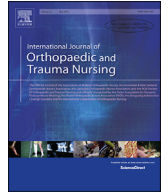




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Hip fracture; an interruption that has consequences four months later. A qualitative study



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ABSTRACT

Background: Effects following a hip fracture often lead to functional disabilities and increased dependence on others. Although persons sustaining a hip fracture constitute a heterogeneous group in Swedish health care, they tend to be treated as a homogenous one.

Aim: The aim of this study was to reveal how previously healthy people, aged 65 years and older, described how they had adapted to daily life four months after a hip fracture.

Method: The follow-up interviews were performed by the first author four months after the hip fracture. Data were analysed using conventional inductive content analysis.

Findings: The results from the interviews highlight that sustaining a hip fracture — even four months later — was seen by the participants as an interruption leading to lasting consequences for everyday life. The recovery process during this period was complex and consisted of both physical and psychological strain. Some were resigned, some strived in order to regain independence and some handled the situation by means of self-confidence and self-efficacy.

Conclusion: Previous healthy and independently-living participants described, in different ways that the hip fracture was an interruption that still affected everyday life. The absence of psychological support may be one of the reasons for dependency after four months.

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1. Introduction

Sustaining a hip fracture is a sudden traumatic event, threatening many aspects of the patient's life due to the effects of functional disability. The reduced mobility often causes increased dependence on others (Magaziner et al., 2000; Pasco et al., 2005). Approximately 17 500 adults sustain a hip fracture annually in Sweden. Data from the Swedish hip fracture register show that 37% of these individuals lived an independent life at the time of the

fracture (Hommel and Bååth, 2015). Restricted mobility has an impact on everyday activities, which in turn affects the patient's emotional state and often results in a loss of confidence. This puts patients at a high risk of becoming permanently disabled and dependent, even after a successful operation (Pasco et al., 2005). There are few studies on why some individuals and patient sub-groups recover after sustaining a hip fracture and others do not (Beaupre et al., 2013; Griffiths et al., 2015).

2. Background

Studies have shown that factors affecting the outcomes of a hip fracture are dominated by a functional restorative focus (Liem et al., 2014; Sherrington et al., 2016). Psychosocial factors have effects on recovery but have not attracted much attention in health care

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(Healee et al., 2011). Mobility problems and impaired physical function may affect mental well-being after a hip fracture and lead to reduced ability to participate in social activities. This may result in long-lasting consequences for up to one year and beyond the fracture (Beaupre et al., 2013; Pasco et al., 2005; Zidén et al., 2010). Safe mobility without falls and the fear of falling have been identified as the most important factors in coping with personal care and day-to-day activities in the recovery phase following a hip fracture (Griffiths et al., 2015). In a previous study elderly people described the consequences as being more insecure, anxious and afraid of falling, resulting in more limited mobility (Zidén et al., 2010).

This study is the second of two. The first study was conducted during the acute phase of care in an acute hospital context where patients described a personal transition in the first few days following hip fracture surgery. From being convinced of recovery at admission, there was a change to uncertainty and doubt about their capacity to regain pre-fracture function. Patients described feeling that they were in a new situation, with or without control. They vacillated between fear and hope regarding whether and how they would recover and return to an independent life. This transition occurred as they adapted to the routines in the acute hospital setting and became passive (Gesar et al., 2017). Findings in previous research show that switching from living an independent life to being dependent on others is a challenge that could be regarded as a life transition (Gabrielsson-Jarhult and Nilsen, 2016). For older people, it may take strenuous effort to cope with and adapt to this life-changing situation, mainly regarding decisions upon which they have limited influence (Janlov et al., 2006). Adapting to health care routines influences a person's sense of identity, autonomy and dignity (Gesar et al., 2017; Janlov et al., 2006). The recovery following hip fracture surgery is complex. Because 37% of previously healthy patients do not recover their pre-hip fracture function, it is important to integrate the patient's perspective into the healthcare process. Obtaining knowledge about the recovery process is essential for healthcare decision-making. To our knowledge, no previous interview studies have followed up the same participants twice. Therefore, patients interviewed at the acute phase (Gesar et al., 2017) were interviewed again four months later.

The aim of this study was to reveal how previously healthy people, aged 65 years and older, describe how they have adapted to daily life, four months after a hip fracture.

3. Method

3.1. Design

The study had an explorative, qualitative, follow up design.

3.2. Data collection

3.2.1. Sampling

Study participants were originally recruited following hip fracture surgery in three Swedish hospitals where the first interview took place (Gesar et al., 2017). They were initially considered eligible for inclusion if they lived an independent life before the fracture, were aged 65 years or older, were previously healthy (none or mild systemic disease), had no cognitive impairment and were able to speak and understand Swedish. Out of these 30 participants, 25 agreed to participate in this follow up study (22 women and three men). Seventeen were aged 80 years and older. At four months after surgery, 14 reported reduced mobility, self-care, reduced activities, dependency and no outdoor activities. Three participants had moved into a nursing home. According to participants' preferences, the interviews were performed in their homes

($n = 24$) and at a café ($n = 1$).

3.2.2. Procedure

The follow-up interviews were performed in Swedish by the first author (BG) four months after the hip fracture, between December 2013 and April 2014. A semi-structured interview guide was used. The participants were contacted by telephone by the first author and agreed to make an appointment for an interview. The interviews took the form of a dialogue including follow-up questions aimed to elicit more detailed responses. They lasted between 38 and 63 min and were recorded and transcribed verbatim. The interview guide included the following questions: 'Please tell me something about how you feel today', 'please tell me something about your expectations for the future' and 'please tell me something about what you think about your possibilities to recover and become rehabilitated to everyday life as it was before the hip fracture surgery'. Field notes were written after each interview to develop a complete understanding of the context.

3.2.3. Data analysis

As no pre-existing theory was apparent, data were analysed using conventional inductive content analysis inspired by Hsieh and Shannon (2005). This method is appropriate when existing theory on a phenomenon is limited. The researchers utilised and organised data into categories. Names for the categories should flow from the data and describe findings in a way that makes them explicit (Hsieh and Shannon, 2005). The analysis consisted of the following steps:

- All transcripts were checked for accuracy and read repeatedly to obtain a sense of the whole.
- Each transcript was read (in Swedish) to capture key thoughts and concepts in relation to the aim of the study. Thoughts were written down using the data notes created from the first impression of the interview. An initial analysis highlighted words or statements.
- The texts were broken down into meaningful units related to each other and to the aim of this study.
- Preliminary labels for codes and subcategories were created by the first author (BG) and were organised and grouped, based on similarities and differences, into a hierarchical structure.
- After initial coding of 15 transcripts by the first author (BG), all authors (BG, AH, CB and HH) reviewed and discussed the preliminary labels of codes and categories.
- The remaining transcripts were coded by the first author (BG). When new labels of codes were discovered, they were combined into an existing subcategory. Some of them were renamed because of abstraction. Subcategories were added to the sheet when data did not fit into an existing one. A large number of subcategories were combined and abstracted.
- To address trustworthiness, the whole research group reviewed the labels of codes and subcategories in several meetings. All 25 transcripts were coded, reviewed and cross-examined until no inconsistencies existed in the research group. This procedure was intended to enhance credibility and conformability (Lincoln and Guba, 1985).
- Finally, four subcategories and one category were generated in order to give general descriptions of the content of the written material (Fig. 1). Selected quotations, codes, subcategories and the category were translated from Swedish to English before writing the manuscript for submission.

3.2.4. Ethical considerations

All participants were given oral and written information

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