

ORIGINAL REPORT

“IF I DIDN’T HAVE ANYBODY, WHAT WOULD I HAVE DONE?”: EXPERIENCES OF OLDER ADULTS AND THEIR DISCHARGE HOME AFTER LOWER LIMB ORTHOPAEDIC SURGERY

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Objective: To explore the perceptions of being discharged home following lower limb orthopaedic surgery in older adults.

Methods: Qualitative interviews with 11 patients over the age of 65 years were conducted between 6 and 12 weeks after discharge home and analysed using interpretative phenomenological analysis (IPA).

Results: Three themes were identified from analysis of the participants’ experiences of rehabilitation during the 6–12 weeks following discharge: (i) lack of a shared decision on when to go home; (ii) dependent on family to go home and to feel confident there; and (iii) trial and error rehabilitation. A further theme: a paternalistic medical model was also identified in participants’ experiences of contact with health professionals.

Conclusion: Participants had positive experiences of being discharged home from hospital. However, few participants played an active role in their discharge, all required the support of family to go home, and many were left unsure of how and when to return to usual activities. A paternalistic medical model was apparent. Family support, not without costs, was integral to discharge and rehabilitation at home.

Key words: qualitative research; patient discharge; lower limb orthopaedic surgery; older adult.

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INTRODUCTION

Globally, people are living longer, and this has resulted in an ageing population with an increasing prevalence of chronic disease and disability (1, 2). Many countries spend between one-third and one-half of their total health expenditure on older adults (1). Two areas of high expenditure are related to osteoarthritis and falls (3, 4). In people aged over 65 years, osteoarthritis and falls have a prevalence of over 30% (3, 4). Osteoarthritis can lead to pain, and disability in activities such as self-care, mobility and community participation (5, 6). When

conservative treatment has been exhausted surgical intervention is effective for reducing pain and improving quality of life (6, 7). Falls also frequently require surgical intervention, as over 35% of falls result in a fracture, from which 80% of people will require hospitalization and a stay in an acute orthopaedic ward (4).

In the post-operative period following lower limb orthopaedic surgery (either as a consequence of osteoarthritis or a fall) patients require care and rehabilitation. While the level and amount of care received is patient-dependent, all patients require good pain relief, good nutrition, and early mobilization (8). However, clinical guidelines recommend an early multidisciplinary approach, initially promoting independent mobility and function (such as washing, dressing, toileting alongside balance and gait re-training), as research has shown that this type of rehabilitation can result in a more rapid attainment of independence, fewer post-hospital complications, and reduced costs in the first 3 months post-surgery (8, 9).

Following surgical intervention some patients may require time in a specialist rehabilitation ward, while others are discharged directly home. Discharge has been defined as “the relinquishing of patient care in whole or in part by a health care provider or organisation” (10). Therefore, events and appointments prior to hospital admission are considered to be a part of the discharge process; from the moment of being referred to the hospital to the moment of discharge, individuals are in part or in whole under the care of various health professionals and staff within the hospital. Discharge can consequently be a process lasting more than several days, months, or years.

A successful transition home is frequently dependent on the physical and psychological condition of the older adult (11). In addition, a collaborative approach by health professionals using a holistic and individualized model of healthcare has been recommended (11, 12). Previous research has explored patients’ perspectives on the recovery process and found that a positive mental outlook, learning to cope with pain, and accepting a (hopefully) temporary loss of independence and function are necessary attributes for coping and managing the process of home rehabilitation (11, 13–19). However, there is limited research, which has specifically explored the experience of being discharged directly home. The aim of this study was to explore patients’ perceptions of the discharge process within the first 3 months of returning home.

METHODS

The qualitative approach of interpretative phenomenological analysis (IPA) (20) was used to explore patients' perceptions and experiences; the "lived experience" of being discharged home after orthopaedic surgery. IPA offers insights into how a given person, in a given context, makes sense of a particular phenomenon, event, or relationship from the descriptions of their cognitive and affective reactions (20, p. 37). IPA is recommended when exploring perceptions of health-related experiences, as the experience or event is frequently contextual and subjective (20). The transition home following a period of hospitalization can be confusing and challenging (21). Although the discharge day itself may be uneventful, older adults have previously reported feeling underprepared, isolated from social networks, worried about who has responsibility for their well-being now that they are home, and grief due to a loss of mobility and independence (21). IPA was selected over other forms of phenomenology because it has growing recognition as an appropriate methodology for applied health research (22), particularly as the health-related experience in this instance, discharge home, is contextual and subjective.

One of the distinguishing features of IPA is that interpretation can occur at many different levels, by both the participant and by the researcher; it is also possible to analyse data at a descriptive content level, via a detailed case-by-case interpretation of differences and similarities of experience of participants, through an interrogative analysis with respect to relevant literature (20). In addition to being interpretative, IPA is also iterative and idiographical. The iterative process occurs as the researcher thinks and reflects back and forth on the data in different ways over a period of time (20, p 28). Idiography refers to the detailed and systematic analysis of the phenomenon as well as the making sense of the phenomenon by the individual. Therefore, the methodology of IPA enabled exploration of the "personal meaning" of the event, and how the individual "made sense of" and "lived" the discharge experience, at multiple levels (20, p. 45).

Participants

A total of 11 participants were recruited for this study, although 22 patients were initially approached (Table I). All those approached had stayed in the acute orthopaedic ward of a teaching hospital in the Greater Wellington Region of New Zealand. Six patients declined to participate in the study prior to going home. From the 16 participants who initially consented: 1 did not meet the inclusion criteria; 1 withdrew consent prior to the interview due to health complications unrelated to the surgery; and 3 who had been initially approached in hospital were advised that sufficient recruitment numbers had been reached.

All participants had received orthopaedic lower limb surgery, were over the age of 65 years, and had been discharged directly home following surgery. In addition, all participants had scored at least 8 on the on the Abbreviated Mental Test (23). The Abbreviated Mental Test is a quick 10-item questionnaire used to assess the presence of

confusion and other cognitive impairment, predominantly in the older adult and in this study was used to confirm participant's ability to recall past and recent events. A score of less than 8 suggests impaired cognitive function (23).

All participants received written and verbal information about the study and gave informed written consent. This study was approved by the Central Region Ethics Committee of New Zealand (CEN/09/07/047).

Study design and data collection

Recruitment of participants took place in 2 phases. On the day preceding their discharge home, patients were approached about the possibility of participating in the study. A nurse, following consultation with the ward physiotherapist, approached patients. Verbal information and an information sheet outlining the purpose of the study were presented at this time explaining that, depending on their willingness to be involved and numbers recruited, they would be contacted in 6 weeks time and final permission to be involved would be sought. Informed written consent was usually gained the following day to allow each patient time to consider and discuss with their family, their possible participation in the study. If the patient had not already completed the Abbreviated Mental Test on admission, this was completed after gaining informed written consent. At week 6 post-hospital discharge, patients were telephoned by SH to reconfirm interest in the study, clarify any further questions, or to advise that sufficient numbers had been reached. A time and date for the interview was set during this telephone call.

All semi-structured interviews were conducted in a location of comfort and convenience to the participants and all participants were given the opportunity to have family and/or support person(s) present. The services of interpreters were available, but were not required. Interviews were semi-structured and did not follow a specific order of questioning. However, 3 main topics were covered via open questions. These topics were: the hospital experience, especially the day of being discharged home; the first few days at home; and what life was like now. In addition to being asked about their experiences immediately prior to their discharge and initial rehabilitation period at home, participants were also briefly asked about their experiences related to events prior to their hospital admission for surgery and experiences while in hospital. This is in keeping with the broadest sense of the term discharge process. More time and questions were spent in some areas with some participants than with others. At the start of the interview, during introductions, SH advised participants she was not a physical health professional. All interviews were recorded with an Olympus DS-55 digital voice recorder and transcribed anonymously verbatim by a contracted transcriber.

Data analysis

The analysis followed IPA guidelines (20, p 82) beginning after completion of the first interview with SH immersing herself in the data by reading the transcripts multiple times. Initial thoughts, such as descriptive comments, then linguistic comments, and finally conceptual comments were recorded in the right-hand margin of each transcript. Emergent themes were subsequently recorded in the left-hand margin, and then connections between themes were established. Themes were then cross-referenced back to the original data, via a table of themes, to verify that the themes represented participants' accounts. As each subsequent transcript was analysed, shared and divergent themes between participants were recorded. The themes were further analysed by MP using inter-coding auditing, which involved MP separately coding 5 of the transcripts in the above method, followed by comparison and discussion of the themes between SH and MP. The computer programme NVivo 8 (QSR 2009) was used to assist thematic organization of data.

RESULTS

The interview process asked participants about their experiences before and after their orthopaedic surgery. This provided a natural descriptive story, and this initial layer of

Table I. *Participants' characteristics*

Participant	Age, years/sex	Ethnicity	Surgery	Days spent in hospital	Days since discharge
1	83/ F	NZE	El Hip	5	35
2	79/ F	NZE	El Hip	4	34
3	88/ F	NZE	T	12	41
4	66/ F	NZE	El Hip	5	36
5	74/ F	NZE	El Knee	6	33
6	73/ M	NZE	El Hip	6	30
7	73/ M	Maori	El Knee	7	30
8	75/ F	NZE	El Knee	5	31
9	81/ F	NZE	T	6	30
10	81/ M	NZE	T	7	33
11	66/ F	Pasifika	El Knee	5	40

M: male; F: female; NZE: New Zealand European; El: elective surgery for osteoarthritis; T: surgery related to a trauma.

analysis resulted in 3 themes being identified, which related to participants' perception of the rehabilitation process from getting ready to leave hospital until the present: (i) Lack of a shared decision on when to go home; (ii) Dependent on family to go home and to feel confident there; (iii) Trial and error rehabilitation. A fourth theme; a paternalistic medical model, was identified after further in-depth analysis.

In the quotations, the use of an em dash (—) indicates a pause, ellipsis (...) indicates the removal of some text that does not alter the meaning of the quote, and square brackets [] indicate the addition of some text to clarify meaning. The abbreviations El. and T. in brackets after each quotation refer to participants who had elective surgery for osteoarthritis, and participants who had trauma-related surgery, respectively.

Lack of a shared decision on when to go home

The process of going home appeared to be seamless. However, this was because participants were unaware of any formal "discharge plan" or care pathway, or having actively contributed to any decision-making about their discharge. Rephrasing the question and using expressions such as "preparing to leave hospital for home" resulted in comments such as, "It's a bit more vague on...going home" (El. 3). Only one participant described having an active part on determining her day of discharge because she specifically asked to go home:

"Friday, about four o'clock, I said to my nurse, 'I want to go home' ... physio ... said 'if you lift your leg, you go home'. Doctor said 'if you lift your leg, you go home. But if you can't lift, you're going to spend the weekend here' ... after I lift my leg up I said to her ... 'let me come home'" (El. 8).

The lack of any shared decision-making regarding day of discharge did not concern the participants. In general, they trusted the system, did what they were told, and had "no complaints" (El. 1). Furthermore, most participants appeared to know themselves that they were ready to leave hospital when they did and "looked forward" (El. 4) to going home. Only one participant believed there was a specific reason for her day of discharge, "I think we were all kicked out. Because it was a long weekend" (T. 1).

Participants were keen to recount all that was done by staff and thought that staff were friendly and positive, "Everyone was very caring" (El. 4). In addition, they acknowledged that their physical independence had been gradually extended in preparation for going home:

"Preparation started the first day after the operation ... They got me up, and walking with a walking frame ... and [then] they brought me ... crutches ... every day I'd go for a walk with the physiotherapist, and the walks would get longer, and longer" (T. 3).

However, the day of discharge did not always go smoothly. Frequently participants were left waiting, anxiously wondering if they would actually be going home until quite late in the day, "Even if you're told the night before, "yeah, you can probably go home tomorrow" ... they don't mention something the next day." (El. 3). Participants had not initially appreci-

ated that discharge was contingent on the final "okay" from the surgeon:

"That's always been a hassle is how long you have to wait for the doctor to come and okay you to be gone" (El. 3).

Dependent on family to go home and to feel confident there

The importance of family to help participants through the post-operative rehabilitation stage was significant. For all elective surgery participants, before their surgery, their worry was finding someone to live with them, for at least the first week, on their return home. They perceived that having someone to look after them was a pre-requisite to surgery:

"If I didn't have anybody, what would I have done?" (El. 1).

After surgery, family members frequently stayed with participants, in essence providing 24-hour unpaid care. Participants perceived that they could not go home unless care, formal or informal, had been arranged. Participants opted for the informal care provided by family members, which was free. In order to provide this care, many family members took leave from work, sometimes using up annual or special leave which had accrued over years. Participants did not want to overburden their family members, as many of the "family carers" had "limited time" (El. 3) due to other commitments, and these sacrifices were appreciated.

Family support gave participants the confidence to go home and stay at home. This support was perceived to be a positive and necessary aspect of their continuing rehabilitation, "I could not have managed without that ... family have been wonderful" (T. 1). Family members provided "company", but more importantly their presence provided a safety net. Participants knew they could rely on family members to help them and thought that their presence might prevent any unforeseen falls or accidents. However, having family providing care in the home was not without tension. Participants were aware of the various sacrifices family members had made to look after them, and while they felt indebted, being dependent was frustrating. When family members provided cups of tea unasked for or completed household chores to a standard different from their own, participants had to learn patience:

"I learnt to be a bit more patient ... [but] it does wear a bit thin" (El. 7).

Trial and error rehabilitation

Participants generally described their first weeks at home as tentative. They were pleased to be home, glad of the care and support provided by carers and family, and the provision of equipment. However, they had no clear ideas about their rehabilitation process. This made the presence of family members whom they could trust even more important. They were afraid of doing harm by over-extending themselves and not sure how long it would take to be back to "normal". While all participants were "extremely cautious" (El. 5), those with trauma-related surgery were particularly concerned about disrupting the healing process and their recovery:

"I didn't want to do anything that was going to interrupt the healing ... I kept on thinking to myself 'gee, I hope I haven't done something stupid while I was sleeping'" (T. 3).

Much of the uncertainty over doing harm related to the amount and duration of pain participants experienced. In particular, the amount of pain felt at night was unexpected. Pain was interpreted to mean doing too much in the day, having done something silly, such as twisting awkwardly, or that the new joint or bone was not healing. Regardless of cause, pain made the participants fearful.

Participants were keen to regain their mobility and independence. However, the first 12 weeks involved a considerable amount of trial and error and not really knowing exactly what to do or expect. "Promised" home visits by a physiotherapist or a nurse were yet to eventuate for 2 participants, and several participants were unsure as to whether to continue with the physiotherapy exercises they were provided in hospital. They devised their own methods of attaining personal goals and used their own initiative on when activities and chores could be attempted. The trial and error strategy was perhaps a consequence of a lack of information; in spite of the numerous information pamphlets they had acquired, some participants voiced a definite lack of information:

"There was a dearth of information about what to expect, in terms of progress ... I would like to have had some encouraging picture of the future...how progress would be, and various milestones, and right timings" (El. 1).

All 11 participants perceived that they were well on their way to recovery at the time of the interview. Most were positive about their progress and were getting back into their normal activities. Having devised their own methods of rehabilitation at home, they attributed this success to self-motivation and self-belief rather than any specific health professional's advice:

"I went to church for the first time yesterday...it's easy to get up and think "oh no, ...I'll give it another week" ...but [I] thought "no, I must try and get into...my groups that I belong to, and do a bit of socialising" (El. 2).

A paternalistic medical model

Aspects of the paternalistic medical model were evident throughout every transcribed interview. The paternalistic model describes and incorporates the patient's acquiescence to medical authority, and this was apparent in participants' experiences prior to and during their stay in hospital and in follow-up visits after surgery. At times, the presence of this theme was overtly demonstrated by language and experiences, and at other times this theme was inherently conveyed by context.

"Out-patients...a doctor I'd never seen before wanted to look at the scar, so I take my pants down for this strange man. He looked at the scar and he said how good it was; I said 'yes, my ankles are more [of a] problem than the hip'. He said 'Well we're only looking at the hip...right, well we'll see you in a year'. We didn't sit down even...but I mean they're all so terribly busy" (El. 3).

All 11 participants were impressed with the efficient general "clockwork" running of the orthopaedic ward, the hospital in general, including nursing care and their initial hospital physiotherapy treatment. While some participants felt patronised, "It was full of ageism" (T.3), all participants wanted to please the

various health professionals, from the top down. Consequently, they fitted into the system and did as they were told:

"[The surgeon] cleared me—last week...doesn't want to see me till October this year, which is about ten months...said that I was a "good boy, good patient" (El. 5).

"Oh, no, they were lovely girls, weren't they? They were lovely...but they made me do everything that I was supposed to do" (T. 3).

DISCUSSION

This study explored the experiences of older adults discharged home following lower limb orthopaedic surgery. Participants mostly had very good experiences whilst in hospital. However, few participants had an active role in their discharge planning, and family or friends were integral to the success of the discharge and beginning of rehabilitation. The regaining of confidence and independence once home was perceived to be partially a result of family support, and not necessarily a direct result of any specific health professionals' actions, as was seen by their trial and error rehabilitation strategies. Despite the participants' positive experiences, a less-than ideal paternalist medical model of health was apparent.

Participants had very little awareness of the discharge process, their own discharge, and who was contributing to the decision-making regarding their discharge home. Findings from this study suggest that participants did not expect to be included in this process; they patiently waited for the surgeon's approval. Readiness for discharge has been described as a "combination of physiological, psychological, and social factors", and should be considered alongside the ability of the family and community to provide needs as required (24). Some older women can find active participation in formal discharge planning meetings difficult, primarily because patients can find it difficult to understand what is being talked about or even feel included in the conversation (25). Despite this, other research has indicated that many older adults want to contribute to the decision-making about their discharge, but are naturally reliant on the "experts" for advice (26). Results from the current study indicate that participants were not provided with a choice about whether they wished to take an active role in their discharge planning.

Participants acknowledged that the presence of family members or close friends was comforting and promoted confidence, enabling them gradually to increase their independence and activity in a safe environment. They trusted the family and friends to provide care and rehabilitation advice, and this appeared to be their preferred choice. However, the perception that family support is a pre-requisite for elective surgery has rarely been reported. All participants in this study were fearful of being liable for the costs of rehabilitation; they were unable to trust that the health system would provide adequately for them, consequently providing their own care, via family or friends was imperative.

Family care was not however "free". Participants reported that family members took un-paid leave, sick leave, annual leave, or leave that had been accrued for long-term service

to care for the participant. Many participants perceived the enormity of the sacrifice that had been made on their behalf, which made accepting their loss of independence even more awkward. Whether health professionals and policy-makers are aware of how important this “free” care is to the successful rehabilitation of older adults following orthopaedic lower limb surgery is unknown.

Participants were uncertain of what to expect once home and experienced a mix of gratitude and frustration towards family. This was due to their perceived isolation and loss of independence. These perceptions have been previously reported in elective surgery and hip fracture literature (13, 14, 18, 19, 27). Being part of a family, having friends, self-regulating by maintaining independence and self-determination, and being spiritual have all been identified as important factors contributing to quality of life for all older adults living in the community (27).

However, frustration was also due to participants being unsure of how or when to progress their activities and if what they were feeling was “normal”. They wanted to return to usual activities, regain their independence and lose their isolation, but did not want to impede the healing process. Many used pain as their guide, but most were unaware that pain may be severe, prolonged over several months, and especially worse at night. Unsurprisingly, participants who had received orthopaedic surgery due to a trauma were particularly worried about the cause or meaning of the pain. Robinson (13) reported this finding in women who had sustained a hip fracture. However, those who had received elective surgery were also extremely cautious. Paradoxically, while most participants were worried about when they should be walking independently, one participant was driving before it was potentially safe. Overall, there appeared to be little understanding of how and when to gradually increase activities or even whether exercises prescribed in hospital should be continued. The resulting trial and error approach may explain why some participants experienced a sharp flare up of pain, especially at night. More expansive discussion between health professionals and patients on pain, pain relief, progression of activities over time, and patient experiences may have alleviated the concern of the participants in this study (28) and enabled the provision of a more individualized and patient-centred care approach.

Participant uncertainties were not due to a lack of information, particularly in the form of pamphlets and handouts. Findings from previous research have advocated the “informing” of patients via pre-operative information for people undergoing elective surgery, and written information can be helpful for increasing confidence (15). However, in the current study, it was apparent that there was almost too much information, making it difficult for some participants to find relevant information in a timely fashion. Some participants would have preferred an individualized discussion about their own particular concerns, while others would have preferred to have had no information at all. This latter finding was made particularly with reference to knowing the risks of surgery. These results illustrate that, while health services may be constrained by resources, and pamphlets may be perceived to provide a ready source of rich

information, this medium of communication is not ideal for everyone. Pamphlets do not allow for the active engagement of the participants on matters that were perceived to be of importance to them. Information gathering and reassurance was difficult, even during consultation, for some participants. The surgeon who was not prepared to discuss anything but matters that were considered important to him or her illustrates the lack of engagement in a biopsychosocial and patient-centred model of healthcare. The participant rationalized and then excused the use of this paternalistic model of healthcare and behaviour by suggesting that the surgeon was a busy person. However, when patients feel they cannot ask, a lack of trust can develop (29).

There has been a growing awareness of the limitations of the paternalistic model for several decades (30). Very simplistically, the paternalistic model of care can be recognized by the patient passively acquiescing to the health professional’s decision-making and authority, and adopting a child-like need to be told what to do or praised for certain behaviours (30, 31); its use in the area of older adults recovering from hip fracture has been reported previously (12). A more favoured approach is that of patient-centred care, which has been recommended across all areas of health, from primary care through to cardiac thoracic surgery (31). Reportedly, patients prefer patient-centred care (32); however, it is possible that some patients, in particular older adults, may “agree” to a paternalistic model of healthcare (33). Others argue that patients who accept a paternalistic model of care have not been shown any alternative model of interaction (30). It is unclear from the findings in this study whether the participants accepted this model of care by choice. The use of language such as “good boy” was not limited to health professionals talking to patients, as numerous participants also commented on the wonderful “wee girls” when referring to the nurses and other health professionals. However, the paternalistic model has been shown to result in poor adherence to medication and exercise advice, and can result in patients needlessly worrying and requiring ultimately more attention by health professionals (31, 32).

Methodological considerations

The epistemology of this study was phenomenology, which is concerned with exploring the essence of an individual’s “lived experience” (20). From this perspective, multiple interpretations may exist and the findings presented in this paper reflect the researchers’ interpretations of the participants’ experiences. In IPA this is described as a double hermeneutic process (20, p. 35). Of note, the experiences of participants analysed in the current study are predominantly from women and are therefore not generalizable. It is possible that women feel more at ease talking about their experiences and feelings than males, and therefore have increased motivation to participate in research (18). However, females have a longer life expectancy than males (1, 2), and a higher rate of hip fractures (4); therefore, there may be more opportunity to interview and recruit female participants. Furthermore, all the researchers involved in this project have intimate experience of the discharge process. Their experiences were either as a consumer of public health services and/or as a health professional in the public health system.

One researcher (SH) interviewed all participants, and all participants knew that SH was not a physical health professional. This potentially allowed participants to express their experiences more freely. In addition, interview questions were kept as open as possible to allow freedom of interpretation. Nonetheless, participants may still have mentioned what they thought the researchers wanted to hear. Analysis of the data was initiated after the first interview, partly to allow for the rephrasing of specific questions or the addition of further questions to the interview schedule; however, no modifications were required. Ongoing analysis also meant that it was possible to determine that no new findings had emerged after the tenth and eleventh interviews, and therefore no further interviews were conducted.

A strong commitment was made to put interviewees at ease, to listen carefully and empathetically to the interviewee's story, and to take care of the interpreted meaning of interviewee's words during the analysis of each transcription, thus demonstrating sensitivity to context (20 p. 181). Rigour was established by the completeness of the data collected, and the level of idiographic engagement and degree of iteration undertaken (20, p. 182). Independent inter-coder auditing was used to ensure validity of the qualitative work alongside cross-referencing the themes back to the original data (20, p. 182).

A two-phase recruitment process was used, as there was a period of up to 3 months between participants initially being recruited when in hospital and before being available for an interview once home. Due to the delay between recruitment and interviews, 3 participants who were initially recruited did not take part in the interview process due to data saturation. Participants were made aware of this possibility at the time of initial recruitment.

Implications and conclusion

The findings indicate the importance of family and/or friends for indirectly providing financial, social and emotional support. Without this support many of the participants perceived that they would have faced severe financial hardship or for those having elective surgery, denial of surgery if the appropriate care could not be found. Participants were unclear about "usual" recovery time frames and what symptoms were expected, and this resulted in a fear of doing harm. This finding was despite participants acknowledging the abundance of informational pamphlets they had received. Consideration of a variety of information mediums is warranted. It is likely, however, that preferences will be related to individual learning styles. A paternalistic model of healthcare, which appeared to be accepted and entered into by the participants, was identified. Conversely, considering some participants' dissatisfaction with the information they had received and lack of any active contribution to their discharge, the merits of patient-centred care should be considered.

In conclusion, participants in this study had positive experiences of being discharged home from hospital. Family support was integral to the discharge home and rehabilitation process. However, few participants played an active role in their discharge and many participants were left unsure of how and when to return to their usual activities.

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REFERENCES

1. Anderson GF, Hussey PS. Population aging: a comparison among industrialized countries. *Health Aff* 2000; 19: 191–203.
2. World Health Organization. Ageing and life course 2011 [cited 2011 May 30]; Available from: <http://www.who.int/ageing/en/index.html>.
3. Bitton R. The economic burden of osteoarthritis. *Am J Manag Care* 2009; 15: S230–S235.
4. Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and non-fatal falls among older adults. *Inj Prev* 2006; 12: 290–295.
5. Dreinhöfer K, Stucki G, Ewert T, Huber E, Ebenbichler G, Gutenbrunner C, et al. ICF core sets for osteoarthritis. *J Rehabil Med* 2004; 36: 75–80.
6. Linsell L, Dawson J, Zondervan K, Randall T, Rose P, Carr A, et al. Prospective study of elderly people comparing treatments following first primary care consultation for a symptomatic hip or knee. *Fam Pract* 2005; 22: 118–125.
7. Ethgen O, Bruyere O, Richy F, Dardennes C, Reginster J-Y. Health-related quality of life in total hip and total knee arthroplasty. A qualitative and systematic review of the literature. *J Bone Joint Surg Am* 2004; 86: 963–974.
8. Currie C, Hutchison J, Abbotts J, Christie J, Collie F, Ferguson K, et al. Management of hip fracture in older people: a national clinical guideline (SIGN 111) NHS Quality Improvement Scotland, Scottish Intercollegiate Guidelines Network. Edinburgh: Elliott House, 2009. Available from: <http://www.sign.ac.uk/pdf/sign111.pdf>.
9. Khan F, Ng L, Gonzalez S, Hale T, Turner-Stokes L (2008). Multi-disciplinary rehabilitation programmes following joint replacement at the hip and knee in chronic arthropathy. *Cochrane Database of Systematic Reviews*. 10.1002/14651858.CD004957.pub3.
10. Health Information Standards Organisation, Referrals, status and discharges business process standard HISO 10011.1, Health Information Strategy Action Committee, Editor. 2007, Ministry of Health: Wellington, New Zealand. Available from: <http://www.hiso.govt.nz>.
11. Fielden JM, Scott S, Horne JG. An investigation of patient satisfaction following discharge after total hip replacement surgery. *Orthop Nurs* 2003; 22: 429–436.
12. Healee DJ, McCallin A, Jones M. Older adult's recovery from hip fracture: a literature review. *Int J Orthop Trauma Nurs* 2011; 15: 18–28.
13. Robinson SB. Transitions in the lives of elderly women who have sustained hip fractures. *J Adv Nurs* 1999; 30: 1341–1348.
14. Archibald G. Patients' experiences of hip fracture. *J Adv Nurs* 2003; 44: 385–392.
15. Heine J, Koch S, Goldie P. Patients' experiences of readiness for discharge following a total hip replacement. *Aust J Physiother* 2004; 50: 227–233.
16. Marcinkowski K, Wong VG, Dignam D. Getting back to the future: a grounded theory study of the patient perspective of total knee joint arthroplasty. *Orthop Nurs* 2005; 24: 202–209.
17. Williams MA, Oberst MT, Bjorklund BC. Posthospital conva-

- lescence in older women with hip fracture. *Orthop Nurs* 1994; 13: 55–64.
18. Ziden L, Scherman MH, Wenestam CG. The break remains – elderly people’s experiences of a hip fracture 1 year after discharge. *Disabil Rehabil* 2009; 1–11.
 19. Ziden L, Wenestam CG, Hansson-Scherman M. A life-breaking event: early experiences of the consequences of a hip fracture for elderly people. *Clin Rehabil* 2008; 22: 801–811.
 20. Smith JA, Flowers P, Larkin M. *Interpretative phenomenological analysis: Theory, method and research*. 1st edn. London: Sage; 2009.
 21. Grimmer K, Moss J, Falco J. Experiences of elderly patients regarding independent community living after discharge from hospital: a longitudinal study. *Int J Qual Health Care* 2004; 16: 465–472.
 22. Brocki JM, Wearden AJ. A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychol Health* 2006; 21: 87–108.
 23. Jitapunkul S, Pillay I, Ebrahim S. The Abbreviated Mental Test: Its use and validity. *Age Ageing* 1991; 20: 332–336.
 24. Fenwick A. An interdisciplinary tool for assessing patients’ readiness for discharge in the rehabilitation setting. *J Adv Nurs* 1979; 4: 9–21.
 25. Efrainsson E, Sandman P-O, Rasmussen BH. ‘They were talking about me’: Elderly women’s experiences of taking part in a discharge planning conference. *Scand J Caring Sci* 2006; 20: 68–78.
 26. Roberts K. Exploring participation: older people on discharge from hospital. *J Adv Nurs* 2002; 40: 413–420.
 27. Register ME, Herman J. Quality of life revisited: the concept of connectedness in older adults. *Adv Nurs Sci* 2010; 33: 53–63.
 28. Bergh I, Jakobsson E, Sjostrom B, Steen B. Ways of talking about experiences of pain among older patients following orthopaedic surgery. *J Adv Nurs* 2005; 52: 351–359.
 29. Sjöling M, Norbergh K-G, Malker H, Asplund K. What information do patients waiting for and undergoing arthroplastic surgery want? Their side of the story. *Int J Orthop Trauma Nurs* 2006; 10: 5–14.
 30. Charles C, Whelan T, Gafni A. What do we mean by partnership in making decisions about treatment? *BMJ* 1999; 319: 780–782.
 31. Coulter A. *After Bristol: Putting patients at the centre*. *BMJ* 2001; 324: 648–651.
 32. Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, et al. Preferences of patients for patient centred approach to consultation in primary care: Observational study. *BMJ* 2001; 322: 468–472.
 33. Dunn N. Patient centred care: Timely, but is it practical? *BMJ* 2002; 324: 652.