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**The Involvement of Older People in their Rehabilitation:
Generating a Substantive Grounded Theory**

Authors

Dr. Norman A.S. Rickard PhD PGCE RN (Corresponding author)

Senior Lecturer

Northumbria University

Coach Lane Campus

Benton

Newcastle upon Tyne

NE7 7XA

Email n.rickard@northumbria.ac.uk

Tel: 01912326002

Professor Charlotte L. Clarke BA MSc PhD DSocSc PGCE RN

Head of School

School of Health in Social Science

University of Edinburgh

Teviot Place

Edinburgh

The Involvement of Older People in their Rehabilitation: Generating a Substantive Grounded Theory

Abstract

Aim: To identify the process of involvement in rehabilitation and produce a substantive theory of involvement based on data from a grounded theory study.

Method: Qualitative data were collected longitudinally from 4 older people and 15 health care staff during the older people's stay in a rehabilitation unit in the UK and after discharge. Data were collected as recorded interviews with the older person in rehabilitation, interviews with their practitioners and routine conversations between the participants and staff.

Results: The results suggest that involvement in rehabilitation operates through a set of Involvement Attributes which are either Psychologically-based or Action-based. The Involvement Attributes are: Vision and Incentive with Goal Planning, Setting and Achievement; a Disposition towards rehabilitation; Personal Learning; and Risk Taking, all operating within Therapeutic Relationships. To be maximally involved, the Involvement Attributes have to be strong and balanced, with alignment between the Psychological and Action-based attributes.

Conclusion: This study describes the components of involvement and how they interact within Therapeutic Relationships. Further research is now needed to demonstrate the transferability of this substantive theory in other settings and with other client groups.

Keywords

rehabilitation, grounded theory, patient participation, older people

Introduction

Patients as consumers of healthcare have been a central theme of NHS reform for many years (Fox, 2003; Calnan, 2010). Consistent with this, the NHS is now more publically accountable and the public are expected to become more involved in healthcare processes and their own health. Legislation designed to embed consumer involvement in healthcare in the UK is abundant (Department of Health, 2000, 2001, 2006, 2012). However, the level of change that policies can effect is dependent on how these policies are implemented and how they influence interactions between health care professionals and the public. Critical to such changing relationships is the extent to which the meaning of involvement is shared by all parties.

Concept analyses on words similar to involvement, such as participation, have been completed (Hook, 2006; Sahlsten, 2008). However, the meaning of involvement in direct health care has not been the subject of rigorous research (Baggott, 2005; Cook & Klein, 2005; Glendinning et al, 2006; Lepage et al, 2007; Staniszewska, 2009) and still requires attention (Coulter, 2011; Forbat, Hubbard, & Kearney, 2009). There also seems to be some confusion in the literature about what involvement in direct care means (Entwistle et al, 2008; Sahlsten et al, 2008) and other words are sometimes used synonymously with involvement such as participation (e.g. Popejoy, 2011) and engagement (e.g. Clancy, 2011).

This study sought to address the conceptual uncertainties in the literature about the process of involvement and to develop a deeper understanding of this concept in healthcare in the light of its central place in policy developments.

Research Aim

To identify the process of involvement in rehabilitation and produce a substantive theory of involvement based on data from a grounded theory study.

Design and Method

Design

A constructivist grounded theory approach based on the work of Charmaz (2006) was used to work with four older people during their time in a 25 bedded rehabilitation unit and after discharge.

Research setting, the rehabilitation unit

The rehabilitation unit was staffed by a multidisciplinary team including physiotherapists, occupational therapists, nurses, medical practitioners and support workers. In this rehabilitation unit the goals were set by the physiotherapist with varying input from the patient. Judgments made about physical ability were based on repeated assessments over a period of time. Older people were guided in their rehabilitation by a physiotherapist about how much to do and not do. Other staff, for example nurses, followed the physiotherapist's lead, working with patients on their goals and communicating progress at weekly team meetings.

Selection and ethical considerations

Each older person participant was invited to take part, based on the potential participant's aspiration to return home, their attitude towards rehabilitation and how they could contribute towards the research (Backman, 1999). The inclusion criteria were: that the older person participant was aged over 65 years; medically stable and well enough to take part in the research; able to provide consent to participate in the research; recovering from an acute condition; and expected to stay in rehabilitation for at least six weeks. Healthcare staff who

clinically assisted and facilitated in the recruited older people's rehabilitation were also invited to participate in the study (with the permission of the older person).

All participants consented to be part of the research after oral and written explanations. The older people were asked for consent to: be interviewed in the presence of a digital recorder; have conversations with themselves and staff recorded; and allow staff to discuss these conversations in recorded interviews. Clinical staff were asked to consent to being interviewed about the older people participants and to have some of their conversations with the older people participants recorded.

Sampling

Estimating the sample size in qualitative research is complex with typical grounded theory studies having sample sizes between 10 and 60 (Starks & Brown, 2007). However, some grounded theory study sizes are smaller for example, Kjerski, et al (2008) included a sample of three older people to investigate the experiences of participation in occupation during home-based rehabilitation.

The four older people at the heart of this longitudinal study (Table One) were identified using purposive and maximum variation sampling (Polit et al, 2001) to achieve theoretical sampling (Charmaz, 2014; Dey, 1999). The choice of the first participant, Joe (all names are pseudonyms), was purposive and based on the *a priori* understanding that Joe was keen to start rehabilitation and to go home (Table One).

Analysis of the data from the first participant revealed some emerging categories that included a strong desire to go home as early as possible. In order to achieve maximum

variation (Polit et al, 2001) and facilitate theoretical sampling, the second participant Josie was chosen because she was uncertain whether or not she would return home or move into a Nursing Home. It became clear to the staff over the rehabilitation period that Josie would not benefit from rehabilitation.

After the analysis of two participants who were keen to participate and could not participate in rehabilitation respectively, it was evident that a set of data missing was from someone who showed little concern about rehabilitation (Gordon). The fourth participant, Jack, was chosen because he seemed to show more independence of thought than the others. After this analysis, there was enough breadth and depth of data to progress to the next stage of the research - categorization (Dey, 1999).

[Insert Table One around here]

Data Collection

The four older person participants were interviewed for up to 45 minutes, on three occasions, at around two week intervals during their in-patient rehabilitation stay and then once at home. Participant Two, Josie was interviewed in a similar way to the other 3 participants except that her last interview took place many weeks after the other interviews, in a Nursing Home. This delay was caused by the lengthy preparation time for the move to the Nursing Home.

Within a few days of each older person interview a member of the rehabilitation staff, by chance always a physiotherapist, who worked closely with the older person, was interviewed about the older person. Around the same time a conversation that occurred within the normal working arrangements between the older person and a member of the health care staff, for example a care assistant, was recorded (Table One).

For each conversation a digital recorder was put in the room with the older person and health care worker. When the health care worker left the room the recording was stopped. The conversations lasted between 15 and 30 minutes and during this time there was no-one else in the room. A total of 15 staff provided data for the research either by being interviewed about a particular older person participant or being recorded in routine conversation with an older person participant. Overall this study generated 40 interviews and recorded conversations for analysis: four interviews with each of the four older people (16), 12 interviews with health care workers who worked clinically with the four older people and 12 routine conversations.

Data Analyses

Interview recordings were analysed by the first author (NR) after each interview was completed to facilitate theoretical sampling and constant comparison of the data as required of the grounded theory approach (Charmaz, 2014). In this initial analysis the interview and conversation recordings were listened to several times after each point of data collection, noting the themes and leads to pursue in future interviews. This collection-analysis process with each participant meant that as the data collection and analysis progressed, the researcher was armed with increasingly useful sets of questions focusing on the emerging themes of involvement for each participant.

Between each participant, the research interviews and conversations were transcribed from the recordings verbatim. This transcribed data were analyzed fully for each participant before the next participant was recruited. During these extended periods of analysis a more complete picture of how the participant related to the staff and the rehabilitation was developed. This analysis furthered an understanding of the components of involvement in rehabilitation in preparation for the choice of the next participant and the next set of data.

As part of the analysis each transcribed interview and conversation was labelled so that at a later date, the order of the interviews and conversations and who took part in them could be identified. Each line of the transcripts was numbered so that individual lines, which could potentially become open codes, could be referred to as part of the audit trail demonstrating the trustworthiness of the research (Streubert & Carpenter, 2011).

In vivo (Corbin & Strauss, 2008) open codes (Charmaz, 2014) were generated from the transcripts which had many open codes (between 82 and 112). An interview with Josie provides an example of an open code:

‘It’s as though I’m one of those, you know, getting sprayed with fig leaves and grapes fed to them’ (Participant (P) 2, Interview (I) 1, Lines (L) 609-612).

The open codes were then grouped into theoretical codes, connected in terms of an aspect of involvement that was derived from the data (Corbin & Strauss, 2008). The open code given above was grouped into the Learning with Adjustment theoretical code.

The last part of the analysis was grouping the theoretical codes into five categories grounded in the data. The Results section will detail these categories and provide illustrative data.

Results

Four of the five categories generated from theoretical coding were called Involvement Attributes and within these the participants demonstrated different strengths. The four categories are:

- **Vision and Incentive and Goals**, a perception of the future related to rehabilitation with an Incentive (a reason for wanting success) associated with Goals such as building up stamina, improving walking ability, getting into bed and wanting to go to

the shops,

- **Personal Learning**, concerned with the adjustment to changing physical abilities.
- A **Disposition** towards rehabilitation, concerned with levels and types of hope, motivation and enthusiasm.
- **Risk Taking**, concerned with the different risk taking strategies the participants adopted as they progressed through their rehabilitation.

These four Involvement Attributes operated within a fifth category, Therapeutic Relationships, which ranged from paternalistic to partnership encounters. Figure One displays the Involvement Attributes with their contributory theoretical codes and the following section provides illustrative data for each Involvement Attribute.

[Insert Figure 1 around here]

Vision and Incentive

There were two types of Vision and Incentive, those that were developed at the beginning of the rehabilitation stay and those that developed during rehabilitation. Jack's Vision and Incentive demonstrated the former:

‘Oh I think getting home and getting myself mobile so I don't become a burden’ (P4, I3, L602-603);

Josie's Vision and Incentive demonstrated the latter:

‘I intended going home first and seeing how things worked out. But the longer I've stayed here and see the way I am, I know it's a waste of time going home’ (P2, I1, L293-294).

Goals

In the current research setting, formal Goals were set by the physiotherapist in agreement with the older person as illustrated in an interview about Joe:

‘Who says what exercises are to be done? (NR)

The physiotherapy team (Physio 1, I1, L11)

How do you decide? (NR)

‘It depends on... its individual and it’s on the day really’ (Physio 1, I1, L13-14)

These Goals were concerned with the physical ability to complete tasks safely such as walking independently. For example, the physiotherapist’s aim for Joe was:

‘To get him home walking independently: Build him up to get him home’ (Physio1, I1 L5-6)

Although there were some written exercises given to the participants for their use in the absence of the physiotherapist, Goals were not recorded for reference by the older person participant or staff. The absence of an easily accessible written record made it difficult for other staff to provide focused support for Goals. Joe was willing to do what he was told by the physiotherapist but did not set Goals for himself.

‘When you go to him [Joe] he’s always ready to go to the gym... wants to do his physio that’s great’. (Physio 2, I2, L317-319)

Joe has been pretty passive actually. Joe has very much gone along with what we've said, he doesn't offer us that much’. (Physio 3, I3, L544-545)

Gordon had no Goals for himself and had to be persuaded to take part in physiotherapy by the physiotherapist.

‘And I was just really quite tough with him and said, “Yeah, you can do it. You can. Come on do it. And he did it, but he was very much just ready to give up’. (Physio 2, I2, L197-199)

Jack had Goals set by the physiotherapist but he also set his own Goals. Jack said,

‘The physiotherapy obviously helps that but it’s not initially the thing that matters it’s getting my strength up so I have increased my diet and tried to get another stone on me. I lost about two stones’. (P4, I4, L165-168)

Disposition

Hope

Four hope states, blind hope, unreasonable hope, little hope, and useful hope, were demonstrated by the participants. Joe's blind hope was based on the trust he had in the rehabilitation staff rather than his own personal accomplishments, exemplified by his comment:

'I make no decisions I just leave it to them. They say you're going to get washed; I lie here and they wash'. (P1, I1, L294-296)

Josie's unreasonable hope was centred on her hope that she would walk again:

'So just to be able to get into the Home, even being able to walk with my Zimmer just to the bathroom is going to be a great thing for me'. (P2, I2, L382-385)

Josie was quite able to make decisions. The physiotherapist said:

'She doesn't ask us to make decisions for her. She'll say, 'This is what I need to do' (Physio 4, I1, L89-9)

However, Josie was bed bound and was unable to respond to physiotherapy.

'She's hardly been out of bed since she came back to us; and that must be, probably, about a month ago. (Physio.4, I1, L47-50)

Gordon's lack of focus about his functional ability showed that his hopes for physical and functional improvement were not very challenging:

'Oh [I am] just happy the way I am'. (P3, I3, L336)

The fourth type of hope was more useful. Jack believed his improvement lay in his personal Goals, for example, increasing his strength, which he hoped to regain. Jack's solutions were personally-owned, for example:

'I need to get weight on; to get strength'. (P4, I3, L173)

Motivation and Enthusiasm

Each of the participants showed different levels of motivation and demonstrated enthusiasm accordingly. Three of the participants demonstrated clear motivation drives which they noted as they recognized their progress. For example, Joe was able to recognize the progress he made towards reaching his Goal in the second interview.

‘One time I had to ring during the night. If I slid down the bed regular I ring them to come to get me back up. Now I find I’ve got the energy to get myself back up. (P1, I2, L36-39)

Although Gordon recognized that improvements had been made, he did not relate these to any Goals. For example, Gordon stated that physiotherapy made him ‘feel good’. (I 1, Line 33)

Personal Learning

The participants’ personal learning is demonstrated through seeking solutions to barriers to their progress. Gordon thought he did not need to learn stating that it was other people’s responsibility to rehabilitate him. When asked who would help him, Gordon said:

‘Somebody in here I suppose’. (P3, I1, L181)

Conversely, Jack had learned about the relationship between exercise and strength. Jack’s Personal Learning was recognized by the physiotherapists:

‘Jack is very on the ball with how he wants things to go’. (Physio 2, I1, L52-53)

Risk Taking

Each of the four participants had different ways of managing risk. Joe took little risk, relying on the staff and said:

‘Me taking the lead, I dare say if I really pushed myself I could do more but I don’t want to sicken myself’. (P1, I2, L52-53)

Similarly, Gordon relied on the practitioners but unlike Joe was unconcerned with the level of his limitations and associated risk factors. Gordon said:

‘When the girls come and get us I try to get up, anything for a quiet life (P3, I2, L223-224)

Conversely Jack knew what risks there were:

‘Oh they don’t let me do anything alone. There’s always somebody with me’ (P 4, I2, L474-475).

Josie showed some sarcasm when the staff made little effort to ask her to help herself or take any risks. When asked how Josie felt when staff cared for her she said:

‘I just let them because I think, well, they say you go back to being like a baby – I might as well just go back to being a baby’. (P2, I2, L806-808)

A Substantive Theory of Involvement

When organized conceptually after the analysis, the participants’ Involvement Attributes fell into two groups: the Psychologically-based Involvement Attributes, which are cognitive and emotionally based (Vision and Incentive and Goal Planning, Disposition and Personal Learning) and the observable Action-Based Involvement Attributes (Risk Taking, Goal Setting and Goal Achievement) (Figure Two).

Overall, the findings showed that each of the four participants’ rehabilitation was uniquely characterized by the Psychologically-based and Action-based Involvement Attributes within fairly stable Therapeutic Relationships with the rehabilitation staff. This unique characterization was named the participants’ Involvement Attribute Set.

[Insert Fig 2 around here]

Involvement in rehabilitation is maximized when the Involvement Attributes are strong, balanced and there is alignment between the Psychologically-based and the Action-based

groups. Strong means that the Involvement Attributes operate well and balanced means that the Involvement Attributes, within either the Psychological or Action-based groups, operate at the same strength. Aligned means that the Action-based Involvement Attributes match the Psychologically-based Involvement Attributes.

This substantive theory explains the longitudinal data from the four older people participants in the current research who had a variety of weaknesses, imbalances and misalignments in their Involvement Attribute Set. Using this substantive theory as a process, involvement may be described as:

‘A joint commitment within Therapeutic Relationships for both older people in rehabilitation and practitioners to determine and be determined in the pursuit of an Involvement Attribute set that is strong, balanced and aligned’ (Rickard, 2012).

In this context ‘to determine’ means to be able to control aspects of the rehabilitation and to ‘be determined’ means be able to hear give consideration and act on the suggestions of others

Participant levels of involvement

Jack developed the strongest Involvement Attribute set with a strong Vision and Incentive, personal Goals and a very positive Disposition. Jack was able to learn about himself and his capabilities. It is possible that Jack did have some misalignment between his Goal Planning and level of Risk Taking concerned with an overestimation of his physical abilities associated with a high risk of falling. Jack said:

‘The risks of becoming too confident and over stretching, stretching further than you can really you know that you cannot make it but you still try’. (P4, I4, L633-636)

This slight misalignment between the Psychologically-based Involvement Attributes and the Action-based Involvement Attributes reduced Jack's level of involvement slightly because his thoughts were not matched to his abilities. Jack ~~did~~ had not learned to match his physical weakness with personal Goal Setting.

Gordon's involvement in his rehabilitation was weak overall. This weakness was identified by a poor Disposition towards his rehabilitation and matched the weakness of his Vision and Incentive and Personal Learning. Gordon had no personal Goals which served to weaken his involvement in his rehabilitation further. Gordon's weak Psychologically-based Involvement Attributes were mostly aligned with his weak Action-based Involvement Attributes.

Joe's Involvement in his rehabilitation was mixed. Joe had a strong Vision and Incentive but this strong Psychologically-based Goal of wanting to go home was out of balance with the absence of personally owned Goal Planning and misaligned with a weak personally-owned Risk Taking strategy.

Josie differed from the other participants in that during her stay in the rehabilitation unit she became bedfast and physically reliant on the staff. This meant that Josie's Involvement Attribute Set had two directions. Firstly, there was a strong involvement concerned with the move to the Nursing Home and secondly, there was weaker involvement in her physical capabilities which included an unreasonable hope to walk again.

With regard to the move to the Nursing Home Josie's Vision and Incentive was strong, she had her own Goals and learned about Nursing Homes from others, chiefly her family and the rehabilitation staff. Josie was self-motivated, hopeful, enthusiastic and able to make

decisions. These decisions included the risk in the choice of Nursing Home, room furnishings and the closure of her own home.

In the second part Josie planned some Goals (Psychologically-based) that required physical abilities that she did not possess. For example, Josie planned to walk to the toilet and ride on a motorized scooter to social events in the Nursing Home.

‘...being able to walk with my Zimmer just to the bathroom is going to be a great thing for me Then, as I say, if I can get a round on my Zimmer... I’ve got two little buggies – you know the ones... Little scooter types?’ (P2, I2, L402-406).

Josie’s physical ambitions were not discussed with the staff and since Josie was bedfast, were very unlikely to come to fruition. This difference between Josie’s Vision and Incentive Personal Learning, her Disposition and her physical abilities caused a serious misalignment between her Psychologically-Based and Action-Based Involvement Attributes. This misalignment weakened Josie’s involvement and does so because Josie’s thoughts about what she planned could not be acted on. When Josie began to align the Psychological and Action-based Involvement Attributes in the Nursing home she began to despair.

‘I pray every night that I don’t wake up the next morning’ (P2, I2, L455)

A fuller explanation of the participants’ Attribute Sets and levels of involvement are available (Rickard 2012).

Discussion

Forbat, et al (2009) concluded that one of the greatest barriers to truly integrating patient involvement into health services, policy and research, is the conceptual muddle with which involvement is articulated, understood and put into action. If improved involvement of patients in rehabilitation is to become more than an aspiration, the language of the approaches

and actions that staff and patients use must become consistent and part of the dominant discourse within health care (Staniszewska, 2009). This is difficult if the component parts of involvement and how these parts operate together, the process of involvement, is poorly understood.

Within the limits of a substantive theory (Glaser & Strauss, 1967) this current research has developed a system of ideas which explains the process of involvement in rehabilitation through the association of four interdependent Involvement Attributes within Therapeutic Relationships between older people and healthcare staff. This level of explanation defines a theory (Walker & Avant, 2014).

In her concept analysis, Sahlsten (2008) defined participation as

‘A relationship between the practitioner and the patient, a surrendering of power by the practitioner, sharing information and knowledge and an active engagement together in intellectual and/or physical activities’ (p.9).

Sahlsten’s (2008) definition is predicated on a relationship between a patient and a practitioner. This current research supports Sahlsten’s (2008) notion of the importance of Relationships in involvement within rehabilitation. Sahlsten (2008) also emphasizes a ‘surrendering of power’ by the practitioner, which is also supported in this current research. However, when the practitioner ‘surrenders power’, the patient has to accept responsibility and take the initiative to effect action. Both patient and practitioner need to be both determined by the context, for example be prepared to be helped by the physiotherapists and determining in the context, for example facilitated to develop their own ideas by the physiotherapists. When being determined and determining occurs with both patient and

practitioners in a therapeutic relationship this may lead to, in Sahlsten's (2008) terms 'an active engagement together in intellectual and/or physical activities'.

Many of the attributes of patient participation, discussed by Sahlsten (2008) are also described within eight partnership attributes (Hook, 2006). These partnership attributes are described as those leading to a relationship (professional competence, communication and patient participation) and those leading to empowerment (shared knowledge, shared power, patient autonomy and shared decision-making) (Hook, 2006). This current research is associated with Hook's (2006) work as involved patients empower themselves and determine their rehabilitation playing a part in defining the healthcare context and sharing responsibility within therapeutic relationships.

The Involvement Attributes

Although the interdependent Involvement Attributes described in this current research have not been linked together in previous research, their importance has been recognized.

Lequerica et al (2009) reported that almost all the occupational therapists in their sample, regularly documented information about patient involvement. However, the constructs of involvement were only personally defined making it difficult for the occupational therapists to use the concepts collegially. These efforts to capture involvement are therefore prone to value judgements (Siegert & Taylor, 2004). This is not surprising, as it is easier to describe more transparent, Action-based aspects of involvement in rehabilitation, such as Goal Planning, Goal Achievement and Risk Taking plans than the more esoteric, Psychologically-based aspects of involvement.

In this current research, the development of Goals and the interactions with the staff provided a lens into the individual Psychologically-based Involvement Attributes.

It is difficult to separate the individual contributions of the participants to the formation of their Goals in this current research. This difficulty occurs because each of the participants was in a Therapeutic relationship with the staff of the rehabilitation unit whose role was to create opportunities for functional improvement through goal planning and setting (Muller, Strobl, & Grill, 2011). Goal planning is an integral part of rehabilitation (Duff, 2004; Struhkamp, 2004; Turner-Stokes, 2015) and from this current research is transitional between the Vision and Incentive and Goal Achievement. It is the work in rehabilitation towards different Goals, together with the Involvement Attribute set (Vision and Incentive Personal Learning, Disposition and Risk Taking) of the participant that leads to progress in rehabilitation and may indeed be facilitated by family engagement (Turner-Stokes et al., 2015).

The practitioners in the research setting took charge of Goal planning and Setting which was described from their perspective. This is in common with much of the rehabilitation literature about the effectiveness of Goal planning and Setting (Arnetz, 2004). Using the constructions of this current research, staff-led approaches to Goal Planning and Goal Setting are likely to lead to weaker patient involvement than if the ideas come from the patients themselves in partnership with staff. This supports recent research that stresses the importance of active involvement in goal planning associated with improved goal attainment and better functional outcomes. (Turner-Stokes et al, 2015).

The utility of this theory in practice is based on the ability of the practitioner to work with the older person in rehabilitation to strengthen the Involvement Attributes such their Vision and

Incentive, balance the groups, for example the Vision and Incentive, Learning and Goal Planning and aligning the Psychological and Action-based Involvement Attributes. This type of rehabilitation work requires a collaborative partnership relationship demonstrated in the mutual pursuit of the Involvement Attribute Set with both patients and staff demonstrating responsibilities equally.

Limitations

This sample size of the current study may be seen as a limitation to the importance of the findings. However, the sample size of this study compares well with some other grounded theory studies, for example Nunney, et al. (2011) interviewed 15 older people and 17 health care professionals once each (32 in all). Similarly, McMullen et al (2012) interviewed 19 older people in their study about taking control after hip fracture. Even so, as with much qualitative research, the findings must be treated as preliminary and further research is needed to test out and use the findings.

Conclusion

The findings of this research and substantive grounded theory suggest that the process of involvement is managed through a set of Involvement Attributes within Therapeutic Relationships. This substantive theory of involvement is associated with earlier research and increases the clarity in the understanding of the process of involvement of older people in rehabilitation. Therefore this theory of involvement develops the healthcare literature within the patient and public involvement debate. Further research is now needed to demonstrate the transferability of this substantive theory in other settings and with other client groups.

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Ethics approval: *for the study and permission to use the clinical data for research and evaluation was obtained from the University that sponsored the research and the National Research Ethics Service (NRES) Number 08/H0908/78. Research governance approval was received from the Local National Health Service Research Department.*

Key Points

This original paper:

- Provides a detailed insight into the components and processes of involvement that can be used to assess, monitor and improve involvement for older people in their physical rehabilitation after acute illness.
- Demonstrates the use of grounded theory in clinical research.
- Provides the background to the importance of involvement of patients in UK healthcare.
- Suggests further research in the area of the involvement of older people in their health care

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Table One: The older person participants, associated practitioner interviews and those in conversation with the older person participant

Older Person Participant	Sampling Technique	Associated Practitioner Interview	Associated Conversation
Participant 1: Joe aged 81; retired miner; reason for rehabilitation - prolonged bedrest after renal failure	Purposive	<ol style="list-style-type: none"> 1. Physio 1 2. Physio 2 3. Physio 2 	<ol style="list-style-type: none"> 1. Care assistant 1 2. Care assistant 3. Care assistant 3

Participant 2: Josie aged 74; Reason for rehabilitation prolonged immobility due to heart failure and lymphoedema	Maximum Variation	<ol style="list-style-type: none"> 1. Physio 3 2. Physio 2 3. Physio 3 	<ol style="list-style-type: none"> 1. Staff Nurse 1 2. Staff nurse 2 3. Staff Nurse 3
Participant 3: Gordon aged 82; retired miner/taxi driver; reason for rehabilitation – immobility due to blackouts and being too frightened to walk independently	Maximum Variation	<ol style="list-style-type: none"> 1. Physio 4 2. Physio 4 3. Physio 4 	<ol style="list-style-type: none"> 1. Care assistant 4 2. Medical Practitioner 1 3. Care assistant 5
Participant 4: Jack aged 82; retired Managing Director; reason for rehabilitation – prolonged bedrest after brain surgery.	Maximum Variation	<ol style="list-style-type: none"> 1. Physio 2 2. Physio 2 3. Physio 4 	<ol style="list-style-type: none"> 1. Physio. 4 2. Physio. 5 3. Staff Nurse 4

Figure One: Grounded theory categories of Involvement.

The outer ring shows the theoretical codes related to the juxtaposed conceptual categories which form the Involvement Attribute Set of the Older people participants. The centre block, shows the fifth conceptual category and related theoretical codes.

Learning with adjustment; Development of solutions to progression barriers; Recognition of personal, functional limitations in relation to the work to be done to achieve progress; and Learning after going home.

Recognition of personal limitations in relation to risk factors; Risk reduction; Management of Uncertainty; Decision making; and Personal responsibility and control.



Hope, Motivation and Enthusiasm.

Development of a Vision Incentive and personal Goals in rehabilitation and beyond the rehabilitation pathway.

Figure Two: The Involvement Attributes and their interrelationships

