only received usual care.

3.1. The chaotic journey: recovering from hip fracture in a nursing home

- A poor start: managing dementia in hospital

All families and nursing home staff interviewed (regardless of whether they received usual care or outreach rehabilitation) reported that the older person was not managed well in hospital. Nursing home staff reported frustration that acute hospital staff did not appear to understand how to encourage participation and engagement when patients suffer dementia.

In general, I don't think they manage dementia well they don't know how to get that person from a sitting to a standing position because the person's got dementia and, like our resident, can be quite resistive. And once they're resistive, that's it. They say they can't be rehabed". (usual care, nursing home staff member)

- Lack of confidence among nursing home staff

Nursing home staff whose residents received usual care reported a lack of confidence due to a dearth of information and guidelines from the acute hospital setting and absence of training regarding handling and managing people after a hip fracture.

Table 2

Themes and subthemes developed following analyses.

The chaotic journey: recovering from hip fracture in a nursing home	Optimism and improved outcomes: when receive addition of rehabilitation into the nursing home
A poor start: managing dementia in hospital	Positive response to rehabilitation exceeded expectations
Lack of confidence among nursing home staff	Increased self-confidence
	Early mobilisation and improved activity levels
Poor patient outcomes for those receiving usual care	Geriatrician input
Loss of hope for residents who received usual care and their families	Improved nutritional status

One staff member queried:

We need information to learn how to handle them. I think it's general practice that after a broken hip, after 2 days they usually stand them. So when are you supposed to stand them? (usual care, nursing home staff)

- Poor patient outcomes for those receiving usual care

Delayed mobilisation and reduced activity levels concerned family and nursing home staff. Nursing home staff caring for those people transferred back without outreach rehabilitation support recognised that the lack of time and skilled staff was an important barrier to supporting people following hip fracture.

The staff who cared for Mrs Davids said,

Sometimes it can take a week to two weeks to get a physio to review that person. Depending when they've come back. So, for example . . . If they come back on a Thursday night, it could be a week before they see a physio. Which makes it very hard to know what to expect them to be able to do. (usual care, nursing home staff).

Pain management was a further area of concern and perceived to be due to a lack of care coordination resulting in pain resolution taking many weeks to be addressed, as well as residents suffering confusion and drowsiness in response to medications. This in turn adversely affected residents' function or increased their risk of falls. Eight of the 14 people who returned to usual care were reported to have endured either ongoing pain or unacceptable medication side effects. Staff caring for Mrs Ireland stated,

We obviously called the doctor and got some more pain relief, which unfortunately made her more drowsy and more confused. So when her family actually insisted that we do get her up and out of the bed, we gave that a go five minutes later, because of her confusion, she forgot she'd done the hip, tried to get up and walk and fell. (usual care, nursing home staff)

Reduced appetite, low food intake and weight loss were recognised by both family and nursing home staff as an issue for those residents who received usual care. The nursing home carer for Mrs Sunderland said,

I could just see her dwindling away, weight-wise. The nutrition is so important . . . because once she's not eating, she's not putting on any weight, any muscle, and while she's lying there, day by day goes past and week by week, the muscles aren't working and less likely, she'll be up and walking 'coz she used to be walking. (usual care, nursing home staff)

- Loss of hope for residents who received usual care and their families

A cascade of problems were described by many of those receiving usual care, as Mrs Gerrard's daughter reported,

The whole thing has just been one disaster after another. She just went rapidly downhill. And then, we had her moved to a high-dependency room. The whole thing has been a nightmare from day one. (usual care, family member)

When describing the journey for people following hip fracture who returned to receive usual care, families and nursing home staff commonly reported residents' loss of hope, lack of motivation to engage in activity as well as a number of people who expressed their desire to die due to their dismal quality of life.

Mr Jackson was described by his wife as having **"become so despondent that he doesn't think it is worth trying."** (usual care, family member).

Both family and nursing home staff in the usual care group reported residents exhibiting marked frustration due to dramatic changes in their physical and emotional status. Five people were reported to experience terror, fear and anxiety at such levels that it was a barrier to them becoming active and participating. Higher than usual levels of confusion were also reported to be a barrier to improvement in six people. Confusion was described as related to persisting delirium, to side effects of medication or due to cognitive decline.

Many of the families reported making daily visits for many weeks due to the concerns they had for their family member.

When you see her crying and upset and screaming and shouting, which has never been her character, it's quite distressing; so at this stage, there hasn't been one day where she hasn't seen at least one member of the family. (usual care, family member)

3.2. Optimism and improved outcomes: when receive addition of rehabilitation into the nursing home

When residents received outreach rehabilitation, the stories shared by family and nursing home staff reflected a more positive journey, with better coordination of care and improved resident confidence.

- Positive response to rehabilitation exceeded expectations

Some trepidation was reported by family members in hospital regarding the recovery journey when the individual was older or had complex health issues, including dementia.

Mrs Maxwell's family member said,

Initially, I thought at her age, 93–93.5, she tells me . . . (chuckling) . . . That from what I've heard of people at that age, I felt, "Well, this is it." (outreach rehabilitation, family member)

But in contrast to her fears, her aunt progressed well after her return home.

Mrs Night's next of kin commented,

There's been hardly a blip on the radar as far as she's concerned. She seems to be back with full movement or as good as she was before. I think the recovery was a lot better than I had expected for her age. I mean, she's nearly 90. (outreach rehabilitation, family member)

None of the respondents felt that the rehabilitation would have been better if provided in a hospital rehabilitation facility. Delivering outreach rehabilitation to those with dementia in their familiar environment was valued by all family members and staff.

Mrs Carter's nursing home staff reported,

The nice thing about it was having all that physio attention. I think, given the dementia, if you have that in a hospital setting, given her level of dementia that would be much more challenging. I think we're always trying to give her the best opportunity to do the best she can, and I think that's what's so lovely about this program, too – is that she's getting the physio she needs, but in the environment that she needs as well. (outreach rehabilitation, nursing home staff)

- Increased self-confidence

The rehabilitation intervention improved residents' feelings of confidence and families' optimism for a recovery pathway.

The nursing home staff who cared for Mrs Roberts commented,

Not just physically, but emotionally she probably needed the team to build up her confidence because when they have a fall, most of the time when they recover, they are afraid of walking again or don't have confidence in us. So in that area, they can try to just let her know, "You know what? You can . . . You will be able to recover really good. And you will be able to walk again". Yes, just to boost up their confidence again. (outreach rehabilitation, nursing home staff)

- Early mobilisation and improved activity levels

Families of those who received the rehabilitation were more likely to express relief around return to mobility. Mrs Gaffrey's daughter said,

I think she really was a great example of how much of a positive impact the intense response is. And within a few days she improved with rehabilitation. She fell on . . . Wednesday, had this operation to repair the hip . . . by the following week, she was on her feet. And stepping. She was mobilising. (outreach rehabilitation, family member)

- Geriatrician input

Participants from both groups described how the person recovering from hip fracture returned to their nursing homes complaining of pain. In contrast to the people who returned to receive usual care, enduring pain and pain management was not raised as a significant issue when residents received outreach rehabilitation. These participants generally received their review from the outreach geriatrics medical team within 72 h of the transfer back to the nursing home and early physiotherapy sessions from outreach rehabilitation staff.

Nursing home staff recognized the complex balance between pain relief, mobilisation and falls risk and valued the involvement of the geriatrician who reviewed all medications, including pain medications.

So sort out the analgesia required to cover the pain, but to have her alert enough to do the transfers and to be on the ball in that process. That's a challenge. And what I see about dementia is that they don't actually remember the event. Do you know? They don't remember the fall. . . . For them, if we just manage the pain and move them forward, it's much better. (outreach rehabilitation, nursing home staff)

In addition early medication review by the geriatrician addressed other medical issues. In particular, a number of family members reported their satisfaction at the medication reviews provided, especially when they were concerned about polypharmacy.

- Improved nutritional status

The people who received outreach rehabilitation also reported substantial weight loss during the hospital phase of their journey. Of the eight people who lost weight, six reported regaining the weight that they had lost. Loss of weight and malnourishment was discussed as a resolving issue for participants receiving outreach rehabilitation. Residents received nourishing, high calorie supplements to support weight gain. Mrs Leigh's nursing home carers reported,

With the Resource drink, because she's so underweight, she actually accepted that. So, that was really good because the couple of kilos that she'd lost, she'd got back on. (outreach rehabilitation, nursing home staff)

4. Discussion

This qualitative study suggests that nursing home residents who fracture their hip generally endure an uncertain journey. Families of the group who received usual care expressed dismay that the experience for their relative was poorly coordinated with no recovery plan in place.

The challenges for the patients and families started in hospital with hospital staff ill-equipped to treat people with dementia and, following discharge home, nursing staff frequently reported poor handovers. The nursing home staff lacked the knowledge and confidence to support their recovery following hip fracture repair. Physiotherapists who work in nursing homes have limited time and were not able to provide timely advice to nursing home staff on how to safely undertake transfers and neither could they provide the intensity of therapy required to promote return of patients' mobility.

Once home, ongoing pain, malnourishment and delirium were common for those receiving usual care, and residents were reported by families to lose hope and motivation with a number of people expressing a desire to die. This chaotic patient journey resulted in considerable burden for family who felt anxious about their relative and obligated to spend considerable time with their family member. Similar outcomes have been reported in other studies where nursing home residents experience high rates of morbidity with very little recovery of functional status and quality of life following hip fracture (Beaupre, Jones, Johnston, Wilson, & Majaumdar, 2012). Similar to this current study, it has been reported that older people who live in nursing homes return from a hospital stay with functional decline and iatrogenic disability due to the lack of function-focused care (Wojtusiak, Levy, Williams, & Alemi, 2016).

The carers and families of people who received outreach rehabilitation from a hospital team were positive about the experience and often surprised at the progress. In addition to good pain management strategies and improved activity levels, those who received outreach were less likely to report anxiety and more often focused on improved quality of life. In this study those people who did not receive the outreach rehabilitation program and were cared for by their own GPs, local physiotherapists and dieticians reported more issues with pain and a slower return to mobilization.

Family and nursing home staff felt that the diagnosis of dementia, more than other co-morbidities, was predictive of the approach provided in hospital following hip fracture. They reported that some of the signs of dementia including confusion, reduced cooperation, combative behavior or lack of responsiveness when challenged were not well understood and interpreted as an inability to engage in therapy.

The residents in this current study were all mobile prior to their hip fracture despite their dementia and the hope for families in hospital was that patients receive appropriate pain relief to allow them to eat and mobilise again with support. They then hoped that their relative would return to the nursing home and continue their recovery, in particular mobility by working with a physiotherapist.

A study that sought to investigate narratives from patients and relatives regarding good and bad caring episodes suggested that "good caring" included such task aspects as timely and accurate assessment, access to information and receiving pain relief and good nutrition (Lovgren, Engstrom, & Norberg, 1996). These aspects of care were also considered to shape each resident's journey in the current trial. Participants of this current trial described residents receiving "bad caring" with usual care residents suffering enduring pain, poor coordination of care and lack of encouragement to move and be active. A further study confirmed that pain is poorly treated in older postoperative

patients following hip fracture. Older patients with normal cognition were disadvantaged and received only 23% of opioid analgesics prescribed, and the care was further jeopardized when individuals had a cognitive impairment by receiving just 16% of prescribed medications (Feldt, Ryden, & Miles, 1998). The fundamental ethical principal of healthcare providers ensuring optimal patient care does not always occur, especially for those who suffer dementia.

When nursing home patients returned to usual care in this current study, families reported a high burden with many feeling obligated to visit their loved one every day for many weeks after their return home. They felt disturbed observing the suffering and were trying to help in any way they could including attempting to comfort and reassure the patient.

When the possibility of a geriatrician and outreach team was suggested to those in the usual care group these families felt that the situation could have been very different if support from a rehabilitation team had been available, and particularly from a rehabilitation physiotherapist. They also felt that a geriatric review could have solved many of the problems encountered, including pain and side effects of pain medications. Other studies have shown that families feel the need to advocate for appropriate care and intervention in the post hip fracture phase for patients from a nursing home as they perceive their loved one is not receiving the care they need (Popejoy, Marek, & Scott-Cawiezell, 2013). Similar to the present study, this substantial assistance and advocacy support resulted in a considerable burden for families. In contrast to these dire outcomes, when the resident received outreach from a rehabilitation team in this current study, family and nursing home staff reported a different journey. The review by a Geriatrician improved the transfer back home, with families and staff valuing pain management, medication reviews and management of comorbidities. Early mobilisation was facilitated by the rehabilitation physiotherapist and nursing home staff reported increased confidence when providing physical assistance due to the training and support provided. Families reported less burden as they felt their family member was receiving appropriate support.

The provision of outreach physiotherapy appeared to be the aspect of the care most valued by participants. Family and nursing home staff reported that the physiotherapy intervention increased the resident's confidence to get out of bed and commence mobilisation. Nursing home staff were pleased to have the physiotherapist encourage the residents and reassure them that they could manage the challenge with their help. The rehabilitation team provided much encouragement, often in conjunction with family members and nursing home staff to provide a safe environment with graduated challenges as the resident attempted to move in bed, get to stand, use stand lifting devices when necessary and undertake stand transfers. Part of the support provided was intrinsic psychological support to help residents overcome their fear of falling and this approach in conjunction with mobility training and strengthening exercises, was valued by all participants. A number of studies have demonstrated the importance of psychological factors in predicting outcomes after hip fracture for older patients. Fear of falling has been shown to be a strong predictor of post hip fracture outcomes in older people (Oude Voshaar et al., 2006) as has feelings of optimism (Waldrop, Lightsey, Ethington, Woemmel, & Coke, 2001). Similar to these other studies, it appears that the participants in this current study who received outreach rehabilitation had a more positive outlook compared to those who received usual care and that this was associated with better functional and participatory outcomes.

Patients' belief about their potential for recovery, motivation and compliance with treatment and increasing feelings of self-

efficacy are all positive predictors of engagement in the recovery process (Proctor et al., 2008). Passive coping strategies such as avoidance of activity and emotional venting is thought to be linked to beliefs that progress is beyond their control while catastrophizing is a cognitive process portrayed by lack of control and an expectation of poor outcomes (Chaves & Brown, 1987). The family members and nursing home staff of residents who received usual care in this current study described similar behaviours and cognitive beliefs in residents which affected their recovery. By contrast, those who received outreach rehabilitation were encouraged to dismiss negative thoughts in therapy sessions and overcome feelings of anxiety by participating in strategies developed by the clinical team to increase success. The experienced rehabilitation clinicians were able to use psychological strategies as part of their rehabilitation program to improve positivity and support feelings of self-efficacy. Although these antecedents did indeed support somatic goal attainment for residents, it was clear that they also markedly affected psychological aspects of residents' welfare and their overall quality of life.

Family members of people with dementia have previously described feelings that suggested that they "suffer from care"; a phenomenon experienced by people who feel ignored and uncared for by healthcare professionals (Hedman et al., 2011; Sundin, Axelsson, Jansson, & Norberg, 2000). This was in contrast to families of patients who had intact cognition when patients generally described positive experiences with family reporting pleasure from seeing them improve. The findings of this current study also suggested that people with dementia and their families "suffer from care". In comparison, residents, family and nursing home staff of those who received outreach rehabilitation indicated that they could enjoy a positive experience as the resident was supported to participate in a restorative pathway, the family found comfort and gained reassurance in response to the involvement of rehabilitation staff and nursing home staff received the training and support they required to confidently assist the resident. When patients received outreach rehabilitation, families felt supported and denied the burden expressed by families of residents who received usual care. Those who were involved with the outreach team expressed a sense that the care was coordinated, and that the rehabilitation approach was developed and monitored throughout the 4 weeks. Families reported a sense of relief that their family member was being given every chance of a good recovery, and were pleased with progress they saw in all domains, including health, physical, nutritional and emotional. This study suggests that providing outreach rehabilitation into nursing homes was valued by families and the coaching model of care used by the visiting team with the nursing home staff was acceptable. The participants in this current research preferred receiving rehabilitation in the nursing home rather than hospital as it allowed residents to return to a familiar and reassuring environment, staffed by people who understood dementia.

In summary, the recovery pathway following hip fracture for people living in nursing homes is fragmented. Nursing home staff tend to have expertise in managing dementia while staff working in acute hospital settings have expertise in post-operative recovery after hip fracture. To improve the experience of those with dementia who live in nursing homes and suffer a hip fracture, ways need to be found for the appropriate expertise to follow the patient. Integrated care pathways for people with dementia and hip fracture are urgently needed to ensure that evidence based guidelines for the management of hip fractures in older persons are applied (NSW Agency for Clinical Innovation, 2014; Mak, Cameron, & March, 2010).

Conflicts of interest

Dr Maggie Killington declares she has no conflicts of interest. Dr Ruth Walker declares she has no conflicts of interest. Professor Maria Crotty declares she has no conflicts of interest.

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