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The meaning of rehabilitation: a qualitative study exploring perspectives of occupational therapists and physiotherapists working with older people in acute care

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Title: The meaning of rehabilitation: a qualitative study exploring perspectives of occupational therapists and physiotherapists working with older people in acute care

Implications for Rehabilitation

- A reductionist version of rehabilitation was evident within this context which placed value on physical improvement, achieving optimum safety and led by physiotherapy.
- This version of rehabilitation was unsatisfactory to occupational therapists and physiotherapists in this setting and different to their ideals.
- Where rehabilitation may be associated with another place, practitioners should reflect on whether this is influencing patients becoming a lower priority for interventions whilst waiting and address this, if required, within their own reasoning, prioritisation and delegation.
- Those who recognise similarities with their own practice context could individually, and within teams, revisit definitions of rehabilitation to notice, document and have conversations about the ideals of their professions versus the reality of practice.
- Occupational therapists and physiotherapists can be champions for organisational and cultural change to promote rehabilitation as a multi-disciplinary phase of care working towards optimising improvements in wellbeing, function and safety, irrespective of location.

Title: The meaning of rehabilitation: a qualitative study exploring perspectives of occupational therapists and physiotherapists working with older people in acute care

Running Head: Meaning of rehabilitation in acute care

Article Category: Research Paper

Abstract

Objective: To explore how occupational therapists and physiotherapists constructed and interpreted the meaning of rehabilitation in relation to older people in acute care.

Design: A focussed ethnographic study was undertaken, primarily using observation, interviewing and review of clinical records within one acute medical ward in a general hospital in the UK. Five patient participants gave consent for their episode of care to be studied, with observations and interviews primarily involving the identified patients and five occupational therapy and physiotherapy professionals.

Results: Four themes were identified: rehabilitation as a process to facilitate physical improvement; rehabilitation as physiotherapy-led; rehabilitation as a place...but not here; and rehabilitation as a process which prioritises safety over function. Such conceptualisations of rehabilitation were recognised as rooted in social and historical perceptions and challenged the ideals of rehabilitation professionals.

Conclusions: The meaning of rehabilitation in acute care is shaped by a range of cultural, contextual and systemic influences. Recognising these influences, and subsequent challenges to rehabilitation ideals, can encourage professionals to work towards meaningful change.

Word Count: 6521

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Title: The meaning of rehabilitation: a qualitative study exploring perspectives of occupational therapists and physiotherapists working with older people in acute care

Keywords – ‘Rehabilitation’, ‘Older People’, ‘Qualitative Research’, ‘Ethnography’

Introduction

Older people can often have extreme responses to even the most straightforward reasons for hospital admissions, are at risk of functional decline during and after acute episodes, and often require a longer recovery phase of care, all of which emphasises the importance of understanding rehabilitation for this group [1]. A rehabilitative phase of care in hospital plays a pivotal role in helping older people to recover after an acute admission [2] and understanding what this phase means to those who deliver rehabilitation is important.

The World Health Organisation (WHO) provides a global definition of rehabilitation as ‘a set of interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment’ [3]. Other definitions focus more on the process of rehabilitation, suggesting that rehabilitation involves an ‘educational, problem-solving process that focuses on activity limitations and aims to optimise patient social participation and well-being, and so reduce stress on carer/family’ [4]. Examples within literature refer to a ‘black box’ of rehabilitative activities, suggestive of multi-faceted interventions but perhaps reflective of difficulty characterising what it actually is [5,6]. To add further complexity, the word rehabilitation is commonly paired with other terms – such as ‘pulmonary’, ‘neurological’, ‘vocational’, and ‘offender’ to name a few – and it is here where specialisms emerge and meanings diversify.

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3 Rehabilitation as a specialism for both clinical practice and research is well-developed.

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5 Whilst there is a vast amount of research pertaining to rehabilitation for older people,
6
7 examples are often concerned with establishing efficacy of particular models of care [7,8] and
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9 often focus on specialist rehabilitation pathways such as orthopaedics [9]. Yet rehabilitation
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11 for older people is not easily categorised by similar clinical conditions or uniform pathways.
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13 For example, one in three patients admitted to hospital live with five or more health
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15 conditions [10] and cognitive impairment has been estimated to be present in 40% of all
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17 patients over 65 admitted to general hospitals [11]. Such statistics illustrate that older people
18
19 are likely to present with diverse and heterogeneous physical, cognitive, psychological and
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21 social rehabilitation needs.
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27 The complexity noted within definitions is also a feature of models of rehabilitation for older
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29 people. Rehabilitation services for older people can include (but is not limited to): inpatient
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31 hospital beds (in acute and sub-acute hospitals); specialist bed-based units within residential
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33 and nursing homes; community rehabilitation in the person's home; and examples of tele-
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35 rehabilitation which could involve interventions provided through information and
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37 communication technologies [7,8,9,12]. Also, the provision of rehabilitation is not just
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39 limited to services identifying themselves as providers of rehabilitation, and is more
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41 realistically being delivered for older people across general wards and teams and by many
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43 and varied providers of health and social care services. Internationally, such models also have
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45 diverse funding and commissioning arrangements and can be delivered by public and private
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47 providers.
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52 Despite rehabilitation for older people receiving ongoing emphasis in UK and international
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54 policy [13,3], over the past 30 years the number of general and acute hospital beds in the UK,
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56 and in other advanced health systems around the world, has fallen, with the majority of this
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58 reduction due to closures of longer-term beds for older people [14]. Bed reductions have
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meant major reorganisations in pathways within acute hospitals and there have also been major reforms to how acute hospital services are commissioned, funded and how they measure quality and efficiency [15,16]. Yet simultaneously, there is an ageing population contributing to increasing unplanned hospital admissions, and well reported financial challenges across the sector [14,17]. Bed-based rehabilitation services for older people which are experiencing high demand, yet require time intensive interventions, are inevitably under pressure. Research suggests that systemic issues such as reorganisations and financial pressures are influencing the culture and meaning of rehabilitation, with the process becoming focussed on discharge planning and outcomes which prioritise safety [18].

Growing critical voices have raised challenges about the alignment of rehabilitation ideals – including principles of empowerment, choice, and collaboration - with the realities of acute care [19,20] suggesting tensions between features of rehabilitation outlined in professional and academic definitions, and how it is understood and enacted in practice. Exploring what rehabilitation means within the acute context therefore adds much needed insight on this important contemporary theme. In addition, studying meaning from the perspective of occupational therapists and physiotherapists – traditionally associated as core professionals who provide rehabilitation in acute contexts and who associate their own professional identity with this [21,22] is a relatively underdeveloped, yet important way of developing understanding. Although the meaning of rehabilitation is debated in commentary and opinion pieces [23] and within international examples [18], there is a paucity of empirical research to explore the meaning of rehabilitation within the context of services for older people in the UK acute care context. Therefore, the aim of this study was to explore the meaning of rehabilitation to occupational therapists and physiotherapists within one acute medical ward in the UK. The study was approved by the Faculty of Health and Life Sciences Research

Ethics Committee at Northumbria University (HLS-PHW141515) and the NHS Research Ethics Committee (15/NE/0322).

Methods

From a social constructionist perspective, meanings are considered to be developed within social contexts and individuals and groups construct meanings and ways of understanding through their social interactions and shared language [24]. Ethnography provides an overriding methodology which supports researchers to participate in the daily pattern of a setting, collecting a broad spectrum of available data to illuminate taken for granted and everyday behaviours, language, rituals and practices, and committing to telling it like it is from the inside [25,26]. More specifically, focussed ethnography is appropriate for **concentrating** on specific groups and distinct issues within identified cultures [27]. Utilising principles of focussed ethnography, this study carried out periods of ethnographic fieldwork within one particular ward environment, focussed on the practice of occupational therapists and physiotherapists and on specific patient cases.

Focussed ethnography is also supported when there is an existing level of familiarity by the researcher of the phenomenon under investigation [28]. The researcher (**GB**) was familiar with rehabilitation for older people within acute care from past clinical experience as an occupational therapist although had not worked clinically within the hospital at the centre of this study and did not have prior working relationships with members of the clinical team. An additional feature of this branch of ethnography is the use of relatively short periods of fieldwork whilst still adopting traditional ethnographic approaches [29].

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Study Context

The cultural context at the centre of this study was one 28-bedded ward in an NHS district general hospital in the UK. With the input of nursing and therapy managers and clinicians, the ward was chosen as it had a remit to provide care and treatment for adults, predominantly older people, admitted for medical reasons but who did not meet criteria for other established hospital pathways (such as stroke or fractured neck of femur). Alongside medical treatment and management, managers and clinicians also indicated that this ward had a remit to provide rehabilitation, particularly for patients whose functional status was different from their pre-admission baseline but who could be discharged home directly from this ward.

Common reasons for hospital admission for patients on the ward included management and treatment following falls, for infections or for delirium, with conditions often co-existing with each other, or with other long term conditions such as heart failure, Parkinson’s Disease or dementia. Although the ward accepted people over the age of 18, due to the demographics of those requiring inpatient hospital services, the majority of individuals were over 65, with a high proportion of patients over 85. Whilst both national and international comparisons are inherently difficult, the demographics of those using acute medical beds in the UK would suggest this ward was in line with national norms [30], with trends thought to be reflective of other high income countries [14].

The team on the ward consisted of qualified and assistant nursing staff, junior medical staff supported by two consultant geriatricians, physiotherapists, occupational therapists, and social workers. The ward was also supported by a range of more peripatetic and hospital-wide services such as pharmacy, psychiatry and speech and language therapy.

The ward was interchangeably referred to by staff who worked there as an ‘acute medical’ ward and a ‘care of the elderly’ ward. Staff did not refer to the ward as a rehabilitation ward

although did identify that the ward provided early rehabilitation and particularly gave the example of providing rehabilitation for those who could be discharged home directly from this ward. Those who required slower stream rehabilitation were often transferred from this ward to an 'elderly rehabilitation' ward on the same hospital site, or to other bed-based rehabilitation facilities within the community.

Study design and participants

Use of multiple data collection methods, and at different points in time, is seen as a strength of ethnographic research to enable a multi-dimensional view of a social context through multiple lenses [31] and periods of fieldwork were subdivided into three main phases over 14 months. Phase one started in April 2016 and involved a two-week period of orientation to the physical, temporal, social and cultural environment with an aim of understanding roles, pathways and systems of work. Interactions with patients during phase one also involved activities to gain feedback to inform elements of the phase two research design, such as gaining feedback on participant information sheets.

Between May-July 2016, phase two took place over an eight week period and involved tracking five patients who were inpatient on the identified ward and primarily focussed on occupational therapy and physiotherapy interactions and interventions with this group of patients. During phases one and two, data were collected by various methods, but primarily through observation, supported by detailed fieldnotes, which is recognised as a central feature of ethnographic research [32]. Observations mainly took place within the identified ward, although also subsequently took place within other locations or wards if patients moved during an admission. Finally, after a break between phases of fieldwork to enable preliminary data analysis, phase three involved indepth interviews with occupational therapists and

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physiotherapists, over the course of one month in April and May, 2017. All observations and interviews were undertaken by the same researcher (GB).

During phase one, written consent was gained from all substantive members of the ward team and public notices were displayed to inform patients, families, and transient members of the team (such as pharmacists, or on-call doctors) that observations were taking place. During phase two, these processes remained in place, although in addition, the researcher utilised principles of purposive sampling to identify five patient participants, gaining written consent to observe them directly during activities and interactions with health professionals and access their clinical records. Processes were developed in order to involve people who lacked capacity to consent and this was used in the case of one patient participant. This involved providing information to the patient and nominated relative, asking the patient for their views, and asking their relative to act as a consultee to advise whether the person should take part in the research. Eligibility screening was undertaken by the researcher through attendance at the daily ward handover meeting and utilised the inclusion criteria outlined in table 1 [table 1 near here].

During phase three, principles of purposive sampling were used to approach six occupational therapists (n=3) and physiotherapists (n=3) who had participated in phase two observations to participate in individual interviews. Five (three occupational therapists and two physiotherapists) responded and provided consent to be interviewed. One physiotherapist, who had moved roles as part of a rotation, did not respond to the request to participate in this phase of data collection. Of the five interviewees, all were employed at NHS band six or seven, and had a minimum of two years of post-qualification experience, with three of the five participants having 10 or more years experience. All had either primary responsibility for therapy services to the identified ward during the earlier stages of data collection, or had

provided therapy (in some cases due to cover arrangements) for one or more of the patients tracked during phase two.

Individual interview questions asked participants to describe the meaning of rehabilitation in their own words, and to describe and share examples of their role in rehabilitation and rehabilitation decision-making. The researcher also shared examples from the earlier stages of fieldwork alongside examples of emergent themes and asked participants to share their own reflections on these examples. In this way, the individual interviews were used in part as a member-checking strategy to strengthen the credibility of findings, although care was taken to encourage reflection on congruence or to open issues for question, rather than simply looking for agreement. Interviews during phase three took place in private rooms within the same hospital but away from the immediate clinical environment, lasted between 40 and 75 minutes, and were audio-recorded and transcribed verbatim.

Throughout all stages of the study, researcher reflexivity was essential to recognise the orientations of the researcher and the potential for this to influence data collection and analysis. Motivation to explore the construct of rehabilitation, and to particularly focus on this construct from the perspective of occupational therapists and physiotherapists grew from the researcher's own clinical experience. Despite not having existing relationships with the ward or participants, the researcher was cognisant during fieldwork to minimise proximity with particular groups (for example making conscious decisions about where to spend breaks away from the ward). Introductions to patients were also carefully considered and made independent of the healthcare team, once again to minimise allegiances with particular groups and to reduce the potential for power imbalance between researcher and researched.

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Data analysis

Researcher fieldnotes were combined with interview transcripts and analysed using thematic analysis to report and interpret patterns [33]. The first stage proposed by Braun and Clarke [33] is familiarisation with the data and extensive time was spent cataloguing the data both chronologically and in relation to different patient episodes, alongside translating short-hand fieldnotes in to long-hand accounts and adding analytic notes and reflections. Following this stage, initial codes were developed, the data was reviewed in line with these codes and initial themes were identified. Although the analysis was predominantly undertaken by one researcher, data were shared (both electronically and through face to face research meetings) with other analysts who represented different disciplines and methodological positions to increase credibility of analysis. The involvement of multiple analysts assisted to challenge any assumptions of the primary researcher, to encourage alternative ways of looking at the preliminary analysis and to validate emerging explanations and themes. After these stages, final themes were named and identified.

Verbatim extracts are presented in the results below, although they are deliberately not attributed to particular participants or disciplines to protect anonymity in the context of a small and localised site. Where there is certainty about exact words (from audio recordings of interview transcripts), indented direct quotes are utilised and the quote is attributed to an interview participant. Other quotes are provided in single quotation marks within the narrative although have been taken from fieldnotes which relied on researcher recall.

Findings

In relation to the over-arching aim of exploring the meaning of rehabilitation, four prominent themes emerged: rehabilitation as 1) a process to facilitate physical improvement 2)

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3 physiotherapy-led 3) a place...but not here and 4) a process which prioritises safety over
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5 function. The four themes are summarised in figure 1 [figure 1 near here].
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10 11 ***Rehabilitation as a process to facilitate physical improvement*** 12

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14 Initially, extracts from interviews suggested that health professional participants viewed
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16 rehabilitation as a process to bring about general improvements and expressed statements
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18 reflecting broad rehabilitation ideals:
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22 [Rehabilitation is] “*Working towards getting them back to that level of function that*
23
24 *they were previously at...we may not be able to get them back to that baseline so that*
25
26 *functional level would drop down. So therefore, you’re rehabilitating back to their*
27
28 *maximum potential*” (Health Professional (HP) 3).
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34 However, observational and interview data suggested the reality of rehabilitation was often
35
36 narrower in focus, and that participants conceptualised rehabilitation as something that
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38 facilitated physical improvements. During one multi-disciplinary team meeting, an
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40 occupational therapist asked whether a patient ‘needs rehab for mobility?’ and this direct link
41
42 between the provision of rehabilitation and a mobility need was just one example of a
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44 common narrative experienced by the researcher. For patients in a rehabilitative phase of
45
46 care, this focus on physical improvement was also reflected in examples from clinical records
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48 (‘aiming to progress to mobility with a stick’) and in responses from patients about what they
49
50 wanted to achieve through rehabilitation (‘to get stronger’).
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55 During interviews, participants demonstrated awareness of this difference between ideal and
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57 reality and attributed this to time and system constraints:
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3 *“All the other areas of rehab have dwindled away...there isn’t the time to look in to*
4 *other areas of ADLs that would need a bit more time...and then, mobility is really the*
5 *last thing that we’re left with perhaps”* (HP5)
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10 One participant emphasised that the focus on physical improvements was not just attributed
11 to one profession but was the focus of the team as a whole:
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16 *“within the team, and that’s the whole team, it always does seem to go down to right,*
17 *transfers, mobility, that seems to be where everyone hones in on”* (HP1)
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21 Observations also suggested that whilst mobility and physical improvement was given
22 significant emphasis, wider psychosocial rehabilitation needs were not attended to in the
23 same way. On one occasion, a member of a liaison psychiatry team visited the ward to review
24 a particular patient in relation to her mood. The entry in the clinical record recommended
25 one-to-one activities and engagement with staff, although it was subsequently discussed by a
26 member of the ward team that this ‘would be nice to do, but not realistic’. For another patient,
27 a member of the same liaison psychiatry team recommended a move out of a side room in to
28 a multi-bedded bay to promote opportunities for social contact and communication although
29 this was not observed to be discussed at handover meetings and did not happen during the
30 episode of care.
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45 **Participants** linked the value placed on physical strength and improvement as being
46 influenced by how rehabilitation is predominantly understood in wider society. That is to say,
47 they linked common understandings of rehabilitation to high-profile specialisms
48 rehabilitating military personnel, or rehabilitating athletes:
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54 [people think of rehabilitation as a] *“getting soldiers to walk again kind of place”*
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56 (HP4)
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60 *“It usually starts with the guy running on the football pitch with the sponge”*(HP3)

Rehabilitation as physiotherapy-led

Whilst fieldwork deliberately focussed on the practice of occupational therapists and physiotherapists, the researcher did observe this practice within a multi-disciplinary team environment including medical, nursing, therapy and social work professionals. However, despite this multi-professional context, a uni-disciplinary paradigm of rehabilitation emerged. On almost a daily basis, the term ‘ongoing physio’ was either verbally discussed or documented in clinical records. During medical ward rounds, discussions such as ‘we’ll get the physios to get you moving’ were observed on a number of occasions. This was not observed to any similar extent in relation to occupational therapy, or indeed other disciplines such as nurses or therapy assistants.

Regarding timing and frequency of rehabilitative interventions, most patients received physiotherapy from the outset of their admission whereas occupational therapy interventions commenced later or not at all and were notably less frequent. Physiotherapists aimed to assess every patient and involvement often included treatment or stabilisation of acute medical issues (such as respiratory assessment or for positional recommendations if unwell) and subsequently continued to a more rehabilitative phase of care. In contrast, occupational therapy adopted a referral system (most often initiated by nursing staff) and tended to become involved when discharge planning was being considered. Although in reality, timings of such phases may not have differed greatly, the researcher experienced an important difference in emphasis **between the two disciplines**.

Participants were aware that the team emphasised the role of physiotherapy in rehabilitation:

“I think if you looked at the wider team and you said ‘what’s rehab?’ to somebody other than the physio’s, the OTs etc., those therapists involved in rehab...I think they

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3 *would give a very simplistic idea of what rehab is...oh yeah you'll walk with the*
4 *physio*" (HP3)
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8 And participants also shared insights that patients and families shared similar views:
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11 [Patients and families think] *"the word rehab...they're going to a rehab ward and*
12 *there's physio's there"* (HP4)
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16 An extract from an interview with an occupational therapy participant highlighted challenges
17 when they did try to **contest** this narrow version of physiotherapy-led rehabilitation:
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21 *"I've recently had someone that...was physio safe and I was kind of pushing for them to*
22 *have further time on the ward because they couldn't manage bed transfers and initially*
23 *it was kind of like, well, can we not just get a carer"* (HP4)
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29 An additional insight was that if a team had a remit to provide rehabilitation but did not have
30 physiotherapy, **the team or service may not be utilised** as a rehabilitation provider:
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34 *"The problem that we've got with [the community team] at the moment is that it*
35 *doesn't have any kind of physio that's...em...connected to the team. So at the moment*
36 *we're not using them that much from the hospital."* (HP1)
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45 ***Rehabilitation as a place...but not here***

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48 During fieldwork, many different observations and discussions alluded to rehabilitation as a
49 particular place, including when someone was 'waiting for rehab', or 'listed [or coming off
50 the list] for rehab'. Most often, these discussions related to a patient waiting for a bed on the
51 elderly rehabilitation ward, or within a bed-based step-down unit on another site. The
52 expressions of 'waiting for' or 'listed for' rehabilitation suggested that it was the next place
53 of care, and hence the move away from the identified ward, which would result in the
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provision of rehabilitation. During observations, one physiotherapist highlighted that ‘[a patient] could potentially make ‘good progress with intensive rehab but don’t feel we have that here’.

The medical team on the ward alluded to transferring people to an inpatient rehabilitation bed when they were medically stable with one of the ward doctors suggesting that when he was ‘only doing smaller things...[it] means they can manage her on [the rehabilitation ward]’.

The implication here was that rehabilitation was a separate phase of care which followed acute medical treatment and was characterised by a movement in place.

Developing this, the change of location was linked to freeing up a specialist bed, with rehabilitation being perceived as being provided in a more generalist location. This is illustrated in the extract below although interestingly, this professional acknowledged that the frequency and intensity of rehabilitative interventions may actually be no different:

“...we talk about patients needing further rehab and they are referred to a care of the elderly ward... because our ward is specifically medical, they need the beds for those patients and then patients would go to a care of the elderly ward which we also refer to as rehab wards. And...it’s no different...there isn’t any increased support there”
(HP5).

An observation of the researcher, supported implicitly by participants, was that this link between rehabilitation and a move to a place could be open to manoeuvring in order to free up a specialist bed, but also to move responsibility for the resolution of complex issues.

During fieldwork observations, a therapist shared a perception that people could be transferred to a bed on a rehabilitation ward when other services ‘don’t know what to do with [them]’.

Another implication of rehabilitation being associated with movement within the system, was that patient and family expectations of the next place of care were often not realistic or not met:

“Because if you say to a patient that you’re going to rehab, the family, they really cling on to that and they’re expecting some intense rehabilitation” (HP5).

An observed implication for one patient was that, when listed for a bed on the rehabilitation ward, he became a lower priority for rehabilitative interventions whilst waiting. The ward physiotherapist discussed ‘handing him over to the assistant’, reflecting that he was now a lower priority because he would not be discharged imminently. This was echoed by the ward occupational therapist who became involved with a patient at a point when the team were discussing discharge home, although subsequently ‘prioritised him out’ when he was listed for the rehabilitation ward.

Rehabilitation as a process which prioritises safety over function

The way participants expressed their own understanding of rehabilitation - as a process to facilitate improvement – has been illustrated in earlier sections and echoed in the participant quote below:

“Rehabilitation is somebody getting back something that they’ve lost. So if they’ve had an ability before then my aim, if I was rehabbing them, would be to try and get them back to that point to where they were before” (HP2)

Yet despite this, a strong organisational narrative emerged during the course of fieldwork that the threshold aim of the institution was becoming safe for discharge rather than optimum

improvement in function. Interview extracts suggested that **participants** were being challenged to reframe their own rehabilitation objectives to align with this:

“We’re not allowed to say we’re getting people back to baseline” (HP2).

“So it used to be, like we said earlier, baseline or better. Then it became baseline only. And now it’s become safe only” (HP3).

Participants, who associated their own professional role and identity with optimising function, expressed challenge and frustration with this organisational narrative. An additional challenge was that to facilitate discharge at an earlier stage and at a lower functional level, they needed confidence in community services to address ongoing rehabilitation needs, and this was something that was reported with concern and a sense of futility:

“The problem that I have with that is that I sort of feel that we’re failing patients because....patients aren’t getting rehabbed back to baseline...in terms of mobility and things. That then has a huge impact on their other functional activities of daily living. And if there’s nobody picking up that baton in the community, and pushing forward to try and get them back to where they were before, then they’re stuck on that point and we’ve missed that window of opportunity and, 2 months time they get readmitted again and are we doing the same thing again” (HP2).

Discussion

Findings illuminate a difference in the rehabilitation ideals of occupational therapists and physiotherapists in this context, and the way in which rehabilitation was being enacted in the reality of practice. Ideals of rehabilitation as a process to promote holistic improvements and

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3 reduce disability were evident although over-ridden by a more narrow focus on physical
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5 improvements. And further still, patient improvement as the desired aim of rehabilitation was
6
7 being reprioritised by the organisation if safety could be achieved first. All of this
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9 compromised the emphasis on wider cognitive, emotional and social needs and contributed to
10
11 a version of rehabilitation at odds with definitions, such as the WHO definition [3], outlined
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13 in the introductory section.
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17 Potentially linked to a one-dimensional process focussed on mobility, physiotherapy was also
18
19 noted as the dominant provider of rehabilitation which could be influenced by, or be
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21 influencing, this central focus on mobility. The differences in working practices of
22
23 physiotherapists and occupational therapists are interesting to note here, such as
24
25 physiotherapists proactively managing blanket referrals in comparison to occupational
26
27 therapists predominantly responding to referrals from others; and the fact that for all five
28
29 patients tracked, physiotherapy interventions were earlier and more frequent. Such working
30
31 practices could be contributing to a culture which centralises physical improvement and the
32
33 role of physiotherapy. Furthermore, research suggests there are instances where occupational
34
35 therapists adapt their language and practice in line with a biomedical focus because they
36
37 perceive that others do not understand their wider scope [34] and this offers a further
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39 explanation for why a dominant focus on mobility may emerge.
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46 Reflection on the working practices above provide noteworthy considerations for
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48 occupational therapists who, in this local context and supported by literature in similar
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50 settings, are struggling to work towards holistic rehabilitation in acute care [35,36]. And
51
52 whilst the centrality of physiotherapy may contribute to value and esteem for this group, it
53
54 may also contribute to pressures and high workload, alongside a lack of autonomy to focus on
55
56 wider areas of need [37].
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3 Limitations in standards for practice in the UK for therapy provision in acute medicine and
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5 older people's services, and insufficient detail (for example about referral pathways or timing
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7 of involvement across an episode of care) within descriptions in published research make it
8
9 difficult to explore more fully whether such working practices are reflective and
10
11 representative of national and international norms. Whilst challenging, **non-standardised**
12
13 **service delivery** is another reality of working with this heterogeneous patient population and
14
15 emphasises the requirement for flexible service design based on local needs.
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20 The focus on physical improvement (and linked to a centralised focus on physiotherapy
21
22 services illustrated in this context) is echoed by theorists encouraging critical examination of
23
24 rehabilitation philosophy. Hammell reflects that the aim to enhance physical function has
25
26 become a preoccupation for rehabilitation professionals although suggests this is inadequate
27
28 for people with deteriorating or chronic conditions where remediation of physical function
29
30 may be an insufficient or unrealistic goal [20].
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34 All of this is particularly important for those involved in rehabilitation for older people: a
35
36 group likely to live with multiple morbidity and at high risk of physical and functional
37
38 decline [38,39]. Whilst recognising that working towards goals of physical improvement is an
39
40 integral element of a rehabilitative process, and indeed likely to be the primary focus of
41
42 rehabilitation goals reported by older people within inpatient contexts [40], there are
43
44 inevitable risks if this becomes an overriding focus. Risks to patients include extended
45
46 periods in bed-based care working towards well-intentioned, yet improbable goals and failing
47
48 to attend to wider holistic needs likely to be present for older people in hospitals [22,41].
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51 Risks to professionals of being unable to address wider social, psychological and
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53 occupational needs include stress, dissatisfaction and potentially conflicted identity [35,36].
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The way in which professionals alluded to rehabilitation as a separate place, and reflected when naming wards in this context as ‘acute medical wards’ or ‘rehabilitation wards’, is perhaps linked to efforts to differentiate rehabilitation as a separate specialism; an issue highlighted in recent commentary [23]. Risks associated with this – such as patients receiving rehabilitation or medical care and disagreements about responsibility – have been noted [23] and were enacted in almost this exact way in this study. Co-locating acute and rehabilitation phases of care is presented as a strategy to assist with this and there is evidence to suggest such services may be equally as effective in improving functional outcomes as traditionally separate services, whilst reducing risks which are inherent with internal transfers [42].

The idea of separate places based on common clinical conditions can also be seen as aligned to a biomedical model of health. Wards and pathways orientated to specific diagnoses or anatomical systems (such as stroke, coronary care, respiratory and orthopaedics) are familiar features of both UK and international health services. And in many cases, where teams and services orientate environments and expertise to common presenting needs, and the more experienced they become in managing these needs, evidence supports better outcomes for patients [44,45]. However, it is also here where a critical paradox emerges for those with non-uniform needs not easily categorised by one primary condition. Despite being the largest users of acute hospitals, the system is arguably orientated away from the needs of older people and struggles to provide a rehabilitative phase of care irrespective of their location.

A key feature of ethnography is the focus on linking everyday occurrences and wider cultural, social and political influences [43]. The over-riding premise that is evident in many of the aspects presented above is the dominance of a bio-medical model of health which permeated the culture of this acute health care system. Despite delivering rehabilitation to older people in an inpatient acute medical setting, when discussing understandings of rehabilitation in their own words, professionals made explicit reference to constructs relating

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3 to military veterans and athletes. This provides insight that the focus on strengthening the
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5 body filters in to professional thinking from wider societal and cultural understandings of
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7 rehabilitation. Perhaps influenced by this, the centrality of physiotherapy, perceived as the
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9 rehabilitation professional who provides treatment to strengthen the body, becomes an
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11 unsurprising finding.
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15 Set against a backdrop of political and financial health-service reform which places value on
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17 attaining efficiencies, managing risks and awarding funding on the basis of key performance
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19 indicators, the theme of rehabilitation prioritising safety over optimum function is also an
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21 understandable reality. Reporting of data such as length of stay, in-hospital falls, and
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23 discharge delays attributable to adult social care are just some of the routine data reported by
24
25 NHS hospital trusts in the UK [16]. Whilst contributing to cultures which place value on
26
27 safety, quality and efficiency, such reporting also emphasises responsibility for harms and
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29 delays and could be said to be influencing an increasingly risk averse culture within
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31 rehabilitation, and a culture which values flow within, and out of, the system. The fact that
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33 internationally, rehabilitation professionals in acute care are increasingly associated with, and
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35 valued in terms of, shortening length of stay and reducing costs [46, 47], provides further
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37 insight in to the pressures facing providers of rehabilitation in this context.
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44 Yet Hammell challenges rehabilitation professionals to return to the goals of their patients
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46 and to question whether safety and independence are the desired goals of those living with
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48 impairments [20]. Despite the passing of over a decade since such critical statements, these
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50 challenges still ring true and are perhaps only increasing in significance in light of pressures
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52 related to rising demand, reduced capacity and the drive for efficiencies. Notably, where
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54 professionals have described working within cultures where needs of organisations are
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56 prioritised above needs of clients, dissatisfaction, burnout and attrition are identified as likely
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58 consequences [34].
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Recommendations for practice:

In this context, professionals recognised the version of rehabilitation was unsatisfactory and different to their ideals. Durocher et al [35] suggest that a first step is to notice, document, and have conversations about such dimensions of practice and this could be an important recommendation for individuals or teams who may recognise similarities between their own practice and the themes reported from this study. Revisiting definitions of rehabilitation to reflect on the ideals of their professions versus the reality of practice presents as an important starting point. Definitions emphasise collaborative problem-solving processes and multi-faceted interventions to optimise function and wellbeing and the challenge for practitioners is to find creative ways to align this holistic approach with resource and system constraints.

Risks associated with conceptualising rehabilitation as a different place included patients becoming lower priority whilst waiting, shifting of responsibility or delays in decision-making. Once again, noticing and reflecting on this is an important step and practitioners can influence change through reflective reasoning when prioritising and delegating cases.

However, the risks associated with this would be reduced by working towards rehabilitation as a phase of care which happens in any place.

The challenge for rehabilitation professionals to meet holistic needs within the context of acute care is not easy to reconcile [35,48]. A concern is that the reductionist version of rehabilitation which prioritises safety over optimum function, and physical improvement to achieve safety, becomes an inevitable part of acute health services for older people. However, reflections that this is unsatisfactory for professionals, and represents an allegiance with employers rather than patients [49] should encourage all rehabilitation professionals to take note. Support to work towards a version of rehabilitation in acute care aligned to core values

and philosophy - from managers, researchers and professional bodies -would also be a welcome development.

Strengths and Limitations

The immersive ethnographic methodology, placing importance on the social construction and meaning of rehabilitation has enabled examination of this concept within the real-time and everyday context in which it is formed, and is proposed as a strength of this study. An additional strength includes the intentional focus given to occupational therapists and physiotherapists, whose practice and identity is interwoven with rehabilitation ideology and yet where a specific focus and emphasis within research enquiry relating to the everyday meaning of rehabilitation is relatively under-developed. Finally, the importance placed on examining these issues in relation to the non-uniform pathways and heterogeneous population of older people is seen as another important strength. As older people are the biggest users of acute hospital systems, extensions to knowledge and understanding in this area is of vital importance.

However, many of these strengths can also be viewed as limitations associated with focussed ethnography and more generally, with qualitative research. Firstly, it is acknowledged that the sample sizes were small – both in relation to patient cases and health professional participants. Although this is justified as gaining rich and in-depth understanding of individual cases and localised contexts, a resultant limitation is that the research findings are difficult to generalise. Findings must therefore be interpreted within the context of this localised setting and there will be many other settings where different versions of rehabilitation develop.

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However, qualitative research is less concerned with generalisability, with emphasis instead placed on relevance [31]. Because many of the issues relating to the acute care system are not unique – such as organisation of medical and rehabilitation wards, and working practices of professionals - readers can potentially make links to areas affecting their own practice in order to consider the themes illuminated within this discussion. An additional important limitation is that the focus on specific disciplines resulted in limited attention to the collaborative context involving patients, families and multiple professionals which is a desired central tenet of rehabilitation environments [3]. Research involving greater numbers of patients, health professionals and rehabilitation settings would be important to understand whether issues presented in this article, such as the focus on physical improvement and on physiotherapy, extend beyond this local setting or are influenced by different contextual factors. Developing definitions and conceptualisations of rehabilitation using consensus development research methods, and to progress unique understandings for particular populations or health contexts would also offer much needed and timely developments.

Conclusion

This study has prioritised understanding rehabilitation for older people as a core issue for research and professional dialogue, recognising the vital contribution that rehabilitation pathways make to the health and wellbeing of older people as they recover from episodes of ill-health and as they experience and adjust to increasing frailty. In the context of one acute hospital ward, a reductionist version of rehabilitation was evident which focusses on physical improvement and safety, and led by physiotherapists. Conceptualising rehabilitation in this way carries risks and challenges for patients, families and professionals. Health professionals

are urged to reflect on the culture and meaning of rehabilitation and consider how to work towards holistic rehabilitation needs within the context of acute care.

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Essential criteria	Additional purposive sampling criteria to reflect characteristics of inpatient population
- Aged over 65 - Current functional level below pre-admission functional level and determined to have rehabilitation needs by the healthcare team - Medically fit to be approached to participate as determined by the healthcare team - Able to communicate in English	- At least 2 participants aged over 85 - At least one participant with cognitive impairment as determined by the healthcare team

Table 1: Inclusion criteria for patient participants in phase 2 observations

Figure 1: Summary of main themes and subthemes

For Peer Review

Figure 1: Summary of main themes and subthemes

184x149mm (96 x 96 DPI)