CLIENT VALUED OUTCOMES FOR HIP FRACTURE CLIENTS IN NURSING HOMES

by

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CHAPTER I

In 1986, the Institute of Medicine (IOM) published Improving the Quality of Care in Nursing Homes, which provided many recommendations for improving nursing home care, many of which were introduced in legislation proposed in 1987. That year the Omnibus Budget Reconciliation Act was signed into law (PL 100-203), mandating an outcome approach to assurance of quality in long term care.

Outcome evaluation of patient care has received considerable attention recently as the most appropriate way to approach the concept of quality. Not only are public policy makers focusing on the need for research on process and outcome measures, but they are calling for patient input on the measures (AHCPR, 1990). The study reported here is the first in a series of studies planned to conceptualize and measure appropriate outcomes for clients in the nursing home setting.

Need for Outcome Research in Long Term Care

Donabedian (1980) distinguishes between quality as defined by the patient (individualized), the professional (absolutist), and the society (social): "When the judgment of quality takes into account the patient's wishes, expectations, valuations, and means, we may speak of an 'individualized' definition of quality" (p. 14). In the absolutist definition, quality is "the management that is expected to achieve the best balance of health benefits and risks" (p. 14), in the professional's judgment. A social definition of quality includes the aggregate net benefit for an entire population, as well as the distribution of that benefit within the population. Of particular importance to this study are the individualized and absolutist definitions of quality.

Donabedian's (1980) conceptual framework for quality assurance uses three approaches to the measurement of quality: structure, process and outcome. Structure is

defined as the "relatively stable characteristics of the providers of care, of the tools and resources they have at their disposal, and of the physical and organizational settings in which they work" (Donabedian, 1980, p. 81). The structure of an organization assures its capability to provide services to the patients. Without adequate numbers of properly prepared personnel, adequate physical facilities and adequate financial resources (including financing mechanisms), an organization does not have the capacity to deliver quality services.

Early efforts at assuring quality in acute care and long term care focused on structural aspects of organizations such as policies, procedures and safety features of building design. Structural aspects are well-defined and easy to measure, and these became the basis for licensing and certification efforts of the Health Care Financing Administration (HCFA) and the Joint Commission for the Accreditation of Health Care Organizations (JCAHCO). The certification process focused on the institutional framework within which care was provided, rather than on the patient (IOM, 1986). The problem with structural criteria is that they measure the capacity to provide quality care but do not measure the care actually given or the outcomes of the care. Thus, facilities could be in compliance with all the structural criteria and, at the same time, have poor client outcomes. Conversely, a facility could demonstrate excellent client outcomes and be cited for paperwork deficiencies. When adequate quality of care did not result from review efforts which were directed at structural criteria, regulation began to focus on process measures.

Process refers to "the set of activities that go on within and between practitioners and patients" (Donabedian, 1980, p. 79). Process includes the technical as well as the interpersonal aspects of care and is based on norms as determined by professional experts or by the society as a whole.

In acute care, JCAHCO accreditation has focused on nursing care plans and

documentation and on measurement of the nursing process. Early research on the measurement of nursing process included the work of Phaneuf, Wandelt, Ager, Hausmann, Hegyvary, Newman, and Bishop and was characterized by tool development and testing, e.g., Nursing Audit, QualPac, and Rush Medicus (Lang & Clinton, 1984).

In 1984, HCFA began to develop a modified survey process for nursing homes, the Patient Care and Services (PaCS) review, that was based primarily on direct patient assessments and outcome-oriented indicators of care (IOM, 1986). This survey required a "detailed review of care provided to a sample of residents, through observation, interviews, and medical record reviews; evaluation of meals, dining, and eating assistance by observing meal service; and observation of drug administration for a sample of residents" (IOM, p. 130).

The difficulty with process criteria, however, is illustrated by the treatment of a skin condition. There are many approaches to the treatment of skin conditions, and what works for one patient may not work for another. This is due to many factors, such as nutrition, mobility, and cardiac status, in addition to the individual's immune response and cooperation with the treatment protocol. Thus, while process criteria are important, they are difficult to agree upon and to measure with any reliability or validity (Gamroth & Smith, 1990).

Outcome evaluation of patient care has received a great deal of attention recently, and it is now generally considered the most appropriate way to approach the concept of quality (AHCPR, 1990). Outcomes are defined as "a change in a patient's current and future health status that can be attributed to antecedent health care" (Donabedian, 1980, p.82). In 1987, the Omnibus Budget Reconciliation Act (PL 100-203) mandated an outcome approach to the assurance of quality in long term care. Outcomes traditionally measured are mortality, morbidity and disability. Kane (1987), however, points to the difficulty of using death,

disability, and discharge as outcome criteria for long term care (LTC). While death rates in acute care may be an appropriate negative quality indicator, death rates in LTC may reflect the attainment of goals for which clients were admitted, e.g., terminal care. Also, disability, while possibly valid as a negative indicator in acute care, is often not a good indicator in LTC because many residents are disabled on admission. Finally, for acute care rehabilitation clients in nursing homes, discharge may be an adequate measure of quality, but it may be invalid for the long-term resident.

Considerable controversy exists about which of the three approaches --structure, process, or outcomes-- represents the best evaluation of quality. Some hold outcomes to be surrogates for process while others maintain the opposite. Donabedian (1987) says that, "the validity of either [process or outcome] depends on the validity of the assumed causal linkage between the two. If that is valid, either can be used to assess quality; if that is invalid, neither can be used. Process and outcome are, therefore, complements to each other in the assessment of quality, not alternatives" (p. 77). It is, however, very difficult to specify appropriate outcomes and the associated processes of care and to demonstrate the relationship between process and outcome (Kurowski & Shaughnessy, 1982). There may be a number of reasons why the linkages between structure, process and outcome have not been demonstrated.

Donabedian (1987) draws a distinction between quality assurance activities and quality of care research: "The information used in monitoring is seldom precise enough or gathered under sufficiently controlled conditions to permit confident conclusions about the relative efficacy of varieties of care" (p. 77). Bond, Gregson, and Atkinson (1989) discuss the difficulties of "detecting change in clinical characteristics and the multidimensional nature of disease in old age" (p. 300). In addition to the need for controlled conditions, quality of care

research requires a clear conceptualization of the phenomenon under study, as well as reliable and valid instruments for measurement of the phenomenon (Lindeman, 1976a).

The need for additional quality of care studies continues to be reiterated by researchers and policy makers. Lang and Clinton (1984) called for descriptive studies that define structure, process and outcome criteria and the relationships among the criteria. Lohr (1988) suggested that "more definitive evidence of process and outcome linkage" is needed (p. 47). Spector and Drugovich (1989) note that "until we have an extensive research agenda that improves understanding of the effectiveness [of treatment], the validity of survey criteria will remain in question" (p. 800). The Agency for Health Care Policy and Research (AHCPR) "supports studies on the outcomes of health care services and procedures" (p. 1), and The National Center for Nursing Research has formed an advisory committee to determine priorities for research in long term care (Hinshaw, Heinrich, & Bloch, 1988).

There is renewed interest in quality of care research that focuses on the processes and outcomes of care. Furthermore, there is renewed interest in the preferences of the individual in determining appropriate processes and outcomes of care (AHCPR, 1990; Donabedian, 1987). Lohr (1988) points out that "the desirability of one outcome rather than another...may differ markedly according to the values and preferences of patients, factors that to date are rarely taken explicitly into account in outcome studies" (p. 38). Similarly, Kane and Kane (1988) state that "the definition of quality LTC must address the elements of care and the outcomes that are meaningful to the clientele" (p.136).

This investigation of hip fractures in the elderly is based on a view of nursing practice as including nurses' involvement in the formation of health policy that: a) assures quality health care for the consumer and b) acknowledges the contribution of consumers and health care providers to such care. This conception of practice is particularly important in the field

of long term care of the elderly because of the prominent position of nurses in that system, as mandated by law (PL 100-203).

Statement of Problem

What appears to the researcher as a logical approach to quality of care studies (conceptualization, tool development and measurement) is in reality a very complex process and, given the current state of the art, one that requires a sequence of studies. Therefore, a series of studies are planned to refine current conceptualizations of client outcomes in nursing homes and to select (or design) appropriate instruments for use in ongoing outcome research. Hip fracture clients, a clinically significant nursing home subpopulation, were chosen as the subject of the first study in this series because they were considered by the investigator to be a relatively homogeneous population in terms of care needs and outcomes.

According to hospital discharge data, in 1985 there were 250,000 persons in the U.S. hospitalized for the acute treatment of hip fractures (Cummings, Kelsey, Nevitt, & O'Dowd, 1985). The United States has one of the highest incidences of hip fractures of any industrialized country. The risk of hip fracture increases dramatically with age, such that 2% of females and 6% of males over the age of 85 will sustain a hip fracture each year (Kelsey, 1977). Thus hip fractures are of great concern to consumers of health care, to providers of health care and to the payors of health care.

The advent of a prospective payment system (PPS) in hospitals has focused new attention on the phenomenon of hip fractures in the elderly. Since the advent of PPS in 1984, the mean length of stay for hip fracture patients has decreased dramatically; for example, a 42% decrease was reported by Fitzgerald, Moore and Dittus (1988). In addition, patients receive fewer physical therapy treatments while hospitalized, greater numbers of patients are discharged to nursing homes, and a greater number of those admitted to nursing homes

remain in the home one year post fracture than before PPS. Fitzgerald et al. raise the question of whether the quality of care in the nursing home setting is adequate to meet the needs of hip fracture patients.

For nurses practicing in nursing homes, whether as administrators or patient care practitioners, the large numbers of hip fracture patients raise a number of questions. What are the desired outcomes for hip fracture clients? What activities of the nurse or other members of the health care team assist persons with a hip fracture to attain their desired outcomes? What factors influence a person's rehabilitation from a hip fracture other than the care provided to the person? What kind of policy decisions are being made based on studies that question the adequacy of care for hip fracture clients in nursing homes, -- for example, the Holladay Park Hospital Skilled Nursing Bed decision issued by the Oregon Office of Health Policy in 1989.

The specific purposes of this study were: a) to identify and define client valued outcomes for elderly hip fracture clients admitted for rehabilitation to a Medicare-certified nursing home, and b) to compare client valued outcomes to family valued outcomes. The study emphasized client-focused outcomes, as opposed to client/family outcomes. This is not to deny the importance of client/family relationships or outcomes; rather the focus was on client outcomes within a family context.

CHAPTER II

Review of Literature

Two bodies of literature were reviewed: a) specific structure, process and outcome studies in long term care (LTC); and b) specific outcome studies, in acute and long term care (nursing homes), related to hip fracture clients. The following chapter is organized around these two bodies of literature.

Research on Quality of Care in LTC

Several studies have examined the relationships between structural and process components of quality in LTC; others have examined the relationship between structural components and outcomes.

Structural and process relationships

Gottesman (1974), in a study of 1144 subjects in 40 nursing homes, reported a relationship between facility structural components (ownership, source of income) and nursing home performance as measured by the number of interactions observed over two 12-hour periods between patients, staff, community and amount of medical care. Residents in non-profit facilities engaged in more self care in activities of daily living (ADL), had equal amounts of medical care and more psychosocial activities with professional staff, family and volunteers than residents in proprietary facilities. Residents in proprietary facilities with high numbers of private pay residents received more medical services, more help with basic services from non-professional staff and more psychosocial activities with community persons and, occasionally, professional nursing home personnel than residents in non-profit facilities or proprietary facilities with high numbers of publicly supported residents. Residents in proprietary facilities with high numbers of public-supported individuals received less assistance with ADLs and had fewer psychosocial contacts, although the residents were more

independent physically than in nonprofit facilities or proprietary facilities with high numbers of private pay residents. There were several limitations to Gottesman's (1974) study, however: a) nursing home performance was poorly conceptualized; b) an underlying assumption existed that more interactions are equivalent to better nursing home performance, whether or not the interactions meet the needs of clients; and c) there was no reported psychometric testing of the observational tool used to measure nursing home performance.

Profit status and ownership of nursing homes were investigated by Greene and Monahan (1981) in a study of 24 skilled nursing facilities in Arizona. Quality was "measured by proxy in terms of available direct patient care resources...(RN) nursing hours, (RN) nursing expenditures, patient dietary expenditures, and miscellaneous direct patient care expenditures, each standardized on a per patient day base" (p. 403). The authors found that for-profit and distantly headquartered chain operations provided lower levels of care than nonprofit, locally owned nursing homes. The study, however, assumed that the provision of services (as accounted for by cost) is a good proxy for a quality product; it could be argued that the same data represent inefficiency of production rather than quality of care.

In a study of 80 patients in four nursing homes using the Quality Patient Care Scale (Qualpacs), Mech (1980) found that patients with similar nursing care requirements received care that was unequal in quality. Mech also found that higher quality of care was given in institutions which were located in urban areas and were non-proprietary in ownership. Higher quality of care correlated with larger staffs, particularly licensed personnel, and utilization of a larger number of support services. The validity of the study is questionable, however, since the investigators used an instrument that was designed for use in the acute care setting, then deleted items and changed the rating scale without further testing of the instrument for reliability or validity in the LTC setting.

Munroe (1990) reported that in 820 California facilities, the higher the ratio of RNs to LPNs, the higher the quality of care as measured by the 1986 Health Care Financing Administration (HCFA) national report on nursing homes. The HCFA report, however, was a listing of deficiencies found on annual review of nursing homes and has questionable reliability and validity as an outcome measure of quality.

Ray, Federspiel, and Schaffner (1980) reported a study of 6000 Medicaid nursing home patients in which they examined the relationship between the use of antipsychotic drugs and various characteristics of nursing homes. Their findings indicated that patients treated in facilities with less direct care received more drugs than patients in other facilities.

Structure and outcome relationships

Linn, Gurel and Linn (1977), in a study of 1000 male Veterans' Administration (VA) patients discharged to 30 nursing homes, found that RN hours per patient were associated with patient survival, patient improvement as measured by a change of two points on the Rapid Disability Rating Scale (RDRS), and patient discharge from the nursing home. While patient survival and discharge from a nursing home may be questioned as appropriate outcome measures for the long term care (LTC) client, this study provided support for a relationship between structure (RN hour) and client outcomes in LTC.

Garrard et al. (1990) evaluated the impact of geriatric nurse practitioners (GNP) employed by nursing homes on quality of patient care and residents' outcomes during a 12-month period. They found that the GNP as a nursing home employee had little impact on residents' functional status, physical condition, or satisfaction. However, fewer newly admitted residents were hospitalized from homes employing GNPs than from those without a GNP.

Rohrer and Hogan (1987) reported an association between the use of resources

(minutes of nursing time) and patient outcomes for 290 patients in two VA nursing homes. Treatment by non-RNs, psychosocial care and presence of physician notes in the medical record were associated with greater independence for patients. Treatment by RNs and the initial physical status of the patient were associated with a decline in physical status of patients. In other words, sicker patients required more treatment by RNs. This study demonstrated that patients' future functional status can be predicted on the basis of their present functional status and the staff time they are consuming. One limitation of the study was that patient functional status was measured at two points in time using two different non-comparable instruments.

In a project designed to develop a reimbursement system for nursing homes based on patient attainment of expected outcomes, Kane, Riegler, Bell, Willson, and Keeler (1983), used a set of measures which included six outcome domains: physical, functional, cognitive, affect, social activity and satisfaction with care and living environment. Kane et al. found that future scale scores can be predicted by previous scale scores but future status changes are more difficult to predict.

In a subsequent study, Kane, Bell, and Riegler (1986) asked nursing home residents to rate the importance of each outcome domain (e.g., physical, functional, discomfort, cognition, affect, social, activities and satisfaction). When the resident ratings were compared to non-resident ratings on the same domains, significant differences were found with residents rating most domains of less importance than non-residents. Non-residents, while imagining that nursing homes were free of any constraining forces such as regulations and finances, also were asked to specify the degree to which nursing homes could influence the eight domains of outcomes. The domains ranked by non-residents as most important were those relating to discomfort and affect, but the nursing home was viewed as able to substantially influence only

discomfort. While this study is limited by its hypothetical nature, it does represent an attempt to look at client perceptions and compare them to non-client perceptions and the perceived ability of the facility to influence outcomes for clients.

Spaulding (1986), in discussions with 457 nursing home residents from 105 nursing homes in 15 cities, asked the residents to identify quality markers of care and of life in the nursing home. The ability to make choices and exercise control over their lives, treatment with dignity, and positive caring attitudes by staff emerged as the critical elements of quality care, underpinning most of the other issues that residents raised. One limitation of this study was the use of group discussions to surface issues, which may have resulted in issues that were not representative of individual members of the group. A second limitation of the study was that it identified processes which may or may not be linked to outcomes of care. The strength of the study, however, was the identification by clients of valued processes of care.

In summary, in the literature on nursing homes the evidence demonstrating a relationship of structure and process to outcomes is inadequate. Several studies in LTC have attempted to establish a relationship between structure, process and outcome measures of quality, but the validity of the findings are questionable because of inadequate conceptualization of the phenomena of study or lack of psychometric testing of the instruments used to measure these phenomena. The studies do provide some foundation, however, for theory development in the measurement of quality in long term care because they identify potential quality indicators and potential linkages between indicators.

Research on Outcomes for Hip Fracture Clients

With the exception of two studies by Barnes (1984) and Barnes and Dunovan (1987), outcome studies on care of hip fracture patients are acute care, not long term care, studies. The outcome variables in the studies include functional status, discharge disposition, hospital

length of stay and mortality.

Functional status.

Functional status outcomes included Activity of Daily Living (ADL) status, Instrumental Activities of Daily Living (IADL) status and independence in ambulation, all of which are primarily measures of physical function. In addition, functional measures have included measures of psychosocial and social function as well as cognitive function.

Physical function has generally been measured by ADL-IADL status and independence in ambulation. ADL-IADL status has been found to be related to characteristics of the individual (e.g., age, pre-fracture physical status, type of fracture, and cognitive status), the individual's social support network, complications, specific processes of treatment (e.g., physical therapist rating) and placement after hospital discharge. Independence in ambulation has also been found to be influenced by characteristics of the individual and processes of treatment.

Characteristics of individuals are known to be related to physical function. Prefracture physical status has been found by several authors (Cobey et al., 1976; Jette, Harris, Cleary, & Campion, 1987; Mossey, Mutran, Knott, & Craik, 1989) to influence physical function as an outcome for hip fracture patients. The same authors found age to be inversely related to physical function recovery. Jette et al. (1987) also reported that intertrochanteric hip fractures were predictive of improved physical function at 6 months. In the study by Cobey et al. (1976), how often the patient got outside the home prefracture was correlated with functional recovery after the hip fracture. Getting out of the home may be a function of physical status, or it may be a function of emotional or social status.

Age is reported to be inversely related to a person's independence in ambulation (Barnes & Dunovan, 1987; Katz, Ford, Heiple, & Newill, 1964; Miller, 1978). Furstenberg

and Mezey (1987) found that race made a significant independent contribution to the explained variance in independence in ambulation. Miller (1978) reported that preoperative cerebral dysfunction and male gender were associated with non-ambulation. Katz et al. (1964) found prefracture disability and concomitant illness to be inversely related to independence in ambulation after a hip fracture. Barnes and Dunovan (1987), in a physical therapy outcome study, found lower extremity contracture, strength of hip abductor muscles and history of a previous fracture to be associated with independence in ambulation.

There is considerable evidence that cognitive and affective status (pre and postoperatively) affect physical function. In a study by Jette et al. (1987), prefracture emotional status affected postfracture physical function. Also, Baker, Duckworth, and Wilkes (1978) reported that prefracture confusion and dementia affected physical function outcome. Cobey et al. (1976) and Cummings et al. (1988) reported postoperative mental status and Cummings et al. reported postoperative emotional status as important predictors of physical function recovery. Mossey et al. (1989) reported postsurgical depression to be negatively correlated with physical function recovery.

It is not surprising that cognitive and affective status affect the physical recovery of hip fracture patients. There may be little that could be done to intervene for conditions of prefracture impairment, but postoperative impairment raises interesting questions. Is the impairment related to the surgery, the trauma of the hip fracture, the significance to the client of the hip fracture, or medical treatment? These are questions unanswered by the research to date.

Social factors have also been found related to physical function. Cummings et al. (1988) found that the number of individuals in a person's "core" network of supports was related to physical recovery, and Thomas and Stevens (1974) reported that perceived

responsibility of the patient for the home or another individual enhanced physical recovery. These factors may also be related to how often the patient got outside the home prefracture (Cobey et al., 1976). In other words, getting out of the home and having a perceived responsibility for another's welfare may relate more to motivational factors (emotional status) than to the social support network.

Complications are reported to be negatively related to physical function. Jette et al. (1987) found that discharge to a nursing home or rehabilitation hospital was related to decreased physical functioning at 6 months and 1 year. It is difficult to know from this study, however, whether the decreased physical functioning was related to the discharge to a nursing home or to some other condition which indicated the need for further treatment.

In a general review article on outcomes for hip fracture patients, Nickens (1983) stated that not living alone, going out shopping or visiting prefracture, the ability to manage household responsibilities and relative independence of social services were good predictors of functional recovery after a hip fracture.

Process variables have been associated with physical functioning and independence in ambulation in two studies. Cobey et al. (1976) found that a physical therapist's rating of recovery potential was correlated with recovery. Barnes and Dunovan (1987) also found certain process measures, such as type of surgical technique, number of visits to physical therapy and number of days from surgery to discharge, to be associated with independence in ambulation.

In addition to physical function, psychosocial and social function are often measured as outcomes for hip fracture clients. Mossey et al. (1989) reported that post surgical depression affected psychological outcomes. Nue, Miller, Lucht, Grymer, and Bartholdy (1985) reported that social function status pre-fracture affected social outcomes after the

fracture. Thomas and Stevens (1974) reported that a poor clinical result and age negatively affected social outcomes after surgery for hip fracture.

Cognitive status is used by some authors as an outcome measure for hip fracture clients. Dolk (1989) reported that a history of a neurological disorder and a delay before surgery were related to confusion during hospitalization. Williams (1979) stated that persons at older ages, on tranquilizers at the time of admission, of male sex, with urinary problems and immobilized were at increased risk of acute confusion while in the hospital for hip fracture surgery.

In summary, pre-fracture physical status (functional ability, general health, comorbid conditions) is well documented as a factor related to post-operative functional status. Many of the studies have shown an inverse relationship between age and functional ability. That relationship probably exists, as well, in the general population without hip fractures. There is some evidence that male gender and race are inversely related to functional recovery. There is less evidence of a relationship between cognitive and affective status and functional outcomes. Cognitive and affective states may be more difficult to measure, which may account for the relatively few studies reported to date. And yet, cognitive and affective status may be key outcomes in themselves that require further definition and description. Likewise, there are few studies on the role of social support in hip fracture functional recovery.

Regardless of the findings, the studies were all designed for and conducted in acute care settings. These studies would need to be replicated or re-designed for the nursing home setting to determine the validity for long term care residents. Barnes's (1974) and Barnes and Dunovan's (1984) studies, the focus of which are physical therapy, are the only studies directly applicable to the nursing home setting.

Discharge Disposition.

Broos, Stappaerts, Luiten, and Gruwez (1988) found that the possibility of return home increased with good pre-operative functional status and ambulatory capacity at discharge. Ceder, Svensson, and Thorngren (1980) found that ambulatory capacity at two weeks after surgery, general medical condition, type of fracture and living with someone all increased the possibility of returning home on discharge. The possibility of returning home is reduced with complications, increased age, and the absence of a relative at home (Broos et al., 1988). Ceder et al. (1980) also found that prefracture ability to visit someone, alternate treatment modalities and age affected ability to remain at home after a fracture.

Fitzgerald, Moore, and Dittus (1988) reported that a higher number of Medicare HMO enrollees are discharged to a nursing home and subsequently home than are regular Medicare enrollees. Fitzgerald et al. (1988) also reported that a higher number of Medicare clients are being discharged from the hospital to a nursing home since the advent of the prospective payment system (PPS) in hospitals. The study by Fitzgerald et al. leads one to believe that there may be other factors, including economic factors, that predict discharge disposition. Gerety, Soderholm-Diffante, and Winograd (1989) found that the presence of an active rehabilitation program in the nursing home was positively correlated with an increased number of admissions of people to the nursing home being discharged back to their homes. Lamont, Sampson, Matthias, and Kane (1983) found that nursing home placement was not related to social support.

In a follow-up study by Fitzgerald and Dittus (1990), younger age, caucasian race, living in a region with higher per capita income and type of insurance coverage were associated with discharge from nursing homes after rehabilitation for a hip fracture. Individuals with Medicare plus supplemental insurance coverage and individuals enrolled in

capitated Medicare programs had the highest discharge rates from nursing homes.

A study by Bonar, Tinett, Speechley and Coney (1990) reported the following factors to be associated with risk of permanent institutionalization after a hip fracture: age over 80 years, disorientation, needing assistance with bathing and transfers or walking, lack of family involvement and fewer hours of physical therapy provided in the facility.

Hospital Length of Stay.

Campion, Jette, Cleary, and Harris (1987) reported a relationship between length of stay and pre-fracture functional status and the type of fracture. Furstenberg and Mezey (1987) found that physical impairment (total diagnoses, urinary incontinence, admission hemoglobin and ambulation before fracture), mental impairment, delays before surgery and living alone predicted longer lengths of stay. Billig, Ahmed, Kenmore, Amaral, and Shakhashiri (1986), on the other hand, found that length of stay was unaffected by mental status change. Hughes, Garnick, Luft, McPhee, and Hunt (1988) reported that presence of heart disease contributes to longer length of stay, as do a hospital's medical school affiliation, and the percent of the county population that is black.

Mortality.

Age (Beals, 1972; El Banna, Raynal, & Gerebtzof, 1984; Gordon, 1971; Ions & Stevens, 1987; Miller, 1978) and male sex (Colbert & O'Muircheartaigh, 1976; Gordon; Miller, 1978) are related to higher mortality rates in hip fracture clients. Concomitant illness is also reported to be associated with higher mortality rates (Colbert & O'Muircheartaigh, 1976; El Banna et al., 1984; Magaziner, Simonsick, Kashner, Hevel, & Kenzora, 1989). Specifically, Hughes et al. (1988) found that diabetes and heart disease were related to higher mortality rates, but Hjortrup, Sorensen, Dyremose, & Kehlet (1985) found that diabetes was not related to mortality as an outcome. Cerebral dysfunction (Miller, 1978), poor cognitive

status (Mossey et al.,1989), mental deterioration (El Banna et al., 1984) and marked delirium at hospital admission (Magaziner et al., 1989) have all been found to be positively related to mortality in elderly hip fracture patients. Pre-fracture dependence in social function (Jensen, Tondevold, & Sorensen, 1979), impaired ambulation prior to injury (Gordon, 1971; Crane & Kernek, 1983), bedsores on admission (Colbert & O'Muircheartaigh, 1976) and inability to shop prior to injury (Ions & Stevens, 1987) were also found to be related to higher mortality rates. Mossey et al. (1989) found that post-surgical self-rated poor or fair health was related to higher mortality rates; El Banna et al. (1984) found that the number of general complications and injuries during the first quarter of the year (Colbert & O'Muircheartaigh, 1976) were related to higher mortality rates. Hughes et al. (1988) found that structural indicators such as public hospital and medical school affiliation were related to higher mortality, while higher volumes and emergency anesthesiologist in house were related to lower mortality rates. Hughes et al. also found that higher mortality rates were related to higher proportions of the county that were black.

Summary

Outcomes reported in the literature on the surgical repair of hip fracture vary in their specificity and sensitivity. Physical function, ambulatory status, and psychosocial functioning are the most specific measures of outcome used. Functional status measures, however, are logically related to process measures as well as pre-fracture characteristics of the individual. Hospital length of stay, while used as an outcome, actually measures the amount of care provided to an individual as a result of the hip fracture and accompanying conditions. Mortality is a commonly reported outcome that is not considered to be sensitive or even related necessarily to structure or process measures. Discharge disposition (discharge to home or nursing home) is an outcome measure that, again, is not related necessarily to structure or

process measures.

Patient characteristics found to affect the outcomes of hospitalization for hip fracture are the following: Age, race, gender, general medical condition/comorbid conditions, pre-fracture functional status (physical, emotional, cognitive, social), and type of fracture. Process variables reported to be related to outcomes are type of surgical technique used in the repair, type and duration of treatment program, number of days of hospitalization prior to surgery, and prediction of recovery by the physical therapist. Intervening variables found to affect outcomes include complications (confusion), absence of a relative in the home and amount of social support available to an individual. Structural variables that affected outcomes include type of insurance coverage that an individual had (HMO), type of facility (hospital, nursing home, rehabilitation hospital), ownership of facility, medical school affiliation of the facilities and expertise and availability of specialized staff.

All of the studies reviewed, with the exception of the two by Barnes (1984) and Barnes and Dunovan (1987), were conducted in acute care hospitals rather than nursing homes or skilled nursing facilities; Barnes's and Barnes and Dunovan's studies were conducted in a skilled nursing facility. Several studies refer to nursing home discharge as an outcome measure (Fitzgerald et al., 1987; Fitzgerald et al., 1988; Gerety et al., 1989; Palmer et al., 1989), but none of these studies included nursing home measures. Also, none of the acute care studies refer to the functional status of the patient at the time of measuring discharge status. Consequently, it is not clear whether discharge status as an outcome is related to the condition of the patient or to other variables affecting the ultimate disposition of the person.

Furthermore, no studies identified outcomes for the hip fracture client from the client's perspective. Nor are there studies which identify outcomes for the hip fracture client from the family perspective. Clearly, there is a need for studies of the outcomes for hip

fracture clients in nursing homes, conducted from the client perspective as well as the provider perspective. This study addressed outcomes from the client perspective.

CHAPTER III

Conceptual Framework

The conceptual framework used in this study was based on Donabedian's model (1980) and the work of Krueger, Nelson, and Wolanin (1978) and Lindeman (1980). While Donabedian's model was designed to provide a framework for the evaluation of quality, it provides a basis for conceptualizing the elements of a theory of patient outcomes. The model incorporates patient characteristics and intervening variables as described by Krueger et al., and emphasizes the importance of the individual as described by Lindeman. The model proposed in this study is intended to provide a framework for an ongoing program of research, the first part of which is presented in here.

The conceptual framework proposes concepts and relationships of concepts to explain outcomes for hip fracture clients. Figure 1 is a graphic depiction of these concepts and relationships:

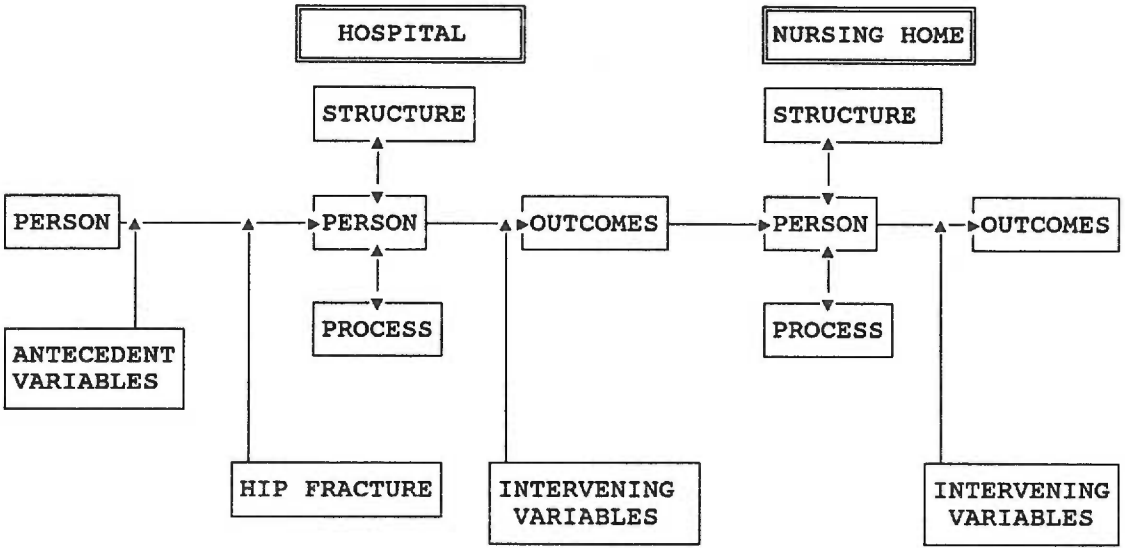

Figure 1. Trajectory of a hip fracture client from fracture through treatment in a nursing home.

Although this conceptual framework is still in development, the basic concepts have been defined as follows.

Structure variables are relatively stable characteristics of the organization, personnel and facility (Donabedian, 1982). Process variables are the activities of the health care personnel related to the care of persons (Donabedian, 1980). Outcome variables are those changes in health status of the person that are thought to be the result of health care activities or processes (Donabedian, 1980). Antecedent variables are those attributes of the individual or the individual's situation that existed prior to an intervention and may influence the intervention and/or the outcome. Intervening variables are those variables that occur unexpectedly between the independent and dependent variables to affect the subjects (Krueger et al., 1978).

Relationships in the model have been delineated as follows: An elderly person, living in the community, enters the hospital after incurring a hip fracture. Once in the hospital, the person interacts with the structure and processes of the hospital setting. In addition to the interaction between the person and the agency, there may be an interaction between the structure and processes of the agency or between the person and intervening variables. Based on these interactions, hospitalization results in a set of outcomes for the patient. On discharge from the hospital, a person may be transferred to a nursing home for rehabilitation services.

Once in the nursing home, there is a similar interaction between the person, the structure and the processes and any intervening variables, all of which result in a set of outcomes for the person. At the time of discharge from the nursing home, the person returns home or is transferred to another level of care.

This study focused on the portion of the model represented in Figure 2.

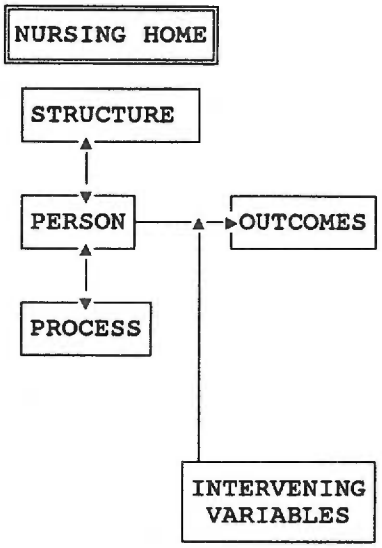

Figure 2. Trajectory of a client from admission to a nursing home through treatment for hip fracture in the nursing home.

The purposes of this study were: a) to identify and define client valued outcomes for elderly hip fracture patients admitted for rehabilitation to a Medicare-certified nursing home, and b) to compare client valued outcomes to family valued outcomes. This study was designed to answer the following questions:

1. What are the client-focused outcomes of rehabilitative care for hip fracture clients in the nursing home setting that are valued by clients and family?
2. How do the valued outcomes identified by clients and family member compare?

CHAPTER IV

Method

Outcomes for hip fracture clients in acute care were well documented in the literature, but there was no evidence to suggest that these outcomes represented the values of the client. Outcomes for hip fracture clients in LTC have been reported in three studies designed to measure acute care outcomes (Fitzgerald, Fagan, Tierney, & Dittus, 1987; Fitzgerald, Moore, & Dittus, 1988; Gerety, Soderholm-Difatte, & Winograd, 1989) and in two studies designed to measure outcomes in nursing homes (Barnes, 1984; Barnes & Dunovan, 1987), but there was no evidence that the outcomes studied represent valued outcomes of the client. There are two underlying assumptions in the studies reported in the literature: a) Provider valued outcomes represent consumer or client valued outcomes; and b) all clients value the same outcomes. Since there is little known about outcomes valued by hip fracture clients themselves in nursing homes, a qualitative study was conducted to explore their views of outcomes.

General conceptual areas (structure, process and outcome) have been identified in the research literature on outcomes of LTC, as have proposed relationships among the conceptual areas. The fact that proposed relationships have not been supported in the research literature led this investigator to believe that the concepts needed further refinement or factors other than those proposed in a quality assurance model were influencing outcomes. Therefore, grounded theory was selected as the methodology of choice with the intent of generating mid-level theory.

According to Strauss (1987), the purpose of grounded theory is to generate new "theory at various levels of generality for a deeper knowledge of social phenomena" (p.6). Grounded theory includes three steps: a) data collection, b) coding of data, and c) memoing.

Data collection can involve multiple sources of data (e.g., interviews, field observations, documents). Coding allows the researcher, using a coding paradigm, to begin to categorize data in such a way as to draw distinctions and make comparisons between categories of data. Memoing assists the researcher to think about categories of data in ways that describe relationships between categories and the relationship of the categories to the phenomenon as a whole; memoing also guides the collection of subsequent data (theoretical sampling). Data collection, coding and memoing take place concurrently and continually throughout the analysis. The focus of the analysis in this study was to refine and extend the conceptual framework by delineating valued outcomes, as well as individual characteristics of clients and other factors that might influence care outcomes.

The study emphasized client-focused outcomes, as opposed to client/family outcomes. This is not to deny the importance of client/family relationships or outcomes; rather, the focus was on client outcomes within a family context. Thus, valued outcomes as perceived by clients were compared with valued outcomes as perceived by family.

Sampling Plan

Two types of sampling were used in this study: purposive sampling and theoretical sampling. Purposive sampling was used to sample individuals known to represent certain aspects of the concept being studied, e.g., a newly admitted client with no complicating conditions and a client with multiple medical problems in addition to the hip fracture, a family member who would assume caregiving responsibility, and a family member without caregiving responsibility. Theoretical sampling is "directed by the evolving theory" (Strauss, 1987, p.21), and is a means "whereby the analyst decides on analytic grounds what data to collect next and where to find them." Purposive sampling followed by theoretical sampling provided a theoretical saturation of the concepts.

Three settings in Oregon were used to obtain the study sample: a) a 130 bed not-for-profit skilled nursing facility in a rural community, b) a 100 bed not-for-profit skilled nursing facility in a major metropolitan area, and c) a 70 bed for-profit skilled nursing facility in a major city. Three facilities were used for data collection purposes to insure an adequate number of clients. These three particular facilities were selected because of comparability of clients served and services provided.

Sample

The sample consisted of current and postdischarge elderly hip fracture clients and family members. The sample included only those persons who had sustained a hip fracture while living in the community and who were hospitalized and subsequently transferred to a nursing home for rehabilitation. Limiting clients to those living in the community at the time of the fracture was based on the view that outcomes for persons living in the community prior to their fracture may substantively differ from outcomes for persons living in institutions. Persons who had sustained spontaneous fractures related to neoplasms and persons who had had elective total hip replacements were also excluded from the study. Persons with spontaneous fractures due to neoplasms or persons having elective total hip replacement may have different outcomes, related to disease trajectory or surgical procedure, from those of persons who sustain an unexpected, accidental hip fracture. In addition, the sample included only those clients whose cognitive status, as assessed by the nursing staff of the facility, enabled them to participate in an interview process.

The total client sample thus included eight clients (see Table 1) who were admitted to a nursing home for rehabilitation of a hip fracture. All the clients were white and they ranged in age from 69 to 92 years with an average age of 84. Five were female and widowed, one was male and widowed, and two were male and married. At the time of the hip fracture, five

of the clients were living alone, two were living with spouses and one was living with a daughter.

Table 1

Client and Family Sample

Client	Age	Marital Status	Gender	Family	Living with Client
1	80	Married	M	Wife	Yes
2	88	Widowed	M	Daughter	Yes
3	84	Widowed	F	Daughter	No
4	86	Widowed	F	Refused	No
5	85	Widowed	F	Daughter	No
6	69	Married	M	Wife	Yes
7	92	Widowed	F	Not completed	-
8	92	Widowed	F	Niece	No

The purposive client sample consisted of seven of the original eight clients. Due to surgical complications, one client was re-hospitalized after the first interview had been completed; consequently only the one interview with this client was included.

Purposive sampling was supplemented by theoretical sampling until theoretical saturation of the concepts was reached. One client fractured her hip while living in a foster care home. She was included in the study to compare valued outcomes for such a client with valued outcomes of clients living in the community at the time of the fracture. The client had

been living in the foster care situation for approximately two months at the time of her accident and had been quite independent in the setting. Two of the clients were interviewed for the third time to enrich the data on one of the client valued outcomes.

The purposive family sample consisted of five family members associated with five of the seven clients (see Table 1). One family member (daughter-in-law) declined to participate in the study because of her own health condition and there was no other family member who shared responsibility for this client. One family was lost to the study because the client was re-hospitalized before the family was contacted. A sixth family member was interviewed to provide the family context for the client from the foster care home.

The family member sample included two spouses, three daughters and one niece, all of whom had some responsibility for the welfare of the given client. One of the daughters lived with the client, one lived in another town and one lived in a different state from the parent.

The rationale for sampling family members was that the family, whether a spouse, another relative or a friend, may be affected in some way by outcomes during care or on discharge from the nursing home. In addition, a family member may influence the ultimate outcome for the client. If a person is to be the caregiver in the home situation, she or he may have different expectations of outcomes than if she simply manages care from a distance or has no responsibility for the provision of care.

Data Collection and Analysis

The interview questions were pre-tested in two interviews. Questions elicited the type of information that the researcher had anticipated. Therefore, with slight modifications in the style of questioning client and family and in the technical details of the interview process, the data collection process was begun. For example, questions were reworded to eliminate "yes"

and "no" responses and to encourage elaboration on the content. The place of the interview was changed to a place other than a patient room to assure quiet and privacy. All clients had assistive devices such as hearing aides and glasses in place and were interviewed in a sitting position to encourage maximum participation.

A designated contact person at each setting was asked to identify potential clients who had fractured a hip while living in the community and, subsequently, were admitted to the nursing home. The investigator then discussed with the director of nursing or the patient care manager the suitability of each client for the study. The designated contact person then ascertained each client's and family member's willingness to participate in the research study. Each client and family member who indicated a willingness to participate in the study was contacted by the investigator. Clients were contacted in person and family members were contacted in person or by telephone. The study was explained to the client or family member along with his or her rights as a participant, including the right to withdraw at any time from the study, and a written consent (see Appendix A) was obtained.

Research Question 1

Using a semi-structured interview schedule (see Appendix B), clients were asked about their own valued outcomes as individuals with a recent hip fracture. They also were asked to identify and describe those care activities or treatments that they perceived made a difference in their progress toward their valued outcomes. The interviews ranged from 30 to 60 minutes in length.

Clients were interviewed at two weeks after admission to the nursing home and within a month after discharge from the nursing home. One client was not discharged from the nursing home but, because of changes in weight-bearing status, was de-certified and re-certified for Medicare coverage twice during her nursing home stay. She was interviewed

within a month of the first decertification. An additional interview was conducted with two clients to explore further the concept of "going home" as a valued outcome.

In addition to interviews with clients and family members, client records were used to collect the following data: a) client age, b) ethnic origin, c) living situation prior to hospitalization, d) insurance coverage, e) diagnoses, and f) type of surgical repair. Additional demographic data, such as educational background, were obtained from the client during the interview process.

The interviews were audio tape-recorded and the tapes transcribed by a transcriptionist. In addition, theoretical and methodological notes were recorded after each interview. The theoretical notes documented emerging themes and hypotheses while the methodological notes documented changes in the procedures used in the data collection and analysis.

The conceptual framework provided a basis for initial categorization of the data. Data were labelled as concepts relating to person, attributes of the individual prior to the fracture, the incident of the fracture, the hospitalization experience, and the structure and process and valued outcomes of the nursing home experience. Transcripts were examined closely to identify additional codes that described the data.

The next phase of analysis focused on the first research question: What are the client-focused outcomes of rehabilitative care for hip fracture clients in the nursing home setting that are valued by clients and family? Codes that emerged represented both distinct outcomes and varying levels of abstraction of "outcomes". Theoretical notes and memoing documented similarities as well as distinctions between categories of client valued outcomes and potential relationships among these categories. Data were then recoded using more inclusive categories of outcomes. It became clear to the investigator in the process of recoding that not all the

data could be coded into well-defined categories. This realization led the researcher back to the data to look for categories or themes that transcended the defined categories. It also became clear that there were qualitative differences between the categories of outcome, e.g., being able to walk versus being able to go home. Because "going home" was a recurrent theme, the interview questions were modified to allow the investigator to elicit more information about the concept "going home"; and additional interviews were conducted to seek information on this concept.

Three major themes emerged from the data and became the basis for a final recoding of the data. During this phase the data for each concept were examined in order to develop definitions and identify dimensions of the concepts. Relationships among themes were explored and refined. Based on this analysis, a tentative model was developed to explain the types of and relationships between valued outcomes for hip fracture clients in nursing homes.

Research Question 2

Using a semi-structured interview schedule (see Appendix B), one family member of each of six clients interviewed was asked about valued outcomes for her family member. The family member also was asked to identify and describe those care activities or treatments that made a difference in the client's progress toward valued outcomes. The interviews lasted from 30 to 60 minutes. Each family member was interviewed two weeks after the client's admission to the nursing home.

The interviews were audio tape-recorded and the tapes transcribed by a transcriptionist. In addition, theoretical and methodological notes were recorded after each interview.

Data analysis included examination of consistencies and discrepancies between the client and family data sets at both aggregate and dyad levels. At the aggregate level of

analysis, differences may be minimized to such an extent that they are not recognized as differences which may affect outcomes. Analysis within the individual dyads can show distinct similarities and discrepancies in perceptions of valued outcomes that may, in turn, affect the attainment of valued outcomes.

Reliability and Validity

The validity of qualitative findings depends on the extent to which the researcher has adequately sampled the phenomenon of interest, conducted a traceable process of analysis that can be verified through an audit (Lincoln & Guba, 1985), verified the findings with the informants who provided the raw data and identified her own potential biases in the context of the data collection and analysis. To the extent that there are logical relationships that led the researcher from the original data to the formulation of valued outcomes, and to the extent that the findings are validated by the subjects and other experts, the findings can be considered to have validity (credibility) and reliability (dependability). The validity of the findings is the extent to which the findings are grounded in the data.

To establish the validity and reliability of the findings from this study, in addition to the analysis completed by the investigator, the data, notes, results and process of analysis were reviewed by two experts in the field of qualitative analysis. The results of coding and analysis were also reviewed by one director of nursing and three R.N. patient care managers in one facility to validate emergent concepts and relationships of concepts. The results were also presented to select clients and a family member who participated in the study.

CHAPTER V

Results and Interpretation

This study was designed to answer the following research questions: a) What are the client-focused outcomes of rehabilitative care for hip fracture clients in the nursing home setting that are valued by clients and family members; and b) how do the valued outcomes identified by clients compare with the valued outcomes identified by family members? The data to be presented in this discussion of the findings include: a) aggregate data on client valued outcomes, b) a comparison of aggregate data on client valued outcomes and aggregate data on family valued outcomes; and, finally c) data on each individual client/family dyad.

Coding and analysis of the data resulted in the emergence of three main themes or categories of client focused outcomes: competency, "going home", and continuity of self. The data will be presented and interpreted for each of these three categories.

Competency

Competency was defined as the ability of the person to function and included the following five subcategories of desired outcomes: 1) ability to ambulate, 2) ability to take care of one's physical self, 3) ability to carry on the instrumental activities of daily living, 4) ability to pursue hobby/work activities, and 5) ability to maintain social contact with family and friends.

The subcategories or domains of competence represent basic functional areas in peoples' lives such as the physical, social and life enriching activities that people often take for granted until something happens to interrupt the normal flow of daily routine. Not only are these domains representative of activity, but they are the ways that persons define themselves as persons and as individuals. Thus the activities are expressions of the individuality of each client. While the domains attempt to represent distinct categories, in

reality the distinctions blur as they are integrated into a person's life.

Ambulation

Client. Every client expressed the desire to be able to walk even if that meant walking with the aid of a supportive device such as a walker or a cane. One client expressed this desire directly "I would like to be able to continue on my daily routine which included walking every day"; while another client expressed a desire to "get on my feet" or "get back up and going".

Of the seven clients interviewed twice, all showed progress in their ability to ambulate at the time of the second interview. Three of the clients were walking independently with a walker, and two were walking with a walker with the assistance of a spouse. One was still on non-weight bearing status and one had returned to a living situation where the pile of the carpet prevented her from using her walker. Her plans were to get larger wheels on the walker so that she could be independent in walking.

Family. Of the six family members interviewed, two indicated a desire for their family member "to be able to walk" and two said that he "has to be mobile enough to get around the house" in order to return home. Two did not mention ambulation as a desired outcome.

Dyads. Of the six client/family dyads, four clients and their respective family members agreed on the desire for ambulation as an outcome of treatment. In another dyad, the client said, "I will walk with a walker," but the family member said that he "can get a motorized cart" to get around the neighborhood and "can function from a wheelchair around the house". One of the family members who did not mention ambulation as a desired outcome did not mention any competency outcomes other than "taking better care of herself"; yet she did express a desire for the client to be able to return home.

Self Care

Client. Five of the eight clients interviewed expressed a desire to be able to take care of self. Client comments included general statements such as "if I can just do enough to take care of myself" as well as specific wishes such as the ability to "get in and out of bed", "go to the bathroom" and "get dressed and undressed".

Three of the clients did not identify self care as a desired outcome. Those clients did, however, expressed a desire to "do everything", "to go on doing the things I did" or to return "back the way it was" -- which included the ability to care for self before the hip fracture.

At the time of the second interview six of seven clients, including one of the clients who was quite discouraged at the first interview, reported progress in self care activities. All the clients, however, still required some assistance in bathing and some needed help toileting.

Family. All family members expressed the desire for self care outcomes for the clients. Comments ranged in specificity from "be somewhat independent" to "get on and off the bed and commode".

Dyads. Of six client/family dyads, four clients and their respective family members agreed on the desire for self care outcomes. In one client/family dyad,the family member's sole desired outcome was for the client to "take better care of herself," which involved "letting me know when things are not going right". The client's wishes were to "continue the way I was". The family member of one of the clients who did not express any desired self care outcomes wanted the client to be able to get around the house and be fairly independent but also said that he could not be left alone. This was in direct conflict to the client's wishes to be alone and independent.

Instrumental Activities of Daily Living (IADL)

In addition to the physical activities of self care, clients and families identified activities related to living in one's own home and functioning within a community as desired outcomes. Such activities have been labeled as instrumental activities of daily living (Lawton, 1972) and they include the ability to use the telephone, shopping, food preparation, housekeeping, laundry, use of transportation and ability to handle finances.

Client. Two of the three male clients in this study did not mention any activities in this area as important to them; one talked about working in the house. Four of the five female clients talked about "doing my own washing," "fixing my own meals," "baking," and "running the sweeper." One client was temporarily inconvenienced by a move within the facility because, she said, "I'll be without my telephone" for a couple of days. The one female client who did not indicate a desire to be involved in any IADLs was the client who had come from and was returning to a foster care home. While a foster care home is not considered an institutional environment, most services are provided for the individuals. The fact that two of the male clients did not identify IADLs as valued outcomes indicates that IADLs may not be part of their social roles.

Of the five clients who mentioned IADLs as valued outcomes in the first interview, only two mentioned IADL activities at the time of the second interview. One of the two clients had returned home and was doing many of her own IADLs. The other client, who had previously talked about the importance of "going to the store," and "doing my own washing and vacuuming" talked only about being inconvenienced by the interruption in her telephone service. She was still in the nursing home at the time of the second interview. One client had been rehospitalized and one had been discharged to a foster care home.

Family. Only three family members articulated IADLS as valued outcomes. One

family member said that the client was always rather fussy and would want to "take care of her own laundry" and "be able to do things on her own". The two other family members talked about their respective clients' desire to be able to "drive the car" again and both clients concurred that driving the car was a valued outcome.

Dyads. Of the six client/family dyads, only one dyad was in agreement on instrumental activities of daily living as valued outcomes. Two other dyads were considered to be in agreement on the client's wish to drive the car as evident in informal discussions of the investigator with the client and family member.

Hobby/Work

One subcategory of competency went beyond the basic activities associated with self care and function within the community. It was unclear from the interviews whether these activities were perceived by clients as work or as hobbies that contributed to the enjoyment of life. Consequently, this subcategory was labeled hobby/work.

Client. Five of eight clients talked about activities that were important to them, ranging from sedentary activities such as "I enjoy sitting and reading" or "listing ships that enter and leave the port" to "taking care of the garden," "usually do all my bedding work" and "like to be doing outside." Only one of the clients mentioned this category of activity on the second interview, however, and he questioned whether or not it was going to be possible to ever do that again.

Family. One family member indicated the importance of "gardening" for the client and one mentioned "watching T.V."; no other mention was made of these hobby/work activities. This may have been due to the fact that the family members were only interviewed once and were more concerned about the client's ability to ambulate and care for self than about activities which were more tangential to managing in the home setting.

Dyads. Of the six client/family dyads, one dyad was in agreement that gardening was a valued outcome for the client; it was not clear to either person in the dyad whether or not gardening was a reasonable expectation for the future. In one other dyad, the family member thought it was important for the client to be able to watch TV, but the client did not mention an interest in any hobby or work activities.

Social

Client. In addition to activities that one could pursue independently of other persons, clients stated the desire for and appreciation of ongoing social contacts with family and friends. Five of the eight clients mentioned the value of their social contacts, whether that was friends --"six or eight of us go to church and then for coffee and talk about what's going on in the world" or "have lunch with a friend" or family -- "all the kids come every day". Clients were not able to clarify why these were important. For those five clients, social outcomes remained important at the time of the second interview. One client talked about wanting "to go to church", and it was difficult to know if this represented a social or a spiritual need, or both.

Family. Five of the six family members interviewed also valued social outcomes. Of the six client/family dyads, two dyads valued social outcomes similarly. In one of the dyads, however, the family member said that the client should have been "participating in some of the facility activities", which did not seem to interest the client at all. The client's interest was in social contacts outside the facility. This same dyad, however, did seem to share feelings about the importance of the family member's visits and assistance with maintaining the client's home. One family member's concerns centered on the client's being "all alone" and the fear that something would happen to the client when the family member was away. The outcome valued by the client was that her friends come to visit her. Three family

members exhibited concern for the client's welfare, while the two spouses mentioned visits by family and friends as important outcomes.

Interpretation

Ambulation as an outcome stands apart from self care activities. Restriction in ambulation was the first and perhaps the most dramatic disruption in these client's lives. Prior to the incident of the hip fracture, all these clients were able to walk; after the fracture they were not able to walk. In one case, the client considered ambulation a condition for discharge and for all clients, ambulation was the key to many of the activities that were a part of the normal routine of clients' lives, as evidenced by client comments such as "get me back up and going" and "get on my feet".

Limitations in self care, on the other hand, became apparent to clients over time and were perceived by some to be not so much limitations of self as expectations of the facility staff. For some, self care activities were so much a part of daily routine that they were taken for granted and not identified as valued outcomes of treatment. However, as clients began preparing to return home, self care activities took on new importance because home was the context in which they took care of themselves. Two of the three clients who did not address self care as a desirable outcome seemed to be discouraged about their present condition. One of them had had a previous stroke, which had affected her ability to communicate at a speed she considered appropriate for social interaction. At the time of her fracture, she had lain on the floor for an undetermined period of time before anyone found her and sought medical attention. The second client had atrial fibrillation on admission to the hospital which had to be corrected prior to surgery. His postoperative therapy for the hip fracture, according to his daughter, was hindered by his presence on a cardiac rather than an orthopedic unit.

For clients, self care outcomes and ambulation were perceived as conditions for

independence and/or control. Independence was perceived as the freedom to manage one's own life, to do enjoyable things, and to maintain social interaction with friends and family. A sense of control over one's body, one's life and one's environment, while related to physical functions, represented a psycho-social need of the client and was in turn related to self-esteem, self-assurance and confidence, which are part of a person's image of her/himself.

For family members ambulation and self care activity took on a different meaning. Family members were concerned about the safety of the client and the safety of the caregiver or the responsible person. For example, one family member said that it was important for the client to be able to "get on and off the bed and commode" because the family member had a bad back. Another family member said that the client was "safer now than in her own home", so while she valued the client's independence, her primary concern was safety. A concern for safety may reflect a person's sense of responsibility for the client and, in that respect, reflect more a provider perspective than a client perspective.

It is difficult to compare the findings of this study with the research literature on hip fracture outcomes because the research studies measured client performance on provider valued outcomes. It is possible, however, to compare the client valued outcomes of this study with the assumptions about client valued outcomes that underly provider valued outcomes in the research literature.

Multiple studies identified physical function as a desired outcome of treatment after hip fracture (Cobey et al., 1976; Jette, Harris, Cleary, & Campion, 1987; Mossey, Mutran, Knott, & Craik, 1989); and that outcome is consistent with client valued physical outcomes in this study. At the aggregate level, all clients in this study wanted to be able to walk and to take care of themselves to some degree. However, at the individual level, there was considerable variation in the level of function that was desired by each client.

At the aggregate level, age may be inversely related to performance of functional activities (Barnes & Dunovan, 1987; Katz, Ford, Heiple, & Newill, 1964; Miller, 1978); but on the individual level, age was not related to valued outcome or even to function in this study. Age, in and of itself, did not make a difference in a client's desire to be able to walk or take care of herself. One 92 year old woman was as anxious to return to her prefracture functional level as a 69 year old man was.

What was more important than age in determining valued outcomes was the prefracture level of function and concomitant illness (Cobey et al., 1976; Jette, Harris, Cleary, & Campion, 1987; Mossey, Mutran, Knott, & Craik, 1989) that clients experienced. Two clients in the study had severe arthritis, one osteoarthritis and one rheumatoid arthritis, and for both of them expectations for functional recovery were more limited than for an 84 year old woman who had never been sick before her fracture.

IADL are activities that relate to household tasks of shopping, cooking, cleaning house, etc. They are generally considered to be of greater complexity than self care tasks (Kane, 1981) and are tasks that older persons can and do hire someone to do as their energies diminish. IADLs are thought to reflect a gender bias because they involve activities often assigned to the role of women. However, if a man is responsible for the household activities, they would apply equally to him.

Whether or not a person identified IADLs as desired outcomes in this study is probably a function of an experienced need for those activities. For example, two of the clients (men) had spouses at home who provided those household functions; the clients, however, identified working around the house and yard and driving the car as desired outcomes. The fact that fewer clients on the second interview and few family members identified IADLs as valued outcomes may simply reflect the priority of self care activities as

the most basic level of functioning, and IADL are not essential to physical independence in one's home. IADLs may, however, be an important valued outcome related to physical recovery (Thomas and Stevens, 1974; Nickens, 1983).

For some persons IADLs may reflect required activities but for some they are also creative activities. For example, cooking or working in the garden may be a necessary task for maintaining a house and it may also be an expression of the individual creativity. It is interesting to think about the relationship of IADL activities to physical function. It may be more of a motivator than an outcome.

Most clients and family members valued social contacts, whether family or friends which supports Cummings et al. (1988) finding about the importance of a person's "core" network of support. Both Cummings et al and Nickens (1983) studies related social factors to predictions of physical recovery. While this study identified valued outcomes rather than predictors of outcomes, the research may say something about the relationships between the various identified outcomes. In addition to social function as a predictor, Nue, Miller, Lucht, Grymer, and Bartholdy (1985) reported that social function status pre-fracture affected social outcomes after the fracture.

The importance of any one domain may vary with the individual, depending upon the role of that domain in self definition and upon whether or not the person lives alone. For example, one client said that he was an "88 year old kid who doesn't play football anymore but he can walk anyplace". To a person such as this, a disruption in the ability to walk becomes a real crisis, not only in how he functions but in how he sees himself. The importance of being able to walk independently is quite different, however, for a client who has had rheumatoid arthritis for 25 years and who even before a fracture sometimes used a walker.

Most of the valued outcomes identified by clients and family members were things to do (competencies), which may be explained by the fact that the interview question asked "What would you like to be able to do as a result of treatment?" In addition to competencies, however, two qualitatively different outcomes were identified by the clients. One outcome, going home, was quite specific but its meaning was somewhat more obscure. The second outcome which was woven throughout the interview, was a desire to return to being the person the client had been before the fracture, that is, to maintain the continuity of self.

Going Home

Client

At the time of the first interview, all the clients with one exception expressed a desire to go home. The one client who did not express a desire to go home exhibited symptoms of depression and had a difficult time verbalizing responses to several of the interview questions. Her difficulty was further complicated by a previous stroke which made it difficult for her to express herself. At the time of the second interview, five of seven clients had returned home and the other two expressed the desire to return home. One of the two had moved to a foster care home (same person that did not express a desire to return home at the time of first interview) and stated that she probably would not be able to return to her home; and although she was "happy here", she "missed her things". She stated that it would "mean a lot to go home" but she said she "could not tell more about the meaning of going home."

Family

All the family members expressed support for the client's desire to return to what the client considered home. Support for the client's wishes was qualified, however, by family concerns. The two spouses and one daughter, who were all living with the respective client, expressed concern about him being able to care for himself because of their own limitations as

caregivers. Two family members wanted the client to be able to go home but were concerned about the safety of the client, since there was no one in the home with the client. And one family member hoped the client could return to the foster care home because "it would do a lot for her pride."

Dyad

In one dyad, there was clear agreement on the desirability of the client returning home, even though the family member expressed some concern about her ability to care for the client. In another dyad, the family member stated, "If he can do these things, he can come home." In a third dyad, the family member expressed, "He has to make progress.... I have a problem with my back." All three of these family members, who were living with the respective client, agreed with the client's wishes to return home but expressed concerns about their ability to care for the client. Two of the three family members had had previous caregiving experience that reinforced the perceptions of their limitations as caregivers.

Two other dyads agreed that it was desirable for the client to return to her prior living situation. The concern expressed by the family members was that the client would be able to meet the self care requirements of the retirement home or foster care home; and that was a concern shared by client and family member.

Another dyad agreed that it was desirable for the client to return to her home but the family member expressed concerns about the client's safety in her own home. The family member was an only child and felt the responsibility for her mother's welfare. The client was "determined to go home" and the family member stated that "It is hard to know whether to allow her to return home." The family member's concern for safety may override the desire to go home as an outcome and adversely affect that outcome for the client. Disagreement between family and client on this valued outcome may be of greater significance than

disagreement on competency outcomes because the client may have less control over decisions made regarding going home.

Interpretation

While it may seem apparent that a person would want to go home, the meaning of "going home" varied significantly across clients. All clients who were asked specifically about home felt that the concept was very difficult to describe, and then would repeat a cliche, such as "There's no place like home" or "It's just home and that's where I want to go." Two followup interviews were added to the study to examine more closely the meanings of going home after a hip fracture.

Home was a dense concept with multiple meanings. Each meaning is presented here as a discreet category but in reality is interrelated with other categories of meanings. And for each client, home represented one or more of the following meanings.

At a minimum, home represented a more desirable alternative than living in a nursing home, as evidenced by the comment "One reason I'm glad to be home is I'm not in a nursing home." A comment such as this may reflect societal attitudes about nursing homes, or it may be explained by comments, such as "I think it means independence. In the facility, they do everything for you and that is not really helping you." And at home, a client had some degree of control even though it may have been tenuous.

Home represented a physical place that provided a psycho-social space of familiarity, comfort, security and recognition. It was seen by one client as a place to "continue the daily routine" and another client as a place where her things (clothes and perfume) were. One client described home as a little two room house that was neat and cozy, and another said that he just enjoyed the house.

Home meant freedom and a place for connecting with family and friends. One client

spoke of family coming and going and friends feeling free to visit. He described it as the place where his wife was and without her he could not even have gone home. When asked whether home symbolized relationships for him, he responded: "Home is a place where you are cared for.... There are people around you that know you and care about you." In contrast, another client who returned to the home that he and his daughter had bought, stated that he "left home three or four years ago" when his wife died and he sold their home. When asked to say more about the experience of leaving home, he was not even aware that he had said it and he would not say anything further about that experience. For this client, if home represented his relationship with his wife and their life together, home is no longer a possibility for him. But it may have represented a time in his life that was meaningful.

Home was the place of the "possible" for clients -- representing what had been possible in their lives, what was currently possible and what was still possible in the future. Home offered the possibility of resuming a normal routine, which included social and other activities that provided pleasure in their lives. Home was the context in which a person defined who he or she was and, in that sense, represented part of the person or the person's image of self. Because the competencies of older individuals were disrupted by the hip fracture, home became the symbol of stability in their rapidly changing experience of self. If a client defined himself by "doing" and he could no longer do, home provided the continuity in his life that he needed to feel like the same person. It was a safe place for persons to evaluate their experience of themselves against an image they had of themselves (continuity of self) and make adjustments in their perceptions: "I can't tell you until I'm out of here and home."

If the return of competencies takes time, as it does, home was the place to be because the client was supported by his or her relationships, belongings and routines that gave him or

her a feeling of security. One client who, in the first two interviews, described herself as needing to get home to do things later described home "as the place that I want to be," which leads to a final speculation that home, for some, is a place within: "I think I could be happy most any place".

Continuity of Self

Three categories that emerged from the data represented the process that a person goes through when confronted by an assault on the self image, such as that posed by a hip fracture. Persons define themselves (self image) by the things they do or cannot do (competencies), social roles, personality traits and self esteem. After the hip fracture, these clients experienced themselves as the same or different from the image they had of self. The process of imaging, experiencing and re-imaging allowed them to reconcile their current or anticipated future self with the self prior to the fracture. As they were able to do this, they experienced continuity in their image of self, even though small details of that image may have changed.

Continuity of self emerged from the data as the core category. Most clients valued, as an outcome of care, a return to the person they were before the fracture. That included many activities (or competencies) that may have been temporarily interrupted, and it included the need to return home, the context within which a person defined herself.

The following excerpts from interviews define the categories of self image, imaging, experience of self and continuity of self. Two cases are used to illustrate the process of imaging, experiencing and re-imaging that the clients went through in the course of recovering from a hip fracture.

Image of Self

One client described himself by his daily routine, which included going to church and

socializing with friends. He described his spouse and social life as a very important part of his life. During the nice weather, he gardened and took care of the maintenance of the house.

Another client described herself as an active person who took care of all household needs and socialized with friends. She described herself as being able to walk fast but not able to get down on her knees to do her gardening anymore, though she had never been sick. When asked about personal characteristics that would influence her recovery, she said "When I set my mind to something, I go to it".

Imaging

Imaging of self was not only an outcome that clients valued but a motivating force and a coping strategy to deal with the hip fracture. The language used by clients to describe imaging was either visual -- "looking for things to get better", cognitive -- "I do think a lot about going home" or affective -- "I just feel it, that's all", and probably reflected dominant communication styles of the clients. What in some clients appeared to be denial (e.g. "No, I haven't changed"), may have been the first step in a process that allowed the self to protect itself until it was both safe and appropriate to weigh the limitations of the current situation against a valued image of self, and to accommodate short or long-term changes into the image of self.

Experience of self

Experience of self was expressed in terms of restrictions such as "can't go any place or do anything"; " My leg doesn't do what I want it to do"; "I want to do things and I can't" or "my right leg gives out on me.". Perceptions of progress were expressed as "I'm not completely cured but I've sure come a long way"; and "There is a little change there every day and sometimes I can almost tell the difference overnight." Some comments described experiences that conflicted with a person's image of self such as, "I think I'm asleep and the

rest of the folks around here say I'm hollering and keeping them awake."

Continuity of Self

To the extent that a person's experience and perception of self were consistent, the person experienced continuity of self. In response to the question, "Have you changed as result of this experience," five of eight clients responded with comments such as "I don't know, you'll have to ask somebody else" or "No, I don't think I've changed". Comments of this kind were indicative of clients' grappling with continuity, or the lack thereof, in their image of self.

Continuity of self seemed to be the underlying theme in one spouse's ongoing concern about an episode of acute delirium that the client had experienced after the hip surgery. Even after the confusion cleared, the spouse continued to express concern about the meaning of the confusion, as well as small changes she had noted in the client's speech and appearance.

Two cases illustrate the process that clients went through in seeking and struggling to maintain continuity of self. In Case 1, through the process of imaging, experiencing and re-imaging, the client adjusted her image of self to make it consistent with her experience of self. In Case 2, the client was not able to make the adjustments in his image of self that would allow him to experience continuity of self.

Case 1

At the time of the first interview, this client was receiving daily therapy but could not bear weight on the affected hip. In response to the question, "What was a typical day like for you before your hip fracture," the client described her life thus:

> I did all my own work...all my washing, cooking, shopping and everything. I'm not one to sit around in a chair, which would just bore me to tears, though I do like to read mysteries. I've got a big place and I usually do all my bedding work. I don't

get down on my knees any more because it's hard to get up, so I just stoop over and it works out all right.

The client defined herself, primarily, by her activities. She kept her own house and her yard. She said that she did not do a lot of work but kept her place nice.

She perceived herself as a healthy person who "can walk fast when she feels like walking." She imaged herself as "getting all well" and "continuing just the way I was." She said that "If the break heals and everything, why I should be able to. I don't see why not." She planned to return to all her activities and her home and said that she "thinks a lot about going home".

Just prior to her hip fracture, she had experienced herself "going down hill." Concurrent with the hospitalization for the hip fracture, she was diagnosed and treated for anemia and afterwards felt "more alive"; and she also said that she "could move her legs better." She was not able to bear weight, but was "not used to being waited on," so "she does what she can for herself." But she still got scared when she looked in the mirror. Her image of self and what she saw were incongruent.

When asked if she had changed as a result of this experience, she stated, "I don't know. You'd have to ask somebody else, I think."

At the time of the second interview, she had just been informed that she could begin to put a little weight on her affected hip. When asked what she'd like to be able to do as a result of her treatment, her response was:

I'd like to be able to go home. I know what I'll have to do for six months and that is use the walker. I'd like to know how long six months is. I'll probably have to hire someone to do the house cleaning and everything. I won't be able to get outside because there are steps up to my front porch and steps down onto the landing and out

the back door. I don't know how I will get down those steps with a walker but they said they do teach it in that physical therapy class. I can just see my daughter vetoing that. Of course I could have someone put a lawn chair on the front porch and I could sit out there.

At the same time that she was imaging some limitations, she was imaging options for herself. "I wonder how long six months is" reflected her question about whether or not she would be able to get out into her yard while it was still summer.

She experienced herself as "stronger now", but said that they would not let her go home until she could walk: "And I believe that's what I was doing just before noon, is walking. The doctor said I could put a little more weight on it and I was walking different this afternoon."

She explained that she was dressed the way she was (she had on a housecoat over a blouse) because the staff had not done her laundry on time. She also explained that she could go to the bathroom independently if the staff would stay with her, but the staff did not have time to stay with her. Her perception was that the facility staff was responsible for the incongruence between her experience of and image of self.

When asked if she had changed as a result of her hip fracture, she said, " I don't know that I have, but I wouldn't want to do it again." She described herself as being more understanding of persons who break their hip because she had experienced the pain and limitations of not being able to do what she usually did. When asked if her life had changed, she said, "I'll be able to answer that a little better, I think, when I get home."

This client was visited a third time when she was just starting full weight bearing. While the purpose of the visit was to enlarge the data on home, she made several statements that related to her image of self: "There isn't much I can do while I'm still using the walker.

I like yard work and I'm going to miss it but home is just a place I want to be."

In the example above, the client made a gradual shift over time from imaging herself as "continuing just the way she was" to "hiring someone to do the housecleaning and everything". While her image of what she was able to do changed, her image of going home was firm: "I'm determined to go home".

The change in imaging seemed be the result of an interplay between the client's image of self and experience of self. This was most obvious in the example of working in her garden. Initially she planned to return home in time to get some strawberry plants set out. At the time of the second interview, she was only beginning to bear weight and was not yet walking without assistance. At this time she talked about sitting on the front porch and saw the summer slipping away. At the time of the third visit, she said that she liked yard work and was "going to miss it."

Her imaging was affected by the experience of her physical limitations and, even though she perceived herself as progressing, the progress was slow because of her weight bearing status. When asked if she had changed at the time of the first interview, she did not know. At the second interview, she also said she did not know but went on to explain that she was more understanding of others with injuries because she had experienced pain and inability to do things that she was used to doing.

She appeared to have changed her image of self. At least for the time being, she saw herself as limited in what she was able to do. But there was no evidence to suggest that she saw herself as a different person than before the fracture. She had experienced a major assault to her body and image of self, which limited her ability to function physically and to do the things which defined her. Yet the following statement demonstrated her adjustment: "There isn't much I can do while I'm still using the walker but home is just a place I want to

be."

Case 2

> When asked to talk about what life was like before his hip fracture, this client said: It was a just a normal life...88 year old kid. Don't run around and play football, but I'd have no hesitation about going any place walking.... Course I wasn't as active then even as I was before, but I wasn't concerned...

The client saw himself as an 88 year old kid. He had made adjustments to not being able to play football anymore and even to not "being as active as he had been." Prior to his hip fracture, he saw himself as the same continuous self, who could walk any place.

He saw himself as being able to make a difference in his life and blamed himself for his injury and his lack of progress. "It's my fault, not theirs [the therapists]." The client exhibited low self esteem, as evidenced by comments like "I don't know anything" and "You can't learn anything from me." His daughter described him as a solitary person who wanted to be by himself and did not like to be told what to do.

When asked what he thought would be different in the future, he responded: "I haven't any idea. It depends on the progress that I make." When asked how he would like it to be, he responded "back the way it was," which included walking any place he wanted. That was his primary description of the "way it was" and an important part of his self image. Yet at the same time, he described another, conflicting image of being wobbly and vibrating when he tried to walk in therapy: "It'll start up when I go in there. That's what it's done the last two or three times." The client could not reconcile these two images, and said "I don't know what I'm going to do. I may go home and try to work it out." The client's image was that once he was home, he could overcome his difficulties with walking and thus return to the person he had been before the fracture.

Prior to his admission to the nursing home, the client had had an unpleasant experience in the hospital, which served to reinforce his feelings of responsibility for lack of progress. In the nursing home, the client experienced himself as "not being able to go any place or do anything." He experienced what he perceived to be a real setback: "Yeah, sad thing. Because at first in therapy I saw great results. I could walk... more than they expected me to. And then a day or so later, I regressed. I just couldn't go on."

What sustained a continuous image of himself as a "kid" was the ability to walk any place. Now "I can't go out walking and I walked everyplace." The continuity of his image of self was broken with his hip, because he could not walk. A doctor had told him that he would be walking in two or three days and he described himself one month later as "walking with three people." Direct observation indicated that he walked with a walker and the assistance of one therapist, but his perception was that it took three people. It may be that the client perceived that one person was too many because "back the way it was" did not include assistance from persons or equipment. If the client's sense of self was tied up in his ability to walk, then he may have experienced a threat to self or a loss of self for which he felt responsible.

"If I'd have known that this was going to be this severe, I would have preferred death over surgery." The client could not reconcile the difference between his image of himself and his experience of himself. He tried to change the experience of self and it did not do any good, and he did not seem able to change the image he had of himself because that represented too much threat to his sense of self. The result, for him, was depression and an "all or nothing attitude." If he could not do everything he did before, then he could not do anything.

At the time of the second interview, it was difficult to know whether or not the image

that the client had of himself had changed. The statement, "I'd like to go for a walk but I can't," might have been an expression of a recognized limitation, reflecting an adjustment in the self image, or it might have reflected a limitation imposed from without by his daughter. Then he immediately stated, "Oh, I could, but I'm not going to." This suggested a switch back to the original image of self as able to walk any place and use of the decision not to as a coping strategy. The original self image was reflected in the statement: "If I were home here alone, it might not be easy but I could take it. I'd get up and get around."

This client's experience indicated that he did use a walker now to get around and said that he could not make it without the walker. He described a fall that he had and the process he went through in successfully getting up and discovering that he was not injured. He also explained that "he had tried exercising and it seemed to have bad effects and he tried not exercising and it had the same effect." His experience clearly included a mixture of successful and unsuccessful experiences.

His experience of himself was furthered tempered by his daughter's expectations of what he could and could not do. Her expectations conflicted with his image of what he could do, yet he said that "maybe she was right." It was difficult to know whether his statement indicated a willingness to look at limitations or whether it was an expression of low self esteem.

The client continued to maintain that he could take care of himself. He sensed that something was changing in his ability to function that he could not control, yet he was resistant to having any help in the home, even physical therapy visits. "I don't know why I have this help." He could not accept a new image of himself.

"You get to doing real good and then you find out that you are not perfect and so you think you have slipped. If I'd of known that it was going to be like this, I would just as soon

not come home. I mean, I might as well be dead as living the way I am." The client could not reconcile his current experience with the image he had of himself. And he was not able to adapt his image of self, even on a temporary basis, to accommodate some limitations.

In this second example, the client was not able to accommodate any changes in his image of self that would allow him to acknowledge any of his strengths, accomplishments, or even his limitations in any realistic way. And he experienced a discontinuity of self or a threat to the self he had known. His struggle to maintain self was fraught with conflicting images that created tension for the client. Perhaps, given more time, the client will improve so that his experience of self is more consistent with his image; or it will be all right for him to accommodate some change in his image of self.

Summary.

In summary, the process of maintaining continuity of self involved imaging, experiencing and re-imaging. The initial image is the image of self that has been relatively constant (continuous) throughout a client's life. Even after the hip fracture, clients maintained their prefracture image of self in their imaging process until they became aware of an experience in conflict with their original image. At the time of the first interview, most clients maintained the prefracture image of themselves. By the time of the second interview, most clients were beginning to modify the image of self to accommodate some limitations, if only on a temporary basis. It is not clear how that change took place in their awareness but it must have been at a time when they were ready and open to the change. As the image of self changed, so the valued outcomes began to take on new priority. Instrumental activities of daily living and outdoor activity became secondary to ambulation and self care activity. That is not to say that they were unimportant but perhaps were not the priority at the time. These clients never saw themselves as part of the nursing home and home remained a priority

throughout the interviews.

As a person was able to accommodate changes in his image of self, even on a temporary basis, he seemed to re-establish a balance in the imaging-experiencing and re-imaging process. If he was not able to reconcile the differences between his image of self and experience of self, a conflict remained and consequently an imbalance remained. He could not integrate the hip fracture and its consequences into his life and discontinuity or "threat to self" remained.

Continuity of self emerged as the core category of valued outcomes. Competencies are a part of self, ways that a client defines himself and experiences himself. Going home is also a part of maintaining a continuity of self. The relationship between home, self and continuity of self needs further refinement. Imaging is a powerful process that clients use to cope with the event of a hip fracture and perhaps used as a motivator for recovery.

Reliability and Validity

Coded data from four interviews, theoretical notes and memos were presented to two experts in qualitative research. Both experts concurred that the data and coding represented an audit trail sufficient to support the reliability of the findings. The same two qualitative experts concurred that the categories of codes fit the interview data as well as the memos and theoretical notes. In addition, the experts concurred that the data supported the constructs of competency, going home and continuity of self.

Categories of outcomes were then reviewed with a group of registered nurses who were responsible for the management of care for hip fracture clients in one of the participating nursing homes. Nurses concurred that the identified outcomes did represent valued outcomes of clients. Nurses began spontaneously relating comments that clients had made to them that they thought supported the categories in the study. They also agreed that,

within the category of competencies, different outcomes are important to different clients depending upon their individual characteristics. The concepts of going home and continuity of self elicited extensive interest and discussion from the nurses.

One of the nurses stated, "Sometimes we feel like we set people up to fail when we try to make it possible for them to go home again." The data from the study provided new insight about the importance to the client of going home and that possibly the nurses were assisting the patient to succeed in another valued outcome (continuity of self).

Findings of the study were also reviewed with two clients and one family member who had been interviewed as a part of the study. Client one concurred with the categories of outcomes. In reviewing the meaning of going home, he clarified that the relationships were important because they made him feel cared for. So he actually extended the interpretation. Continuity of self was a value for him though he was not sure he would ever be able to do some of the things he did before.

The family member concurred with the outcomes identified in the study and was most concerned about his acute confusional state that occurred after his fracture. For her, continuity of self was especially meaningful. She stated that she was definitely concerned about whether the confusion would clear and whether he would be the same person he had been before the hip fracture.

When the investigator began sharing the findings of the study with a second client, the client started finishing the sentences for the investigator. That was interpreted by the investigator as agreement. This client also went on to further explore the meaning of going home. She felt that going home really meant independence for clients and the ability to continue those activities in life that are meaningful. She also stated that an event like a hip fracture is bound to change a person. When questioned further about whether she had

changed, she described what she was not able to do anymore but felt like she was the same person.

Meetings with experts in qualitative research, experts in nursing management of hip fracture clients, hip fracture clients and one family member resulted in validation of the client valued outcomes that emerged from the data in this study. Meetings with clients also served to enhance the meaning that clients assign to the identified outcomes.

CHAPTER VI

Conclusions

This study was the first in a series of studies designed to conceptualize and measure appropriate outcomes for clients in nursing homes. The study was designed to answer the following research questions: a) What are the client-focused outcomes of rehabilitative care for hip fracture clients in the nursing home that are valued by clients and family; and b) how do the valued outcomes identified by clients compare with the outcomes identified by family?

A qualitative study was conducted to answer the research questions. Semi-structured interviews were conducted with clients and family members. The medical records were reviewed for other data to supplement the interview data. Data were analyzed using constant comparative analysis to identify and define the concepts and relationships central to the research questions.

The client sample included eight clients, 65 years of age and older, who were admitted to the nursing home for rehabilitation of a hip fracture. The number of clients interviewed was determined by saturation of the categories on the first research question. The family member sample included two spouses, three daughters and one niece, all of whom had some responsibility for the welfare of the respective client.

Interview data from clients, as well as the research literature on hip fracture outcomes in nursing homes and generic outcomes for nursing home clients were examined to answer the first research question. Data analysis for the second research question included a discussion of consistencies and discrepancies within the individual client/family dyads.

Valued Outcomes

Competencies were the most explicit outcomes valued by clients and their respective family members. At the aggregate level, ambulation and self care were of primary concern

and instrumental activities of daily living, hobby or work activities, and social activities were secondary in importance. At the individual level, however, the importance of one set of competencies over another depended on previous functional status and the importance of those competencies in self definition.

The importance to family members of one set of competencies over another was related to the perceived role that each family member played in the respective client's life. Caregivers demonstrated a concern for the well being of the client but also a concern for their own well being. Other family members were concerned about the safety and well-being of the client and indicated a "feeling of responsibility" for the clients, though not for direct care. The differences between client valued and family valued competency outcomes did not appear to represent a disagreement on desired outcomes so much as different perspectives on the importance to the client or family member of the particular outcome.

All clients and family members valued going home as an outcome. While the importance of "going home" is clear from the data, the meaning that it held for each client varied. Home symbolized a place of continuity and stability during a time of considerable change in clients' lives, and a safe place in which limitations could be assessed and assimilated into the self image.

Different perspectives between family and client on this valued outcome may be of greater significance than different perspectives on competency outcomes because the client may have less control over decisions made regarding going home. For example, a family member's concern for safety may override the desire to go home and adversely affect that outcome for the client.

Continuity of self emerged as the core category of the study. Most clients valued, as an outcome of care, a return to being the person they were before the fracture; that is, they

wished to maintain the continuity of self.

If a person's self image was defined exclusively by what she did (competencies), the image of self was fractured along with the hip. If the client was unable to re-image herself based on a new experience of self, the difference between the old image and the new experience created a sense of discontinuity of self for the client. If the central part of a person is defined apart from what she does and what social roles she plays, many changes are possible externally and the person remains essentially who she is; that is to say, she maintains a sense of self. Home was the context in which such an evaluation of self could take place.

Theoretical Implications for Quality Assurance Model

Donabedian's model, which was designed to provide a framework for the evaluation of quality, provided a basis for conceptualizing the elements of a theory of patient outcomes. The model, presented in Chapter Three of this study, incorporates patient characteristics and intervening variables as described by Krueger et al., and emphasizes the importance of the individual as described by Lindeman.

This study supported the view that each of the variables in the model is important and that the position of the person is central to the process. The primary limitation of the model is that it is linear; and this study clearly showed that recovery from a hip fracture is not a linear phenomenon. The model needs to be refined to more adequately reflect the centrality and uniqueness of the individual in the process involved in maintaining continuity of self, the most valued outcome for clients.

Ethical considerations

Three ethical concerns emerged during the study. First, when is it justified to ask questions that are known to have surfaced upsetting experiences for clients that may require clinical intervention? The interview questions for this study were designed to obtain specific

information about valued outcomes for clients with hip fractures. The questions served that purpose well but also surfaced feelings and experiences that were upsetting to two clients. Both clients exhibited signs of depression which the investigator discussed with appropriate staff or family to secure adequate follow-up.

The possibility of "upsetting" feelings was specified in the consent that was discussed with and signed by each client and family member. But the ethical question remain: is it justified to surface such issues in situations where there may not be adequate resources to intervene. Surfacing feelings and experiences that are upsetting with appropriate intervention may ultimately be helpful to the client, but that depends on the client's openness and readiness for such intervention.

Second, when is it ethical to go back to clients who may be experiencing discontinuity of self, for validation of concepts and analysis? Because of the investigator's concern for the welfare of the client, it did not seem appropriate to validate the findings with persons who, in the investigator's judgment, were experiencing discontinuity of self. Consequently, the validation of concepts and analysis by clients included clients experiencing continuity but not discontinuity of self.

And third, if imaging is a defense mechanism, nurses need to be very careful about interfering in a process that may be in delicate balance. One must be very careful about orientating the client to the reality of his hip fracture to the detriment of his own imaging process. The client needs to maintain control of the process with appropriate support of staff and family.

Further Research

The competency outcomes identified by the clients in this study reflect the literature on domains of care for long term care. What was significant in this study was that the

importance of each of these domains varied with the individuals though this was a subpopulation that one would expect to be relatively homogeneous. We do not know what the role is of competencies for cognitively impaired individuals or individuals with other disabling conditions. Further studies are needed to determine the relationship between individual characteristics and valued outcomes.

Home as a discharge destination and factors associated with going home are well documented in the literature as provider-valued outcomes. But what does "going home" mean to hip fracture and other clients in nursing homes? What does "going home" mean to the family or caregiver? What roles do "going home" play in adaptation of self image or in getting ready for the next stage in life? Will it mean the same thing for future generations of old-old? Can and should nurses assist clients in changing the meaning of "going home" when a return to home is not possible for the client. Further research is needed to answer these questions.

The model of continuity of self needs conceptual refinement. We do not know what the relationship is between self image and imaging. How important is the imaging process in the maintenance of a continuity of self? Not only do we need to refine the continuity model, but hypothesized relationships between going home and continuity, competencies and continuity, going home and competencies all need to be tested.

Saturation of data was completed for outcomes as perceived by clients. There was no attempt to saturate for family valued outcomes or for client/family valued outcomes. Further studies are needed to identify valued outcomes of families; these need to include male family members as well as female. And finally, the continuity model needs to be tested with other subpopulations of clients and caregivers.

Practice Implications

Not all outcomes are equally important to hip fracture clients in nursing homes. It is important for staff to acknowledge the outcomes that are valued by each client and to have some understanding of the significance of those outcomes for the client. Nursing staff can then assist the client in achieving his or her desired outcomes. In this study, nursing staff were not perceived as assisting the clients in their rehabilitation goals. Staff of nursing homes need to provide more opportunities and support for independence and a sense of control on the part of the client, e.g., assistance with toileting, encouragement to do the things that a person did for himself at home.

Perhaps the most important thing about the significance of "going home" for clients with hip fractures is knowing what it means for the client. Nurses and physical therapists must assess the meaning of "going home" to the client and family so that the care provided includes the goals of the client. If home is a safe place to evaluate the disabilities experienced from the hip fracture and "going home" is synonymous with a physical place, then it is important that a client goes home. It may also be important for the staff to support the client's goal to return home even if the client remains at home for only a short time.

What are the implications for client and for nursing staff if the client is not able to return to his or her home? Can and/or should nurses assist the clients in changing the meaning of "going home" when a return is not possible? In what way can nurses assist the client and family to create a homelike environment where a client and family can "feel at home?"

Family interventions may be necessary when there are differences between client and family valued outcomes. A difference of perspective on the importance of going home may be of particular importance. The meaning of going home for the client may have an impact

on the decisions that a family member makes for or with the client.

Many of the implications of home are yet unexplored, but it is obvious from this research that home is a powerful image in clients' lives. For clients, verbalizing the importance of home may help them in imaging the "possible" for themselves.

Nurses need to be aware of manifestations of discontinuity of self. If a client cannot reconcile her image of self with her experience of self, she may become depressed and clinical intervention may be necessary. The process of imaging with a client could be used as an intervention in the therapy process. If there were enough hip fracture clients in the nursing home at one time, staff could form imaging groups in which clients could help one another.

This study, above all else, has led this investigator to appreciate the complexity of an event such as a hip fracture, in the lives of older person. While competencies outcomes identified by clients were the outcomes expected by this investigator, discovering the importance that competency outcomes, going home and imaging all play in the struggle to maintain continuity of self was unexpected.

This study has also reinforced the belief that older persons are unique individuals who are quite capable of being agents of their own care. To the extent that nurses recognize clients as agents of their own care, nursing practice will change to more adequately acknowledge the role of the client in the health care process.

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Appendix A

Interview Guide
Client

Tell me how you fractured your hip.

How did you happen to come to this facility instead of going home?

In what ways has this hip fracture changed your life?
What is different now?

What do you think will be different in the future?

What would you like to be able to do as a result of your care/treatment here?
When you finish your treatment here, what would you like to be able to do?

In what ways can the staff help you to achieve those goals?
Can you think of an example of something or someone who has been most helpful to you in achieving your goals? Tell me about that situation.
What has been least helpful to you?

In what ways can others help you?

Have you changed (grown) as a result of this experience. How? Why?

What is it about you that will help you to attain your goals?
What is it about you that may keep you from attaining your goals?
(use language of client as stated in response to question #4)

Are there other factors, besides what we've talked about, that may make a difference in your recovery?

DEMOGRAPHICS

Birth Date _ _ / _ _ / _ _ _ _
Month Day Year

Gender Male ____ Female ____

Living situation:
____Living alone
____Living alone with help in the home
____Living in the home of relative
____Other (describe)

What is your race?

____White
____Black
____Asian
____Hispanic
____Native American
____Mixed Race
____Prefer not to answer
____Blank

What is the highest grade in school that you completed?

____Never attended school
____Attended grade school
____Completed 8th grade
____Attended high school
____Complete high school
____Post-high school training
____Attended college
____Completed college

What is your insurance coverage?

____Kaiser
____Medicare
____Other

Interview Guide
Family member

In what ways has the hip fracture changed _____life?

In what way(s) has this/these change(s) affected your life?

What do you see as important outcomes of treatment/care for _____?
What would you like _____ to be able to do as a result of treatment?

Do you think those outcomes are important to _____?

In what ways can the staff in this agency help _____to achieve those outcomes?
Can you think of an example of something or someone who has been most helpful? Tell me about that.
What has been the least helpful to _____.

In what ways can others help _____to achieve those outcomes?

Has _____changed (grown) as a result of this experience. How? Why?

What traits does _____possess that will assist her/him in attaining her/his goals?
What is there about _____that will help or interfere with achieving his/her goals?

Are there other factors, other than what we've talked about, that may make a difference in her/his recovery?

DEMOGRAPHICS
FAMILY/FRIEND

What is your relationship to client? You are his/her:

____Spouse
____Child
____Child-in-law
____Other relative
____Other non-relative

Do you live with the client? ____No _____Yes

Birth Date _ _ / _ _ / _ _ _ _
Month Day Year

Gender Male ____ Female ____

What is your race?

____White
____Black
____Asian
____Hispanic
____Native American
____Mixed Race
____Prefer not to answer
____Blank

Appendix B

1/18/91

Oregon Health Sciences University
Informed Consent
Client

TITLE
Client Valued Outcomes for Treatment of Hip Fracture

PRINCIPAL INVESTIGATOR
Lucia Gamroth, RN, MS
(Doctoral Student)

Phone: 503-494-7709

PURPOSE
Lucia Gamroth, a doctoral student in the School of Nursing, is doing a research project designed to understand more about how clients and their families view the significance of the client's hip fracture, the desired outcomes of treatment for that hip fracture and how outcomes valued by clients compare with outcomes valued by health care professionals.

PROCEDURES
I understand that, if I agree to participate in this project, Lucia will ask me questions about how I fractured my hip, how life is different for me since the fracture, what I would like to be able to do in the future and what would help me achieve those goals for myself. The interview will take about 1 hour. I will be interviewed twice and Lucia may call me to arrange a third interview. I understand that the interviews will be tape recorded. Following transcription, the tapes will be destroyed.

RISKS AND DISCOMFORTS
Some of the questions may touch on experiences that are upsetting to me. I understand that if, during the course of the interview, elder abuse is discovered, Lucia is required by law to report this to the health care agency and/or to Senior Services Division.

BENEFITS

I understand that I may not benefit directly from participating in this study, but that it might help other people in the future.

CONFIDENTIALITY

Neither my name nor my identity will be used for publication or publicity purposes.

COSTS

There are no costs involved for me as an informant.

LIABILITY

I understand that it is not the policy of U.S. Department of Health and Human Services or any agency funding the research project which I am conducting to compensate or provide medical treatment for human subjects in the event the research results in physical injury. The Oregon Health Sciences University, as an agency of the state is covered by the State Liability Fund. If I suffer any injury from the research project, compensation would be available only if I establish that the injury occurred through the fault of the University, its officers, or employees. If I have further questions, I can call Dr. Michael Baird at 494-8014.

Lucia Gamroth has agreed to answer any questions I may have. I may refuse to participate in this study or withdraw at any time without affecting my relationship with or treatment at this agency or the Oregon Health Sciences University. I understand that I will be given a copy of this consent form. My signature below indicates that I have read the foregoing and agree to participate in this study.

_____

Client's Name Date

_____

Witness' Name Date

1/18/91

Oregon Health Sciences University
Informed Consent
Family/Friend

TITLE
Client Valued Outcomes for Treatment of Hip Fracture

PRINCIPAL INVESTIGATOR
Lucia Gamroth, RN, MS
(Doctoral Student)

Phone: 503-494-7709

PURPOSE
Lucia Gamroth, a doctoral student in the School of Nursing, is doing a research project designed to understand more about how clients and their families view the significance of the client's hip fracture, the desired outcomes of treatment for that hip fracture and how outcomes valued by clients compare with outcomes valued by health care professionals.

PROCEDURES
I understand that, if I agree to participate in this project, Lucia will ask me questions about how life is different for my family member/friend since the fracture, what I would like for him/her to be able to do in the future and what would help him/her to achieve those goals. The interview will take about 1 hour. I will be interviewed twice and Lucia may call me to arrange a third interview. I understand that the interviews will be tape recorded. Following transcription, the tapes will be destroyed.

RISKS AND DISCOMFORTS
Some of the questions may touch on experiences that are upsetting to me. I understand that if, during the course of the interview, elder abuse is discovered, Lucia is required by law to report this to the health care agency and/or to Senior Services Division.

BENEFITS

I understand that I may not benefit directly from participating in this study, but that it might help other people in the future.

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LIABILITY

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Lucia Gamroth has agreed to answer any questions I may have. I may refuse to participate in this study or withdraw at any time without affecting my relationship with or treatment at this agency or the Oregon Health Sciences University. I understand that I will be given a copy of this consent form. My signature below indicates that I have read the foregoing and agree to participate in this study.

_____

Informant's Name Date

_____

Witness' Name Date

Appendix C

Interview: Client 3-A
Interviewer:Lucia Gamroth
Date: March 8, 1991

		Code	Theoretical Note	Recode	Memo
IN:	Tell me how you fractured your hip, what happened?				
RE:	I use a shopping cart to go shopping. I took books and magazines back to the library, I read a lot. Then I went, a friend of mine met me there and we went on up to the store to do our grocery shopping. It was raining. I really should have turned around and gone back home but we went on up to the store and did our shopping. There's a little (inaudible....description of fast food restaurant, Wendy's or the like) and we usually stop there and have coffee when we come back. Which we were going to do that day. So there is a walk around, on each side of the restaurant that sticks up about this far (gestured a height of about 5-6 inches). And I had to pull my cart up over it, usually it works out just fine, but that day was just my bad day I guess. And it slipped back and just pulled me right out onto the parking lot. I broke it in three places.	Library Social support Grocery shopping Self blame Social support With someone	Importance of independence mobility, social interaction With someone when accident happened.	Social Interaction Control Independence IADL Enjoyment Social support	
IN:	So then what happened.				
RE:	There was a man from Buck's Ambulance right there, Buck is right across the street. So he hollered at his partner. Cause actually I couldn't even feel anything in that leg. So then they helped me inside cause, like I say, it was raining. Finally got me to sit down on the bench there and then asked me		EMT's on the scene when she fell so she had immediate attention. Trust in ambulance crew as part of medical system.		

	about...course I didn't know I'd go to the hospital but then I knew I had to do...there was something wrong with my leg. So they put me on the gurney and took me over to K. I have Medicare Plus II.	Immobilized Insurance coverage	Maintains a sense of control over the situation.	Control
IN:	How did it happen that you came here then after hospital?			
RE:	I think that Kaiser send their patients here cause they had it all set up and everything.	Not included in decision Expectation of insurance		
IN:	So, you knew all along that you'd be coming here.			
RE:	No, not in this particular spot but I knew about this place. I had been over here to visit my sister-in-law one time. But they didn't tell me that this was where they were bringing me. They just said that they were taking me to a nursing home.	Not involved in decision. Informed		Process
IN:	How did you feel about that?			
RE:	Oh, all right. I thought well I guess I had to go someplace after the stay in the hospital. I got a little bit of therapy in the hospital but not a great deal and I knew I had to have some more. I went in, that is going to stand out in my memory, Tuesday the 13th of February (she laughs). I think maybe I was there two weeks.	Rationalized Legitimized admission Needed therapy Unforgettable event	Decision made sense to her I knew I had to have more. She sees a need-an attempt to maintain control or directions?	Process Maintaining Control
IN:	Thinking about before your fracture, what was a typical day like for you?			

RE:	Oh, well, I did all my work...all my washing and everything. Did my own cooking. I live by myself. Maybe I didn't do as good a job as I should have. I didn't vacuum as often and I wasn't really feeling up to par anyway. And I found out after I came over to the hospital. My doctor from the clinic thought I had bleeding ulcers but I had test for that but it wasn't...what I had was...see I have pernicious anemia, and what I had was another form of anemia. So I found that out over in the hospital. That's why I wasn't feeling up to par. So that day I went to the store, I should have really turned around and went back home. But in a way, it was a blessing because then I found out that I had anemia and needed...now I'm taking iron for it...so otherwise I'd have probably never said a word about it. I'd of just went on....well, that's what my daughter says, "you don't say nothing".	Washing Housework Cooking Lives alone Expectations Not feeling well Medical reason for not feeling well Self blame Looking for positive aspect Daughter's concern	Was basically independent before the accident and lived life according to her wishes. According to whose standards Explanation for not meeting "should have" requirements. Sorry the accident happened but glad to have a medical reason (correctable) for not feeling well. Agreeing with her daughter that she never says anything.	IADL Control Control
IN:	So thinking about the way things were before, how has this changed your life.			
RE:	I can't tell you until I'm out of here and home how it will be. But I still plan on going to the store and I want to get home...I want to get all well so I can get home and set out a couple of strawberry bushes and maybe a couple of hills of cucumbers, so I'm not just one to sit around in a chair. That would just bore me to tears anyway. I don't watch	Home Mobility Shopping Gardening (hobby) Activity Physical	Does not see herself as part of this place. Does not see that her life has changed. This is a temporary inconvenience. life is defined in terms of home and previous activity. At least not sit around with no purposeful activity.	Image of Self Mobility IADL Enjoyment

	much TV-that bores me too. And soap operas...oh, Lord. I like to read, mysteries especially. Sometimes my daughter picks me out books that she likes and I read them too, so I'm not just entirely on mystery stories.	Activity Intellectual	Uses "sit around" as contrast to physical activity. Distinguishes between passive intellectual activity (watching T.V.) and active intellectual (reading mysteries) as also describes variety.	Cognitive
IN:	You mentioned the friend that goes with you to the library and grocery store, is that someone who lives close.			
RE:	Yea, I go up to her place. Sometimes I go up and have lunch with her. She can't, of course she gets around O.K., she doesn't have a broken leg or anything, but she has to use a cane because she has a bad hip. But she does a lot of walking. She has arthritis.	Social support	She has a disability unrelated to my condition. Even with disability she does a lot of walking.	Social interaction Imaging Process
IN:	How far is it from your home to library and store.			
RE:	Oh, five blocks. Bad part of it is 50th and Woodstock because it is such a busy intersection. They are supposed to put a light there. That would help her because she can't walk very fast. Course I can walk fast when I feel like walking. So all together, 8 or 10 blocks one way. But when I feel good I don't mind it at all. But I was going down hill. I feel much better since I've been taking iron.	Perception of health, vitality Perception of decline	Feeling better may be related to iron and may be related to the identification of a medical reason for not feeling well.	Image of self Vitality Control?
IN:	How will things be different in the future?			

RE:	Oh, I've got a big place. I usually do all my bedding work. I plant my annuals. I don't get down on my knees anymore because it's hard to get up, so I just stoop over. It works out all right.	Gardening Limitation Adaptation	Perception of lots of work to do.	Enjoyment Limitations
IN:	So you're hoping to do all of that again.			
RE:	Right (with emphasis). I hope I can continue just the way I was. And if the break heals and everything, why I should be able to. I don't see why not.	Optimistic Determined	Is it optimism or unrealistic expectations	Image of Self Motivation Process
IN:	In what ways have staff been helpful to you.			
RE:	Well, I go to therapy 5 days a week. I'm just doing exercises with my arms and exercising my leg. They would like me to get up and hop with a walker. But doctor says "no way", he wrote right on the paper that he sent back. "She is not to do anything like that".	Process Therapy Trust in M.D.		Trust Control
IN:	He doesn't want you to put any...			
RE:	He don't want me hopping either. And that's what they want me to do. They can't get it through their head that he don't want to do that. They even said that they were going to call him. I told them it wouldn't do them any good because the doctor told me it wouldn't. That's what he said yesterday. I told him they'd be disappointed. He said "that's just too bad" (laugh).	Conflict between MD and PT Control	Doctor and client are in charge and they are in agreement. Client has assumed role of directing her own care (with M.D.) and of being go between with nurses and P.T.	Control Confidence
IN:	Can you think of an example of something or someone that has been the most helpful to you.			

RE:	My daughter. She's doing a whole lot. She has her own work to do too. She's doing all my book work. She's still feeding on the ranch because the grass hasn't grown yet. She takes care of utility bills, bank statements, etc. my money of course, but she's taking care of it all. We visited at the doctor's office yesterday while we waited for the cab to bring me back here.	Family support Assistance Appreciation Independence	Immediately directs her attention to life outside the nursing home	Social Interaction Social support Appreciation Control
IN:	How have you changed as a result of fracturing your hip?			
RE:	I don't know. You'd have to ask somebody else, I think. I've tried not to be a real nasty patient and they seem to all like me here so maybe I'm not taking their heads off.	Self image Self as likeable Humor	I don't see me any differently. Maybe someone else would Her manner indicated a sense of humor. Frequent smiles and kind of laughs at self.	Image of Self Contentment Satisfaction
IN:	So it doesn't seem to you like you've changed.			
RE:	No. I think now that I'm feeling better and I really can moved my legs better, I feel more alive like. Course the other day, I have caught a slight cold and I didn't feel good that day. And then of course when I went into the hospital I seemed to have a congested chest but I didn't start getting up anything until I came over here. Now I can cough up phlegm. I was short winded on that account.	Denial of health problems	She hasn't changed but she "feels more alive". Nothing related to hip fracture. Perceives change as "feeling worse" or "going downhill"	Image of self Experience of Self Negative perception of change
IN:	So generally, your feeling better.			
RE:	Oh, yes.			
IN:	Do you think there are things about you as a person that are going to help you get where you want to be.			

RE:	I haven't thought much about it. I do think a lot about going home. There's no place like home, you know (smile). And I'd just like to continue the way I was. I wasn't maybe, you know, too ambitious or anything, I didn't do a lot of work around the neighborhood or anything like that. But I kept my place, my yard looks nice. I'm 84.	Imaging Importance of going home Contented with lifestyle	Images herself going home Home as security, home as feeling good, home as comfort, home as contentment, home as where I can "be". Distinguishes "being the way I was" from "doing a lot of work". Her "fit" in the neighborhood. is the yard looking nice an extension of client looking nice?	Imaging process Comfort Contentment Being Image of Self	Psychologic al
IN:	You don't look 84.				
RE:	Well, thanks, but I know how I look. My hair is a mess. It don't usually look like this because I'm kind of fussy about my hair. I cut my own hair. When I shampoo it, all I do is push it back and it curls.	Concern for appearance Independence Self image	 And "I like it" implied.	Image of self Control Comfort	
IN:	Maybe you'll be doing that for yourself again soon here.				
RE:	Well I go to the bathroom and brush my teeth. One of the aides said she'd do it, but I said that I'd do it. I'm not used to being waited on. So I do what I can for myself but I still get scared when I look in the mirror (laugh).	Importance of independence. Control Self image Humor	Asserts herself to keep control over activities that she can do for herself.	Control Humor	
IN:	Do you think there is any characteristic about you that might keep you from attaining your goal.				
RE:	I don't think so. When I set my mind to do something, I go to it.	Self determination Self image	She does not see any obstacles to her recovery.	Image of Self Process	
IN:	Are there any other things, besides what we've talked about, that will make a difference in your recovery.				

RE:	It all takes time. Never been sick or hospitalized before. This is a first experience. If I had been feeling good, I don't think it would have happened. But like I said, I was going down hill and I really needed the iron.	Self blame. Self image does not fit her image of self as healthy and active	Recovery takes time- implies an adjustment. Never been hospitalized before. Never experienced restrictions of institution?	 Image of self Process

End of interview.

Appendix D

AMBULATION

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	Walking every day	I can walk	He's walking now with walker Walk with cane
2	I will walk with walker It'll be a long time before I walk without walker	I get around on this I'd like to go for a walk	Can get motorized car
3	Not one to sit around I hope I can continue just the way I was	They wouldn't let me go until I can walk Until I could walk	
4	Walk with walker Get to use a cane later	I can go all through the house I have to use a walker I'll have to walk with cane	
5		I'm walking much better I have walker all time	She wants to walk Want her to be able to walk
6	Walk with walker Get me back up and going	I use walker with help	Has to be mobile enough to get around house
7	Get on my feet		
8	I can walk little way I can walk with walker	Walk with walker	Walk with walker Semi-mobile

SELF CARE

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	Take care of self dress feed p.6 Learn to do things for self p.7 Get up from chair p.12	I can go to bed Able to take care of self. p.1 Getting exercise p.2	Take care of self p.3 Get up out of chair p.4 Do some exercising p.4
2		She bathes me p.4	Get up p.6 Go to the bathroom- doing that now p.6 Get around house p.6
3	Cut and style my own hair p.6 Go to bathroom p.6 Brush teeth p.6 I do what I can for myself p.6	I can go to the bathroom p.3 Get dressed and undressed p.3 Get into bed P.3	Take better care of herself p.2
4	Just do enough to take care of myself p.7 Don't know how it's going to be for a bath	Take sponge baths with assist p.2 Having a shower put in p.2 Washes my hair with assistance Get up pretty good now p.3	
5		Able to do my teeth in morning p.1 I get up at night to bathroom p.2	Feed herself p.7 Be sort of independent p.5
6	Get out of this chair p.4	Getting so I can do more things p.2 Get up myself p.2 Get to bathroom with help p.2 Stand up better p.2 Shave myself p.2 Got himself out of bed p.10	Get on the bed p.7 Get off the bed p.7 Get on the commode p.7
7			
8	Get in and out of bed p.3 Not bother A p.3 I could get on commode p.3 Her to help me take my bath p.3	I can stand up Get my clothes adjusted & set back down p.1 Use the commode p.1 Bathe with help p.3	Somewhat independent p.4

IADL

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1			
2			
3	Went to the store to do grocery shopping p.1 Planning on going to store p.3 Did all my washing p.2 Didn't vacuum as often p.2	I'll be without my telephone p.2	
4	Fixing my own meals p.7 Little housework p.7 Kind of wait on myself p.8	Get my own meals Do up my dishes and things. p.1 Have trouble with making bed p.1	
5	Baking p.3 Make my bed p.3		Be able to do things on her own p.6 Take care of own laundry p.7 Do own ironing p.7
6	Work in house p.5		Drive the car
7	Always did own housework p.5 Did my own cooking p.5 I'd run the sweeper p.5		
8			

HOBBY/WORK

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	Take care of garden Care of yard Care around house p.5	Planting garden Wax mobile home Trim shrubs p.2	Can't drive Gardening p.5
2	I enjoy sitting & reading I still read p.6		
3	I read a lot p.1 I like to read mysteries p.3 Took books back to library p.1 Usually do all my bedding work p.4 Plant annuals p.4 Set out strawberry bushes Set out cucumbers		
4	Like to be doing outside p.3		
5			Watch TV p.7
6	Listing ships that enter and leave the port p.2		
7			
8			

SOCIAL

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	6-8 of us go to Church & for coffee Talk about what's going on in world p.9 Trips every year p.10	Trips every year	
2			
3	Have lunch with p.3 Friend of mine met at library p.1 Stop there and have coffee p.1		
4		D-i-l wants to take me out in the car p.2	
5	To go to church p.3		Got to be around when something happens All alone p.4 Take her to church p.8
6			Family comes to visit p.
7	Between my daughters, grandsons and nephews p.5 Didn't go unless some one with me p.5 Kids were come and take me places p.6 All come every day p.8		
8		I don't know where S. is p.2 Go to the dining room to be with others p.6	She'd love to have visitors p.1 I come every day p.6 Finding someone that she really liked p.11

HOME

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	Is a place to work outside work p.6 Continue on daily routine p.8	It never looked so good p.3 No place like home, p.3 ********** The food. Service was better. Everybody likes their home p.1 Have your family there. p.1 Your wife to take care of you Your kids coming in and out My wife was there Nothing can take the place of home. I don't care if you live in a shack. Friends can drop in to see you. If wife wasn't here, I couldn't even come home Have TV & can watch what you want My garden and the flowers	We can do this at home p.5 Doesn't know why he has to be here so long p.8 Anxious to get home & back to normal p.9 P.T. He thinks he should be home.
2	He said I couldn't go home p.3 I may go home & try to work it out p.3	It was wonderful to get home p.4 If I'd of known that it was going to be like this, ..just as soon not come home. I've been away from home for 2-3 years p.5 My wife died p.5 That was our home p.6 It was really nice then p.6 When you're not home, where are you p.5 One reason is I'm not in a nursing home p.5	He thinks if he could just go home by himself, he could do this p.8 He wants to go home but I have a problem with my back p.9 he has to make progress. p.9 he thinks that if he could just go home everything would be all right p.9 Cocker Spaniel at home p.9
3	I want to get home p.3 I can't tell you until I'm out of here and home p.3 There's no place like home p.5	I'd like to be able to go home p.3 I think I'll be able to answer that a little better when I get home p.8 I'm determined to go home p.8 ********** It means a lot to me Id' rather be home than here I couldn't really say Its just that it's home and I want to go to it. Place that I want to be Being home is enjoying flowers and yard. Enjoying yard work which I'm going to miss.	Safer now than when in her own home. It hard to know whether to allow here to go back to her own home p.2 I know she'd like to & I'd like for her to p.2

4	I hope eventually to get home p.2 Had things pretty nice Don't own my own home Little two room house Very neat and cozy p.3	Of course it's nice to get home It's always nice to get home p.2 I'm naturally a home body. I don't care about going p.2 I'm happy here just the way it is.p.2 I think I could be happy most any place p.4 I don't have to have a lot to be happy. p.4 They keep a nice home. p.4 I'm home and it took me quite awhile to get my appetite back. p.12	
5	I haven't lived there very long p.2	I means a lot to me p.1 I can't tell you more about that p.1 I miss all my things, my blouses, slacks and my perfume p.1 I don't think I'll be able to go home p.2 I'm happy here p.2	She loves it there p.1 Not sure she'll be able to go back p.1
6	I enjoy the house p.3 Who would want to stay here p.4	Kind of up to you what happens and what doesn't happen p.5	He's in a nursing home which he hates p.3 I gotta get out p.4 If he can do these things, he can come home p.7 He wants to go home so badly p.12 Whole affect & appearance was different in home setting.
7	Someday I might get home and then go on doing the things I did p.6 Until I get on my feet and get home p.7		
8	S. wanted me to be able to go home, to the foster care home p.6	I like it here p.4 I got away from there p.4 It would be quieter p.6 I'd be able to go to the dining room p.6 To be with others p.6 Yes, it feels like home p.8	Become somewhat familiar p.3 She wanted to go back to foster care home p.4 Have the skills that will allow her to do that p.7 Will do a lot for her pride p.7 Ability to live independently p.7 Consider that her home p.11

Self Image

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	Competencies (above) define self She's a very important part p.5 Social life part of my life p.9	Can't do that anymore p.2 Daughter around a lot p.3	He doesn't have that problem p.6 80 sounds old, but he's never felt old p. Don't have to be busy We live unexciting life & like it
2	Felt secure without cane pp.1 I don't know what I'm going to do p.3 I haven't any idea p.5 I don't know p.6 I'm not afraid of anything p.4 I wasn't as active then even as I was before p.5 I wasn't concerned p.5 88 yr old kid p.5 Have no hesitation about walking p.5 Eyesight has slowed down p.6 It's my fault, not theirs p.7 Just me (I'm the least helpful) p.8 They don't know anything about me & I don't know... p.9 I don't know anything p.10 It's me p.10 I had not the slightest idea that I'd ever fall. p.11	Clumsy, you know p.1 I don't think I could make it without the walker p.1 It's awful hard for me to live and not bend my legs p.3 I don't know p.3 i think I could p.3 I could bathe myself p.4 Maybe she's right p.4 I don't like to be so dumb p.4 When I'm alone, I can think of things to say p.5 You can't learn from me p.8	He used a cane He would go out walking p.2 When he gets tense & people give him directions, he just short circuits p.4 Nurse thought he was an old man & old people don't get better p.5 He doesn't like to be told what to do p.5 He's a solitary person p.7 Wants to be by himself p.7 Always been really active, build things around house p.8 He doesn't cooperate p.8 Tendency to fall - unbalanced p.9
3	Course, I can walk fast p.3 Maybe didn't do as good a job as I should have p.2 I'd of just went on p.3 Don't get down on my knees anymore p.4 Not too ambitious p.5 Didn't do a lot of work p.5 But I kept my place nice p.6 Kind of fussy about hair p.,6 Not used to being waited on p.6 When I set my mind to something I go to it p.6 Never been sick p.6	I'm determined	The idea of being someplace other than her own home p.1 She is pretty antisocial p.1 Least wanted of 11 children p.2 If she got sick more work p.2 never tells me when something is wrong p.2 Always been single-minded about things. p.4

4	Crippled up with arthritis for long time Couldn't work anymore Don't like to stoop over to weed p.3 Series of accidents this year p.5 have to give up gardening, just can't do it anymore p.7 I lost a lot of patience p.11 I guess because I'm me p.12 I've always been a person that does what needs to be done p.12 Dutch stubborness p.12	Don't bother me to be alone p.2 I can't do that now. p.3 it don't take material things to be happy. That to me, doesn't mean happiness at all. As long as I've got a little something to read and can watch a little TV, I'm perfectly happy by myself p.4 Not that I don't like people p.4 Guess it's part of my nature p.4 I've always tried to have a positive attitude p.8 Doctor all tell me "You've made a remarkable recovery".p.8 It could just ring and they could call the next day if they wanted me p.11	Real sense of self acceptance comes through here from client.
5	Life was good p.2 I worked all my life p.2 I did everything that I wanted to do p.2 I don't know p.4 I have always been active p.5	I look wonderful but I have a stroke in my leg p.2 I'm sorry that I look like this. p.3	Stroke affected speech Walk slowed down p.2 Go getter...fire ball p.2 Worked all her life p.2 Very proud woman p.2 Owned own restaurant p. Had a few falls Needs supervision p.5 Self sufficient p.6 She's fussy person p.7 Very determine person p.8 Stubborn p.9 When has a goal, tried hard p.9

6	Burden to my wife p.1 My wife's had to take over everything now p.3 I enjoy the house p.3 I know that garden is out p.3 I have to do it myself p.4 I hate to be dependent on people and that's what I've become p.5 I don't think of any p.5	I really didn't need that much help p.4 I think I can accept p.7 I don't get riled up if something just doesn't go right p.7 No, I don't think so p.7	Just can't help himself at all p.4 he was not very mobile to begin with p.5 All he did was walk in house, small steps p.5 He feels very inadequate p.5 He can't work in the yard p.5 He gets upset because I have to do it p.5 He's not a very vocal person p.7 He's not very outgoing person. p.7 It's ruined your self image p.7 You can't do anything p.7 Feel you're not worth very much p.7 Not real motivated person p.12 Doesn't feel good much of time p.12
7	Always had fear of falling p.3 I always did everything but I quit going up and down steps p.5 Wonderful family p.6		
8	You'll have to ask S. p.1 Maybe it was my fault p.4 I was in the heap too p.4	I've sprained her back p.2 I've got cataracts p.6 We've had regular diapers to put on p.5 Sometimes I wonder if it's the diaper p.8 Considerate	Never really up or down, just kind of here p.1 Always lived a routine life p.3 Always had her own room p.3 Tell her what she needs to do, she'll do it p.4 Very organized and very structured p.4 Pride p.7 Quite independent p.8 Very even p.8 I'm very old p.8 Very stubborn p.10 Very patient p.10 Very even temper p.10 At time of last interview, client talked about feeling like she was being tossed around.

IMAGING

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	"Way you dress, undress, eat" p.3 All things you're used to doing p.3 Depend more on wife p.4 Will change quite a bit in future p.3 I don't know if you're handicapped p.5 Some tell me I can, some tell me I can't p.6 Sometimes things come up that I haven't thought about p.11 By next week, I'll be... p12 That's what I see from my side p.5 With hip cured p.10	I just couldn't place myself with that sign p.	Maybe he forgot & doesn't think it's necessary p 4,5 That's what we're hoping for. Thinks about getting home & back to old routine p.9 I don't think we'll take that round trip anymore p.15 I hate to think that he has to have a baby sitter p.5
2	I didn't have any idea anything was broken p.1 I just couldn't go on p.3 It'll start up when I go in there p.3 He told me I'd be walking in a couple days p.6 I will walker with walker p.7 It'll be a long time before I walk without walker p.7 I don't know what I'm going to have p.7 Inability to recuperate p.8	Thinking maybe I was going to die p.1 They told me it would be 2-3 days & I'd be walking p.2 If I were home here alone, I can take it p.5 I think i could get along without it p.8	He feels like this is the end p.2 Nurse told him he was going to go to a nursing home p.4 Letting him set his pace & determine his direction p.8 He can't stay alone p.10 Basic conflict between not being able to be alone anymore and client's need to be alone.
3	I want to get all well p.4 I don't see why not p.4 I do think a lot about going home p.5	I'll have to use the walker p.3 I don't know if that includes April or May p.3 I'll probably have to hire someone to do cleaning p.4 I won't be able to get outside because of steps p.4 Just see daughter vetoing p.4 Steps are not all that wide p.4 i could have someone put lawn chair out there p.4 Summer will be gone p.5	Nursing home was end of line p.1 She thought she would be here couple of weeks. p.1 Mother thought she was going to a foster care home or a nursing home.p.3
4	I think it will be quite a bit different when I get home p.4 I'll probably be crippled a little more p.4 Probably can't get out as much p.4	Nothing to judge it by because I've never had anything like this before p.1 Until I'm a little more confident p.1 Not going to be too long until I can walk without the walker. p.1	

	Won't be able to walk as much p.4 Have to be more careful getting outside p.4 If I could just take care of myself, I'd be happy p.7 Don't know how it's going to be now p.7 Only way I'll even get so i can do it p.9 Looking for things to get better too fast p.9 If things go the way they're going, it's just a matter of time p.14	Can almost do it now. p.1 Don't think I could get out of a car. p.3 It won't be very long until I can just do pretty near anything. p.6 He's going to see to it that I walk as good as I did before. p.6 I have that prospect to look forward to p.7 I'm hoping for the best p.7 Kind of have to look at the bad part as well as the good.p. 7 I just feel it, that's all p.10 I just knew I was so much better p.10 I just felt like it was a better day, or something p.10	
5	I'd like to be able to do everything p.3 I think I might die p.3 I hope I have a heart attack & die p.4	I would like to go to Reno p.2 I always like Reno before I had this thing p.3 It doesn't seem possible p.3 I wished it were different p.3	I don't think mother will be alone p.4 We do want to put her back in that unity p.4
6	I'm not going to be getting around as good as I was p.1 I've never seen anything as beautiful as South Pacific p.3 Going to have trouble getting around. p.3 Hope I can still move p.3 I'm on my way p.4		He was not going to be happy here. p.6 Hopefully, at some point he'll be better p.6 Unless something happens p.12 He's not getting there. p.12 Just thinking of being here longer is very depressing for him p.12 Hopefully he'll pick up on it if he realizes that's what it takes. p.14
7	Someday maybe I might get home and then go on doing the things I did p.6 Just want it to hurry up and get well p.8 I just want to get back on my feet again p.9		
8	I just thought I'd let the leg heal and I'd use it when it comes time to use it p.1	I don't know if I just imagine it or if it really is that way p.5 I wish I could have more eyesight p.6	I was always supposed to go first p.2 The choice was pretty easy p.4 Wanting to have the best care and get her up and back in operating in her normal lifestyle p.5 It would be very nice if she could walk without a walker p.6

Walker will give her additional confidence p.7
How difficult it would be for her to live in a LTC facility p.7
My goals are much more aggressive than her goals p.8
If her motivation would start to wane p.10
Definite preconceived notion that she would be here for 6-8 months p.10
Could be looking forward p.11
She should do fine there p.12

EXPERIENCE OF SELF

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	I am cautious p.7 I have some trouble with steps p.7 Something's not the way it was p.3 Not so sure of myself p.8 There is a lot of difference p.11 Just slows life down p.3 Hard to remember p.12 Not completely cured, but sure come a long way p.1 Go slower & take it easier Set in chair more p.2 Slowed down a bit p.1 He's almost O.K. p.2 We're noticing every little thing p.3 Sometimes he forgets p.4 Hasn't talked quite as slurry p.7 Eyes kind of bug out a little p.10 He can only do a little at a time p.15		
2	Started using cane p.1 Couldn't even stand up p.1 It was too painful p.2 I could walk p.3 I regressed p.3 Really wobbly p.3 That's what it's done the last 2 times p.3 I vibrate p.4 I can't tell where my foot's going to go p.4 The extent of my activity is restricted p.4 They tell you what to do p.4 Can't go anyplace or do anything p.5 It's getting easier p.7 This is it p.6 Walking with 3 people p.6 Can't walk over to windows p.6 Very slow process p.6 Stumble a bit & walk p.7	I've tried exercising & not exercising p.1 I fell once p.1 I didn't die, so I got up p.1 Was not easy getting up p.1 Get to thinking you're doing real good Find out you're not perfect It's been quite a few p.2 I haven't seen anybody yet p.2 I'm not permitted p.3 I wasn't afraid to try & I kept trying p.3 You're with a group of people that don't make happiness or pleasantness p.6 Time helps most p.7 Sad, but true p.8	He can't get up & walk p.2 Bad experience in hospital p.3 Hospital was really hard on him p.3 Nurse dropped him in hospital p.3 Terrified of hospital p.5 He's relaxed & he's doing well p.8

3	Something wrong with my leg . p1 It usually works out just fine p.1 They seem to all like me p.5 I really can move my legs better, p.5 i feel more alive p.5 But I know how I look p.6 I don't usually look like this p.6 Still get scared when I look in mirror p.6 This is first experience.	I'm stronger, p.5 No. I didn't tell her either p.5 That's what I was doing is walking p.6 Not putting any weight p.6 I was walking different this afternoon p.6 I did PT in my bed p.6 That's why I'm dressed like I am p.6 I don't try walking by myself p.7 They hang on to me p.8 Pain & not being able to do what they usually do p.9	That has really changed for her p.1 Attention to leg strengthening exercises p.4
4	Couldn't stand up p.1 I couldn't take care of myself p.2 Hasn't been enough experience with leg yet to know p.9 Sometimes getting out of bed is pretty rugged p.9 Getting tired of having everyone wait on him p.9 There is a little change there everyday p.10 i guess I'm not doing too badly p.10 Sometimes almost tell the difference overnight p.10 I want to do things and I can't p.14	I must be doing okay p.1 I'm a little bit afraid yet p.1 I got a lot of good out of it p.4 They were very encouraging p.5 I couldn't get away from the hurt p.7 You've made a remarkable recovery p.8 You can't tell, of course, until you start walking again. p.9 A little hard yet. p.9 I had one little tumble p.11 I was scared for two days p.11 Taught me a lesson p.11 If I lay down, then I don't rest as good at night p.12 Would feel like me trying to sleep on rocks. p.13	
5	I fell on the floor for 2 days p.1 I felt like I needed that p.2 When you fall & you have something happen to you, do you think that it's not hard? p.5	It bothers me when I walk. It doesn't do what I want it to do p.2	Had a stroke and fell p.1 Think she's had many strokes p.1 Doesn't like to talk anymore p.2 She's not interested in watching TV p.7 Brought her hearing aid, but she doesn't wear it p.7 Doesn't talk because it's hard for her p.9 Doesn't like people to know that she can't communicate as well p.2

6	Seems to get worse as I get older p.2 Things kind of crumbled p.2 Something I could do p.2 My wife's had to take over everything now. p.3	M still has to help p.2 Getting so I can do more things p.2 Exercises that they give you p.3 Used to leave me in chair p.6	He was in just excruciating pain. p.2 Well, I couldn't walk today p.3 He's in a nursing home which he hates p.3 I don't care p.3 Got bladder problems so he's afraid to drink water p.3 No way I can lift him p.4 Now I know what my mother felt p.6 Weekends he slips back p.10 He can't use his own urinal p.11 He doesn't like the food p.11
7	Having trouble with this leg p.3		
8	Nurse holding on to the strap p.4 Right leg gives out on me p.4 Well, you could do that yourself p.4 My feet are heavier than the rest of me. p.5	I've had my second fall. p.1 I can't do that p.2 I think I'm asleep & the rest of the folks around here say I'm hollering and keeping them awake p.2 Made me kind of miserable p.5 Whether I just imagine it or if it really is that way p.5 I don't like the idea. p.7 We had the diaper before we did the hollering p.9 I don't think I'm feeling better p.9	Having to adjust to change p.3 Being in a room with someone else p.3 Done remarkably well p.4 As unsettled as her life has been p.5 Attitude was markedly lower when I got back p.6 She felt that her wishes are ignored or are not taken seriously. p.9 Was encouraged to really believe that p.10 When she's not feeling well, everything she tries is harder and then her motivation dips p.11

CONTINUITY OF SELF

CLIENT	INTERVIEW ONE	INTERVIEW TWO	FAMILY INTERVIEW
1	I'm really happy I am where I am p.10 I'd be happy, return to normal way of living p.10 It hasn't changed too much yet p.3 Hard to say what's going to happen now p.11 No, not that I know of p.2 You'll have to ask C that, I haven't noticed, p.3 Hip fx caused disorientation p.3 He wants to get better really bad p.5 No, I really don't think so p.7 A little bit "in the clouds" p.8 Get home and back to normal p.9		
2	Back the way it was p.5 Just a normal life p.5 I haven't any idea p.9 What have you go to gain if you don't gain anything. No matter what yo go through, if you gain something from it, but if you don't gain, then i don't know...p.9 If I'd have known that this was going to be this severe, I would have preferred death over surgery p.9	You think you've slipped p.2 I don't like having a nursemaid p.3 I don't know why I have the help p.4 I might as well be dead as living the way I am p.4 I don't know whether I need it or not p.4 I'm speaking for myself, not my daughter p.5 I wasn't perfectly normal p.8	No, I don't think he's changed p.9
3	Hope I can continue just the way I was p.4 I don't know. You'll have to ask somebody else p.5 I'd like to continue the way I was p.5	I don't know that I've changed p.8 I'll be able to answer that a little better later p.8 Well I hope not. If there is, I'd like to find out p.9	She knows that I'm not going to desert her p.1 I don't think my mother will ever change p.3 She's always been like she is p.3 Mother hasn't been the same since Dad died p.4
4	It hasn't changed any because I've been here all the time so I have nothing to compare it to p.4 I'd feel pretty lucky p.7 I would be happy p.7 An experience like this is bound to change a person p.11	Well, if I am, I don't know it p.2 You kind of have to look at the bad part as well as the good. You can't take it all one way. p.7 I've always been that way. p.10	

	I've always been a person that... p.12 Since I've got older, that has kind of left me too p.12		
5	I don't know what happened to me p.2 I would like to go to church p.3 Yes, I think I have changed p.4 I think that I better get better p.5	I wished it were different p.3	Become more of an introvert p.2 Don't know what's going to happen p.5 Otherwise, that would destroy her
6	Something I could do p.2 Just get me back up and going p.3 I hate to be dependent on people and that's what I've become p.5	I don't know of any (difference rheumatoid arthritis would have made in recovery) p.11	Has gradually become less and less mobile, i don't know why. p.6 He's getting withdrawn p.11 It's hard to believe in ten days p.11 I don't know what's going to happen p.13
7	Don't think I can answer that until I get on my feet and get home p.7 No, I don't think I've changed p.8		
8	I'm short winded and I don't know why I should be p.5 I suppose I have changed but I don't notice it. p.5	I don't know what I'd be hollering about p.2 I've had to change some in order to get around in the wheelchair p.7	She's safer in walker p.6 I want to have her around as long as I can keep her p.8

Abstract

In 1986, the Institute of Medicine (IOM) published Improving the Quality of Care in Nursing Homes, which provided many recommendations for improving nursing home care, many of which were introduced in legislation proposed in 1987. That year the Omnibus Budget Reconciliation Act was signed into law (PL 100-203), mandating an outcome approach to assurance of quality in long term care. Not only are public policy makers focusing on the need for research on process and outcome measures, but they are calling for patient input on the measures (AHCPR, 1990).

This study was the first in a series of studies designed to conceptualize and measure appropriate outcomes for clients in nursing homes. The study was designed to answer the following research questions: a) What are the client-focused outcomes of rehabilitative care for hip fracture clients in the nursing home that are valued by clients and family; and b) how do the valued outcomes identified by clients compare with the outcomes identified by family?

A qualitative study was conducted to answer the research questions. Semi-structured interviews were conducted with clients (n=8) over the age of 65 and associated family members (n=6). The medical records were reviewed for other data to supplement the interview data. Data were analyzed using constant comparative analysis to identify and define the concepts and relationships central to the research questions.

Competencies are the most explicit outcomes valued by clients and their respective family members. At the aggregate level, ambulation and self care are of primary concern and instrumental activities of daily living, hobby or work activities, and social activities are secondary in importance. At the individual level, however, the importance of one set of competencies over another depends on previous functional status and the importance of those competencies in self definition. The importance to family members of one set of

competencies over another is related to the perceived role that each family member plays in the respective client's life.

All clients and family members value going home as an outcome. While the importance of "going home" is clear from the data, the meaning that it holds for each client varies. Different perspectives between family and client on this valued outcome may be of greater significance than different perspectives on competency outcomes because the client may have less control over decisions made regarding going home. Continuity of self emerged as the core category of the study. Most clients value, as an outcome of care, a return to being the person they were before the fracture; that is, they wish to maintain the continuity of self. If a person's self image is defined exclusively by what she does (competencies), the image of self is fractured along with the hip. If the client is unable to re-image herself based on a new experience of self, the difference between the old image and the new experience creates a sense of discontinuity of self for the client. Home is the context in which such an evaluation of self takes place.

Not all outcomes are equally important to hip fracture clients in nursing homes. It is important for staff to acknowledge the outcomes that are valued by each client and to have some understanding of the significance of those outcomes for the client. Staff can then assist the client and family in achieving the client valued outcomes.