

AN EXPLORATION OF THE CONTRIBUTION OF NURSES AND CARE
ASSISTANTS TO PATIENTS' MOBILITY REHABILITATION.

BY

ROSIE KNEAFSEY

A thesis submitted to the University of Birmingham for the degree of
DOCTOR OF PHILOSOPHY.

February 2012

School of Health and Population Science,
College of Medical and Dental Science,
University of Birmingham,
February 2012.

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ABSTRACT

Aim of the thesis: To report on a study to describe and explain the contribution of registered nurses' and care assistants' to hospitalised patients' mobility rehabilitation.

Background: Studies internationally have shown that older adults often experience a decrease in their ability to mobilise during and after hospitalisation. Rehabilitation nursing interventions could be important in maximising the functional abilities of this population.

Methods: A grounded theory approach structured data collection and analysis. Data were derived from three hospital settings (general rehabilitation, spinal injuries and stroke rehabilitation) and included 39 staff interviews and 61 hours of observation.

Findings: Mobility rehabilitation is an 'embedded activity' and is achieved indirectly when nurses and care assistants transfer patients safely from one place to another. These events are described as 'A to B transfers'. Practitioners perceive distinct differences in the process and purpose of 'A to B' transfers in comparison to 'therapeutic handling' activities undertaken by physiotherapists and occupational therapists. The core category for the grounded theory (Care to keep safe: Safe to care) is used to explain the findings.

Conclusion: Theoretically, the nursing team could implement more structured 'intentional strategies' to promote patients' mobility rehabilitation. However, teamworking arrangements and work environments do not facilitate this.

Acknowledgments

There are many people to thank and acknowledge for their support with the production of this thesis. Firstly, I am grateful to the nurses, care assistants and rehabilitation team members who participated in this study and the patients who allowed me to be present during their care. Without their consent, the data within this thesis could not have been collected. A huge amount of gratitude is owed to my parents (Sue and Paul Kneafsey) for their faith in my abilities and never ending support. Thanks must go to my sister Moya and her husband Mick for their encouragement over the years. I wish also to thank my husband Charlie for his unfailing support, and the encouragement and interest from my children (Robyn, Heather and Joseph). Looking further back, I would also like to say thank you to Professor Roger Watson, who initially encouraged me to write and develop my ideas. I would also like to thank Dr Sheila Rodgers who first taught me about research methods during my undergraduate nursing degree. Professor Andrew Long was an important influence on my research career and provided me with many developmental opportunities and valuable research mentorship so thank you to him also. Lastly, sincere thanks must also go to my supervisors, Professor Collette Clifford and Dr Sheila Greenfield for keeping me focused and for reading the many drafts of this work.

Dedication

For my children, Robyn, Heather and Joseph and my husband Charlie.

Preface to the study

My interest in patient handling was initially prompted when I sustained a back injury as a student nurse. At the time I was attempting to undertake a one person, manual, bed to chair transfer with a patient who had suffered a stroke. After the incident, I was frustrated and angry that I had ‘made a mistake’ that might potentially cost me my career. My mistake was to think that I could transfer a patient safely if I followed the guidance and practices of the physiotherapist. I worried that reporting the incident would result in blame being applied and that my new ‘weakness’ might threaten my future employment as a nurse. Consequently, the incident was never formally reported. At the time, I wondered how many other nurses had been in the same position as me. From this point stemmed a desire to understand the wider context for my own personal predicament.

After a spell working on a neurosurgery ward and later on a high dependency unit for head injured patients, my old back injury reoccurred. This prompted a strategic move into nursing research working as a full time researcher on a project which explored the role of the nurse in rehabilitation practice (Long et. al. 2001, 2002 and 2003). Following this, I undertook a further three research projects which helped to shape the focus of the study reported here. The first examined the impact of nurse education on pre-registration students’ patient handling practices (Kneafsey and Haigh 2007, Kneafsey 2007a). The second comprised a systematic review of nursing contributions to promote mobility rehabilitation (Kneafsey 2007b) and the third consisted of a survey to examine nurses’ views on the handling of rehabilitation patients (Kneafsey & Haigh 2009). These studies are connected by two common threads - the nurse’s contribution to patient handling and nurses’ rehabilitation

practices. The study presented within this thesis combines these two threads together to create a new and unique study. Based on my own understanding of the literature, of nursing practice, education and rehabilitation research, this study was underpinned from the outset by the basic assumption that nurses do contribute to patients' mobility rehabilitation, although the nature of this contribution has remained unclear.

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GLOSSARY OF KEY TERMS

Care handling: Moving the individual from place to place to enable the person to meet a particular need.

Immobility: This relates to restrictions in mobility and where an individual requires help to move or change position.

Mobility: This relates to the person's ability to move about freely. Unrestricted mobility requires voluntary motor and sensory control of all body regions. Mobility relates to the act of walking, standing and sitting down, changing position and movement in bed.

Moving and Handling Trainer: A moving and handling trainer (sometimes called manual handling trainer or co-ordinator) is employed to provide training sessions to staff within the employing organisation (e.g hospital). Training often focuses on explaining the responsibilities of employer and employee in relation to the Moving and Handling Operations Regulations (HSE 1992). The trainer will also demonstrate how to use moving and handling equipment. Trainers may come from different professional backgrounds, such as nursing, physiotherapy or occupational therapy.

Nursing Care Assistant: A paid helper who may, or may not, have undertaken further training to attain a National Vocational qualification. Sometimes the title of support worker, health care assistant or nursing auxiliary is used.

'Nursing Team': The phrase 'the nursing team' is generally understood to denote a group of registered nurses and care assistants who work together to manage and deliver the care of a particular patient group.

Patient Handling: Patient handling can be defined as 'an encounter and an interaction between the nurse and the patient' whereby 'nurses assist or lift a patient

from one location to another (e.g transfer from bed to wheelchair) or from one position to another' (Johnsson (2005, p2).

Patient handling equipment and aids: These include gait belts, sliding boards, stand aids to assist with standing and repositioning, full body sling lifts, transfer chairs and improvements in bed design with adjustable sections (de Castro 2004).

Patient Moving and Handling: This relates to the assistance given to patients to help them mobilise, stand, sit down, change position or move in bed. Assistance may be given through manual support given by a nurse, care assistant or therapist or other person. Assistance is often provided through the use of patient handling aids and equipment. The phrase 'patient moving and handling' refers to the same activities as those described above in relation to 'patient handling.'

Registered Nurse/Nurse: An individual who has attained entry to the professional register of the Nursing and Midwifery Council whose role is regulated by this professional body.

Rehabilitation: A process which has an educational and problem-solving focus directed at restoring or promoting adaptation to an individual's activity limitations in order to optimise social participation and well being, and to reduce family and carer stress (Wade 2005).

Rehabilitation Handling: Includes all activities which involve handling as part of the patients' rehabilitation programme. As well as the treating physiotherapist, this also includes other staff, relatives or carers who are advised on handling procedures (CSP 2002).

Rehabilitation Nursing: Nursing is the use of clinical judgment in the provision of care to enable people to improve, maintain or recover health, to cope with health problems and to achieve the best possible quality of life, whatever their disease or disability, until death (RCN 2008). Rehabilitation nursing is nursing care which is further underpinned by a rehabilitation philosophy.

Rehabilitation Team: A group of people whose time is occupied with assisting an individual's rehabilitation and achievement of rehabilitation goals. Rehabilitation teams are composed of a relatively permanent core group of people and a peripheral group of people who will join the team depending on the patients needs.

Therapeutic Handling: Therapeutic handling involves guiding, facilitating and manipulation whilst manually handling a patient. It includes treatments where force is applied through any part of the therapist's body to any part of the patient's body. Therapeutic handling may involve the taking of calculated risks to facilitate the patients' progress towards optimal function (CSP 2002).

Treatment Handling: A term most commonly used to denote the manual handling activities adopted within physiotherapy treatment programmes (CSP 2002).

CHAPTER 1:

INTRODUCTION AND OUTLINE OF THE THESIS

1.0 Introduction

As older adults reach later life, it is common to suffer more from the effects of disease and illness, which culminates in a reduced ability to be active and mobile. Physical inactivity is a major health risk and often leads to further chronic health problems associated with ageing. As immobility increases, and physical freedom is reduced many older adults become confined to their homes or may move to a supported care setting where they can access help. Crucial daily activities such as eating, getting dressed or walking to the toilet may become difficult. Without freedom of movement, it may also become a challenge to maintain usual patterns of social interaction with others, leading to feelings of isolation (Rush and Ouellet 1998, 1993).

An important factor influencing the older adult's ability to mobilise is hospitalisation. Studies have shown that older adults often experience a significant decrease in their ability to mobilise and move independently during and after an in-patient stay (McCusker et al. 2002). Brown et al. (2009) refer to an 'under-recognised epidemic of low mobility' (p1660). Using a pedometer to measure the mobility levels of hospitalised older adults in the United States of America (U.S.A.) (n=45 patients), it was found that during a hospital stay of approximately five days, older adults spent on average, 83% of the time lying down in bed. All of the patients were able to walk in the two weeks preceding admission. Extended periods of inactivity may lead to a range of undesirable effects, such as deep vein thrombosis, pressure ulcers and chest infections. However, a complication of particular importance to the present study is the rapid speed at which muscle mass, strength and fitness deteriorates when prolonged immobility is combined with advancing age.

For hospitalised older adults, a decrease in mobility is frequently due to the presence of symptoms such as pain or breathlessness which arise from the acute illness or the exacerbation of a chronic condition. Medical attachments, such as catheters or intravenous lines may also impede or make movement uncomfortable. In addition,

destinations of interest in the hospital may be lacking, reducing patients' motivation to mobilise. Together these factors increase the likelihood of patients' choosing to stay in bed. Low mobility may also arise from attitudinal barriers to mobilisation such as the fear of falling or a lack of encouragement from health care professionals to mobilise. Ageist attitudes may lead to older adults being treated as unable to manage by hospital staff, resulting in learned helplessness and a permanent loss of physical abilities.

Registered nurses are a key group of health care professionals within the hospital setting, providing support to patients 24 hours a day and seven days a week. In this capacity, nurses undertake patient assessment activities, plan and deliver care and evaluate the impact and effectiveness of nursing interventions. They are generally assisted in the hospital setting by care assistants, who will undertake a range of delegated tasks with and without direct supervision. Together, registered nurses and care assistants comprise the 'nursing team' and will interact with a range of other health care professionals and other 'teams' to care for groups of patients.

When caring for a patient who is weak, in pain, immobile, injured or ill, promoting comfort is a key priority. It is also vital that the patient's body is protected to ensure that when their medical condition improves, the patient will be capable of resuming as many previously achievable activities as possible. One aspect of this care is to make certain that the patient is positioned properly, that joints are supported and remain mobile, and pressure areas are protected. These interventions may be critical to the prevention of pressure ulcers, contractures, and muscle or nerve damage. Complications such as these could ultimately limit the patient's ability to resume previous movement based activities. Nurses and care assistants may also help patients to move in bed, transfer from place to place (e.g. from bed to chair) and walk (mobilise), using aids where needed. In combination, these activities may be crucial to the patient maintaining muscle strength and full participation in activities of living. For the purpose of this thesis, nursing goals and interventions such as these are broadly described as supporting the patient's 'mobility rehabilitation.'

Unfortunately, some patients may never be able to move or mobilise independently. In this situation, nurses and care assistants will compensate for the patient's self care

difficulties by using patient handling equipment such as hoists and slide sheets and manual approaches to rolling and transferring patients from place to place. In this scenario, the nurse or care assistant will 'do for' the patient that which he or she cannot do independently. For some patients this level of dependency may be transitory. With time, patient motivation and support from health care staff, the patient may have the potential to regain and improve lost or deteriorating abilities in movement and mobility. This requires health care professionals to adopt a rehabilitation approach and to implement rehabilitation interventions.

Although much has been written regarding 'rehabilitation nursing', less is known about how nurses engage specifically in the process of 'mobility rehabilitation' and what activities are carried out. Neither does existing evidence clearly articulate how the activities of nurses and care assistants interface with other health care professionals who also focus on patients' mobility, such as the physiotherapist and occupational therapist. Indeed, although 'teamworking' is generally viewed as the cornerstone of effective rehabilitation provision, there is little specific evidence to set out how this is implemented in relation to mobility rehabilitation.

The focus of this thesis is on the contribution of hospital based nurses and care assistants to one key aspect of rehabilitation; the promotion of mobility and movement. Elucidating the nursing contribution to the process of mobility rehabilitation is important. The phenomenon of low mobility in hospitalised older adults is becoming an issue of both national and international concern. As human life-spans have become longer, the size of the older adult population has grown. Along with this, the incidence of long term conditions has also increased. Together, age and the presence of chronic health problems invariably impacts on the individual's mobility.

Within westernised health care systems faced with rising health care costs, it has become vital that the effectiveness of health care inputs is maximised. In the hospital setting, a significant proportion of health care inputs come in the form of nursing care. Finding the best ways to maintain and improve the mobility levels of adults in hospital has become an essential goal. It is therefore imperative that the nursing interventions implemented are efficacious in order to counteract the negative impact

of illness and hospitalisation on the patient's mobility. However, without knowledge of what the nursing 'input' is regarding mobility rehabilitation, it is not possible to identify how this can be enhanced.

Identifying nurses' and care assistants' specific contribution to mobility rehabilitation is a challenging task. Numerous authors have argued that nursing contributions to rehabilitation are poorly defined and undervalued (Kearney and Lever 2010). Whilst it is possible to 'measure' the length of time physiotherapists' spend treating individual patients, it is more difficult to measure rehabilitation nursing inputs. Particular variations in the way that nurses and physiotherapists work contribute to a difference in the visibility of profession specific rehabilitation inputs. For example, physiotherapists in hospital tend to work individually or in pairs with one patient at a time, providing discrete time-limited treatment sessions. These treatment sessions may occur within a therapy gym, therapy treatment room or by the patient's bedside and tend not to be interrupted whilst in process. The event will be clearly documented. In contrast, nursing activities with individual patients tend to be less formalised, occurring in bathrooms and at bedsides and rehabilitation activities may be embedded in the process of providing 'care'. This 'process' is one which is frequently interrupted mid-way through by other events, people, phone calls or other patient's requests. Rarely will the precise nature of care inputs be documented or categorised as 'therapy' or a specific rehabilitation treatment.

Thus, clarity is needed regarding the activities nurses and care assistants engage in to maintain and promote patients' mobility, to ensure that these are acknowledged. It is also necessary to ascertain whether nursing activities to promote mobility rehabilitation are appropriate and evidence based. This is vital to identify whether further developments in the nursing contribution to mobility rehabilitation are necessary and feasible.

The remainder of this chapter provides an introduction to the thesis. It begins with an overview of the barriers which typically restrict the physical mobility of older adults and moves on to summarise key developments in rehabilitation service provision. It provides an overview of some of the challenges for rehabilitation nursing and sets out particular contradictions which have provided the context for the research questions

for this study. The research aim and objectives are also presented. The chapter will conclude with a brief outline of the content of each chapter within the thesis.

1.1 Barriers to Movement and Mobility

There are many benefits associated with maintaining physical activity in later life. Physical activity is recognised as a way of maintaining functional ability and positive mood and of decreasing the risk of chronic diseases. Improved flexibility, stronger muscles and balance can also reduce the risk of falls. Preventing falls is critical as often, a fall may lead to a skeletal fracture, a period of hospitalisation and loss of independence. Thus, at the level of the individual, it is important that support, encouragement and practical help is provided to help older adults to retain the ability to move and mobilise wherever possible. This assistance may come from family and community resources. It may also come from health and social care professionals.

However, there is evidence to suggest that for older adults, there are often many factors that limit the ability to mobilise, both within the community and hospital setting. Chen's (2010) qualitative study with 90 Taiwanese older adults living in residential care identified that the attitudes of older adults themselves limited their attempts to mobilise. Many of those interviewed did not value exercise and seemed unaware of the dangers of a sedentary lifestyle. The study also suggested that health care professionals did too little to promote physical activity for older adults. Whilst it is likely that cultural differences in attitude and behaviour between Taiwanese and British populations exist, this study, though small-scale, highlights the powerful impact that health beliefs and attitude may have on patients' desire and ability to mobilise.

A recent Canadian study also identifies the influence of the patient's own decisions on their ability to move and mobilise. Fox et al's. (2009) in-depth, qualitative study examined the perspectives of 46 patients with chronic illness residing in continuing care facilities to understand their perceptions of staying in bed during day time hours. The average number of bed days taken by this group was 4.5 bed days per week (range 2-7 days). Many of the participants used bed days as a strategy to manage fatigue, to give time to rest and to conserve energy for the next day. Some patients

chose to stay in bed to exercise control. However, as the authors note, staying in bed tended to worsen existing illnesses, leading to a vicious cycle of dependency whereby the individual eventually became permanently confined to bed.

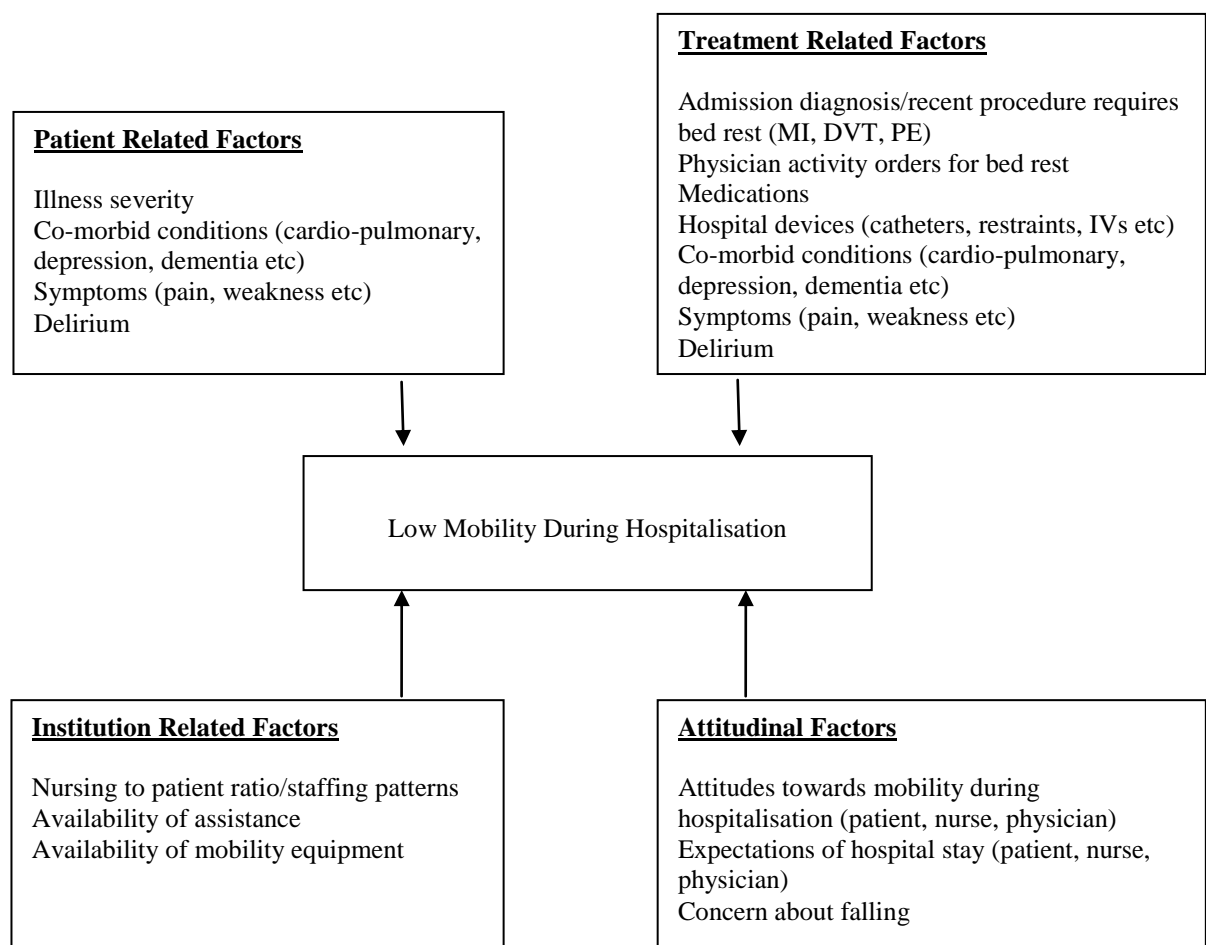
Becoming confined to bed, or 'bedridden' has been identified as a gradual process, hastened by periods of hospitalisation. Zegelin's (2008) grounded theory research involved interviews with 32, older bedridden adults. The study described the process of 'gradual local confinement' which often began with initial instability (such as dizziness), followed by an 'incident' of some kind such as a fall or hospital admission, followed by immobility and local confinement in a room, which later culminated in being bedridden. In this study, a stay in hospital proved to be a defining factor for many of the older adults interviewed. Participants described how they were mostly left 'lying in bed' or chose to restrict themselves to their bed space to ensure their availability to nurses and doctors.

The hospital environment may pose both subtle and obvious barriers to the ability of older adults to mobilise. Brown et al's. (2007) conceptual model is illustrative and identifies four key areas where barriers may present (see figure 1, p7). Whilst some barriers may be difficult to eliminate, such as the patient's level of illness, other factors are amenable to alteration. For example, attitudinal factors could be the focus of practice development initiatives directed at inducing change. Practical interventions such as the early removal of urinary catheters and intravenous lines could be implemented. The development of walking programmes might also be valuable in taking a proactive approach to rehabilitation

Patients and professionals however, may have differing views on what facilitates and restricts patients' ability to move and mobilise. Brown et al. (2007) tested the accuracy of their initial conceptual model by undertaking interviews with nurses, doctors and hospitalised patients. Although the model was largely confirmed a number of contradictions between professional and patient perspectives emerged. For example, whilst health care professionals frequently cited the risk of falls as a barrier to mobility, patients rarely did. In addition, whilst professionals blamed poor motivation for patients' reduced mobility, patients' perceived that staff were disinterested in helping them to mobilise.

Being dependent on others for help with mobility clearly places hospitalised patients in a vulnerable position. Although preventing immobility should be a priority for nurses and carers, who are theoretically well placed to assist patients to mobilise and engage in upright activities (Fox et al. 2009), the reality may be quite different. However, at present, little is known about whether, or to what extent nurses do focus on preventing mobility and promoting mobility.

Figure 1: Conceptual model of barriers to mobility during hospitalisation of older persons (Brown et al. 2007)



The quality of any assistance given and the way that it is provided will also have an impact on the patient's perception of being cared for, being comfortable and on their actual process of recovery and rehabilitation (Kjellberg et al. 2004). For example, the older adults in Zegelin (2008) study described how they were 'tugged' from one place

to another, neither active or purposeful in the movement from bed to chair for example. When practitioners complained about transferring the patient or did not disguise the physical strain associated with giving assistance, patients reduced their requests for help.

Zegelin contends that the process of ‘gradual local confinement’ can be halted through the interventions of health care professionals, if only attitudes, expectations and skills are changed. She argues that hospital staff must possess the knowledge to instigate programmes of mobility rehabilitation, and falls prevention to reduce the likelihood of patients being readmitted to hospital and to promote rehabilitation. Through this approach, whilst the onset of illness or injury may still result in the patient experiencing a loss or reduction in their ability to mobilise, this loss may only be temporary.

1.2 Rehabilitation Practice

There are many definitions of rehabilitation and there has been much debate over the best and least useful approaches. A readily understood definition of rehabilitation was provided by Waters and Luker in 1996. Their influential work identified rehabilitation as ‘the whole process of enabling and facilitating the restoration of the disabled person to regain optimal functioning (physically, socially and psychologically) to the level he/she is able, or motivated to achieve’ (p107). This definition has been cited in much of the nursing literature and continues to be well recognised by practitioners working in the British ‘national health service’ today.

Since 1996 however, many new definitions have been proffered (e.g. Stokes 2000). These have not only increased the specific emphasis on health promotion but they have also identified the need to involve both hospital, community and intermediate care services in order to shorten illness episodes, prevent illness progression and limit further complications of the disability or the illness condition (Naidoo and Wills 2000). Perhaps more importantly though has been the growing acceptance that patients themselves should have greater influence over their rehabilitation care and treatment. For example, the RCN (2000) ‘Rehabilitating Older People’ Guide states that the process of rehabilitation must be of therapeutic value to the individual

involved, and should be directed at making the most of the person's social well being. It draws attention to the need for rehabilitation to be a person centred and active process where the goals of rehabilitation are selected in partnership between the individual and the rehabilitation team.

Definitions of rehabilitation have also become more holistic, accepting that physical rehabilitation may not always be the most important aspect from the patient's perspective. For example, Routasalo et al. (2004) argue on the basis of a systematized review of the literature, that rehabilitation processes should be about supporting patients' self determination, the ability to lead a meaningful life, life satisfaction, mental well being, social status, and emotional wellbeing.

Whilst defining rehabilitation is difficult, there is more agreement regarding the 'rehabilitation process'. This process is widely recognised as consisting of four main stages which include: comprehensive assessment; setting of short, medium, and long term goals; development of a plan towards the goals; and evaluation of the progress towards goals (Jester 2007). Booth and Jester (Jester 2007) provide a useful classification of those conditions requiring rehabilitation, distinguishing between acute onset conditions such as stroke or myocardial infarction, conditions with a gradual onset or relapsing course (for example, multiple sclerosis and rheumatoid arthritis), conditions with acute onset but a constant course such as spinal cord injury or traumatic amputation and finally those disease conditions with a gradual onset and progressive course, such as osteoarthritis and cardiac failure.

The rehabilitation process generally relies on the combined activities of the rehabilitation team, within which the patient's participation is central. Typical hospital ward based rehabilitation teams include a core of nurses, care assistants, physiotherapists, occupational therapists and doctors. In some settings, generic rehabilitation assistants may also complement the rehabilitation team. Other staff will engage with the team depending on the patient's needs, such as the speech and language therapist, dietician, pharmacist and psychologist for example. Rehabilitation teams may have different configurations and a number of different models of team-working exist (see chapter 2, p32).

As the need for rehabilitation services to meet population demands has grown, there has been an increasing emphasis on the potential of nurses to contribute to the rehabilitation process. However, there have also been difficulties in defining the exact nature of rehabilitation nursing.

1.3 Rehabilitation Nursing

As prime care givers, care co-ordinators, care managers and leaders, nurses have been identified as a key professional group able to support the provision of rehabilitation and health promotion services (Jester 2007). However, within the literature, the nurse's role in the rehabilitation process has been described as ambiguous and often overlooked by nurses, other members of the multi-professional team and patients alike. Where it has been recognised it has been defined as a secondary support to the work of therapists with the aim of reinforcing the rehabilitation treatment devised by other professionals (Nolan and Nolan 1997). The Royal College of Nursing Rehabilitation and Intermediate Care Nurses' Forum (RCN RICNF 2002) note the propensity of nurses to feel intimidated when therapy staff use new terminology and rehabilitation jargon. Jester (2007) draws attention to the dominance of 'therapists' within rehabilitation service provision which is reflected in the fact that rehabilitation is often simply referred to as 'physio' or 'therapy'.

Influential nursing research identified the propensity of nurses to view rehabilitation as the domain of 'therapy disciplines', such as the physiotherapist and occupational therapist (Booth and Waters 1995). Nurses in Waters and Luker (1996, p108) viewed rehabilitation as 'what the physios and OT's do' with both nurses and therapists identifying therapists as the experts in rehabilitation. This perspective was reflected in much of the rehabilitation literature. For example, Lincoln et al. (1996) identified the 'therapeutic' rehabilitation day to be between 9-4.30 pm when therapists were on site, disregarding the contribution of nurses to rehabilitation over the 24 hour period.

More recently, these perspectives have been critiqued and largely debunked. It has been argued that rehabilitation nurses should be identified as therapists in their own right and that nursing care should be reconceptualised as 'therapy.' Pryor and O'Connell (2008) explore the root cause of these points of controversy. They identify

that practitioners may hold a mistaken belief that rehabilitation is a separate phase of healthcare which follows acute care (Pryor and O'Connell 2008). Others may be under the impression that a contradiction exists between the 'caring' focus of nursing versus the perceived 'active therapy' component of rehabilitation (Burton 2000, p175).

It has often been assumed that 'traditional nursing care' is different to rehabilitation practice (Kirkevold 1997). Traditional nursing care has been viewed as adopting a compensatory approach which maintains the patient in an inactive and dependent position. This is viewed as a polar opposite to rehabilitation, which requires the patient's active participation. However, Kirkevold refutes this position and argues that 'the assumed opposition between rehabilitation goals and the meeting of basic needs is unfounded' (p59). She identifies that helping the patient to maintain normal functions and preventing complications are crucial to the rehabilitation process, and are essential to enabling the patient to also engage in 'intense rehabilitative therapies' (p 59).

Indeed, it has been argued that far from being the sole domain of therapists, that the rehabilitation concept may be used as an underpinning theoretical basis for nursing care. For example, the American Association of Rehabilitation Nurses (2010) describes rehabilitation as a philosophy of care rather than a work setting or period of treatment. Offering a UK perspective, Long et al. (2002) suggest that all nursing care has the potential to be rehabilitative noting that:

'all nurses assess needs, provide physical and technical care, support the client and their family....differences in the nurse's role across settings may lie in the extent to which these activities are pursued mindful of and geared towards implementing a rehabilitative model.' (p76).

As well as the different opinions held by health care professionals, patients' perceptions of nurses as rehabilitation team members also reveal an ambiguous picture. Patients in Secrest's study (2002) viewed nurses as carers who would 'do for', rather than therapists in their own right. In addition, none could 'articulate a therapeutic benefit' associated with nurses (p180). Nurses, in Pryor and O'Connell's

(2008) study, also identified how patients expected nurses to do everything for them and saw rehabilitation as an episodic activity undertaken by therapy staff.

For nurses with a desire to adopt a rehabilitation approach, patients' perceptions of the nurse as someone who will 'do for' rather than someone who will coach may have a significant impact on what they are able to achieve. This difficulty is often thrown into sharp relief when nurses attempt to assist patients with mobility, transfer the patient from bed to chair or promote greater physical independence. A common refrain is that patients 'perform' better for the physiotherapist whilst they are more likely to adopt the sick role for the nurse (Pryor and O'Connell 2008).

In addition, the introduction of the Manual Handling Operations Regulations (HSE 1992) has impacted on the provision of rehabilitation nursing care. Whilst these regulations were developed to reduce the high incidence of back injuries in the workforce in general, this legislation has been applied to health care associated patient handling activities. The result has been that the activities involved in helping patients with physical movement and mobility have become associated with a risk management approach. In all British hospitals, this has led to the introduction of manual handling policies. Nurses have argued that the resultant 'no-lift' ethos that now pervades many hospitals has prevented them from engaging fully in a role in physical rehabilitation (Griffith and Stevens 2004, RCN RICNF 1999).

Against this backdrop, a study was designed to explore the nursing contribution to mobility rehabilitation in more detail.

1.4 Research Aim

The aim of the work reported here was to explore registered nurse and care assistants' contributions to promoting patients' mobility rehabilitation within a range of in-patient rehabilitation settings.

Research Objectives

Three key objectives were established:

- To describe nurses' and care assistants' contributions to patients' mobility rehabilitation.
- To examine how nurses' and care assistants' activities to promote patients' mobility rehabilitation contribute to the rehabilitation team effort.
- To explore the impact of hospital patient handling policy on nurses' and care assistants' contributions to mobility rehabilitation.

To address the aim and objectives noted, three hospital based settings were studied. These included a general rehabilitation ward, spinal injuries unit and a stroke rehabilitation ward (case study sites 1, 2 and 3 respectively). Semi-structured interviews with 39 rehabilitation staff and sixty-one hours of non-participant observation comprised the data set.

1.5 Outline of the Thesis

The next section of the thesis is chapter two which explores the literature surrounding rehabilitation nursing, the nurse's role in mobility rehabilitation, the nurse within the rehabilitation team and the legislative, policy and professional context for patient handling. Following this, the third chapter outlines the methodological underpinnings to the study and the way that these were applied to the data collection and analysis. Three chapters (chapters four, five and six) are then devoted to the case study sites to set out the findings which emerged from the data collected. Chapter seven provides a synthesis of the case study findings and discussion of related literature. It is concluded with a presentation of the grounded theory to describe and explain nurses' and care assistants' contributions to mobility rehabilitation. Finally, chapter eight brings the thesis to a close, setting out the implications of the findings for practice, research and education. The chapter draws to an end with an evaluation of the study quality.

1.6 Chapter Summary

This chapter has provided an introduction to the study, setting out the background to the research questions. For older adults admitted to hospital, loss of mobility may

become a significant problem. Although nurses may be well placed to assist patients to retain and improve their mobility, significant difficulties have been identified with nurses' rehabilitation role. The study focuses on the contribution of hospital based nurses and care assistants to one aspect of the rehabilitation process: the promotion of mobility and movement.

CHAPTER 2

REVIEW OF THE LITERATURE

2.0 Introduction to the Chapter

This chapter provides an overview of literature relevant to the present study. A wide range of research, spanning three decades (1980 – 2010), provides the basis for this review. The problem of low mobility of hospitalised older adults is a matter of concern for health care systems in many developed countries. As such, evidence is drawn from the United Kingdom (UK), the USA and Canada. Scandinavian and Australian perspectives are also reflected where literature was available. The key stages of the literature search methodology are provided in appendix 1 (p228). The review is structured broadly in alignment with the research objectives. The first section discusses the role of the nurse in rehabilitation practice. The second examines the nurse's specific contribution to mobility rehabilitation. The third section explores the role of the nurse within the context of the multi-professional team. The fourth discusses the legislative, policy and professional context to nurses' contributions to mobility rehabilitation.

Despite its prominent position in the thesis, the literature was largely accessed *after* data collection and analysis had taken place. It is argued within grounded theory literature that undertaking a literature review prior to data collection can lead to the researcher being driven by concepts evident in the existing discourse rather than focusing on emerging data from the field, thus undermining the grounded theory (Lincoln and Guba 1985). In contrast, it has also been suggested that published materials can provide a useful source of theoretical codes, can enhance theoretical sensitivity and may be conceived as a further strand of data to be sampled and reviewed prior to data collection (Strauss and Corbin 1998).

At the point of embarking on this work, I was already theoretically sensitized by prior experience to relevant evidence which would influence my data and the interpretations that developed (McGhee et al. 2007). I therefore decided against undertaking an initial detailed review of the literature as I felt this might obscure a fresh response to the settings and the data (Neill 2008).

2.1 Nursing Roles in Rehabilitation

It is possible to identify a wide range of definitions and descriptions of rehabilitation nursing within the international literature as researchers, practitioners and educationalists have sought to clarify the position of nursing within the rehabilitation process. Table 1 overleaf provides a summary of the rehabilitation nursing role as described by key professional nursing associations with English language publications available on the internet. What is of interest is the similarity in the identified roles for rehabilitation nurses and in the practical nursing competencies specified. This suggests a common understanding and a level of agreement at an international level regarding the component parts of the rehabilitation role and the skills and knowledge required to fulfil this role. However, it could be argued that professional guidance documents such as these provide a simplistic perspective on rehabilitation nursing rather than reflecting the realities of clinical practice with its many complexities and challenges. It is therefore of great value that a substantial body of nursing research has also been published which provides greater insight into the actual reality of rehabilitation nursing practice.

A key question that seems to drive much of the published rehabilitation nursing research is ‘what is it that makes rehabilitation nursing ‘special’ and different to nursing in general?’ Appendix 2 (p232) provides a summary of key studies (and their strengths and weaknesses) that inform a discussion of this issue. Whilst this chapter does not take the form of a systematic review, a systematised approach was taken to the literature review allowing some overall commentary to be provided regarding the nature of the evidence.

Table 1: Definitions of Rehabilitation Nursing from Prominent Rehabilitation Nursing Organisations

Professional Organisation	Aim of document	Key content
Royal College of Nursing Rehabilitation and Intermediate Care Nurses' Forum (2007). UK.	Presents a framework for rehabilitation nursing.	8 categories of nursing activity: - Essential nursing skills - Therapeutic practice - Co-ordination - Education - Advocacy - Political awareness - Advice and counsellor - Clinical Governance
Association of Rehabilitation Nurses (2011) USA.	Describes rehabilitation nursing as a philosophy of care, not a work setting or phase of treatment.	Identifies a range of rehabilitation nursing roles: Administrator Admissions liaison Case manager Clinical nurse specialist Researcher Staff nurse Educator Caregiver Counsellor Co-ordinator
Australasian Rehabilitation Nursing Association (2011) Australia.	Describes the nature and scope of rehabilitation nursing and details the competencies expected of a rehabilitation nurse. Goals of rehabilitation nursing are to maximise self determination, restore function & optimise lifestyle choices for clients through a range of activities.	Details 7 rehabilitation nursing competencies: Adopts a rehabilitation approach to the person. Views every interaction with the person as a teaching /learning opportunity. Incorporates observation, assessment and interpretation into everyday practice. Administers and monitors therapeutic interventions. Manages rapidly changing situations. Fulfils a management, advocacy and co-ordination role. Monitors and ensures the quality of health care practices.
Canadian Association of Rehabilitation Nurses (2011)	Presents a list of competencies which must be passed to achieve the Rehabilitation Nursing Certification Exam	Competencies include: Foundations and principles of rehabilitation nursing. Discharge and transition planning. Functional health patterns: mobility, sexuality, sleep and rest patterns, sensory and pain, communication and cognition, nutrition, elimination, skin integrity, cardiopulmonary deconditioning. Psychosocial health patterns. Care of clients with stroke, traumatic brain injury, amputation, burns, spinal cord injury, cancer, mental health problems.

The first notable observation is that only two studies reviewed adopted a clinical trial design (e.g Burton and Gibbon 2005, Tseng et al. 2006) and attempted to discern whether rehabilitation nursing inputs had a detectable impact on measurable patient outcomes. In contrast, numerous authors have undertaken research with the purpose

of defining, describing and categorising nursing contributions to rehabilitation using a qualitative approach. However, the individual generalisability of many studies published during the 1990's and later are limited by the small sample sizes from which data are drawn (e.g. Brillhard and Sills 1994, Hill and Johnson 1999, Singleton 2000, Kvigne et al. 2005, Barecca and Wilkins 2008). In addition, very few authors adopted a purposive or theoretical sampling approach, relying instead on 'convenience' sampling (Waters and Luker 1996, Pellat 2003). Clearly, the limitation to this method is that the respondents included may not be the most informative or knowledgeable about the field of practice being investigated.

Exploration of the rehabilitation nursing evidence base also reveals that many of the studies have focused on stroke care (e.g. Kirkevold 1997, Jones et al. 1998, O'Connor 2000a and 2000b, Burton 2000). For this distinct rehabilitation nursing speciality the accumulating research is of great benefit. However, it cannot be assumed that the findings derived from stroke rehabilitation settings will have general relevance for other rehabilitation specialities. In addition, many of the studies retrieved report on single site research projects, the settings for which are only briefly described, if at all (e.g. Newall 1997, Dowswell 2000, Singleton 2000, Booth et al. 2001). Without adequate insight into the context from whence data are derived, such as staffing structures, teamworking patterns and patient profiles, it is difficult for the reader to assess the significance of the findings for current practice or other locations.

Some large scale surveys have been conducted to explore nurses' perceptions of their rehabilitation role (Strasser et al. 1994, Routesalo et al. 2004, Kneafsey and Haigh 2009). Whilst the findings are of interest, surveys are not able to provide sufficient explanation for their results. Most of the remaining studies located collected data via semi-structured interview (e.g. O'Connor 2000b, Dalley 2001, Pryor 2002) although one relied on nurses' reflective accounts (e.g. Burton 2000) and one used diary records (e.g. Brillhard and Sills 1994). Diaries, reflective accounts and interview data can be particularly rich and may provide valuable insight into peoples' opinions. However, interviews tend to draw out 'espoused theories' of practice and best intentions, rather than providing a record of what people actually do in practice. Retrospective data collection approaches also rely on respondents' ability to accurately recall events and may be prone to elaborations and re-interpretations.

To overcome this limitation, some studies have used data triangulation, utilising the approach of non-participant observation (Reed 1993, Long et al. 2001, Pryor 2009). As an approach to data collection, non-participant observation has the potential to provide the researcher with a window into reality and the opportunity to gain detailed insight into work patterns and activities. However, non-participation observation may also have pitfalls. For example, in some of the studies reviewed, too little detail is provided regarding 'how much' observation was carried out, what was observed and how appropriate events for observation were selected (e.g. Kirkevold 1997, Singleton 2000). A number of studies used a time sampling approach and a system of categorising the activities witnessed (Ellul et al. 1993, Jones et al. 1998, Dowswell 2000) whilst other researchers focused on specific events (Booth et. al. 2001, Gibbon 1999). Clearly, a level of subjective judgement is used when devising the recording schedule and when completing it in 'real time', despite attempts to standardise and increase the validity of data collected.

Two particularly influential studies in the U.K to explore the position and role of rehabilitation nursing were funded by the English National Board for Nursing, Midwifery and Health Visiting. The first study (Nolan et al. 1997) comprised a systematic review of literature. This study concluded that the full potential of a nursing contribution to rehabilitation had yet to be realized. It also highlighted the lack of 'outcome' research relating to rehabilitation nursing. The second influential study was empirical in nature (Long et al. 2001) and provided an important benchmark regarding the state of rehabilitation nursing in the UK at that time (Long et al. 2001).

Unlike many other studies in this field, Long et al's. (2001) research was conducted on a national scale and adopted an in-depth ethnographic approach. Both data collection and researcher triangulation served to enhance the trustworthiness of the findings derived from the data collected. The data set itself was also extensive and included 330 hours of observational work, 88 interviews with health care staff, 49 interviews with patients and 21 interviews with patient's primary carers. Data were collected over two years and sampling took place across three different geographical areas and related to three different condition type (stroke, fractured neck of femur and

rheumatoid arthritis). The study also included a panel review of findings to assess the overall generalisability of the results. As well as the individual value of the results gained from this study, it was also a pivotal piece of research because its findings served to cement the results of the smaller individual studies published in the previous decade. Indeed, despite the methodological limitations of much of the research literature, when considered together, significant coherence in the UK evidence base can be identified.

Since that time, a significant volume of research literature has also been published by Julie Pryor (Pryor 2002, Pryor 2008a, Pryor 2008b, Pryor 2009) whose well constructed and rigorous grounded theory study explored the role of the nurse in rehabilitation in Australia. Again, this study included a large sample size involving interviews with 53 nurses working across five different rehabilitation settings. The results published in Pryor's papers are detailed and echo many of those reported by Long et al's (2001) work, despite originating from another continent. Indeed, an examination of the literature, both national and international, enables a number of key foci to the nurse's role to be identified. The following section attempts to give a flavour of this.

2.1.1 Creating a Rehabilitation Ethos

Many authors credit nurses and care assistants as having a key role in generating a rehabilitation ethos (Singleton 2000). The rehabilitation ethos or 'atmosphere' is seen as an essential part of the environment within which other rehabilitation treatments will take place (O'Connor 2000). According to the writings of Peplau (1989, cited in Thomas et. al. 2002) this atmosphere or 'therapeutic milieu' may also be a 'treatment modality' in itself (p99) providing it is safe, supportive and time rich. O'Connor (2000) surveyed 43 stroke units and interviewed 90 registered nurses. A particularly important finding related to the 'mode of care' nurses adopted in the stroke rehabilitation setting. This 'mode of care' comprised a distinct 'manner' or style of nursing and referred to the way in which nurses interacted with patients to develop a therapeutic, positive, encouraging relationship. Within the context of this relationship, a 'doing for' approach was replaced with a coaching and teaching role.

Similar findings were also derived from Pryor's (2002) study which involved interviews with 13 nurses and focus groups with a further 29 nurses. This study also concluded that it was the 'rehabilitative approach' which comprised the distinctive feature of rehabilitation nursing, describing it as 'the way nurses conceptualise and think about their practice and the people they interact with...a style or way of doing nursing, rather than the actual activities' (2002, p13).

Descriptions of the rehabilitation ethos seem to present nurses who behave in a different manner to traditional notions of the caring nurse who 'does for' the patient (Long et al. 2001, Hill and Johnson 1999). This requires nurses to stand back from patients, and to repress their desire to assist the patient with physical activities that they may well be able to undertake independently with additional time. Indeed, O'Connor (2000) describes the importance of nurses' 'non-interventions' – of nurses knowing when, and when not to intervene and being skilled in withdrawing care on a systematic basis...' (p184). Jester (2007) identifies that this type of 'hands-off' approach necessitates an important shift in thinking, which focuses less on 'getting things done' in favour of an individualised approach to patients' rehabilitation progress (Jester 2007, p16).

Standing back and restricting the instinct to help patients is not easy to achieve. Not only are nurses socialised into a culture where getting nursing work done swiftly is a valued ability, many patients and staff (other nurses and other members of the multi-professional team) hold stereotypical views of the nurse as someone who 'does for' and 'cares for' (Long et al. 2001). This poses a challenge for nurses who wish to work in a rehabilitation manner as not only must they learn to stand back, giving patients time to do things for themselves (O'Connor 2000), they must also risk criticism from patients and relatives. Three insightful studies, albeit drawing on small samples sizes, lend weight to this perception. The eight nurses in Barecca and Wilkins (2008) phenomenological study worried that they would be criticised if they did not help patients, as opposed to giving them space to try activities by themselves. Hill and Johnson (1999) found that nurses were also concerned that patients would view them as uncaring if they let them struggle to become independent, rather than intervening. Pellat (2003) interviews with 14 nurses also identified the tension between the caring

role and the rehabilitation philosophy as nurses felt that when they encouraged ‘self care’ this could be viewed as ‘hard and bullying.’

More recently, the potential of practice development initiatives to maximise the nursing role in generating a rehabilitation ethos has been explored. Pryor and Buzio (2010) described the introduction of nurse led patient engagement activities articulated as ‘rehabilitative milieu therapy’ into a 38 bedded Australian rehabilitation ward. Although the authors allude to nurses’ negative attitudes to these activities, these are not described. However, it is concluded that nurse led activities held in the ‘dining room’ led to greater engagement of both nurses and patients in the rehabilitation process and a stronger rehabilitation identity for the nurses. Whether or not this led to improved patient outcomes is not discussed.

Whilst the essence of the rehabilitation ethos may be difficult to capture, other interventions such as the provision of physical care might be assumed to be generally more visible.

2.1.2 Physical Care

A key nursing function within rehabilitation settings is to provide physical care of the ‘body’ such as help with washing, dressing, movement, getting ready for therapy, skin care, eating, maintaining continence, administering medications and applying wound dressings (Long et al. 2002). Substantial levels of physical care may also be needed to care for ‘poorly’ or acutely ill patients admitted to hospital rehabilitation wards, and those rehabilitation patients who develop unpredicted illnesses. Some authors have identified that the nurse’s role in providing physical care can often limit her/his ability to participate in rehabilitation activities. Indeed, preventing and managing new illnesses arising from the initial cause for hospital admission can demand much of the nurse’s time. Nurses and other team members in Pryor (2007) study did not view the management of new health problems (such as chest infections) which developed as a result of a primary condition (e.g. an initial stroke) as part of the rehabilitation process. Unfortunately the effect of this was to disregard the importance of much of what nurses did.

Daily nursing activities associated with the provision of physical care have also been conceptualised as ‘routine’ (Hill and Johnson 1999) or ‘maintenance work’ (Waters and Luker 1996). Pellat’s (2003) study of spinal rehabilitation nursing identified the tendency of others to overlook the importance of the nursing role. Despite nurses acting as the ‘bedrock of rehabilitation’, with responsibility for encouraging, explaining, helping patients with things they could not do, assisting with bladder and bowel function, washing and dressing as well as emotional support, this contribution was easily overlooked, and only noticed when it was absent.

Kirkevold (1997) influential analysis of stroke nursing care describes nurses’ ‘conserving function’ in maintaining patients’ normal functions, preventing complications and meeting the hygiene, eliminatory and mobility needs. However, she notes that ‘the pervasiveness of this function and the everyday character of the activities associated with it, as well as the inconspicuousness of the results (that is, the absence of complications), frequently made this an overlooked or unappreciated function among both nurses and other health care professionals’ (p59).

2.1.3 The Carry-on role

A number of authors have explored how nurses working in rehabilitation settings may use the provision of physical care as an opportunity to implement therapy treatment normally provided by other team members (Hill and Johnson 1999, Jones et al. 1998). Waters and Luker’s (1996) study, based on two rehabilitation wards for older adults, involved interviews with 56 nursing staff. This study was important because it was one of the first to openly articulate that nurses often undertook activities usually undertaken by therapists when therapists were not present. Whilst these activities were delegated informally, at the time, these ideas were controversial, raising issues to do with professional role boundaries, role sharing and role protectionism.

The most frequently documented examples of therapy ‘carry-over’ in the literature relate to dressing, undressing and encouraging mobility. Burton (2000) analysed the reflective diaries of 13 rehabilitation nurses working in stroke care. Whilst retrospective data may be subject to reporting bias and selective memory, these diaries revealed that nurses undertook a range of activities that could be perceived to

be the domain of others, such as physiotherapists, translating these skills into physical functions within activities of living. Similarly, O'Connor (2000) explained how nurse's interviews indicated how they assisted patients to 'rehearse' and practice activities and regimens planned by therapists. Long et al. (2002) used vivid observational data to illustrate how nurses engaged in both 'therapy carry-on' (in order to implement prescribed therapy treatments) and 'therapy integration'. This involved creating a therapeutic milieu and integrating the treatments prescribed by therapists into the patients' activities of living.

It has been suggested however, that when nurses engage in therapy carry-over activities that this locates them in an 'understudy' role to the therapist, denoting both lesser status and authority. However, O'Connor (2000) argues that rather than viewing the nurse as an understudy to the therapist it should be acknowledged that nurses use their own specialist skill and expertise to tailor therapists' prescriptions to the context presented to them, in the immediate situation within which care is provided. Indeed, the therapy carry on role has been identified as an important aspect of the nurse's contribution to rehabilitation due to the limits of formal therapy provision, and one to be expanded (Newall et al. 1997).

Ellul et al. (1993) explored the potential of nurses to facilitate greater patient engagement in rehabilitation activities. An initial observational survey of patient activity on four rehabilitation wards for older adults found that most patients spent their day in the day room listening to the radio, watching television with the authors concluding that the time spent in 'useful activities' was 'unacceptably low' for most patients. A two pronged nursing intervention was designed to focus on nurses' promoting physical rehabilitation on an hourly basis by asking patients to stand, transfer or mobilise (following a predefined programme designed by the physiotherapist and nurse in conjunction). The study found that whilst patients' engagement in rehabilitation activities did increase significantly during the period of observation, the initial enthusiasm for the interventions quickly waned due to staff turnover, and that staff regressed back into traditional roles.

Indeed, nurses have argued in the past that they lack the time to engage in therapy carry-over work (Long et al. 2002). Kirkevold (1997) wrote that whilst some nurses

engaged in an ‘integrative function’ to help patients to translate new skills and abilities learnt during therapy into daily activities mostly, patients spent their time passively and non-productively. Thus, whilst the therapy carry-over role may seem to be a logical extension to the nursing focus on patients’ physical care, the extent to which this is implemented may be variable and context dependent.

2.1.4 Emotional Care

On perhaps more familiar territory, many studies have described the importance of the rehabilitation nurses’ role in providing emotional support (Burton 2000, 2003). Hill and Johnson (1999) identified that nurses provided counselling and listening time to hear patients’ grief. Kirkevold’s (1997) analysis of stroke rehabilitation nursing identified the nurse’s interpretative and consoling function. This involved the development of a trusting relationship with patients and families in order to enable coping, understanding, hope and to provide emotional support.

Long et al’s. (2002) study noted how nurses provided reassurance, explanation, and encouragement, and spent time finding out about patients’ fears. This description links across to the nurse’s primary role in ‘coaching patients to self care’ as depicted by Pryor and Smith (2002). Pryor and Smith describe this as a way of interacting with patients that focused on teaching them about their own rehabilitation and actively supporting them to self-care, thus positioning nurses as agents of change. Work by O’Connor (2000) lends support to the notion of the nurse as facilitator. He found that nurses implemented ‘positive enacting interventions’ which encouraged patients to participate actively in their own rehabilitation, and incorporated the giving of time for the supervision of patients activities.

2.1.5 Co-ordination

A common thread in all of the papers refers to the nurse’s role as a care co-ordinator. Hill and Johnson’s (1999) study found that nurses viewed themselves as the ‘glue that holds things together’ (p156) as a direct result of their 24 hour contact with patients. O’Connor (2000) described this lynchpin role as ‘continuity care’. Pryor and Smith

(2002) describe the nursing role in management, advocacy and co-ordination of and between the multi-professional team

Long et al. (2002) described the co-ordination role in more depth, identifying the importance of 'gathering, synthesizing and disseminating information' (p73) amongst the rehabilitation team, as well as liaison, referral, negotiation and discharge planning work. Nurses also fed information back to the team regarding clients' progress with areas such as mobility, transferring and positioning. This moved the patient's rehabilitation progress along by ensuring that therapists could then adapt treatment plans and rehabilitation goals.

Whilst this aspect of the nurse's role was highly valued by nurses themselves, nurses sometimes perceived that other members of the team did not recognise the effort that it required and the challenges that it presented. This study also identified some deficiencies in the way that co-ordination occurred, particularly the lack of instruction and supervision provided to ensure that care assistants followed the rehabilitative plan of care and worked consistently to achieve clients' rehabilitative goals.

Thus, as the research literature demonstrates, nurses have been credited with a range of important contributions to the rehabilitation process. In addition, when examined in further depth, it is possible to identify specific nursing contributions to promoting patients' mobility rehabilitation.

2.2 Nursing and Mobility Rehabilitation

When nurses care for patients, they must frequently assist them with movement, positioning and mobility. Some techniques will require manual patient handling approaches, whilst other forms of assistance will involve using equipment. It is in this capacity as someone who helps the patient to move, that nurses have the potential to make great contributions to the patient's recovery and independence. By helping the patient to regain strength, balance, co-ordination and stamina, nurses' activities bind them to a role in promoting mobility rehabilitation. Often, whether or not a patient retains or regains their ability to move, to transfer and mobilise will have a direct impact on whether they can continue to live in their own home and their overall

quality of life. The following section examines potential nursing contributions to promoting patients' mobility and movement.

2.2.1 Interventions to Promote Mobility Rehabilitation

Much of the general assistance with movement and mobility given to patients is provided by nurses and nursing care assistants who are frequently the first to identify impaired mobility and activity intolerance through their 24 hour, 7 day presence (Bourett et al. 2002, Mol and Baker 1991, Mayer et al. 1990, Levin et al. 1989,). Indeed, many definitions of nursing and nursing models identify the importance of the nurse in assisting the patient with mobility and movement (Henderson 1966).

Helping patients to move may therefore constitute a significant part of the nurse's work. Mayer et al's. (1990) observational study of direct nursing care provided to patients in an American sub-acute rehabilitation centre for people with head trauma is informative. Observations were conducted for four hours during four day shifts, 3 evening shifts and 3 night shifts. The results showed that patient care activities relating to positioning, mobility and transfers constituted 12% of the total direct patient care occurring in a 24 hour period. Notably, this study also identified that care assistants, rather than registered nurses delivered this care. Although differences may exist in the way care is provided between different facilities and across different countries, these results should not lead to the assumption that registered nurses were therefore not involved in patients' mobility and movement needs. Indeed, Sawin's (1992) large-scale exploration of the most frequently used nursing diagnoses by 346 American nurses found that the diagnosis of impaired physical mobility was rated in the top 10 by respondents.

Unfortunately, until recently there has been little research evidence to guide nurses' practice in relation to mobility rehabilitation. For example, Hignett (2003) identified a lack of research evidence to support rehabilitation practice when supporting patients in walking or standing positions. She argued that this issue must become a focus for research in order to address 'concerns about patient handling in rehabilitation activities' (p545). More recently, Cortez (2009) identifies the lack of knowledge regarding the impact of early mobilisation within the context of cardiac rehabilitation

(Cortes 2009) and Stockley et al. (2010) noted the lack of reliable evidence regarding the use of passive movements on patients' limbs in intensive care units.

However, some progress relating to the nurse's contribution to mobility rehabilitation was made by Kneafsey's (2007b) systematic review. The aim of this review was to identify literature discussing interventions and activities undertaken by nurses, directed at promoting improvements in patients' mobility function. The review also sought to ascertain the nature and strength of the retrieved evidence and included 16 research and 33 informational papers. A key finding was the fragmented nature of the evidence base. In addition, most of the studies included derived their results from very small sample sizes and weak research designs. Whilst these factors limit the validity of the conclusions drawn from the literature, an attempt is made to suggest directions for nursing interventions.

For example, the review suggests that the assessment of patients' movement abilities should be considered the cornerstone to a nursing role in promoting patients' mobility. It also sets out potential areas for nursing assessment. These included assessing; the quality of patients' movement, ability in functional activities, gait pattern, presence of spasticity, activity intolerance, activity order, muscle strength, risk of falls, presence of depression, nutritional assessment, the drug profile and patients' moving and handling needs.

A set of nursing goals aimed at promoting maximum mobility were also extracted from the literature. These included promoting normal movement, promoting maximum mobility, promoting sleep and rest, increasing activity tolerance, conserving energy, reducing fatigue and pain, and improving balance and posture. The related nursing interventions were also detailed (see table 2 below, page 29). In addition, the review identified some evidence suggesting that nurses could affect patients' functional outcomes through the implementation of structured walking and exercise programmes.

Table 2: Nursing interventions to promote mobility (adapted from Kneafsey 2007b)

Developing relationships with patients	Using splints to treat and minimize spasticity and contractures
Use motivational and teaching skills	Isotonic and isometric muscle exercises to maintain and improve strength
Therapeutic positioning and transferring of patients to treat and reduce abnormal tone	Implement exercise and walking programmes to increase strength, balance and activity tolerance
ROM exercise to maintain and improve joint flexibility	

More recent literature provides further guidance for nurses relating to mobility rehabilitation. For example, Rensink et al. (2009) reviewed the evidence relating to the impact of task orientated training for stroke patients. The review found that task oriented training did lead to improved functional outcomes compared with traditional therapies. They advocate nurses incorporating task orientated training activities into daily nursing care. A range of activities in which nurses could engage is tabled such as: assisting patients with mobility and walking practice, assisting with activities of living, guiding balance exercises during standing up and sitting down, training patients to reach for items by putting them further away, exercises to improve balance; and promoting physical fitness outside of therapy sessions. Whilst reviews of this nature are of great value, the assumption is made that nurses are able to take up these tasks, simply because of the 24 hour nursing presence. Whilst the authors advocate that nurses could ‘bridg(ing) the gap between disciplines’ (p738) it is also acknowledged in the limitations that none of the studies reviewed directly examined task oriented training in relation to nursing. As such, the recommendations are based on extrapolations, rather than actual feasibility studies.

Others have argued that nurses should focus their attention on enabling patients to retain joint flexibility in order to maximise mobility in particular. For example, Tseng et al’s. (2006) RCT in Taiwan involving 59 bedridden stroke patients examined the impact of a four week programme of nurse led range of motion exercises in improving the functional outcomes for older residents who had suffered a stroke, living in residential care. The authors suggest that if the correct training is given, nurses could

assist patients with such exercises. Three groups were included – a control group which consisted of usual care (group 1), an intervention group where the nurses supervised the range of movement activities, (group 2) and a second intervention group where the nurse physically assisted the patient to complete the exercises (group 3). Results demonstrated significant increases in patients' joint ranges in the intervention groups as well as reduced experience of pain and improved mood, with the best improvements in joint range seen in group 3 where nurses physically assisted the patient. Unfortunately, the study did not involve measuring how long the positive effects of ROM exercises lasted. However, the authors identify that nurses may be 'the only hope' (p189) for patients who do not have access to physiotherapy due to staffing shortages, service limitations and referral criteria. However, they also identify the possibility that role conflict may occur between nurses and physiotherapists in this sphere of clinical practice.

Since the above study, further guidance on how best to promote rehabilitation has been published. Miller et al. (2010) provides a 'scientific statement' and summary of evidence relating to the management of post stroke patients in both inpatient and outpatient rehabilitation settings. The evidence summarized identifies a range of treatment modalities that have shown the most promise in terms of increasing patients' functional and motor abilities. Constraint induced therapy, treadmill training (with and without body weight support), task specific walking practise (known as gait orientated training), and strength training of the lower extremities (but particularly of the knee extensor) are all identified as resulting in improved walking outcomes.

2.2.2 Increasing the Nurse's Role in Mobility Rehabilitation

It has been concluded that nurses could potentially make a much bigger contribution to promoting patients' mobility rehabilitation, particularly in relation to stroke patients. This perspective has gained momentum as studies have begun to accumulate showing that earlier mobilization post-stroke and more intensive therapy is associated with better levels of functional recovery (Kwakkel et al. 2004, Indredavik et al. 1999). In addition, there has also been a growing awareness that rehabilitation patients often spend their time engaged in non-therapeutic activities (Hoijsben-Schoenmakers et al. 2009). For example, De Wit et al. (2005) examined differences in the use of time by

stroke patients in four rehabilitation centres across four European countries. Patients in the UK spent the least time in therapy and most time alone in comparison to patients in Belgium, Switzerland and Germany. One key finding was the fact that most of the therapeutic time available to patients in the UK was provided in the form of nursing care.

One of the key arguments for a greater nursing role in specific therapy activities is the nurse's continuous presence. Indeed, the link between a greater proportion of registered rehabilitation nurse and shorter patient lengths of stay has been suggested (Nelson et al. 2007). Hoijben-Schoenmakers et al. (2009) argues that although rehabilitation interventions such as 'task-orientated training' are largely driven by physiotherapists, these should be built into the daily nursing care provided in hospital wards, particularly as there are often very few physiotherapists, who are able to devote only a short time to each patient. These authors conclude that nurses could be key in the development of 'evidence-based mobilization programmes' to increase the level of activation and training of patients in daily life activities. However, the actual practicalities regarding how such programmes would be implemented, how often, for how long and by whom, is left unarticulated.

However, for many nurses, assisting patients with mobility and movement and positioning may be considered merely a routine daily nursing task rather than a rehabilitative activity (Hill and Johnston 1999). Whilst American nurses may use extensive diagnostic and assessment skills to address patients' mobility needs (Chang 1995 Pierce et al. 1995), it has been suggested in the past that the response of British nurses is to contact the physiotherapist (Dalley and Simm 2001, Burton 2000). Alternatively, some authors have argued that nurses lack the time to engage in mobility rehabilitation. For example, patients in a study by Johnsson (2005) felt that when nurses were busy and had a shortage of time, asking for help with transfers was interrupting and disturbing the nurses. Unfortunately, Johnsson (2005) also identified that older people's experiences of being moved and handled by nurses were not always positive. Sometimes older people, feared that they would fall or would experience pain on being handled.

Indeed, some studies have suggested that nurses lack the skills and knowledge to engage fully in mobility rehabilitation activities (Nolan 1997, Long et al. 2002). Numerous authors identify that direct care activities including ‘handling and positioning’ of patients require extra skills and knowledge (Waters 1991, 1996, Gibbon 1993, O’Connor 2000). In the research by Dowswell et al. (2000) it was observed that stroke patients were often seated and positioned poorly in their chairs and were not repositioned until mealtimes. Other studies involving student nurses have suggested that registered nurses continue to use ‘banned’ methods of handling and moving patients known to cause injury and pain to patients (Cornish and Jones 2009, Smallwood 2008).

In summary, this section has attempted to draw out the specific nursing contributions to promoting patients’ mobility rehabilitation advocated within the research literature. However, whatever nurses do contribute, it is clear that the nurse does not act alone, but works within the context of a rehabilitation team.

2.3 The Nurse Within the Rehabilitation Team

It is widely accepted that no one health care professional can be skilled in all areas of the rehabilitation process (Atwal 2005). For this reason, a team is needed whose ‘collective skills and knowledge meet their clients’ needs’ (Jester 2007, p6). According to Xyrichis and Ream’s (2008) concept analysis, teamwork is a ‘dynamic process involving two or more health care professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, or evaluating patient care’. The positive advantages of teamwork normally cited include, for staff, greater job satisfaction, recognition of individual contributions, improved mental health and reduced duplication of roles. For patients, the benefits are related to improved quality of care, value added patient outcomes and satisfaction with services. Although effective teamwork is argued to reduce fragmentation in the rehabilitation approach (Nocan and Baldwin 1998), the efficacy of the rehabilitation team is dependent on the quality of team relations. This issue is discussed in the following section.

2.3.1 Teamwork for Rehabilitation Practice

Within the rehabilitation literature, a range of terminology are used in relation to 'teamwork'. The term 'multi-professional' is generally used to describe any of three main types of teamwork identified as either multi, inter, or trans-disciplinary. Although precise definitions are illusive, it is possible to glean some broad distinctions from the literature. For example, multi-disciplinary teams tend to be characterised by professional role distinctions and boundaries, discipline specific goals and limited team communication. Inter-disciplinary teams work together more closely and share patient goals. Trans-disciplinary teams involve role blurring across professional boundaries and shared training to ensure clarity of team effort (Mumma and Nelson 2002).

Within hospital rehabilitation practice, a specific advantage of the team approach advocated is the notion that team members are often able to 'cover' in the face of another team member's absence, even if that individual is from another profession. According to Wade (2005), it is this characteristic of the team which makes it 'resilient to degradation' stating for example, that the 'absence of a physiotherapist due to holiday or sickness does not mean that the practice of walking and transferring stops. Rather, for a week at least, other team members can draw on the advice of the missing therapist to continue the treatment' (p2)

Although much theoretical literature extols the virtues of teamwork, research evidence identifies the patchy application of teamworking principles and in particular, the failure of team members to work towards the same patient focused rehabilitation goals (Routasalo et al. 2004). Pryor's (2008) study, spanning five rehabilitation settings found that collaboration between nurses and members of the multi-disciplinary rehabilitation team was often haphazard and team members rarely worked towards common rehabilitation goals. This was blamed on 'ambiguities and unresolved tensions about the roles of nursing and allied health staff in in-patient rehabilitation.' (p316).

Others have identified organisational challenges to rehabilitation teamwork such as poor staffing ratios and staff turnover (Dalley and Simm 2001, Gibbon 1999), nurses'

lack of time to attend team meetings, differing work patterns between professionals and differences in line management arrangements (Long et al. 2002). Pryor (2008b) found that nurses were marginalised from the 'social world of the multi-professional team' (p32) and describes segregation between team members as a contextual condition within the rehabilitation settings studied. This meant that teamwork was always suboptimal. Three factors contributed to divided work practices including the separation of therapy activities into different parts of the built environment, timetabling of therapy activities and nursing's continuous multiple patient care load.

Nolan (1997) suggests that nurses experience a lack of role specificity in comparison to other health professionals such as physiotherapy, dietetics or speech and language therapy because nursing is a 'boundary discipline' drawing on knowledge from a range of sources. Whilst breadth of knowledge is useful, it means that much of it is at a superficial level. For example, nurses may often describe themselves as a 'jack of all trades,' being required to know about and participate in a wide range of activities and treatments rather than focusing on a tightly defined remit (Pellat 2003, p156, Hill and Johnson (1999)).

Often, the extent to which patients experience continuity within their rehabilitation is dependent on the willingness of the various team members to collaborate, communicate and respect each other (Anderson and Dorsay 1998). A number of studies have highlighted that collaboration within rehabilitation teams is often manifest through role sharing. For example, nurses in Burton's (2000) study were prepared to undertake work aspects traditionally associated with therapists. Nurses' reasons for doing this revolved around the fact that physiotherapists had only limited time with patients, thus impeding the patient's potential for recovery.

Other researchers however, have illustrated that professional jealousies, lack of respect (Gibbon 1999) and 'protectionism' of professional skills may inhibit such role sharing. Long et al. (2002) found that some therapists within the rehabilitation team preferred nurses not to stray into their specific professional domain when assessing patients. Nursing role expansion was viewed negatively by some therapists as a professional development exercise 'encroaching into the work of other professionals, rather than a genuine attempt by nurses to improve the quality of rehabilitative care'.

(p67). Strasser et al's. (1994) survey of 113 staff within hospital rehabilitation teams regarding teamworking found that 50% of participants agreed that team members sometimes encroached on their professional territory and one in five felt that team members were defensive about their professional judgement. Indeed, skill sharing in aspects of rehabilitation such as therapeutic positioning may raise sensitive issues relating to professional status and autonomy which threaten the effectiveness of inter-professional working (Dowswell et al. 1999). For example, in the study by Lennon and Ashburn (2000), although most therapists agreed that patients should practice outside of therapy sessions, some were concerned about the quality of supervision being provided by non-therapists such as nurses.

Thus, nurses may engage in role sharing and blurring in order to minimise the effect of therapy staff shortages and to maximise the patient's rehabilitation recovery. However, when nurses themselves feel under pressure due to an increase in workload, an expanded role in rehabilitation may create tensions and questions over reciprocity within the team (Low 2003, Barecca and Wilkins 2008). Nurses in Long et al's. (2002) and Pellat's (2003) study desired reciprocity from therapists not only of the physical workload, but also to ensure that therapists drew on nursing expertise, for example, in skin care, knowledge of medications and of underlying medical conditions, to ensure that patients received holistic care. Nurses argued that there were many missed rehabilitation opportunities when nurses' specialist skills were either not recognised, used or sufficiently well developed. Dowswell et al. (1999) also suggested that nurse resented following 'prescriptions' provided by physiotherapists and occupational therapists because of the lack of reciprocity and because the activities were viewed as low status, unwanted activities (Dally and Simm 2001).

Increasingly, generic rehabilitation assistants have been introduced into rehabilitation teams in order to solve some of these tensions. Though little research has been undertaken to evaluate the effectiveness of such workforce developments (Lizarondo et al. 2010), some relevant publications can be identified. For example, Pullenayegum et al. (2005) brief case study describes the perceived benefits of employing rehabilitation assistants in one 28 bedded rehabilitation ward. In this instance, the introduction of the new role was to ensure therapy carry-over occurred over the weekend as nurses had concerns that rehabilitation stopped at 5pm on a

Friday, leading to decreased patient mobility and motivation. Indeed, Knight et. al (2004) undertook a structured evaluation of the rehabilitation assistant role by asking thirteen assistants to complete activity time sheets. This revealed that the dominant activity in which they engaged was helping patients with mobility tasks, washing and dressing and activities of living. Stanmore and Waterman (2007) ethnographic study provides a more detailed exploration of the role of rehabilitation assistants. Drawing on 55 interviews with a range of professionals, rehabilitation assistants themselves and patients, the rehabilitation assistant role was viewed as including: working with patients towards rehabilitation goals; supporting patients in activities of living; therapy carry-over; promoting independence and providing feedback to other members of the team. Although it has yet to be proven whether innovative team models such as these lead to better patient outcomes, the possibility that registered nurse role could be replaced by rehabilitation assistants has been raised (Ostaszkiwicz 2006).

Evidently, tensions within multiprofessional teams will create problems for staff, but also for patients who await treatment from them. Pryor (2008a) details how nurses responded to ineffective teamwork. Rather than taking a proactive approach to address deficiencies in collaboration, nurses 'distanced' themselves from poor teamwork, preferring to focus on the 'here and now' of patient care rather than attempting to remedy entrenched teamworking issues. Nurses avoided direct interactions with allied health professionals and contributed minimally to multi-professional team meetings. Similarly, nurses in the study by Barecca and Wilkins (2008) dealt with problems arising on the stroke unit by either walking away or using humour to solve difficulties. Unfortunately, strategies such as these achieved little improvement in teamworking arrangements.

In situations such as these, the importance of effective team leadership becomes clear. For example, Burton et al's. (2009) study of two Canadian stroke rehabilitation units identified the importance of nursing leadership to both raise the profile of 'stroke care' as a specialist service and drive forward service quality. However, within the rehabilitation setting, multiple teams may exist, such as the nursing team, the therapy team, the medical team and the multi-professional rehabilitation team. Each team may

be driven by very different goals, pressures, lines of managerial control and styles of leadership, causing barriers to collaboration (Axelsson and Axelsson 2009).

At the level of the rehabilitation team, the doctor has traditionally been viewed as the automatic team leader (Davis and O'Connor 1999), reflecting the socio-historic context for rehabilitation practice (Reeves et al. 2010). However, increasingly, individual patients' care will be managed and co-ordinated by the professional with the most involvement with the patient and his or her most pressing issue. In the face of such complexity, the rehabilitation team is in need of competent leadership. Leadership is needed to help develop a shared understanding of the goals and tasks of the rehabilitation team, to encourage individuals to respect and listen to each other and enable team disagreements to be discussed openly and constructively. Leadership within rehabilitation teams is also needed to enable feedback on the performance of the team to be provided (Bach and Ellis 2011). Without a steer from a leader or manager, role boundary frictions, hierarchical imbalances and professional 'turf wars' (Reeves et al. 2010) may detract from the provision of quality patient rehabilitation.

2.3.2 Nursing and Physiotherapy

A number of studies have shed light on the specific relationship between nurses and physiotherapists suggesting that lack of rapport can often exist (Dalley and Simm 2001). For example, Reed (1983) examined the ways in which nurses assessed the mobility needs of elderly patients across 3 elderly care wards by observing clinical practice and by conducting 34 semi-structured interviews. This revealed that rather than being a united team, nurses viewed physiotherapist in long term care, not as colleagues, but as competitors for control over the patient. Nurses also appeared to lack knowledge of physiotherapy practices and skills.

Clearly, this study is now quite dated and it is possible that interprofessional learning opportunities within undergraduate programmes ensure that health professional students qualify with a good understanding of the roles and scope of their colleagues. Indeed, if team members are to work well with each other, it would seem that a shared level of knowledge and understanding should exist between the different team members. However, nurses and physiotherapists may lack insight into each others'

roles if they do not have opportunities to work together closely. This in turn, may lead to professional misunderstandings.

In rehabilitation practice, nurses and physiotherapists may often work separately, without knowing what their respective goals and objectives are (Routasalo et al. 2004). For example, Pryor (2008b) reports that nurses working across the five in-patient rehabilitation settings involved in data collection, consistently reported physiotherapists to be the 'least likely to work with them' (316).

Another source of tension in the relationship between nurses and physiotherapist might relate to which professional makes key decisions regarding the patient's treatment. Gibbon's (1999) study of rehabilitation team conferences involving 111 observations of practice, concluded that the physiotherapist generally posed 'a challenge to the authority of the nurse' (p251). Whilst the nurse generally took on the role of leader by co-ordinating the meeting, the physiotherapist made the most patient progress decisions.

Whilst nurses in Reed (1993) viewed nursing and physiotherapy to be unrelated and separate, this perspective appears to have changed in recent years. Nurses in two large scale surveys identify the clear relationship between nursing and physiotherapy. Routasalo et al. (2004) found that most nurses, but especially Danish nurses (93%), agreed that nursing helps in the provision of physiotherapy (58%). Kneafsey and Haigh (2009) UK survey also explored the relationship between nursing care and physiotherapy. Overall, the results were positive with most nurses reporting a clear understanding of how nursing care contributed to physiotherapy treatment plans. In addition, nurses valued the knowledge of the physiotherapist. A final question asked nurses to indicate their views on the statement 'Physiotherapists have a lot to teach nurses about mobility and movement', and 461 (92%) nurses agreed with this. Although potentially enlightening, this study suffered from a low response rate with the possibility that only those with an interest in rehabilitation practice replied.

To summarise, it is generally recognised that a planned and co-ordinated team approach between the different professionals is needed for the benefit of patients' rehabilitation. One area where this is an expectation is in the sphere of mobility

rehabilitation. However, it has become difficult to discuss the nurse's contribution to patients' mobility rehabilitation without reference to nurses' risk of back injury. This issue is discussed in the following section.

2.4 The Influence of Legislation, Policy and 'the Professions' on Nurses' Mobility Rehabilitation Activities.

Whilst providing assistance with movement and mobility is central to many rehabilitation nursing activities, it has long been, and continues to be a problematic aspect of work. Historically, it was commonplace for nurses and care assistants to physically lift a patient's entire weight in order to move them. Whilst now designated as 'banned moves' patient manoeuvres such as the orthodox lift, Australian lift and cradle lift were all developed to allow nurses to achieve this frequent activity in the most efficient manner. However, nursing practice does not occur within a vacuum, but is influenced by legislation, policy and professional mandates. This section explores how these external influences have affected nurses' practices and attitudes towards mobility rehabilitation.

2.4.1 Musculo-Skeletal Injuries and Patient Handling

Studies from across the globe and over decades demonstrate that nurses are at high risk of work induced musculo-skeletal injury (MSI) involving the neck, shoulder and back (Sienkiewicz et al. 2007, Bos et al. 2007, Cunningham, et al. 2006, Hou et al. 2006, Trinkoff et al. 2006, Smith et al. 2005, French et al. 1997, Buckle 1987). The Department of Health in the United Kingdom (DOH 2002) reported that one in four nurses has taken time off with a back injury sustained at work. Although these statistics are now dated, there has been no recent UK study to collect epidemiological data regarding nurses' back or musculo-skeletal injury rates. Indeed, the National Audit Office (NAO 2003) draw on data originally reported in 1996 by the Institute of Employment Studies (Seccombe and Smith 1996). This study found that at least 80,000 nurses hurt their back each year.

Patient handling activities are often blamed for the high rate of musculo-skeletal injuries in nurses (Alexopulis et al. 2003, Pheasant and Stubbs 1992). During patient

handling activities, the biomechanical peak load on the spine can reach unacceptably high levels posing a threat to spinal health (Yip 2004). The nature of nursing work means that the cumulative load grows as patient transfer tasks are repeated over the shift, throughout the week, over the month and so on into the years worked by the nurse. Nurses in a study by Engkvist (2006) undertook on average 20 patient transfers per work shift. The most frequent patient transfers were, moving up the bed, turning or rolling patients in bed, or moving the patient from lying to sitting in bed.

Other risk factors often compound the patient transfer task including heavy lifting, repetitive strain and awkward postures (Yip 2004). The nature of the work organisation may cause difficulties such as the infrequency of rest breaks, the distribution of tasks and the timing of certain activities during the day which may increase the level of risk. The work environment too may be important, as the flooring, lighting and the space available will affect how patient handling manoeuvres are carried out. The characteristics of the patient must also be considered. For example, patients with contractures, spinal injuries, orthopaedic conditions, catheters, drains, excess weight, poor cognition and limited mobility may present the practitioner with particular difficulties when moving them (de Castro 2004). Patients who are unable to cooperate or have cognitive difficulties may also pose additional challenges.

The risks associated with nursing work have long been recognised with early authors noting the dangers associated with transferring patients from bed to toilet, to wheelchairs and to commodes for example (Garg and Owen 1992, Marras et al. 1999). Menzel et al. (2004) identify high risk patient handling tasks for work related musculo-skeletal disorders such as turning, bathing and dressing patients, moving patients up the bed and transferring patients from bed to chair/toilet. A range of typical and everyday nursing activities such as these are designated as either, high risk, higher risk or highest risk as detailed in table 3 (p41). What is evident is that this table encompasses most rehabilitation nursing activities which relate to direct patient care suggesting that most rehabilitation nursing activities are inherently risky. Clearly, work activities and working environments have important effects on the physical and mental health of workers.

Table 3: Patient Handling Tasks by Risk Category (from Menzel et al. 2004)

High Risk	Higher Risk	Highest Risk
Pushing patient in wheelchair	Transferring patient from bed to wheelchair using a mechanical lift	Manually transferring patient from wheelchair/bath to toilet/bed or from toilet/bed to wheelchair/bath
Transporting patient in a shower trolley	Repositioning patient in bed (to head of bed)	Repositioning a patient in a chair or wheelchair
Bathing patient in a shower chair/trolley	Moving patient from side to side in bed	Making an occupied bed
Applying compression stockings	Weighing patient using sling lift/bed scale	Dressing a patient
	Lifting patient from floor using mechanical lift	Manually transferring a patient from bed to trolley
	Manually transferring patient from bed to shower trolley	Performing neurogenic bowel care
	Bathing patient in bed	Transferring a patient from bed to chair using a stand assist lift

2.4.2 The Manual Handling Regulations and ‘No-Lift’ Policies

In 1992, the Manual Handling Operations Regulations (MHOR) legislation was introduced to protect all workers from injuries associated with manual handling (HSE 1992). This set out legal requirements for employers to assess all manual handling operations such as patient handling, to identify potential risks of injury to either patients or staff members and to minimise existing dangers. This legislation also highlighted the legal duty of practitioners as employees to ‘make full and proper use of any system of work provided by their employer,’ in order to fulfil their duty to take reasonable care over their own health and safety (Pellat 2005, Dimond 2002).

In the UK, this legislation led to a raft of guidance and policy which discouraged the use of manual approaches to handling patients (Smith 2005, HSE 1998). At that time, the guidance issued from the RCN on patient handling (the 1996 Code of Practice for Patient Handling) after the introduction of the legislation was particularly influential.

A key message promoted within this guidance was that manual patient handling should be eliminated, except in exceptional or life threatening situations. Although the document contained a number of provisos, it was largely interpreted as stating that all manual patient handling should cease. Similarly, UK Government health and safety policy (HSE 1998) identified ‘special situations’ which might involve manual handling with higher risk, such as assisting patients’ with mobility. However, despite this, many hospitals and community services introduced ‘no-lifting policies’, to which all staff were expected to adhere (p221 Smith 2005).

Much debate ensued as practitioners questioned whether it was actually possible to adhere to this policy whilst caring for patients. Hignett and Richardson (1995) identified that nurses could feel alienated by rules on ‘no-lifting’. They highlighted the fact that the MHOR’s were developed initially in relation to the handling of inanimate loads, leading to questions regarding their relevance to the handling of people. They stated that:

‘the extraneous and unpredictable factors that often complicate the handling of animate loads in a health care context , such as shape, size, disability and compliance may preclude the use of the safest handling techniques’ (p221).

Griffith and McArthur (1999) discussed the conflict between the care of self and the duty to care for the patient, identifying that some carers took the view that a ‘no-lifting’ ethos contradicted the core purposes of the carer’s role. Indeed, in 1997, a unified concern was voiced by the nursing, physio- and occupational therapy professions that ‘no lifting’ policies would constrain rehabilitation practice, to the detriment of patient care (Chartered Society of Physiotherapy, the College of Occupational Therapists and the Royal College of Nursing 1997). In particular, rehabilitation nurses argued that the new legislation and related restrictions meant that they could no longer provide patients with sufficient opportunities to weight bear or undertake walking practice (RCN RICNF 1999).

Since the introduction of such policies, the potential and actual conflict between the Human Rights Act (1998) and health and safety legislation (MHOR 1992) has been clearly identified (Hignett et al. 2007). In adhering to strict no-lift policies, health

care professionals have been accused of breaching their duty of care to patients. For example Mandelstam (2003) outlines the complex case of A&B versus East Sussex County Council (2003) which revolved around the assessed needs of two profoundly disabled women living at home with their parents. In this situation a disagreement between the parents and the local authority regarding how their daughters should be moved, led to a series of principles being established in the court of law. For example, it was judged that 'likely to be unlawful would be manual handling policies that in blanket fashion a) ban lifting, b) ban lifting unless life is at risk, or c) automatically ban lifting unless equipment cannot be used.' (p529). However, in other court cases, practitioners who have sustained career ending back injuries as a result of manual patient handling have been denied compensation (e.g. Sussex Ambulance Trust V King 2002).

The complexity of interpreting the law in relation to patients' rights and health and safety has led to the conclusion that Manual Handling Advisors must take account of the views of all parties involved to ensure that a 'balanced decision' is made (Mandelstam 2005). This accepts that practitioners may be required to participate in an element of manual handling at higher risk because the routine use of hoists cannot be accepted, and since the law courts have deemed blanket 'no-lift' policies to be unlawful.

2.4.3 Therapeutic Handling: An Alternative Approach

Despite initial ethical and legal concerns with the application of the MHOR's in health care settings, the RCN initially chose to adopt the no-lifting stance, and argued that using equipment to move patients should be favoured over manual approaches (RCN 1997). In contrast, the CSP (2002) took the stance that the wholesale avoidance of manual patient handling activities would result in physiotherapists being forced to abandon the goal of the rehabilitation of patients.

In its guidance for physiotherapists (CSP 2002, p11) the CSP stated that the RCN manual on patient handling (RCN 1997) was not necessarily appropriate for the profession of physiotherapy which had opted for an 'alternative philosophical approach'. This approach focused more on providing patients' with opportunities to

practice perhaps limited abilities, using manual approaches to patient handling. As a result of the differences in the way the legislation was interpreted by the professional bodies for nursing and physiotherapy, physiotherapists, continued to engage in ‘therapeutic manual handling’ whilst nurses were professionally required to adopt the no-lifting stance.

To some extent, this led to increasingly clear delineations between the roles of nursing and physiotherapy in relation to patient handling and mobility. This was further reflected within the policies of healthcare organisations as they sought to identify which healthcare workers could engage in what activities. An example of this is provided in table 4 below which details a comparison of therapeutic handling and care handling provided by Leicestershire County and Rutland NHS Primary Trust (2008). This policy was developed with the purpose of clarifying for staff the process of delegating and providing advice regarding therapeutic handling.

Table 4: Moving and Handling Policy, Leicestershire County and Rutland NHS Primary Trust (2008)

Therapeutic Handling	Care Handling
Exclusively initiated by therapy staff	All patient handlers receive manual handling training
Could involve calculated risk taking	Could involve minimal risk taking
Is short in duration	Is constant
Usually involves patient participation	Patient participation is not essential
Aims to improve or maintain function	Meeting basic needs
A level of professional knowledge e.g. OT or PT	Awareness of safe handling principles
An individual goal oriented structured approach	Task oriented handling
Formal assessment of changes and ongoing review documented	Care plans are updated as necessary

What is interesting about this distinction is the identification of therapeutic handling as the ‘exclusive’ domain of ‘therapy staff’. Although the academic nursing literature argues that nurses could well be classified as ‘therapists’, in that nursing interventions can be identified as therapeutic (McMahon and Pearson 2002), within the NHS this title refers to physio- and occupational therapists, thus excluding nurses from this type of patient handling. As such, though nurses may possess a commitment to promoting

patients' mobility, compulsory 'no lifting' policies may be perceived as a hindrance to the rehabilitation process and to the nurses' contribution. Indeed, 77.6 % of the 501 nurse respondents to Kneafsey and Haigh (2009) postal survey identified that 'no-lifting' policies were used in the workplace and 33.4% of these respondents felt the policies interfered with rehabilitation.

2.4.4 A Proliferation of Terminology

Since the introduction of the MHOR (HSE1992), there has been the proliferation of new terminology relating to patient handling. With the publication of the Manual Handling Operations Regulations (MHOR) most practitioners became familiar very quickly with the definition of *manual handling* used within the regulations, which described it as '...any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or bodily force' (HSE 1992). However, the ensuing debate within and between the professions regarding how the regulations should be interpreted and implemented in relation to rehabilitation practice, led to an increase in the range of terminology used to describe patient handling.

A number of new terms were detailed within the physiotherapy literature in particular. These included the terms 'care handling', 'treatment handling', 'therapeutic handling' and 'rehabilitation handling'. However, the meaning of these new terms was not initially clear until around 2002 when a series of professional publications were released. *Care handling* was defined by the RCN rehabilitation and intermediate care nursing forum as patient handling activities undertaken with the aim of enabling the patient to meet a nursing need (RCN RICNF 2002). The CSP (2002) provided a definition of *treatment handling* describing it as 'any manual handling involved in a physiotherapy treatment programme' (p16). This definition appeared not to relate to nursing practice. The CSP also defined *therapeutic handling* describing it as 'manual handling which may involve the taking of calculated risks as part of a treatment or rehabilitation programme, which are appropriate and essential to the patient's progress towards optimal function. It can be distinguished from the need to handle patients in order to just move them from place to place, commonly referred to as care

handling' (CSP 2002). At that time, the CSP also identified that there may be 'potential conflict' between the objectives of progressing the patient's rehabilitation programme and minimising manual handling risk. '*Rehabilitation handling*' was defined by the CSP (2002) as 'all the activities which involve handling as part of the patient's rehabilitation programme. This includes the handling that is undertaken by the key treating physiotherapist themselves and staff, relatives or carers who are delegated to or advised on handling procedures' (p4).

However, whilst these definitions can be derived from the legislative, policy and professional literature, it is not clear whether nurses working at the coalface of practice share these understandings. For example, Kneafsey and Haigh (2009) identify the lack of clarity in the definition of key terms relating to patient handling used in common parlance amongst rehabilitation practitioners. Of a sample of 501 responding nurses, 196 (38.9%) respondents felt the terms 'rehabilitation' handling and 'therapeutic' handling referred to different activities whilst the remainder believed they were the same thing.

2.4.5 The Importance of Patient Handling Equipment

The introduction of the 'no-lifting' approach brought about an increased emphasis on using equipment to handle and move patients as a way of avoiding manual handling. Internationally, using assistive patient handling equipment has been identified as an important ergonomic control to reduce the risks associated with lifting, moving, and pulling loads (de Castro 2004). For example, Engkvist (2007) documents the introduction of a no-lifting policy into two Australian hospitals and reports that nurses working in the no-lifting intervention experienced increased well being at work. An unexpected result was that the second most often reported benefit of the intervention was that nurses' perceived that patients became more independent in their movement and found transfers safer and more comfortable. It is not clear how this information was ascertained and this finding is not explored in detail. However, one might surmise that nurses developed greater ability to coach patients to assist themselves.

Debates and questions over whether equipment is a help or a hindrance to rehabilitation processes continue. Whilst it is largely accepted that using handling

equipment reduces caregiver strain, some practitioners continue to fear that over-using patient handling equipment could lead to immobility and limit patients' functional independence (Mitchell et al. 2005). For example, Kneafsey & Haigh's (2009) survey found that although almost two thirds (325, 65%) of the nurses found that handling patients manually was more tiring than when using a handling aid, almost one half (200, 40%) believed that manually helping patients stand or transfer helped them to regain more mobility than if an aid were used.

Therapists' beliefs about equipment use have also been explored. Darragh et al. (2009) analysed therapists' attitudes to using equipment within a 'minimal lift' environment. Many felt initially that using equipment did interfere with the rehabilitation process and delayed independence. However, on further discussion, it became evident that despite this, a wide range of equipment was used at different phases of the patient's recovery with good effect for both patient progress and for the therapist's safety.

Indeed, there has been growing unity from nursing and therapy professions on the value of using equipment to enable 'therapeutic safe patient handling' and to promote rehabilitation. This new level of agreement has been fuelled by a growing body of research to show that nurses are not alone in being at risk of developing musculo-skeletal injury (MSI). Indeed, the problem of back pain and MSI in physiotherapists has begun to receive much greater attention, becoming an internationally recognized phenomenon of its own (Nyland and Grimmer 2003, Glover et al. 2005, CSP 2008, Alrowayeh et al. 2010, Siquerira et al. 2008).

Physiotherapists have traditionally been viewed by themselves and others, as immune from MSI. A common perception has been that the physiotherapist's expertise, knowledge and skill in patient handling offers protection from injury (Campo and Darragh 2010). As such, physiotherapists have traditionally worked at higher risk. For example, a survey by Tyson et al. (2008) identified that therapists may hold strong preferences for the use of manual facilitation techniques, viewing patient handling equipment as a hindrance to rehabilitation strategies (Darragh et al. 2009, Ruzala and Musa 2005). However, current professional physiotherapy guidance (CSP 2008) now urges therapists to take precautions to prevent their personal risk of

MSI. It is stated that ‘if the use of equipment can significantly reduce any risks as far as reasonably practicable and still allow rehabilitation, then the physiotherapist must use the equipment’ (p24).

In the UK, Ruzsala and Musa (2005) present an additional argument for the use of equipment to assist in the process of moving patients in the early stages of rehabilitation. They suggest that equipment use may provide greater consistency of patient movement and is preferable to poorly performed manual techniques. However, they also offer a cautionary note and argue that equipment must not be used as a wholesale alternative to manual facilitation of movement. After evaluating four patient handling devices used to facilitate sit to stand transfers they questioned whether stand aids could be used to promote normal patterns of movement (p36). In addition, they found that equipment led to therapists adopting awkward postures and limited their ability to respond to patients’ treatment needs.

Thus, since the introduction of the MHOR’s, new ideas have emerged in relation to patient handling such as the need to avoid lifting and of the value of handling equipment. A major influence has been the development of the concept of the ‘safety culture’ which continues to alter the way in which this aspect of rehabilitation practice is viewed and carried out.

2.4.6 ‘Safer’ Patient Handling

Cooper (2000) describes safety culture as a sub-facet of organisational culture, which is thought to impact on members’ beliefs and attitudes towards the organisation’s health and safety performance. The aim of improving the safety culture is to reduce the number of accidents that arise from routine tasks (Engkvist 2003). As the concept of safety culture has been applied to patient handling, the ‘safer patient handling’ movement has emerged. The components of a ‘safer patient handling approach’ include the reduction of manual patient lifting wherever possible, thorough ergonomic assessment of the workplace, education for staff regarding safer handling, combined with patient assessment skills and evaluation processes to monitor the implementation of the safer handling approach (de Castro 2004, Wilson 2001).

From this description, it can be seen that the safer handling approach is much less simplistic than previous 'no -lifting' rules. Indeed, recent writers have provided strong critique of such draconian measures. For example, De Ruiter (2008) identifies that no-lift policies imply that nurses and caregivers lack the cognitive ability to make sensible judgements about their personal safety and therefore require protection from themselves. De Ruiter argues that this attitude undermines nurses' professional autonomy and judgement. Through his sensitive and detailed institutional ethnography of patient handling in an American neurology rehabilitation unit, De Ruiter provides vivid descriptions of nurses' patient handling activities.

The findings from this study shed light on nurses' reasons for not following hospital patient handling policy. These reasons often related to patients' preferences to be left alone, or to be moved manually due to pain. In this study caregivers often lacked the time to get equipment or were distracted from their activities by other patients and call bells. Whilst these reasons may make rational sense to fellow nurses, in the face of institutional policy, they were not defensible. Indeed, De Riuter concludes that the immediate demands of the patient care environment often make it difficult for nurses to apply 'theoretical models' (p167).

Whilst the application of a 'safer handling approach' may appear to be straightforward, it is not without challenge. For example, a safer handling approach requires substantial support from management tiers to make it a reality, not least to provide the patient handling equipment needed to reduce manual handling (Smith 2005, Mark et al. 2007). Engkvist (2003) investigated factors involved in the accident process preceding over-exertion back injuries among nurses in a Melbourne hospital. All nurses (n=127) who sustained an injury in the 13 month study period were interviewed using an ergonomic checklist. This study found that most back injuries occurred during routine patient transfer tasks occurring in the bed or to/from the bed. Nurses were also often compelled to work in awkward positions because of a lack of space and relied on their own musculo-skeletal strength and that of their co-workers, to complete the transfer. Nurses tended not to use handling devices, largely because they were unavailable and felt stressed and rushed during the transfer.

Adopting a safer handling approach may also lead to conflict within the multi-professional team. For example, Kneafsey (2007) identifies that nurses working in rehabilitation settings may face difficult dilemmas of whether to a) comply with legislative requirements and professional nursing standards in safe moving and handling or b) contribute to inter-professional rehabilitation care and therapy carry-on work. Kneafsey (2007) defines these competing demands as reflections of two distinct paradigms, with differing centres of gravity - the safety culture paradigm and the rehabilitation practice paradigm. The implementation of rehabilitation patient handling represents the interface of these differing paradigms.

An example of this conflict is described by Mutch (2004) who explains how nurses on one stroke care ward were challenged to change their patient handling practice in order to adhere to the no-lifting Trust policy. Nurses were told that Bobath based patient transfer techniques used by the physiotherapist were no longer tenable. Despite resistance to change from nurses and patients, three stand aid hoists were trialled. Although initial fears were voiced that the hoist would detract from the rehabilitation process, staff, patients and the physiotherapist found the stand aid to be a valuable addition to the rehabilitation process, leading to safer, less tiring transfers particularly in the early phase rehabilitation. Similar issues are raised by Mitchell et al's. (2005) action research study which aimed to foster much greater nursing ownership of patient handling practices and to enhance shared working between nurses and patients

2.5 Chapter Summary

Drawing on the research literature, this chapter has illustrated a number of components to the rehabilitation nursing role including creating a rehabilitation ethos, providing emotional support and co-ordinating the activities of the rehabilitation team. Nurses are also recognised as central to the provision of patients' physical bodily care with a linked contribution to therapy carry-on and integration. Although the therapy carry-on role is advocated as a valuable aspect of the nurse's role, little attention is given in the literature as to the feasibility and consistency of this contribution.

Whilst the volume of research literature is scant, a range of potential nursing contributions to promoting patients' mobility can also be determined. Most recently, it has been argued that nurses could implement 'evidence based mobilisation programmes', including activities such as task oriented training, balance and fitness exercises, joint flexibility exercises, treadmill training and walking programmes. However, the actual practicability of nurses' implementing such interventions is not explored. For example, studies have yet to identify how the most appropriate individual programme would be determined for each patient, by whom and how often and for how long such programmes would be implemented. Clearly, an intervention such as this would require a well co-ordinated and effectively functioning team with an appropriate level of shared knowledge. Unfortunately, an examination of literature relating to rehabilitation teamworking reveals particular difficulties with the team approach such as role protectionism, professional jealousies, and segregation of nursing and therapy staff.

This literature review has also exposed the problematic nature of patient handling activities. Since patient handling is associated with an increased risk of nurse injuries, nurses have been encouraged to use equipment to facilitate patient movement as a way of minimising injury rates. This has restricted nurses to a care handling approach. Whilst occupational and physiotherapists have continued to adopt a therapeutic approach to handling. This dichotomy has established the potential for delineation to develop within the rehabilitation team regarding who can and does what in relation to mobility rehabilitation.

CHAPTER 3

METHODOLOGY AND METHODS

3.0 Introduction

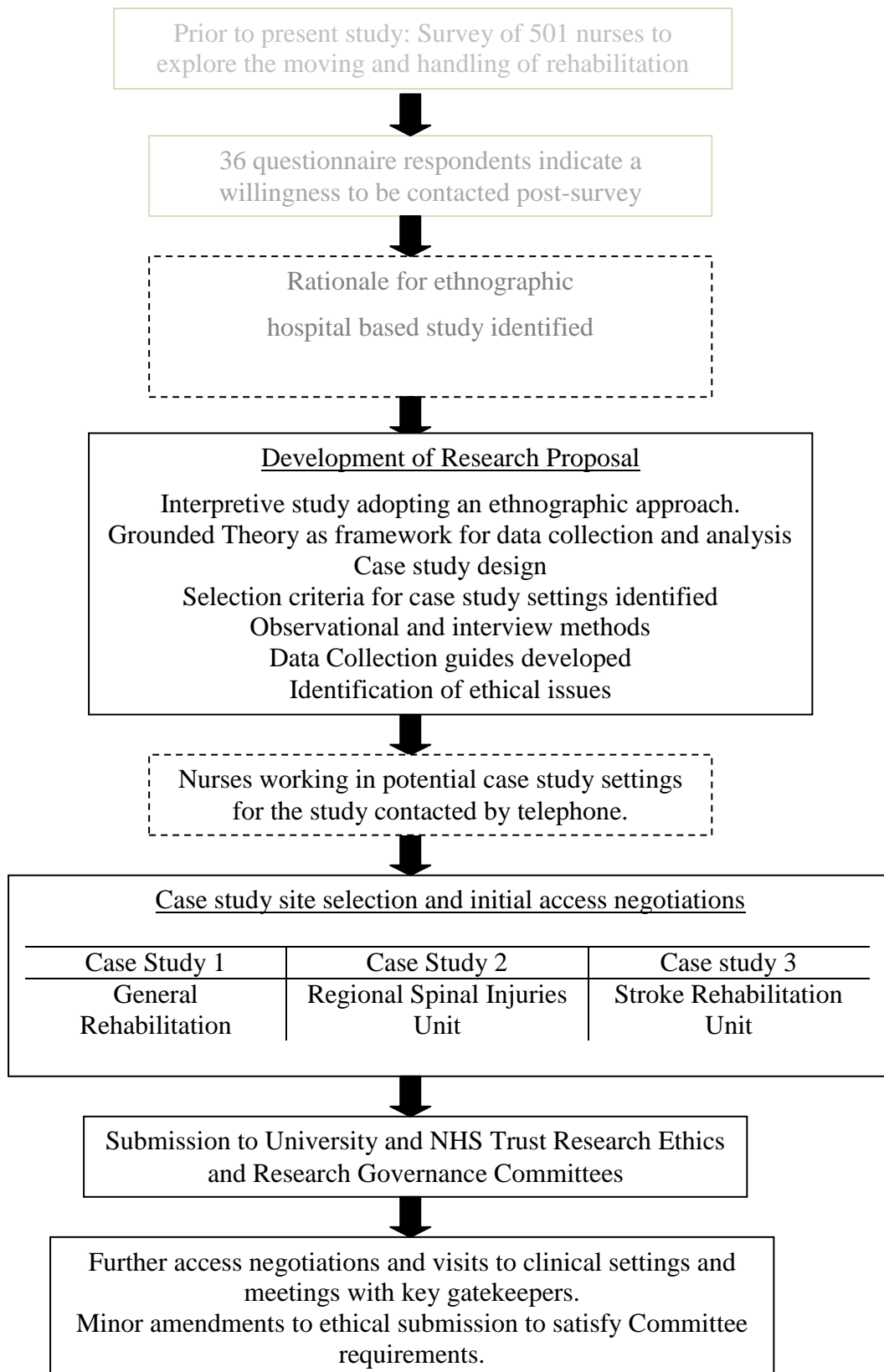
This chapter presents an overview of the methodology and methods adopted for the study and the underpinning philosophical and theoretical perspectives that guided it. The study was qualitative in nature and used a constructivist Grounded Theory approach to guide data collection and analysis, based within a multiple case study design. It involved the collection and organisation of empirical data regarding nurses' and care assistants' activities in relation to mobility rehabilitation to allow both a descriptive and explanatory theory to be developed (Punch 2000). Three hospital based settings comprised the cases or clinical settings for the study and included a general rehabilitation ward, spinal injuries unit and a stroke rehabilitation ward (case study sites 1, 2 and 3 respectively). Figure 2 overleaf provides an overview of the research process for the study.

3.1 Underpinning theoretical perspectives to the study

There are different ways of viewing the world and varying perspectives on what constitutes legitimate knowledge and suitable topics for research investigation. The researcher's ontological and epistemological stance therefore shape the choices that are made regarding what is to be investigated and also determines the methodological approach taken in the conduct of the study (Crotty 2003). Whilst quantitative research methods have the potential to provide valuable numerical and statistical data, these do not generally allow people's interpretations of the world and their interactions with others to be deeply explored. For this study, gaining an in-depth understanding of nurses' activities, views and experiences was an important goal. To achieve this, a qualitative approach was deemed most appropriate.

Qualitative research, in its many guises, allows researchers to adopt an interpretive and naturalistic approach. This means that qualitative researchers study things in their natural settings, 'attempting to make sense of, or to interpret phenomenon in terms of the meanings people bring to them' (Denzin and Lincoln 2000, p3)

Figure 2: The Research Process



Early social science research was typically modelled on the positivistic natural science approach and realist assumptions. These assumptions centre on a belief in the existence of an independent truth which can be discovered using appropriate methods. As such, proponents of the interpretive tradition argued that through the use of rigorous research methods, 'bias' and data contamination could be removed in order to objectively represent and 'reproduce' the true nature of phenomenon, to reveal the causation of human activity (Hammersley 1992, Schwandt 2000).

However, these early ideas evolved to include much greater understanding of the influence of society and social interaction on behaviour, belief and our conceptions of reality (Crotty 2003). Critics of the scientific approach argued that the excessive emphasis on procedural approaches to data collection meant that researchers were more likely to impose their own assumptions on the social world, rather than discovering new knowledge. Treating social phenomena as defined and distinct was also deemed problematic in failing to acknowledge the processes by which they changed and developed depending on culture and context (Hammersley 1992). From within the interpretive movement, a theory of symbolic interactionism was articulated by Margaret Mead and with further development by Herbert Blumer, through a series of publications during the 1930s to 1960s (Moule and Goodman 2009). This argued that the organisation of daily life and reality occurs and is constructed through interactions between people, and that people develop their identity through interactions with others and through their interpretations of them. It was however, Anselm Strauss who made the link between symbolic interactionism and the grounded theory method (Strauss and Corbin 1998).

These influential ideas led to the development of the constructivist perspective (Crotty 2003). This perspective asserts that meaning, rather than being discovered, is constructed through symbolic interaction between persons and objects. In addition, rather than the existence of one single true or valid interpretation, there exist multiple interpretations that arise out of the interaction and interpretation between people, culture and objects.

Postmodern ideas have also influenced the interpretivist paradigm by urging researchers to adopt a more critical attitude. It is argued that researchers must

question the shared understandings, interpretations and assumptions that are often possessed, simply through membership of the wider culture and exposure to its dominant discourse. Postmodernism also recognises that our understandings of reality will always be influenced by interpretations of the past, present and future, leaving us with the knowledge that there is no independent truth. All accounts are seen as constructions, neither impartial, neutral, nor complete, making obsolete the belief in privileged accounts (Brewer 2000).

On the basis of these theoretical underpinnings a set of assumptions were established for the study as detailed in table 5.

Table 5: Assumptions underpinning the study

- Natural sciences methods (such as experiments and structured surveys) are not appropriate for the study of social life because social life is not governed by law like regularities but is mediated through meaning and human agency.
- The chosen research methods should enable exploration and understanding of the social world using both the participant's and the researcher's understanding.
- The researcher and the social world affect, influence and change each other. The researcher's perspectives, values and social interactions will influence those being studied and the resultant findings. Therefore, it is impossible to conduct objective, value free research. Research data produced are not privileged, but are value mediated (Snape and Spencer 2006).
- Researchers should declare and be transparent about assumptions and viewpoints through a reflexive approach.
- Truth in qualitative research is not viewed as an 'independent reality'. Rather, it is a true representation of a socially constructed reality, developed through a process of consensus (Snape and Spencer 2006).

To enable the contribution of rehabilitation nurses and care assistants to patients' mobility rehabilitation to be explored, a suitable methodological approach had to be identified. Phenomenology has had important influences on the development of qualitative research. A key focus of phenomenology is to explore individuals' everyday constructions of their life world, or the 'lived experience'. Another important approach to qualitative research draws from the anthropological and ethnographic tradition and tries to understand the impact of culture on the patterns of experience and meaning developed by groups. Since the study was seeking to understand nurses' and care assistants' activities within a work context and in relation to team members, it seemed that the ethnographic approach was particularly suitable for this end.

3.1.1 An Ethnographic Approach

Ethnography seeks to generate an understanding of particular social worlds through immersion in specific communities to provide detailed descriptions of the culture, beliefs, activities and social meanings of people in a given field (Snape and Spencer 2006, Brewer 2000, Atkinson and Hammersley 1994). A variety of unstructured data are used such as in-depth interviews and document analysis, but a key approach is participant observation. This involves interacting with people in natural environments to understand the social world. Participant observation is based on the belief that complex social organisations are 'latent' organisations – unrecognised and undescribed by the members of the social world itself (McCall and Simmons 1969).

A true ethnography requires complete immersion in the field. Whilst this study did use naturalistic fieldwork methods that allowed me to experience the social world and culture of the informants (Johnson 1997 p8), there was also a need to sample a range of rehabilitation environments. Therefore, a trade off was made between complete immersion and the need to undertake theoretical sampling in order to enhance the possible generalisability of the study. According to Charmaz (2006) ethnography has typically been criticised, not least for its positivist traditions, but also for the length of time required for fieldwork, for the haphazard approach to sampling decisions, for the uncritical reporting of research participants' views', and its emphasis on describing

settings, rather than processes. In contrast, Charmaz (2006) offers grounded theory (within an ethnographic mindset) as a way of overcoming some of these possible pitfalls. She suggests that through the use of systematic guidelines for probing beneath the surface of the data, grounded theory methods can help to maintain control over the research process by focusing, structuring and organising it (p23). Accordingly, she states that:

'A grounded theory emphasis on comparative method leads ethnographers to 1) compare data with data from the beginning of the research, not after all the data are collected, 2) to compare data with emerging codes and categories and 3) to demonstrate relations between concepts and categories' (p23)

3.1.2 Grounded Theory Methodology

Grounded Theory relies on a process of inductive theory building which is based on a rigorous process of observing social life and interrogating data as it is collected (Crotty 2003). Originally developed by Barney Glaser and Anselm Strauss in the 1960s, it was underpinned by two key underpinning assumptions - a belief in an objective external reality and the neutral observer who 'discovers' data (Charmaz 2000). However, as criticism of the positivist paradigm has mounted, grounded theory methodology has evolved. For example, later versions of grounded theory presented by Strauss and Corbin (1990, 1998) adopted a post-positivistic stance. Whilst still wedded to the notion of an objective reality, this stance acknowledged that reality can only ever be 'imperfectly perceived' (Birks and Mills 2011). Thus, although clear attempts are made to reduce bias during data collection and analysis, much greater focus is on 'giving voice' to respondents. It is also suggested that to represent these voices as accurately as possible, researchers should ensure that their own biases do not infringe on the analysis. To achieve this, the following strategies are recommended:

- Compare incident to incident, introducing the approach of constant comparative analysis.
- Looking at the literature to stimulate analysis and interpretation.

- Obtaining multiple viewpoints of the topic of focus by collecting data in different ways such as observation, interview and the use of records (triangulation).
- Discussing analysis with respondents to ascertain whether there is a ‘fit.’

Although Mills et al. (2007) argue that the original proponent of a constructivist grounded theory was Anselm Strauss, these ideas have been more recently developed by Kathy Charmaz (2006) and further, by Adele Clarke (2005) who moves grounded theory into the post-modern paradigm. In contrast to early interpretivist beliefs, constructivist and post modern versions of grounded theory celebrate the inherent subjectivity of the knowledge creation process and acknowledge the interactional process of co-construction of meaning which occurs between the researcher and participant

Despite these ontological and epistemological variations, grounded theory tends to follow a recognisable pattern as a form of qualitative research which endeavours, through the systematic collection and analysis of empirical data, to generate a theory in relation to human action (for example, nurses’ patient handling practices) through an inductive-deductive interplay. The researcher begins with a broad topic of study and allows the theory to develop from the data. It is argued that because the theory is grounded in the data it is able to provide greater clarity and understanding regarding the research problem.

The process of theory development begins with the process of describing a phenomena and conceptual ordering and through to theorising as concepts are linked systematically to each other in order to create an ‘explanatory scheme’ (Strauss and Corbin 1998). Data collection and analysis occur consecutively and simultaneously. As data is collected, further decisions are made about what new data is needed and what questions might be asked of the data. The researcher must become immersed in the data in order to become sensitive to the subject being explored, and the connections that might be made between data and emerging concepts. This immersion spawns the need for a reflexive approach from the researcher. The researcher must

acknowledge that her own values, culture and experiences will impact on the researchers understanding and interpretation.

Charmaz (2000) identifies the key processes of Grounded Theory as 1) the simultaneous collection and analysis of data, 2) a logical and reportable coding process, 3) comparative methods, 4) memo writing to assist in conceptual analysis, 5) theoretical sampling, and 6) integration of the theoretical framework. Whilst these processes remain faithful to earlier presentation of Grounded Theory method, Charmaz argues that Grounded Theory processes do not need to be inflexible, but should seek to maximise the interpretive understanding that may be achieved.

Having established that an ethnographic approach would provide the overall ethos to the study, and that grounded theory would provide a structure to the data collection and analysis processes, a rationale for the location and settings for the research data collection was needed. It was anticipated that the study would have wider descriptive and explanatory relevance if data were collected from more than one clinical setting and spanned different nursing specialities. To achieve this, a multiple case study design was selected.

3.2 Multiple Case Study Design

According to Yin (1993, p3) 'The case study is the method of choice when the phenomenon under study is not distinguishable from its context' and where the focus is on a 'contemporary phenomenon in a real life context' (Yin, 1993, p3). In this case, the multiple case study design was selected to enable an 'holistic and meaningful' understanding of practitioners' experiences of promoting mobility rehabilitation, and the influence these have on their actual practice (Yin 1993, p3).

Case study designs generally follow an emergent and inductive approach which fitted well with the underpinning theoretical principles of the study. Case studies can be used well to gain insight into how people understand themselves or their setting, people's underlying feelings, and perceptions of what is going on around them (Gillham 2000). Qualitative methods are the main way of collecting information,

such as interviews and observational methods, as well as written documents. By using a range of data, it is possible to triangulate these to assess whether the information gained is convergent or divergent and to explain any differences.

3.2.1 Sampling of the Case Study Settings

Within the scientific tradition, generalisation has been accepted as a logical progression from the explanation and prediction achieved from scientific research. However, within the interpretive paradigm, this issue has been long debated. For example, case studies have been criticised for providing too little basis for generalisation (Yin 1993). Williams (2002) explores the arguments for and against making generalisations from interpretive research. One argument against is that because interpretive research is undertaken by a 'situated agent (the researcher) of a never to be repeated event or setting, it follows from this that the particulars of such accounts of the social world therefore cannot be used to generalise to other instances.' (p125). On the other hand, Williams suggests that it is vital and very much possible for interpretive researchers to make claims about the wider social world based on an assumption that some level of cultural consistency exists. Indeed, ethnographers often justify making generalisations from ethnographic studies based on theoretical inference or empirical generalisations (Hammersley 1992). Theoretical inferences are established on the belief that ethnography can generate theoretical insights with relevance to other populations of cases. The power of inference depends not on the typicality of the case, but on the strength of the theoretical reasoning (Seale 1994).

However, it is generally recognised that sampling strategies have a bearing on whether a generalisation can be made. Representative sampling involves trying to select a sample which is representative of the total empirical population of study. This is usually discussed in terms of the sample having the same or a similar proportion of characteristics (such as age, gender, ethnicity) to the total population about which one wishes to make generalisations. To do this, one must know the parameters of the total population to develop a sampling frame. By accessing a representative microcosm of the population, it becomes possible to claim that the patterns discovered within the microcosm are likely to appear in similar ways in the total population.

Therefore, if interpretivist researchers wish to make generalisations, a sample must be identified that will reflect important characteristics of the larger group to which it is wished to generalise. Although it is never possible to be certain that the sample and those people or settings within it will be the 'ideal type' to allow firm generalisations, it is largely accepted that 'cultural consistency' enables the researcher to interact meaningfully with the researched and to make reasonable comparisons between places and situations.

To this end, the cases were not selected on the basis of sampling logic, but followed a 'replication logic'. It was anticipated that findings which emerged across the three sites would be more likely to be trustworthy than those gained from one site (Yin 1994). Three varying clinical locations were selected to enable cross-contextual comparisons to be made. The aim was to use the detail of how people, teams and systems work in one setting to be able to understand work processes in other settings and to ascertain differences and similarities. The aim of the sample was to provide access to different interpretative experiences and a range of data to enable theory generation. The sample size needed to be large enough to enable the social process to be understood rather than to represent the population. The aim was not to establish causality, but to develop explanations.

Drawing on the work of Schofield (2002), a set of selection criteria were established to assist in identifying suitable case study sites. As the study focus was on hospital based nurses' and care assistants' experiences, the target locations would be in-patient settings. It was envisaged that generalist and specialist rehabilitation settings would be included and that these would be meeting the needs of patients with different conditions (sudden onset and chronic diseases). It was decided that both generalist and specialist clinical settings should be selected and any atypical features identified. Two key questions were asked - 1) How typical is the case? and 2) In what way is the case heterogeneous?

Whilst the Australian Association of Rehabilitation Nurses offers definitions of different types of rehabilitation facility, no such definitions could be identified for the UK. As such, defining what was meant by 'typical' was initially difficult to

articulate. However, a number of characteristics of a typical rehabilitation setting were developed from personal experience and knowledge of policy (Memorandum H19) shown in table 6 below. Similarly, it was not initially clear what might constitute an atypical example or case study which could represent ‘*what may be*’ or ‘*what could be*’ (Schofield 2002). However, an attempt was made to anticipate the types of characteristics that might be perceived as ‘leading edge’ or specialist (see table 6). Two additional criteria were also included. The setting needed to be within a reasonable travelling distance as regular contact would be needed to enable an ethnographic approach to be used. The manager of the clinical setting would also need to be willing to host a research project.

Table 6: Guiding inclusion criteria for a ‘generalist’ and ‘specialist rehabilitation setting

<p>Features of a Typical Hospital Rehabilitation Setting</p> <ul style="list-style-type: none"> • Focus on providing sub-acute care; • Staffed largely by a permanent nursing team (registered nurses and nursing care assistants) to provide 24 hour cover and carry over rehabilitation programme into daily activities; • Physiotherapy and occupational therapy staff attached to, but not permanently based on the ward; • Therapy provision Monday to Friday on a 9-5 basis; • Weekly multi-professional team meetings; • Medical staff cover and weekly consultant led ward rounds; • Accepts adults, mostly older with a range of conditions and illnesses that might require rehabilitation interventions, but mostly focusing on physical needs. <p>Possible Features of an ‘Atypical’ or Specialist Hospital Rehabilitation Setting</p> <ul style="list-style-type: none"> • Staffed by a higher proportion of registered nurses than generalist setting; • Dedicated therapy team - potentially present seven days a week; • Patients receive daily intensive therapy (more than 1 hours a day); • Role blurring between rehabilitation members and inter-disciplinary working; • Specific patient population.
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Once a set of inclusion criteria had been developed a number of clinical settings were contacted to discuss the research project. A subset of thirty-six respondents to an earlier postal survey (Kneafsey and Haigh 2009) who had indicated a willingness to be contacted in the future were telephoned and the project was discussed following a structured format (see appendix 4). These early scoping conversations revealed that some settings did not meet the broad inclusion criteria or were too far away (e.g. Northern Scotland). Finally, three settings were identified and initial agreement from the ward manager secured.

Table 7: Selection of case study sites

SITE	REASONS FOR SELECTION
General Rehabilitation Ward	An example of a generalist setting – covers a range of patient groups such as, medical, acute surgical and palliative care patients. Two Consultants, weekly multiprofessional meetings (but mainly nurses and doctors). However, also an example of the ‘ <i>atypical</i> ’ or an example of ‘ <i>what could be</i> ’ – two therapy assistant practitioners work on the ward who have completed a 2 year foundation degree in order to do physiotherapy and occupational therapy work. Classed as part of the nursing numbers.
Regional Spinal Injuries Unit	An example of the ‘specialist’ setting – spinal patients only and dedicated therapy cover (weekdays only) and medical team. Also a possible example of ‘ <i>atypical</i> ’ as the unit has its own ‘in-house’ training for patient handling. The ward sister states that the Trust is ‘no-lifting’ and that they are able to abide by this. Range of age groups accepted to the unit providing a contrast to an older adult only setting.
Stroke Unit	An example of a ‘specialist’ unit as admits only stroke patients and has a dedicated therapy team, though only weekdays. Also, possibly an example of the ‘ <i>atypical</i> ’ as the unit is covered by a ‘therapeutic handling policy’. This allows nurses to undertake manual handling as per physiotherapy instructions. This could be an example of ‘ <i>what could be</i> ’. As a specialised unit, it may provide a useful contrast to the general rehabilitation ward.

3.2.2 Justification for Hospital Focus and Inclusion of Care Assistants in Sampling

Although rehabilitation services have traditionally been provided within an inpatient setting, there has been greater focus at an ideological and political level on community based rehabilitation services in recent decades. The publication of documents such as the National Service Framework for Older People (DH 2001) and the National Stroke Strategy (2007) advocated the development of early supported discharge services in conjunction with inpatient specialist rehabilitation provision. The impact of such policies has been the widespread acceptance that in-patient hospital environments may be particularly damaging for older people. This, alongside the increasing pressure on acute care beds has led to greater development of intermediate care service such as hospital at home teams and early supported discharge programmes.

However, despite the philosophical shift towards community care, most rehabilitation provision continues to be provided within hospital settings. For example, even in the area of stroke care, a clearly defined specialism supported by a developing evidence base, community service provision is patchy and underdeveloped (RCP 2007). Murray et al. (2008) identifies the lack of community stroke care co-ordinators and others have identified that nurses are not always centrally involved or even present in community rehabilitation teams, despite their potentially important contribution (Langhorne et al. 2010, McGinnes et al. 2010. Kneafsey et al. 2003).

For this reason, the study selected to focus on hospital based rehabilitation nursing. It was anticipated that the hospital based setting would provide a more accessible 'critical mass' of nurses with a focus on rehabilitation who would be best able to inform the study. The study also included specialist rehabilitation settings, as well as one generalist rehabilitation setting. There are known advantages of specialist rehabilitation service provision over general inpatient settings. It is widely acknowledged that rehabilitation provided by specialist units leads to reduced mortality, better functional recovery, shorter inpatient stays and greater patient and care satisfaction (Jester 2007, p32). Most explanations for these benefits are related to effective teamworking, staff expertise and exclusive focus on rehabilitation.

Virtually all of the literature reviewed in relation to this study has focused on clarifying the role of the registered nurse in rehabilitation. The study reported here deviated from this pattern and included care assistants in the sample. There were a number of reasons for this. Registered nurses and care assistants work together as a 'nursing team' to provide patient care. As such, their roles are fundamentally intertwined. Existing literature suggests that care assistants may often function as substitutes for registered nurses and will complete most activities without supervision (Thornley 2000). Indeed, it has been acknowledged that the distinctions between the roles of registered nurses and care assistants is become blurred (McKenna and Hasson 2004).

A decision to exclude care assistants from data collection would have limited the extent to which an understanding of the registered nurse role would be possible, by removing part of the work context and important working relationships. Including care assistants was also logical because it is generally known that care assistants undertake much of the patient's direct physical care (Conway and Kearin 2007). Moreover, literature relating to patient moving and handling identifies the crucially important role of care assistants in moving, positioning and transferring patients (Rodgers 1985). In addition, more recent research highlights the fact that care assistants are often perceived by registered nurses and therapists as best placed to deliver therapy carry-over because of their active involvement in assisting patients with activities of living (Atwal et al. 2005). Excluding this group would lead to a potentially important contribution being overlooked.

3.3 Accessing the Sites, Ethics and Participant Recruitment

Before data collection could begin, access to the fieldwork settings had to be gained (see appendix 5). This began with a series of informal meetings with key gatekeepers such as the ward managers for each setting. Following this, an application was made to the NHS Research Ethics and Governance Committee as well as the University Ethics Committee.

Ethical issues often arise during the process of fieldwork and data analysis and later when the study is written up for publication. In particular, research relationships can often be characterised by disparities in power and status in the researcher's favour. As such, it was important to demonstrate that due attention would be paid to the protection of the wellbeing of participants. The culmination of ethical consideration and review lead to a set of parameters to which I was obliged to comply. It was agreed that interview digital recordings would be kept securely until the end of the project to facilitate data validation. Any subsequent reports using direct quotations would have the interviewee source and identity disguised. It was also clarified that as a qualified nurse I was bound by my professional code of conduct despite working within a research role. It was agreed that if practice was witnessed that was incompatible with that code then I would step out of the research role to intervene. This was made clear to unit staff both in the information sheet (see appendix 6) and on the day of the observation itself. No attempts were made to observe the rehabilitation treatment of very sick patients or those who could not provide informed consent. Further, I did not observe patients receiving help with movement or mobility if this had the potential to embarrass the patient or impinge on their dignity.

Once formal ethical approval had been gained, it was important to plan with the ward managers how data collection activities would be arranged and to clarify the process of recruiting and securing consent from staff and patients. Participants for interview were recruited from the clinical areas after invitations to take part and study information (see appendix 6) had been circulated to potential interviewees. This occurred approximately two weeks before interviews were scheduled for staff members. Nursing teams are composed of a range of staff, including nursing care assistants who mostly hold National Vocational Qualifications and registered nurses with varying lengths of employment experience and levels of educational attainment (including diplomas, undergraduate degrees and post-graduate degrees, and different exposure to 'continuing professional development' courses). To gain insight into the range of perspectives which may exist within nursing teams, it was important to include different nursing grades including nursing care assistants, and registered nurse grades 5, 6 and 7. Other members of the multi-professional team who were involved in patient handling were also included in data collection where appropriate such as physiotherapists and occupational therapists.

Although patients were not the focus of this study, the way in which their treatment and care was provided had the potential to be observed. It was also possible that patients' moving and handling assessments would provide useful data. As such, the permission of all patients receiving assistance with movement and mobility was secured before observing any aspect of their care or looking at documentation relating to them. Information about the project was circulated to patients who required help with movement once staff interviews had begun (see appendix 7). However, consent to observe nursing care was sought only two days prior to data collection. Circulating information sheets earlier than this was avoided because of the likelihood of some patients being discharged home or moving to other wards. Inclusion in the study was subject to completion and signing of a consent form. Written consent was gained from staff and patients on the day of data collection (see appendix 8 for patient consent form and appendix 9 for staff consent form). There was no obligation on staff or patients to agree to take part. If staff or patients did not consent to be involved this was respected.

All transcripts were coded to maintain interviewee anonymity and confidentiality. All staff participants had the opportunity to read a copy of their interview transcript to check that their anonymity had been fully protected. It also allowed respondents the chance to further add to their interview or change any statements that they had made. None chose to do this. The ward sister was provided with a case study report at the end of data collection to further check anonymity had been preserved and to comment on the findings if desired. Patients' names were not recorded.

3.4 Data Collection Methods

Data collection methods were selected which would provide a 'thick description' of the phenomena of interest (Geertz 1973). Not only would this allow generalisation of findings from the included study settings to others, on the basis of 'fit' (Lincoln and Guba 2002), it would also provide the opportunity to make 'naturalistic generalisation' (Stake 2002). Naturalistic generalisation relies on providing others with the 'vicarious experience' in order to understand the phenomenon. To achieve this, the setting or phenomenon must be represented 'authentically' and more than a

surface approach to data collection must be taken. To achieve this, observational methods and semi-structured interviewing were selected as the main modes of data collection.

3.4.1 Participant Observation

The nature of participant observation has been debated and contested. It can be viewed as a positivist approach whereby observation is conducted with minimum interference, in contrast to the view that the observer must fully participate to gain an understanding of shared meanings (Savage 2000). The classic text by Gold (1958, cited in Atkinson and Hammersley 1994) outlined 4 variations on the role of observer ranging along a continuum of complete participant to complete observer. It is suggested that these roles may overlap and vary depending on the circumstances at a given time.

Observational methods of data collection are ideally suited when benefit can be gained from obtaining first hand experience of naturally occurring events. It is important to learn about what people 'do' in context rather than relying only on what they 'say' or think they do. Indeed, not all knowledge is '*articulable, recountable or constructable*' through retrospective interviews but is embedded in practice, rather than speech (Mason 2002 p85). Charmaz (2006 p25) notes that participants' most important explanations may consist of tacit understandings seldom spoken out loud or amongst the group, let alone to outsiders.

From a qualitative perspective, the aim of observational fieldwork is to immerse oneself in the day to day activities of the setting or organisation or the group which is the focus of understanding (May 1993). The focus of the observation is inductive with the aim of developing ideas rather than testing them (Mason 2002). It is anticipated that by participating in the lives of those in whom we are interested, an 'empathic understanding of the social scene' can be gained (May 1993, p114).

However, the value of observational data collection methods has been questioned. Critics argue that the researcher's presence means that objective data cannot be gathered. However, if it is accepted that the ethnographer becomes the instrument of

data collection, then the observer does not seek to ‘stand-apart’ from the context as a way of maintaining objectivity (May 1993). Rather, it is accepted that all knowledge is a co-construction (Mulhall 2003) and involves an active process of interaction between observer and observed (Kite 1999).

Angrosino & Mays de Perez (2000) argue that the conscious adoption of a situational identity, which may evolve and respond to different individuals, is an important means of undertaking an observational role. They argue that by adopting a particular role, the researcher is able to take part in a setting rather than reacting passively within it in a position assigned by others. Ashworth (1995) suggests that acceptance within a group requires openness and the occupation of a niche within the group that is acceptable, whilst enabling the researcher to complete data collection activities.

Working in the field requires a continuous process of renegotiation, often assisted by informal support as well as official gatekeepers. Gatekeepers may be suspicious or anxious about the researcher, who may be perceived as an ‘expert’, ‘critic’, or ‘spy’. To develop rapport with respondents, the researcher must therefore manage personal appearance (speech, dress, attitude) and employ tactics such as naiveté, friendship and questioning (Hammersley and Atkinson 1992). Table 8 provides insight into the way in which I conceived my own role and niche in the fieldwork setting.

Table 8: Reflexive Note on Observer Role:

<p>On entering the field, I made a conscious decision to be open about my purpose and I adopted a friendly manner. I explained to all staff about my role as a nurse, teacher and researcher. I presented the research on the unit as an opportunity for staff to discuss their role, the teamwork arrangements and the rehabilitation process. My niche within the group was therefore to facilitate reflection, to provide grounds for discussions and to raise the profile of nursing and issues related to moving and handling. This role was readily accepted, partly because each of the settings regularly had students on the ward, visiting lecturers and other researchers but also because of the ward manager’s support. It was important to share the observation and interview schedule with the nursing and therapy staff working within the settings, not only to</p>

check whether there were avenues that had not been considered, but also to inform the staff of the way in which the study was being conducted. This allayed the fears of some that they ‘might not be able to give the right answer’. Individual nurses’ and physiotherapists’ reactions to my presence varied. Some nurses were curious as to why anyone would want to study the subject, whilst others welcomed the interest and felt it was an opportunity to have nursing noticed. Some were initially anxious about being observed and worried that their standards of patient handling practice would be found lacking. This response was informative as it highlighted the very real pressure that nurses feel to perform to standards and the fear of being criticised.

3.4.2 Use of Participant Observation in the Study

Participant observation in this study involved spending time in the clinical environment and observing the activities, behaviours and interactions of rehabilitation team members. The aim being to comprehend everyday life experiences in order to begin to develop theoretical explanations for what was observed (Savage 2000). Although there have been debates over whether the production of observational topic guides are appropriate to grounded theory or whether they force data into ‘preconceived frameworks’ (Charmaz 2006 p18), a guide was produced to satisfy research ethics committee requirements (see table 9 overleaf). During observation periods, all events occurring relating to mobility rehabilitation had the potential to be observed (if both staff and patients consented). Interest lay in observing instances where manual handling approaches or equipment was used to assist or move patients. Occasions where nurses and physiotherapists worked together to help or coach a patient with movement were also of interest.

It was acknowledged that practitioners might change their behaviour because of the researcher’s presence. However, it was hoped that staff would become habituated to the researcher’s presence at least by the time the second visit had been completed and a number of staff interviews had been undertaken. It was regularly reaffirmed that the purpose of observation was not to audit, criticise or judge, but to describe and understand the realities of nurses’ rehabilitation practice.

Table 9: Observational Data Collection Tool

Observational Schedule
<p style="text-align: center;">Describing patient handling episodes</p> <p>Interest will lie in observing different types of event where the patient is being helped or coached with movement. For example, this might include observing:</p> <ul style="list-style-type: none">• Different types of activity – e.g. helping a patient move in bed, transfer from bed to chair, to walk, to change position, to stand up.• Events where one or more nurses/care assistants are engaged in providing assistance,• Situations where nurses/care assistants and physiotherapists are working together to move and handle a patient,• Other patient handling events using equipment or using manual approaches, <p style="text-align: center;">Naturally occurring conversations</p> <p>Conversations between nurses, care assistants and/or physiotherapists and/or patients will also be considered important sources of data.</p>

The observational role adopted was participant in nature, seeking to gain a subjective understanding of the nature of nurse's and care assistants' work in relation to mobility rehabilitation. Although an observation guide was generated before entering the field, decisions about what to observe were flexible. An 'event sampling' approach (Gillham 2000) was used because it was expected that mobility rehabilitation activities would not be occurring continuously but would occur sporadically. My level of involvement with the social setting varied depending on the circumstances of the observation. At times, I stood back, observing from a distance, or sat at the nurse's station or stood at the end of a bay. When the nurses and care assistants were very busy, under pressure, did not know me well, or patients in the bay were very ill, I tended to keep a low profile. I did not want to get in the way or add to pressure.

Neither did I wish to intimidate nervous individuals or pressurise them into allowing me to ‘tag along.’ Standing back sometimes felt right.

At other times, I made tea for the nursing team, helped move furniture or gathered bed linen if needed. I did not attempt to maintain a neutral stance as a way of reducing the effect of bias on the generation of data. Some staff were open and actively involved me by talking to me whilst they helped the patient, or engaged me in conversations with the patient. This was helpful and gave greater access to the circumstances of care provision. However, I did not assume that this gave me an epistemological privilege or that because I was involved in the social event that I could effectively understand the phenomenon in the same way as the nursing team members.

During the observation, I was compelled to regularly reaffirm or renegotiate my role and identity and to become actively reflexive regarding my ‘ethnographic self’ (Coffey 1999). Whilst some nurses were well aware of my lecturer status others clearly thought I was a novice and suggested I should ‘get involved’ and do some patient handling. At the time because of the presence of patients, it did not seem appropriate to ‘confess’ that I actually taught student nurses about patient handling and rehabilitation and that I was actually also a qualified nurse. Although I felt uncomfortable withholding the information at the immediate moment, I also did not want to distract the staff member who was in the midst of patient care. Later, I was able to clarify my role and purpose in the setting. Overall, I would characterise my persona within the setting as enquiring, naïve, accommodating, open and enthusiastic. Although it is not possible to ascertain whether I was truly ‘accepted’ within the settings, I felt that once the ward manager as a key informant had agreed to my presence, this smoothed access issues and staff tended to be reasonably relaxed with me. There were two exceptions to this where my interactions with two nurses bore little fruit apart from hostility. Both nurses worked on the same ward and were hoping to leave.

The process of observing enabled a corpus of fieldnotes to be generated for each case study setting. Fieldnotes are recognised as a form of representation created through an active process of interpretation and sense making, allowing a version of the social world to be preserved and later studied and analysed (Emerson 2001). Fieldnotes

consisted of descriptions of; events taking place; organisational features of the buildings; the actions, behaviours and roles of particular people; key events such as ward rounds, team meetings, handovers or telephone calls; conversations and dialogue. Fieldnotes also included personal reflective notes, theoretical comments and analysis.

During the process of observing, memos were written openly and as fully as possible. These were later typed up in full both chronologically but also as a way of relating earlier events to more recent observed activities or dialogues. The table below provides a summary of the observational data collected. A more detailed breakdown is provided in appendix 10.

Table 10: Summary of Observational Data Collected

Activity N=number of episodes observed	Case Study 1	Case Study 2	Case Study 3
Hoisting	1	7	0
Sliding a patient	0	2	0
Helping patient walk	5	1	4
Sitting patient up in bed	1	5	0
Putting on stockings	0	4	0
Helping patient stand & transfer	6	1	6
Moving a limb	0	2	0
Wheeling a patient	4	0	0
Conversation about mobility	4	4	2
Joint working	0	0	0
Therapy treatment session	3	3	1
TOTAL DATA	24 events observed over 18 hours, across 5 days	29 events observed over 25 hours, across 5 days	13 events observed, over 18 hours, across 5 days

3.4.3 Interviewing

Within ethnographic studies, interviews are often used to find out about participants' 'intentions, motives and interpretations of events' as a way of supplementing direct observations (p4, McCall and Simmons 1969). In this study, interviews were selected because of a belief that people's knowledge, interpretations and experiences provided meaningful information regarding the social reality which the research questions aimed to explore (Mason 2002). However, the value of interviews is reliant on people's ability to verbalise and explain their views and give accounts of their perspective.

The qualitative interview seeks out rich, in-depth experiential accounts of events or experiences. In approach, it is vastly different to the way in which interviews are conducted in survey research. In survey research, questions are asked in a structured format and in the same order in an effort to increase objectivity. By doing this, it is assumed that any differences in participants answers are 'real' rather than the result of variations across the interview situation itself (May 1993). However, this study was not seeking comparability between participants' responses. A semi-structured interview approach was adopted (see table 11 for interview guide), but interviews had the potential to be open-ended if respondents wished to talk in more depth about a particular issue. Participants were invited to expand on certain points of relevance and clarification was sought where appropriate. In addition, because people within groups have their own particular language and meanings attached to words, additional probes and prompts were sometimes used.

Within a constructivist perspective, interviews are not viewed as impartial or 'neutral tools of data gathering but active interactions between two (or more) people leading to negotiated, contextually based results' (Fontana and Frey 2000, p646). As such, the meaning created is dependent on the context of the interview and the relationship between researcher and respondent (Mills et al. 2006). People may seek social approval within the interview, giving responses thought most appropriate, rather than those reflecting their real thoughts, feelings and actions (Zelditch 1969).

Table 11: Interview Guide

Interview Schedule
Introductions and general questions.
Promoting mobility and movement.
Attitudes to and use of equipment/aids to move and handle rehabilitation patients.
Beliefs about and use of manual techniques to move and handle rehabilitation patients.
Impact of moving and handling policies on nurses' and care assistants' roles in mobility rehabilitation and on patient handling practice.
Team-working and mobility rehabilitation.
Skills and knowledge relating to mobility rehabilitation and to the handling of rehabilitation patients.

The conduct of the interview was carefully considered as it was important to develop a genuine relationship of trust with respondents rather than manipulating the volunteer to be forthcoming. After the initial welcome, the interview was explained; its purpose, the topics for exploration; the process of interview transcription, verification and analysis and the way in which individuals' anonymity and confidentiality would be protected. After checking the digital recorder was switched on, this gave way to the substantive phase of the interview where the initial questions were asked and space provided for the respondent to volunteer their perspective. Where appropriate or asked, I volunteered my own ideas and did not evade direct questioning by the respondent. I was aware of the difference in status and role between myself and respondents although this did not seem to be problematic. On most occasions the interview seemed to follow the structure of a 'real' conversation in which views, opinions and experiences were shared.

Interviews were carried out with a range of staff in each clinical setting staff (see table 12). Each interview lasted up to an hour, and was recorded with consent, and most were undertaken in a private room at the case study site. Only a proportion of staff

working in each case study setting were asked to participate although a balance of different professional groups and grades were included. The aim was to maximise the breadth of experience and responsibility of the participating staff and anticipate the potential for variation in individuals' views and perspectives. Further detail regarding the sample is provided in appendix 10.

Table 12: Interview Participants

Interview Participant	Case study 1	Case Study 2	Case Study 3
Care assistant	2	3	5
Registered nurse	4	5	5
Ward sister	2	4	1
Physiotherapist	2	2 (short, not taped)	2
Occupational Therapist	1	1	0
Therapy assistant practitioner	1	0	0
Moving and handling co-ordinator	1	0	0
Total interviews	13	13	13

Case studies rely on the collection of evidence from multiple sources to enable the development of ‘converging lines of enquiry’ (Yin 1993). Whilst in this study, the main sources of evidence were interview and non-participant observational data, site specific documents (e.g. ward or Trust based moving and handling policies, educational and training documents, patients’ moving and handling assessments or audit data) were also valuable in either corroborating or augmenting evidence from other sources.

3.5 The Process of Analysis

Brewer (2000) defines ‘analysis’ as a process occurring simultaneously to data collection and the mechanism of bringing order to the data and interpretation. As data is organised into categories, inter-relationships between the data are identified.

Interpretation involves attaching meanings to the analysis in order to explain patterns and is a creative activity reliant on the researcher's imagination (Brewer 2000). In this study, the approach to analysis outlined by Charmaz (2006) was particularly valuable. Figure 3 (p80) provides a summary of this process.

All interview transcripts and observational notes were initially typed out verbatim and read. Codes were then attached to the data and inserted into the margins of each page, alongside notable extracts and events. Charmaz (2006) defines coding as the process of 'categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data.' (p43) The first phase of coding is described as 'initial' or 'open coding' (Charmaz 2006). This is achieved through the process of line-by-line coding which as a process assists in shedding new light on perhaps familiar or mundane phenomenon (see appendix 11 for example). Corbin and Strauss (1998) identify this as 'open coding and microanalysis' where fragments of data (words, lines, segments and incidents) are examined. During this phase, labels for data were derived from participants' terms to generate '*in vivo*' codes. The process of using *in vivo* codes to actively name the data provides a 'symbolic marker of participants' speech and meanings' (p55). Other codes applied can be described as '*gerunds*' to denote processes (Charmaz 2006) or may be drawn from extant theory (Birks and Mills 2011). For example, the codes 'negotiated order' and 'ethic of care' in this study could be considered extant codes. Codes initially identified are provisional and are grounded in the data. For each interview or observational extract, a front cover sheet provided a list of the codes that had been attached. This then allowed open codes to be compared across the data, between incidents both similar and dissimilar, following the process of 'constant comparative method'.

The second phase outlined by Charmaz (2006) is focused coding. Here, the most useful codes are selected out and further described and delineated. In this thesis, these focused codes were described as 'major codes.' Major codes were used to sort, synthesize, integrate and organise large amounts of data. Throughout the data collection and ongoing process of analysis, a set of analytic questions devised by Corbin and Strauss (1998) and Charmaz (2006) were used to probe the data (see appendix 12). The approach of constant comparison was also adopted to compare

events, incidents and codes across settings (see appendix 13 for example). This led onto further data collection based on theoretical sampling.

The third analytic stage is ‘conceptualising’. Once the open coding and focused coding process has begun, it is possible to begin to group together similar or related major codes into categories (described as ‘sub-categories’ in this study) and to develop possible linkages between categories. This is the process of conceptualising and enables large volumes of data to be reduced and understood. Strauss and Corbin (1998) also delineate the process of linking together categories using relational statements through the process of construction (see appendix 14 for example). This allows the data to be used in an explanatory way.

In order to develop a grounded theory, it is also necessary to be able to situate the phenomenon under study within the micro and macro-context. Strauss and Corbin (1998) suggest that the development of a ‘conditional/consequential’ matrix can be a useful analytic tool to enhance understanding of the micro-context. However, other authors have criticised the process of developing such matrices for being overly time consuming, leading to conceptual confusion and researchers who become ‘lost within the minutia of data’ (Allan 2003 p2). Charmaz (2006) suggests that axial coding may ‘cast a technological overlay on the data, and perhaps on (the) final analysis’ (p63).

An alternative, post-modern approach to conceptualising is offered by Clarke (2005) to enable the researcher to set the findings within the macro-context. To do this, the researcher engages in the conscious construction of maps – a process known as situational analysis. Three types of map are identified to include situational maps, social worlds/arenas maps and positional maps. Table 13 overleaf summarises the nature of these.

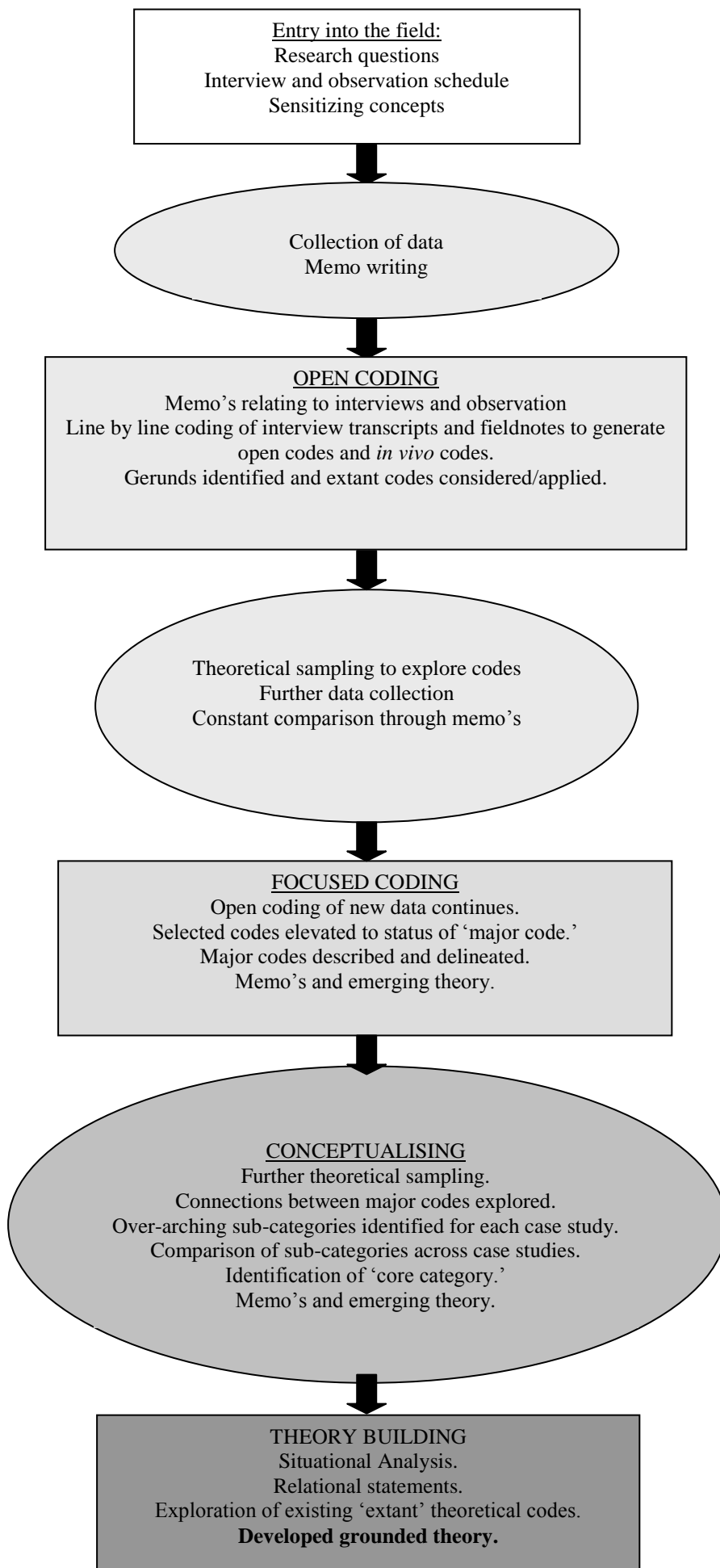
The aim of constructing such maps is to open up the data and to identify potential linkages between codes, and categories and the researcher’s own perceptions. Such maps also help the researcher to become aware of ‘sites of silence’ in the data (Clarke 2005, Mills et al. 2007). This approach was the preferred option for this study and appendix 15 provides an example of one positional map. This was developed to facilitate analysis of data relating to the range of possible standpoints adopted by

practitioners in relation to the use of patient handling equipment. Appendix 16 provides an example of a situational map devised to clarify a range of different facets and influences affecting the research topic area.

Table 13: Situational Maps (after Clarke 2005, pxxii)

Type of Map	Purpose of Map
SITUATIONAL	Outline the major human, non-human, historical, symbolic, cultural and political aspects related to the research subject.
SOCIAL WORLDS/ARENAS	Lay out the key actors, non-human elements and the 'arenas of commitment within which they are engaged in ongoing discourse and negotiations'. Look at social, organisation, institutional and discursive influences on the study/the phenomenon and actors. Identify how the situation could be different given differences in any of the above.
POSITIONAL	Set out the main positions taken by individual and collective groups regarding the phenomenon, identify controversial positions, contradictions, presence of multiple positions and discourse.

Figure 3: Analytic Processes



3.5.1 Reflexivity in Analysis

Throughout the data collection and analysis it was important to maintain a reflexive approach. Reflexivity is a core component of the constructivist paradigm ensuring that the researcher acknowledges their role in the construction of meaning, as opposed to maintaining the illusion of objective scientist (Mills et al. 2007). Appendix 17 provides an example of memos which explore the influence of my own life and experience on the research situation. Birks et al. (2008) suggests that through the process of memoing, the researcher develops greater insight into the data by filtering it through their own interpretive lens, placing the researcher in the role of 'research instrument'. Memos also provide an opportunity to make linkages between different codes and categories (Ryan and Bernard 2000)

Memos were often stimulated by a period of observation or series of interviews. Early memos were personal and short but an important way of preserving ideas and thoughts, whilst later, they became more in-depth and analytical. Recording my reflections within memos assisted me in becoming immersed in the data, drawing data together, and also in moving from description to conceptual development and ordering. It was also a process which allowed me to identify areas to explore further in the data in future data collection episodes. Constant comparison occurred within memos and similarities and differences could be identified amongst the data. Once tentative ideas about the data had been derived, further theoretical sampling could be carried out through additional observations, interviews and use of documents. Appendix 18 provides an example of how this took place.

3.5.2 Theoretical Sampling and Saturation

Theoretical sampling refers to the attempt to seek relevant data that might assist the developing theory. As codes are identified and comparisons are made between them, gaps in the data are identified and other potentially fruitful avenues for exploration are suggested (Strauss and Corbin 1998). The theoretical sampling approach then drives the researcher to collect further data across a range of events, settings and situations to explore how certain codes or categories vary in different circumstances. As the

theory develops, the researcher targets the sampling more specifically with the aim of detailing and saturating a category (Charmaz 2006).

According to traditional thought, qualitative researchers should aim for theoretical saturation. Theoretical saturation refers to a stage in data collection and analysis when new data no longer adds detail or understanding of a category (Charmaz 2006). (p113). However, whether theoretical saturation can ever be achieved has been debated (Bowen 2008). Dey (1999) challenges this notion and argues that we can only achieve ‘categories suggested by data’ rather than categories saturated with data. Dey prefers the terms ‘theoretical sufficiency’ (p257) to reflect the fact that researchers can only ever sample partially and code partially and that the process can only ever be incomplete. Appendix 19 provides an example of how a number of major codes were saturated to the level of ‘theoretical sufficiency’ in order to produce a well delineated category.

3.5.3 Theoretical Integration and Theory Development

The goal of grounded theory is to develop some form of ‘explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity’ (Birks and Mills 2011, p113). In this study, rather than a focus on prediction and explanation, the aim was to generate further understanding of the phenomenon of study through the process of conceptualising, abstraction and theoretical integration. Whilst a ‘theory’ is presented in chapter 7, it is acknowledged that this is only one subjective interpretation and as such, is both time and context bound and value mediated (Charmaz 2006).

The process of theoretical integration began with the conceptualising phase, which involved the construction of situational maps and relational statements. Tabling the major codes and categories (following the approach of Andrade 2009), also provided a structure for comparative analysis across the three case studies. Appendix 20 provides a summary of how this was achieved. The process of conceptualising and theory building depended on the selection of a central or core category around which to organise the other major categories. The core category was chosen because of its frequent emergence within the data and the connections that were repeatedly made

between it and the other major codes and categories (Birks and Mills 2011). In this way, the core category was able to provide an explanation for the findings of the study and provide a focal point for the theory.

3.6 The Case Study Settings

It was recognised that no case could be representative of the whole population of cases, but would always be unique and distinctive and affected by its local context. It was anticipated that by selecting a diverse set of cases and comparing the findings across them, this would maximise the relevance of the findings to rehabilitation nurses working in a wider range of rehabilitation settings. This section provides information about the fieldwork sites to enable readers to judge the nature of the setting and to be able to assess the relevance of the findings to their own field of practice and therefore the transferability of the findings (Lincoln and Guba 2002).

3.6.1 Case Study 1: General Rehabilitation Ward

Case study site one comprised a 24 bed general rehabilitation ward with four extra winter pressure beds. The ward was fully staffed with an establishment of 29 nursing staff at the time of data collection. There were 2 consultants, 2 registrars and 2 senior house officers. Multi-disciplinary meetings occurred on a weekly basis, attended by the nurse in charge for each side, the physiotherapist, occupational therapist, speech and language therapist, social worker and consultant. The meeting usually lasted about 2 hours and was spent discussing patient progress, plans for home visits and professional goals for rehabilitation. The ward supported student nurses, nurse cadets and student doctors.

The ward was part of the medical directorate and had an overall rehabilitation manager known as the matron. The 4 'winter pressure beds' were staffed by agency workers. Normal staff ratios were 6 on the early shift (2 registered nurses each side, plus one care assistant each side), 5 on the late shift (3 registered, 2 care assistants) and 4 on the night shift (one staff nurse and one care assistant each side). Early shifts ran from 7.30 – 3 or 7.30 – 1.30 pm. Later shifts were 1.30 – 9pm or 3 – 9pm. Night duty was from 8.45 pm to 7.45 am. The ward had its own ward philosophy which

placed emphasis on promoting patients' self esteem, privacy, participation, independence, choice and control through empathic care.

A clear ward routine was established. At 7.30 a.m the nurse in charge took handover from the night staff. By 8 a.m patients were receiving breakfast. By 9 am the occupational and physiotherapists had arrived on the ward and were starting to see people. Between 10 and 12 o'clock, patients went down to the gym and at 12.30, lunch arrived. After lunch until about 3pm, patients were using the gym. The evening meal arrived at around 4pm. Visiting hours were from 2 pm.

The ward was divided into two sides – the north side and south side, with a nursing station situated at each end and the ward clerk's desk in the middle. All patients had electric profiling electric beds. There was one standing hoist (Arjo) and the ward manager had secured $\frac{3}{4}$ funding for a second. The ward had one electric profiling chair, although more were said to be needed by the ward manager. There was one full lift hoist, one manual bath hoist and one electric bath hoist. There were two shower rooms, although only one was functioning. Banana boards were used regularly. Storage of equipment was difficult, since the day room was converted into a 4 bed bay to cater for winter pressure beds almost 2 years ago.

The ward had a number of activities ongoing for patients, including twice weekly chair exercise and standing exercise groups, and weekly breakfast club, card making, manicure service and hairdresser on request. Patients stayed in 4 bedded bays, which were either male or female but could vary depending on the patients admitted. There was no visiting between 8 am – 1 pm and this was explained via a notice on the wall, stating that patients need time for their therapy, personal care, and treatments.

3.6.2 Case Study 2 - Regional Spinal Injuries Unit

This Regional Spinal Injuries unit provided care and treatment for people with spinal cord injury (with and without mechanical ventilation) or related neurological disorders. It consisted of a 19 bed rehabilitation facility with plans for expansion later in the year to include a further 4 beds. The unit also included six high dependency beds and four intensive care beds. The core mission of the unit was to provide every

opportunity for individuals to reach their maximum potential and to adopt the lifestyle of their choice within the extent of their ability. The unit philosophy also emphasised the importance of partnership between the person receiving care, their family and carers.

The unit received patients from across the local region but also more widely across the UK. All referrals to the unit had to be approved, prior to admission, by a Consultant in Spinal Injuries appointed to the Centre. The total catchment area for the unit comprised a population of over 5.5 million people, treating approximately 150 in-patients per year. Patients stayed on the unit on average between 3-6 months and 75% of patients admitted return home. The average patient age was 48 years. The Centre provides access to hydrotherapy facilities, individualised physio- and occupational therapy programmes, and support with reintegration into the community setting. Where appropriate and following in-depth assessment, patients can also be assisted with upright mobility using the latest technological equipment.

Typical shift patterns meant that 17 staff were on duty on an early shift and 9 staff on a late shift. Registered nurse shifts began at 7.30 and ended at 3pm, whilst care assistants finished at 4pm. Later shifts started at 1.45 p.m for RGNs and 1.15 p.m for care assistants and finished at 9.15pm. A typical daily routine was observable with breakfast at 7.30 am, physiotherapy from 10.45 a.m onwards, lunch at 12-12.45 p.m, occupational therapy and gym from 1pm onwards with an end to therapy sessions at 4-4.30 pm. The ward round took place on a Monday morning from 9.30-12 with a multi-disciplinary case conference following this. Additional senior house officer ward rounds took place on Wednesday and Thursday mornings at 10am. Open visiting was implemented from 12-9 pm. The physiotherapy room and occupational therapy rooms were outside of the main sleeping and living area of the unit. The unit itself had a pool, large gym and several independent living flats which were used for therapy sessions and staged discharge.

3.6.3 Case Study 3

The third case study setting was an 18 bedded stroke rehabilitation unit situated within a large city centre teaching hospital. The rehabilitation unit was only one part of a larger neuroscience division, servicing the needs of a population of 2.2 million

people. The unit admitted patients of all ages after suffering a stroke. The ward philosophy stated an emphasis on evidence based practice and supported a range of different research activities, but specifically clinical trial studies. The ward philosophy also professed a commitment to individualised patient care and recognised the uniqueness of patients' physical, psychological and spiritual needs.

Teamwork was clearly articulated within the ward core values as a means of generating a supportive ward environment and included a focus on fostering good relationships with patients, family and carers. The ward had restricted visiting hours between 3-4 pm and 6.30 – 8pm with only two visitors per bed and no visitors at meal times. A weekly Consultant led ward round and case conference were conducted on a Tuesday. An additional mid week ward round was also held by the Registrar. Four stroke physicians serviced the unit with the support of a stroke specialist nurse, therapy team, part time psychologist and the nursing team. At the time of data collection (July – December 2008), nineteen staff members were in position. However, the unit had three vacant staff nurse posts and one care assistant post which were to be filled in September. The ward consisted of four bays, each with space for four beds and two side rooms. The nursing station was located at the entrance to the unit

3.7 Chapter Summary

This chapter has detailed the philosophical and methodological underpinnings to the study. The study was qualitative in nature and adopted a constructivist, grounded theory approach. Three case study settings (general rehabilitation, spinal, and stroke rehabilitation) provided sites for data collection, analysis and interpretation, selected in order to allow comparison across and between the settings. Data collection involved both interviews with rehabilitation team members and participation observation of nurses and care assistants at work. The data analysis process was ongoing during data collection and led to further theoretical sampling. Analysis consisted of three main phases open coding, focused coding, leading on to further conceptualisation. A reflexive approach to analysis was enabled by the process of memoing. Once major codes and sub-categories had been identified for each case study, a set of cross cutting categories was developed which spanned each of the three case studies, unified by a 'core category'.

CHAPTER 4

CASE STUDY 1 – GENERAL REHABILITATION WARD

FINDINGS

4.0 Introduction

This chapter draws on the 13 interviews carried out with staff working on the general rehabilitation ward and the 18 hours of observational data collected. It provides an overview of the findings using verbatim extracts from interviews, and fieldwork notes drawn from the observational data. The findings for this case study are described by way of four sub-categories and four sets of related major codes, as detailed in Table 14. This chapter discusses each of the four subcategories and the related codes in turn.

Table 14: Case Study 1 Sub-Categories and Major Codes

Sub-Category	Major Codes
Encouraging Mobility: Variable Contributions	Encouraging mobility and movement. Different Approaches to Patient Handling.
Role Demarcation	Non-experts and experts. Role Boundaries and accepted boundary transgressions.
Risk: inherent, essential and accepted	A context of risk. Dealing with the 'here and now.' Guilty admissions: manual handling happens.
Interpreting the policy	Changes in Handling Practice: Looking back. Impact of policy on the rehabilitation ethos. Moving and Handling Training: a technology of power?

4.1 Subcategory 1: Encouraging Mobility: Variable Contributions

This category comprised two major codes. These were encouraging mobility and movement; and different approaches to patient handling. What emerged through this category was the important role that nurses and care assistants played in the rehabilitation care of patients on the ward. However, it appeared that nurses and care assistants lacked time to devote much attention to patients' mobility needs. There were also profound differences between the handling practices used by the nursing team during the day and those used by physiotherapists during treatment sessions.

4.1.1 Encouraging Mobility and Movement

In this setting, most patients were perceived as having significant difficulties with mobility and particular moving and handling needs. Nurses and care assistants were involved in a multitude of activities which contributed to mobility rehabilitation. The ward sister highlighted the importance of this aspect of the patient's rehabilitation to a successful discharge:

'We try and keep the patients mobile from the beginning and try and instil in them they are here now to start going home and that they will need to increase their mobility and independence.' (Ward Sister 2, GR)

Mobility rehabilitation activities were embedded in episodes of care which required nurses and care assistants to move and handle patients, such as hoisting patients from bed to chair, turning patients, helping patients to walk, assisting with transfer from bed to chair, sitting patients up, helping patients to stand and pushing patients in wheelchairs. Encouraging patients' mobility was achieved by every day 'doing a bit more and a bit more' until patients became 'stronger and more confident' (CA5, GR) in order to get 'everything strengthened up' (CA2, GR). One experienced care assistant talked at length about ensuring the correct chair was selected for a patient. She later explained how she would spend time teaching patients how to walk with rollator and zimmer frame correctly.

'When I go to a patient I always think ' is that the right chair for them to be sitting in? Is it the right height? Any way I can help the patient to perform better, that's what I'm looking for...you want a chair where their feet, they can put them on the floor and when you want them to stand they'll be able to move forward in the chair and can push themselves up...you make sure they know how to use the frame properly, because a lot of them will put too much weight on them (the frame) when they stand up and the important thing is that they push up from the chair...and you take it slowly, then you do a couple of steps, and if you don't think he is steady, you put a chair behind him and ask for assistance.' (Care Assistant 5, GR)

The descriptions of the assistance given demonstrated a compensatory approach which focused on helping the person move despite their limitations. The extract below illustrates how one care assistant thought of her work with patients:

'...because he can't get out of the bed and they are finding it hard to roll from side to side, it's ... just say...you know....changing a sheet, 'roll over'', 'I can't'. "Right, why can't you?" And then I'll get assistance to help me and then somebody will say, I'm helping a person roll, the other person will take their hand to put them on the bars, so they have got something safe to hold onto, and if they can roll, then you know they've got movement, so you can encourage them.' (Care Assistant 2, GR)

She also explained how the patient's mood was intrinsically linked to their mobility and rehabilitation as a whole and how her approach would involve cheering the patient up and encouraging physical activity.

'So, when they come in you try, I try to lift their spirits up as much as I can and then they get to know you. Once they get to know you, they warm to you. And then when you ask them things, you know like 'are you ready to go to the toilet?' If you can get an answer out of them ... but it's You just assess them..erm...what they want to do. Nine times out of ten, a lot of them are just depressed and their moods are very low, and they don't want to do anything. They want to stay in bed. So it's getting to know them, what they like and then getting round them.' (Care Assistant 2, GR)

Registered nurses' responses were similar to those of care assistants but additional aspects were identified in relation to mobility rehabilitation such as the prevention of pressure area damage, prevention of deep vein thrombosis and other complications associated with immobility. Specific activities included; taking a history, asking the patient about their movement, observing the patient to see how much they could do and how much help was needed, offering the patient a frame, coaching the patient to move and stand, assessing exercise tolerance, assessing whether the person can talk and move at the same time, and seeing if the patient is breathless or malnourished. Registered nurses also carried out falls assessments. However, as the extract from a registered nurse below illustrates, the nurse's contribution to mobility rehabilitation could be constrained by time pressures. Walking patients was not always high on the agenda if other competing pressures arose. Nurses could also feel ill-prepared to 'walk' patients if they were not confident about the 'status' of the patient – for example, if they did not know what the physiotherapist had done or said as a result of an assessment, or they had not cared for the patient before. In addition, the extract identifies the patient's view that irregular physiotherapy might be impeding recovery. The nurse's response is to defend the physiotherapist who must divide her time up between all of the patients.

'if we've got time and we know that patient's status and they're walking and they (physios) said to me 'can you take them for a little walk', well then we would. You know what I mean? We would take them for a walk. Or, very often, I might say to the physio 'Mrs so and so wants a little walk, are we able to give her a walk'. So ... sometimes the patients don't feel as if they're having enough physio and will say 'I've only been going once or twice a week', but the physios have got to get around everyone.' (Registered Nurse 1, GR)

As well as a lack of time impeding nurses' involvement in mobility rehabilitation, it also seemed that nurses and care assistants struggled to motivate patients to 'perform' as they would for the physiotherapists. It was perceived that patients often held expectations of nurses as someone who would 'do for'. For example, as registered nurse 4 said *'some of the patients are very happy to lie there and let you do it for them'*. This meant that patients asked nurses and care assistants to help them more, rather than being ambitious to try things for themselves.

'the patient's expect us to do absolutely everything for them and we say, oh no, you can do that' and they say 'don't be awful'. I say 'we are not being awful but you are here to try to become more independent. You can't just expect the nurses to do everything' – they think we are here to do everything for them and they will only do it for the physios and OTs.' (Registered Nurse 1, GR)

Whilst registered nurses were quick to inform patients that nursing care was an important component of mobility rehabilitation, they were not always able to devote sufficient time to this activity. Despite this, the Moving and Handling trainer below argued that promoting mobility rehabilitation should be viewed as an essential component of the nurse's work.

'So mobilisation is very important. Mobilisation, I don't feel should just be left to physiotherapists. The nurse needs to make some type of judgement call, or an assessment, on to how that patient can be moved. If they feel that they haven't got the right kind of knowledge to move them then they need to ask somebody more specialized. That's my bearing on it. It shouldn't just be left. The patient shouldn't just be left to, 'Oh well we can't move this patient. They've had a stroke we will leave it to the physiotherapists.' (Moving and Handling Trainer, GR)

4.1.2 Different Approaches to Patient Handling

Within the interviews with therapists in particular, it was possible to distinguish clearly between two types of patient handling. However, whilst nurses and care assistants alluded to differences in the style of patient handling used between them and therapists, very few were able to articulate clearly what this difference consisted of. For example, one staff nurse stated.

'I think we do do it in a slightly different way...I can't off the top of my head think what...I think we do...there are...we're doing it as well...in a way we've got a set period of time.....we just get them out of bed and walk them to the toilet, but when physios do it they are actually looking at something, they are looking at it totally

different to what we are...they do things for different reasons to us.' (Registered Nurse 4, GR)

However, what was evident was that nurses' and care assistants' practices were focused on safety. During interview dialogues, these staff spoke in cautious terms – nurses 'see how they go', 'play it safe', 'making sure it is safe' and 'take it slowly' and have to 'be happy' before they will allow a patient try something. For example, the staff nurse below indicates a sense of uncertainty when moving patients.

'Generally, we'll transfer them with two, if we're not quite sure.' (Registered Nurse 4, GR)

The language used by registered nurses regarding the handling of patients was also generally non-specific and ambiguous. Nurses' assessments about patients' movement and mobility were focused on safety – what the patient could safely do without placing the nurse at risk. The ward sister below was at pains to point out that all nurses and care assistants were encouraged to do their own risk assessments before moving patients to ensure safe practice.

'So we inbreed in them that they must assess them (the patient) each time as to whether it is safe or not, and whether you can proceed or need to get help.' (Ward Sister 1, GR)

Others identified the importance of minimising risk to themselves and to the patient and described instances where their rehabilitation input would have to be limited. For example, nurses and care assistants might sometimes choose not to walk patients to the toilet if it was considered too dangerous, even though the physiotherapists might be undertaking such activities.

'So we'll walk them to the toilet and back, so that's part of the practice, unless it's too dangerous for us to practice. There are some things we won't do that the physios will do, but they have two or three physios around them. We just don't have that amount of staff – three staff to one patient.' (Registered Nurse 4, GR)

At other times, nurses felt that patients were too unstable to sit out in a chair and so would care for the individual in bed. In contrast, physiotherapists would undertake sitting out as part of physiotherapy treatment activities.

‘sometimes we’ve got a patient who has no sitting balance, so we can’t get them out of bed safely, whereas the physio will do the moving and handling treatment, but we’ll just get them safe in the bed.’ (Registered Nurse 3, GR)

The two physiotherapists and OT described the types of handling which involved a to b transfers. ‘A to b’ transfers were largely equated with nursing care practices and were based on the patient handling techniques taught during Trust Moving and Handling training. These approaches were focused on safety. Therapeutic handling was described differently and emphasised physically supporting patients during treatment with a view to the patient improving the quality of their movement. This approach was viewed as rehabilitative.

The second physiotherapist below saw a clear difference between manual handling and therapeutic handling. She described therapeutic handling as being about getting the patient working, ‘using their own muscles’, ‘creating a good technique’, seeing it as the ‘only way’ to get a patient actively rehabilitating. The ability to use a therapeutic handling approach was viewed as a way of reducing the amount of physical moving and handling that was required from the helper.

Interviewer: when you talk about therapeutic handling, how do you define that?

Physiotherapist: ‘I think the difference between therapeutic handling and manual handling is that you’re looking at facilitating a patient to move in the best way possible. It’s not just a case of moving them from a to b. So obviously, something like a hoist, which the patient does nothing and the hoist does everything, there is zero therapeutic value in that because the patient is just very flaccid, whereas if you were to use the stand aid and you were using it properly the patient has to use their quads, their trunk control. They are actually moving the correct way from sit to stand. So it has some therapeutic value in that it is working the right muscles and its creating a good technique...and I think when it comes to sort of actually manually handling the patients without any aids at all, I think therapeutic handling is a way of sort of

positioning yourself and the patient where they can do the most themselves and you're not actually having to lift them or haul them up. So it's almost sort of giving the patients the tools and the techniques in order to do as much of the movement themselves and less that you actually have to manually handle them.

Interviewer: Do you think that nurses use this approach?

Physiotherapist: If I'm honest, no. No, I've not seen much evidence of what I would consider therapeutic handling. It is more manual handling. Getting the patients from a to b in whatever way.' (Physiotherapist 2, GR)

Interviews with nurses and care assistants suggested a number of conditions which needed to be satisfied to enable therapeutic handling approaches to occur such as: sufficient time to think, assess, prepare and plan; communication with the patient; skills to analyse movement and identify problems; confidence; and the ability to take safe risks. Although both physiotherapists felt it was easier and safer for staff to focus on safe manual handling, rather than trying to implement therapeutic handling this was not viewed as the most beneficial approach for patients.

'I think the primary big difference between a physio assessing and a nurse assessing, is that the nurse is assessing as a means to an end basically. How do I get a patient from a to b ? – they need to get them from the bed onto the toilet and I think their priority of thinking is ease for them. They're not thinking about what's therapeutic value for a patient and maybe, what is sometimes the easiest way isn't always the best therapeutic way for the patient.' (Physiotherapist 2, GR)

The OT's held a similar view on nurses' patient handling practices and identified that on occasion, nurses would 'just put them in a hoist' for ease and speed and that nurses' practices were not always rehabilitative or even correct. The OT felt that differences between the patient handling practices of different professional groups was detrimental to patients' recovery and caused confusion. The Moving and Handling trainer, whilst firmly committed to ensuring staff safety, also suggested that the 'safe' approach adopted by many nursing staff left patients in receipt of a 'minimum' standard of rehabilitation with many opportunities for rehabilitation being missed. Her view was that nurses lacked the underpinning knowledge in relation to movement and mobility. This meant it was safer for patients if nurses adopted a 'safe

handling approach.’ For example, hoisting a patient who might otherwise stand and walk with an experienced rehabilitation practitioner. As a result of nurses’ lack of skill, knowledge and time to engage with the process of therapeutic handling, the nurses’ role in relation to mobility rehabilitation was focused on maintenance.

‘You are maintaining the patient at a certain level.’ (Moving and Handling Trainer, GR)

There existed a tacit understanding that therapists would be the key professional to coach a patient through the various stages of their physical rehabilitation. The interview with the OT below describes how patients worked with therapists to achieve a level of stability in the way in which they moved and were assisted. Once patients had reached a level of stability in movement and positioning, the nurses and care assistants would begin to handle the patient in the same way as the therapist. The rationale for nurses to move and handle patients in a different way was based on the assumption that nurses lacked the time and necessary skills to participate in therapeutic handling, and also that nurses had more patients to handle at any one time placing them at greater risk of work induced injury. Patients’ varying abilities to move over the course of a day were also cited as a rationale for nurses and care assistants to engage in ‘safe’ handling as opposed to therapeutic handling

‘What they might do in therapy they might not be able to do that all the time because they are still working, building up their strength so they won’t be able to do it every time with the nursing staff, or every time with a physio, or every time with an OT, it would be too much. It’s kind of grading and then when we get them to a level when they are consistently stable then we’ll do joint sessions with the nurses to get them in.’(Occupational Therapist, GR)

4.2 Subcategory 2: Role Demarcation

The above section identified the profound difference between the handling practices used by nurses and care assistants during the day and those used by physiotherapists and occupational therapists during patients’ treatment sessions. This finding was a clear manifestation of ‘role demarcation’ within the multi-professional team. This

subcategory was comprised of two major codes: non-experts and experts and; accepted boundary transgressions. Nurses and care assistants largely viewed themselves as non-specialists in relation to mobility rehabilitation and patient handling and tended to defer to the physiotherapist who was perceived as the expert. At the same time, nurses were required and expected to take on a decision making role in relation to patients' mobility and movement when physiotherapists were not available.

4.2.1 Non-Experts and Experts

Whilst many nurses and care assistants talked about encouraging patients' mobility, it was evident that they did not consider themselves to be experts in relation to this activity. An example of this is illustrated through the descriptions of the assessment process offered. To enable them to care for patients and meet essential needs, registered nurses first had to be able to undertake a risk assessment of the patient's movement abilities. This enabled a decision to be made about how much assistance (such as equipment, or one or two staff) if any, the patient needed to move about. Although the registered nurse reported being the first health care professional to undertake an assessment of the patient's moving and handling needs, this was placed in the preliminary and 'basic' category, to make do with until the physiotherapists completed the 'full' assessment. The 'full assessment' was described vaguely but seemed to carry considerable mystique. The extract below from a registered nurse and therapy assistant reflect this.

'The initial assessment in only a basic one...we see if they can walk to the toilet, you can just tell, you can walk them round with a chair...' (Registered Nurse 4, GR)

'Initially, when they first come in through the door...we assess them and we do the moving and handling risk assessment. It's basic until the physios actually get to see them and we will just concentrate on the standing and transferring, moving on the bed and assisting to go to the toilet and establish what support they need within 10 minutes of being here, but its only a rough guide to cover us until the physios actually come along' to do a full assessment and they report back to the nursing staff to say that she manages this way.' (Therapy Assistant Practitioner, GR)

Nurses' assessment of patients' mobility focused on what patients 'could do' in relation to standing, walking, sitting and moving in bed. The focus was not on the quality of the patient's movement, or the potential for progress to be made. The information gained during the initial nursing assessment was used to make a decision about the patient's moving and handling needs. It was not used to set short or long term goals for mobility and movement rehabilitation. The emphasis was on ensuring the patient was moved safely, without injury to themselves or the nurse. It was clearly viewed as preferable that the physiotherapist did the first assessment as the ward sister below indicates.

'we'll get them (the physio) to assess them first so that we know we are starting from a baseline that we are going to proceed from. If the physios aren't there we do our own risk assessment, and obviously carry on with that until such time as the physios are on duty to do their assessment.' (Ward Sister 2, GR)

For the Moving and Handling trainer (a nurse by background), learning additional physiotherapy skills had been important in enabling her to work effectively in a rehabilitation team whilst in a previous role. This respondent was concerned that some nurses lacked skills in patient handling that could place the patient at risk.

'Many times I've seen patients who've tried to be moved, not successfully by nursing staff, and have had their tone increased. So from being a rather, say limp low tone arm, because it's been touched in a particular way, it's actually increased the tone spasticity in that arm, whereas if a physio was moving that patient's arm, it would not have happened. So the lack of knowledge in moving a patient would actually probably, say increase the risks for the patient.' (Moving and Handling Trainer, GR)

A number of respondents alluded to possible gaps in their skills and knowledge and identified the potential benefits of in-house shared training regarding physiotherapy and its treatments. The majority of nurses and care assistants had received no additional training or education in rehabilitation nursing. A few had spent half a day shadowing the physiotherapist when first appointed into post. The individual below was not specific about the additional skills and knowledge that would be helpful but

suggested that there were times when physiotherapists needed to impart their knowledge.

'It's a long time since I done a course on anatomy and physiology as well, but they give you guidance, they sort of stick up a piece of paper to give you guidance....a kind of hip protection kind of guideline and er... with people what had a stroke, you'd need to be aware not to be pulling on their arm that's affecting it, otherwise you could dislocate it and no-one would know about it.' (Registered Nurse 4, GR).

The physiotherapist below felt that because nurses lacked knowledge regarding how to facilitate patients' movement, this actually made moving and handling rehabilitation patients more dangerous for both themselves and the patient.

'I think you need to have a good awareness of sort of movement analysis really, to be able to pick out what's going wrong and where you might need to come in and help. I don't think the nurses have the time to sit back and look at what their patients are doing and think 'well what is it that is missing' and 'what do I need to help with?' Quite often the nurse will actually get their arm around the patient and actually help physically lift them up. The only thing that is missing is that they (the patient) are missing the forward lean in order to get up. They've got the power in their legs and they've got the power in their arms to get from sit to stand but what they lack is that confidence to come forward and get a good technique. So I, quite often, just sit and stand someone just with my hand resting on their back in order to facilitate them into a forward lean and up into standing, whereas you'll see a nurse with the same patient actually getting in there and physically lifting them, you know. I think if they had a little bit of training in kind of movement analysis and thinking of what components are missing and how can I help? I think that would help.' (Physiotherapist 2, GR)

Observational data also supported the notion that nurses lacked skills and knowledge regarding how to move and handle patients and how to promote maximum independence. The fieldwork extract in box 1 suggested that nurses did not always take a proactive approach to promoting patients' mobility, or indeed, dealing with difficulties in moving and handling patients. The example below illustrates that although nurses had been struggling to transfer a particular patient for several days,

knowledge that the patient's condition in the morning made transferring with one helper difficult, was not cascaded amongst the nursing team, nor to the physiotherapist. Observed transfers with the physiotherapist later on in the day were much less problematic than those observed when care assistants helped. The action of standing was also facilitated in a different way to the methods used by the care assistants, although this approach could easily have been incorporated into nursing care.

Box 1: Observational Extract 1: Case Study 1

Nursing Handover 12/4/07 - 1.45pm – A patient's difficulty with transfers is identified

The Ward Sister is giving report on a patient called Roger, age 88, admitted after a fall, with Parkinson's disease. The ward sister explains that the patient's co-ordination is very poor and 'when he's anxious, if he needs the toilet, he's not very steady'. A staff nurse asks – 'is he transfer with two?'. The care assistant states 'no, he's with one'. The ward sister replies - 'this morning he was really unsteady and if it had been a little person (transferring him), they would have struggled.

25/4/07 - 7.30 am – Helping Roger stand

The staff nurse asks a 2nd year diploma student nurse to help Roger get up for breakfast. Roger is lying down in bed, but its time for everyone to sit up for breakfast. She asks him to swing his legs out of bed – 'a bit more if you can...just get your balance a minute – can you shuffle yourself forwards.' He's managed to swing his legs out of bed and sit up, but he's very stiff. He doesn't quite manage to swivel all the way round, so she helps him swing his legs down. The student has never helped Roger up before and she's working unsupervised. Roger starts to stand up, but he wants to pull up on his frame. The student asks him to push up from the bed. He can't quite do it, so the student gives him a bit of help by grasping him on his underarm. He's standing now, but he's leaning backwards – the tips of his feet are lifting up – his toes. He starts to move his feet, but he's leaning backwards. He almost slips. I try to offer some support, but I'm in a terrible position because the bed

is in the way. I can't reach his lower back, but I don't have much option so I reach out to his underarm to steady him and pull the chair around. He flops into it, legs flying upwards as he sinks into the chair – a relief to us all – the student looks flushed.

The student speaks to the staff nurse who is passing by doing the morning drugs round. She tells her it was difficult to move him. The S/N says 'well, he has Parkinson's...I got him up on my own yesterday and....' She trails off and pulls a face (a grimace). Her silence implies that it was less than straight forward.

Later (at about 10.30 a.m), I talk to the physiotherapist and occupational therapist about Roger. I tell them about the difficulties the student nurse had getting him to transfer. The OT agrees and says he is at risk of falling. The Physiotherapist is surprised.

Later that day, I watch the physiotherapy treatment session with Roger. The physiotherapist asks Roger to shuffle forward – he does this really well, much better than this morning with the student nurse. He starts to reach for the zimmer frame. She reminds him of yesterday's treatment – 'remember what we said yesterday, lean forward, right forward, now push up from the chair, now straighten up.' He does this really well – his feet aren't tipping up, he looks safe. Then she asks him to walk around to the chair. He does this smoothly but then he starts to look like he's going to try and sit down before he's right in front of the chair (like this morning). The physiotherapist puts a hand on his hip and comes in close to him. She has steadied him and he sits down safely.

The physiotherapist says he's a good example of therapeutic handling. 'I can actually get him to stand with minimal support, just finger tips on his shoulders to guide him up, and he can do that. Whereas some of the nurses will actually manually help him up, and he will use the nurses like a pivot, he'll shoot upwards, then start to lean back, but then rely on the nurses to push him forward. So really its poor technique - its not that he's not strong enough – he has the strength, but he needs lots of prompting.' We go into the treatment room. The physiotherapist says she is going to practice some sit to standing using a low stool to act as a visual cue for him to lean forward. The stool is placed in front and he is reminded to lean over the stool and put his nose above the

hole in the top of the stool. I feel that the exercise the physiotherapist is using would be helpful for the nurses to know about.

Without variation, all respondents viewed physiotherapists as the ‘professionals’, the ‘experts’ and ‘specialists’ in relation to patients’ mobility and movement. The physiotherapy assessment was generally described as ‘*more in-depth*’, ‘*looking at muscles*’ and a valuable guide to nursing practice on how to transfer and move patients. Physiotherapists provided nurses with instructions on ‘what’ they could do with patients, such as what equipment to use and how to transfer a patient and how to promote mobility.

Interviewer: Do you use any of those little round turntables?...

Registered Nurse: We have done but not for quite a few years, you would be better speaking to the physios about that cause they are the ones who actually decide what aids for the patient to use really and we have to go off what the physios say.

Interviewer: But you as nurses you’ve not been using them?

Registered Nurse: If the physio say that’s how to get them out of bed to stand then yes we use them but the physio’s always make the decision....it’s the same with the hoist and anything like that they are the ones who ultimately decide.’ (Registered Nurse 3, GR)

Following physiotherapy instruction was viewed as an important way of safeguarding patients’ wellbeing, protecting them from possible injuries caused by incorrect patient handling techniques. When asked what they would teach newly qualified nurses or student nurses in relation to moving and handling, most nurses referred to the Trust moving and handling policy and the physiotherapist, but rarely themselves.

However, whilst nurses held similar views regarding this, the physiotherapist’s perspective was somewhat different. Interview and informal discussions with both physiotherapists identified reticence to teach nurses about patient handling because of the risk associated with advising another professional. The physiotherapist below described examples of ‘unofficially’ providing one to one instruction to nurses and care assistants about how to move and handle individual patients but when asked about providing in-house formal training to nurses, she was more reluctant:

Physiotherapist: 'there is no like book to say this is how you teach therapeutic handling... there is no guideline there is no... so whatever we teach we are teaching from experience and what knowledge we have from what training we have or things we have found out but there is no official, if it all comes back to that court of law there isn't an official guideline to follow. The only guideline is that you would hoist him or use the standing hoist.' (Physiotherapist 2, GR)

4.2.2 Accepted Boundary Transgressions

Although the physiotherapy assessment was viewed as *'the baseline'* assessment, thus placing the nursing assessment in a secondary and subordinate position, at times, nurses had to rely on their own assessment to make a clinical decision or a 'judgement call'. For example, the staff nurse describes the nurse's role in assessing in the absence of the physiotherapist:

Interviewer: 'Do nurses do any moving and handling assessments on this ward?'

Registered Nurse: Yes they do....sometimes the patient arrives and you are just the only one there so you have to take a decision, but you don't have a final say until the physio is done.' (Registered Nurse 6, GR)

The extract below from the ward sister is illustrative of the negotiated working practices at play. The ward sister's perception of the physiotherapist as expert is clear and is justified by their perceived superior knowledge base. At the same time, it is out of necessity that nurses are 'allowed' to make decisions regarding patients' mobility over weekends. The ward sister also identifies the tacitly agreed limits to nurses' transgression into the professional territory of the physiotherapist. For example, the nurse would 'not transfer a patient onto sticks.'

'the physios they look at it more in depth and we are very much guided by them of what they want ...but having said that, we're working with patients at the weekend and if they show the ability that they are able to do it... do things.... err.... We don't usually transfer people over to sticks or anything like that unless the physios say, 'you can do if you like', but .. you can take them on the commode to the toilet and

walk them on the way back, or only transfer if ...you know we'll say 'just try a few steps to the bottom of the bed', and we will proceed from there. So the nurses are allowed to use their initiative on that and as long as they're confident to do it and we'll hand it back to the physios and say that this patient was able to do this over the weekend.' (Ward Sister 2, GR)

Interviews with therapy staff also revealed an expectation that nurses would continue, in their absence, to work on treatments and activities prescribed by them to promote the patient's mobility. However, therapists' acknowledged that whilst nurses and care assistants had a willingness to blur roles, there were profound limitations to this role. For example, the OT interviewed stated with regards to therapy carry-over '*when they can, they do*' and only '*when they feel comfortable*'. The directing of nurses' work was done informally presumably because it would be problematic to place nurses in a subordinate position to therapists. The OT described a system whereby she would write out '*exercise plans and treatment plans...particular things that we want them to do.*' The first physiotherapist was also of the opinion that nurses '*will carry on doing the assisted transfers*' for example in order to provide patients with ongoing rehabilitation throughout the day, rather than patients benefiting only from short bursts of '*intensive physiotherapy.*' The second physiotherapist also identified the need for a degree of role overlap, particularly in relation to assessing patients' moving and handling needs over the weekend.

'You've got your care handling and your therapeutic handling the actual treatment. But then I suppose as I talked about before there is somewhere in-between when they get to a certain level. We liaise with the nurses and they will promote some level of therapeutic handling in every transfer which is when they are too good for the hoist but still need physical hands on help to transfer more than what the guidelines that we're taught are. We work with the nurses at that point and we will make sure they are happy with all the techniques.' (Physiotherapist 1, GR)

Nurses, physiotherapists and occupational therapists on this ward held each other in positive regard and respected the input of each professional group. However, a number of respondents critiqued the way in which multidisciplinary teamwork

operated and described it as an imperfect system. For example the lack of physiotherapists and occupational therapists was mentioned by therapists and the impact of this on weekend rehabilitation processes. Apart from references to the weekly multiprofessional team meetings, there was no obvious interview commentary to indicate that nurses and physiotherapists on a day to day basis discussed the treatment or rehabilitation plan for individual patients and how this was to be carried out or facilitated by nurses. Even when opportunities arose where nurses and care assistants could work with physiotherapists, these were not seized. The fieldwork observation below provides a flavour of two specific instances where this was observed.

Box 2: Observational Extract 2: Case Study 1

Missed Opportunities to Work Together 25/4/07

10 am: A care assistant apologetically calls the physiotherapist over – she wants to get a patient up and only asks the physiotherapist to help because ‘all the others are on training courses’. This is the first and only example of where I’ve seen a nursing team member ask a physiotherapist to help with something. However, in the end, another care assistant comes around the corner and the first one says, its ok and they work together instead.

11am: Bill is having his false leg put on by the physiotherapist . She has brought his zimmer frame along. I observe as they get him to stand. I see quite a lot of support being given at his waist band. Initially the physiotherapist asks a passing care assistant to help her, but then another physiotherapist comes along and she asks her instead. This could have been a good time to involve the nursing team.

The main area of overlap between nurses and physiotherapists in relation to patients’ mobility rehabilitation was how patients were to ‘transfer’ (for example with the help of one or two nurses or using a hoist) or walk (for example, with support of one or two helpers or with a frame of some description). Some nurses did not seem to want full involvement in patients’ mobility rehabilitation and were content to leave this area to the physiotherapists. Indeed, physiotherapy practice was like a black box - the

contents of which were only partially known. Observational fieldwork identified that physiotherapy work with patients could be very detailed, focused and directed towards the patient improving the achievement of activities of living. However, interview data did not suggest that nurses had a full understanding of what occurred during physiotherapy treatment sessions. Typical comments were that the physiotherapist only 'saw' the patient for 5-10 minutes a day, whilst the nurses were with them over a 24 hour period.

Most interview respondents viewed additional teamworking as desirable. In particular, it was argued that therapists needed to be present in the early morning to assist patients with movement when their abilities were most limited. Teamwork between nurses, physiotherapists and occupational therapists was problem driven, rather than part of routine practice, as the extract below indicates:

Interviewer: 'Do you think the amount of shared working is sufficient?'

Ward Sister: It does happen occasionally, but it's often nurse led; we are having a problem and we feel we want your input. It's not in the general practice but it's something that we would like to get going again.' (Ward Sister 2, GR)

Although all staff professed to communicating with the various members of the team, whether this translated into a meaningful impact on the patient's rehabilitation was unclear. Lack of role sharing was attributed to a lack of staff time in general. The following care assistant suggested that if there were more nurses, there would be greater involvement in promoting patients' mobility and movement.

'If they took rehab seriously...you'd have a lot more nurses on this ward to actually have the time to do the physio...and you'd have the time to do the exercises...I really don't know if they take it seriously enough.' (Care Assistant 5, GR)

Observations of teamwork and nurses' practices suggested that team members did not always share the same language. The extract from the physiotherapist below illustrates the way in which assumptions of a shared understanding of commonly used phraseology could result in ambiguities over how patients should be supported or assisted with their rehabilitation.

'I think we, probably as a profession, physios, if we've assessed, we need to be a bit more specific about what 'walking with one' means, or at least give some training as to what walking with one means so that we are all sort of 'talking the same language.' (Physiotherapist 2, GR)

The second physiotherapist was not entirely satisfied with the direction of negotiations regarding work and role activities between nurses and herself. She expressed a preference for more joint working and closer communication with nurses. However, her latter comments suggest that the prime motivator for this was a desire to increase the proportion of time that she would spend engaged in structured therapy activities with patients, rather than a desire to assist further with activities perceived to fall within a nursing domain. In this way, a reported aspiration for closer teamworking was belied by an entrenched attitude which separated caring activities (personal care activities, essential activities of living such as getting to the toilet and washing) from therapy treatment activities.

'The nursing and therapeutic staff seem to still be quite distant from each other....we don't actually do joint working together. It's very much like we do the care and you do the therapy, but quite often we are called on to do the care as well. Obviously the nurses are so short staffed on here and they are running round doing everything. If a patient needs a toilet we in our therapy unit have made a decision that we are not going to walk past that patient. If they need the toilet we will use that as a good excuse to get them up on their feet and walk them across and make it therapeutic. So we actually in part do a lot of nursing as part of our job and sometimes that sort of distracts from you doing the therapy that you want to do with the patient because you've spent 2 hours toileting and helping wash and dress and all this kind of stuff, but I don't think we necessarily get that back in return, it would be nice to have them come into therapy sessions and see.' (Physiotherapist 2, GR)

4.3 Subcategory 3: Risk - Inherent, Essential and Accepted

This category included three major codes. These were; nurses at risk; dealing with the here and now; and guilty admissions. Overall, this subcategory was developed to

delineate the risks to nurses' and care assistants' wellbeing which resulted from the workplace context. Dealing with the here and now related to the pressures that all practitioners experienced when delivering rehabilitation care and treatment. Whether these pressures arose from a lack of staffing, or a lack of equipment, or simply, the urgency of patients' immediate needs, many respondents explained how they could influence the activities in which they engaged with patients and the way they moved and handled patients. Often, these explanations included guilty admissions – that manual handling did happen and was inescapable within rehabilitation practice (inherent risk). Numerous respondents also explained with conviction that an element of manual handling was essential to patients' rehabilitation (essential risk) and that it was part of a rehabilitation practitioners role to take a degree of measured risk (accepted risk).

4.3.1 Nurses at Risk

Within the transcripts there was a sense that nurses and care assistants were 'at risk' of musculo-skeletal injury as a result of the pressures of the workplace. Nurses generally felt that they worked at speed, which reduced their thinking time. They worked without sufficient patient handling equipment required to help patients in the 'here and now'. However, there was a sense that service limitations simply had to be accepted because ...*'we are in the constraints of what we have got'* (ward sister 2, CS1). Indeed, moving and handling equipment had previously been paid for through charitable donations. It was as though staff felt they were trapped between a rock and a hard place – whilst policy required them to use equipment wherever possible to move patients, a lack of essential equipment meant that meeting this expectation was often difficult. Those interviewed also worried that they might face criticism if their patient handling practices were measured against Moving and Handling policy. For this reason, nurses were viewed and viewed themselves as 'vulnerable'. One way in which nurses managed this vulnerability was to place physiotherapists in the role of protector. By identifying the correct level of assistance to be given to the patient, the physiotherapist was perceived as providing a safety net for the nurses.

The two physiotherapists interviewed readily accepted the role of protector. Whilst they accepted that patient handling during therapy treatment sessions could involve

providing significant levels of manual physical support, this was not seen as a sustainable approach for nurses and care assistants. Nurses and care assistants were perceived to have more patient handling to do throughout the day and night than themselves. They were not viewed to be sufficiently skilled to undertake manual handling safely. With this in mind, the physiotherapists endeavoured to provide nurses and care assistants with instructions regarding the safest way for a patient to be moved and tried to limit the degree to which manual handling was required.

‘So from a physio and OT point of view, a physio will be doing more of a hands on handling but then we will look at ways to help the nurses, to make it easier for them because they are having to handle them 24/7 for all the toileting and the transfers so we might look at what we’ve got to make it easier. So it could be that we’ve got a standing hoist and a sitting hoist and a walking hoist. So we might say the nurses will be transferring with the hoist but then from a therapy point of view we will actually be doing physical standing with them.’ (Physiotherapist 1, GR)

4.3.2 Dealing with the ‘Here and Now’ - Tasks and Time Constraints

Nurses’ and care assistants’ activities in relation to patient handling were influenced by the number of staff on duty. When there were less staff on duty, those working the shift had less time to spend with each individual patient and to complete routine activities. This meant that nurses and care assistants described their practices as ‘rushed’. ‘Being rushed’ was considered a key limit on their involvement in rehabilitation and on their ability to follow through with therapy activities. Neither could nurses work together in two’s or three’s with individual patients as needed if they were to undertake more complex patient handling activities. Nurses described their own practice as ‘task orientated’ in a way that physiotherapists were not. Nurses needed to help patients meet essential needs, which were prioritised before specific assessment or therapy activities.

‘but we tend to do it in a rush and physios, they’re looking at things, and documenting, while we’re not sitting there and going like that , and move the leg around, and take the leg round to a certain degree. We have a task to do...but the physios are doing a full assessment ... we’re more task orientated. We’ll take them to

the toilet, but then there's the next patient. We're not getting them out of bed to see what they can do...I just don't have time to be doing exercises with them...which is a shame....I have a task in mind to get them to the toilet and I'm not looking at gait or anything like that. I'm working on a task.' (Registered Nurse 4, GR)

Indeed, nurses descriptions of their work implied that often, they had simply to deal with the 'here and now' to meet patients immediate needs and requirements. From the perspective of the ward sister below, dealing with the here and now meant dispensing with the rehabilitation approach which would require more time, and reverting back to 'the norm of doing for.' Dealing with the here and now was viewed as a contradiction to rehabilitation which relies on planned activities and working towards forward looking goals. The ward sister below identified that because of the necessity of working at speed, nurses were not gaining sufficient experience of implementing the rehabilitation approach.

'If you've got a complex patient the nurses will just tend to do the general washing and dressing. They'll give a patient a bowl and say "have a wash" but they won't observe. It takes a lot of patience to get the nurses not doing things for patients. You're there to observe and interact. Now they may not observe a patient struggling with his dexterity...that's not being fed back because they haven't got the experience and because of the pressures on this ward, sometimes they (the nurses) are not getting the experience (of the rehabilitation approach), because they have got to revert back to doing the general nursing as opposed to doing the rehab because that's the nature of the patients and the workload we've got on the ward.' (Ward Sister 2, GR)

Dealing with the here and now was also necessary when patients were admitted who were very poorly and unready for rehabilitation. As the fieldwork extract below illustrates, at times, the demands of the service also dominated nurses' and care assistants' actions and distracted them from a rehabilitation approach.

Box 3: Observational Extract 3: Case Study 1

Making ‘male’ and ‘female’ bays 12/4/07

The care assistants are busy moving patients and their beds from bay to bay, in order to create an empty bay that can be ‘male’ or ‘female’ . However, this is a lot of work as patients have to be moved, as well as all their belongings. It has taken a couple of hours work. The care assistant answers a patient’s buzzer who is in the toilet. She brings her back in a wheelchair. The physiotherapy sign above her bed says ‘walk with one’. I wonder why she was wheeled – perhaps she was in a hurry for the toilet – or was it the competing priorities of re-arranging the ward? The nurses are concerned about moving the beds because they know they are one nurse short on the late shift as an agency nurse is off sick. The nurses are discussing the patient’s bottom saying they need to make sure it doesn’t go red now the air mattress has been removed. I think to myself that walking more frequently would help.

Being ‘hectic’ was also one of the key reasons nurses gave for their guilty admissions – that manual ‘lifting’ did sometimes happen.

4.3.3 Guilty Admissions: Manual Handling Happens

Nurses and care assistants admitted to using manual techniques to move and handle patients. However, this was seen as a necessary and unavoidable part of practice. It was viewed as the inherent risk associated with caring for people. The care assistant below explained how sitting patients back in their chair could be problematic:

‘As they say, it’s a no lifting hospital, but to be honest we do a lot of lifting because you just can’t do it the way they’re telling you to do it all the time. I mean, the first thing they’ll say to you is ‘you’ve got to sit somebody back in a chair’, and they’ll say “well hoist them’. By the time you’ve looked for a hoist, put the sling on – I know it’s most likely is basically our fault, but it’s all time consuming as well – so we would physically help lift the patient back.’ (Care Assistant 2, GR)

The physiotherapist also recounted how the need to meet patients' immediate needs created a moral and ethical dilemma due to a lack of staff or equipment. Manual handling was viewed as something that was inescapable. The practitioner's duty to maintain the patient's dignity placed an obligation on the staff member to place their own needs for safety secondary to the patient's need for dignity. In the extract below, the patient's needs are immediate and striking. The patient is desperate for the toilet, he might soil himself with the consequent diminishing of his dignity. Dignity and self respect are vital aspects of being human. The physio 'admits' to 'taking chances' in order to preserve the patient's self respect, to get the patient to the toilet on time. She admits to sometimes 'ending up doing bad moving and handling' because the safest practice 'is not always an option'. This is often because they are 'waiting' for the equipment. The ward has to share its equipment, the equipment is used for 'caring' activities as well as 'therapy' activities.

'Quite often if you've got a patient that is very desperate to transfer onto the toilet, sometimes if a bit of equipment isn't readily available you think 'we'll chance it, we'll just see if we can do this,' and you end up doing bad manual handling because there is not the equipment available when you need it, waiting is not an option – its either that or the patient messes themselves.' (Physiotherapist 2, GR)

Not only did the lack of equipment place the practitioner at risk, it also inhibited the provision of therapy and risked the patient's dignity. Using the correct technique was seen as 'pie in the sky' and unrealistic when staff ratios were lower than that expected for the ward. Using the correct technique was viewed as too time consuming and more trouble than it was worth.

'sometimes it will just take too long to do it perfectly the way ... you know....it's done ... it would just take far too long...to do it would just take too many staff.' (Registered Nurse 4, GR)

Many of the respondents viewed manual handling as an essential aspect of rehabilitation practice, not only because of the nature of the patients and the necessity of meeting perhaps urgent needs (dealing with the 'here and now'), but also because of a lack of time and equipment being ready at hand. However, manual handling was

also viewed as a way of enabling patients to develop greater independence. To do this though, the practitioner needed to know their own limitations and abilities and balance these against the perceived level of risk associated with the activity.

Other staff identified the importance of getting the patient comfortable and saw this as an occasion when manual handling was needed, even if they knew the manoeuvre to be classified as unsafe. However, when ‘admitting’ to undertaking manual handling, almost all practitioners alluded to the risk that they would later be blamed or criticised for their course of action. Staff also identified the mismatch between what they were ‘told’ to do in a manual handling training session, in comparison to the reality of practice. Although all staff valued the use of moving and handling equipment, a number were critical that the difficulties of using equipment were not acknowledged. For example, nurses and care assistants stated that patient handling equipment such as hoists were cumbersome and required a lot of strength to manoeuvre once a patient occupied the sling.

4.4 Subcategory 4: Interpreting the Policy

This category included three major codes. These included: changes in practice, looking back; impact of policy on the rehabilitation ethos; and moving and handling training- a technology of power. Many respondents felt that rehabilitation practice did not fit easily alongside the policy regarding manual handling. Others believed that physiotherapists were exempt from manual handling guidelines. Finally, there was sense that rather than being protective, hospital policy relating to manual handling was a potential threat.

4.4.1 Changes in Practice: Looking Back

Many respondents described changes in their practice which had resulted from the introduction of manual handling policy within the hospital. For the physiotherapist below, the introduction of the policy meant that she and other physiotherapists became very conscious of the need to justify activities involving manual handling. Attempts to write a new therapeutic handling policy to reflect their practice were thwarted by the complexity of everyday work.

'And what we said was you had to justify why you were doing the transfer a to b, and what was the purpose and if you could justify it - because in the guidelines you shouldn't do any transfers bringing patients from the front, but in a stroke patient you have to. So if it was getting from a to b, is it more beneficial to hoist them and then do your treatment? Or if you could justify why you would do a manual technique to transfer, it would be to bring the weight forward to get weight bearing on their feet, then you have to justify it. And we were actually putting at one point, we had to write down a justification of why we would manually handle from the front but it got very long winded and we just made sure we were writing why we were transferring. And then we did try to have a document so we could refer to it but it never happened.'
(Physiotherapist 1, GR)

Although the emphasis on justifying clinical decisions regarding patient handling was time consuming, the physiotherapist, ward sister and staff nurse all identified the positive changes that had occurred within nurses' practice :

'Gone are the days...it used to be that somebody would get someone round the top and somebody else would get the legs, lift them into bed, we used to do it, I hold my hands up , years ago. That would not happen any more.' (Ward Sister1, GR)

For some practitioners, the changes in patient handling practice resulting from legislation were a mixed blessing. Whilst these individuals could see the safety benefits of the policy, the regulated nature of practice meant that meeting a patient's immediate needs was overlaid by the threat of later retribution.

'With the stroke patients we always used to do the front stand assisting them, but we don't do that now, unless we are with very experienced people and yet you can usually move one person, could stand a patient doing that as long as you were of matched height and size, quite easily, but we're not allowed to do that anymore. So, some people will do it and some people won't because they've been told categorically they cannot, but if you're in a confined space, like a toilet, and you want to move someone, you can't get two people down. So I will often, if the nurses come to me and say they are having difficulty, I will assess that patient and see

whether I can do it with them... I will do that sometimes to help out in a difficult situation.' (Ward Sister 2, GR)

A number of respondents suggested that one negative result of the policy had been an increase in nurses' reluctance to move and handle patients, leading to patients becoming de-conditioned through hospitalisation.

'So I think in some senses it's had the effect, the moving and handling, of making patients more hospitalised....because people are afraid to get them out of bed and they become weaker, with muscle weakness.' (Registered Nurse 2, GR)

4.4.2 Impact of Policy on the Rehabilitation Ethos

Many practitioners displayed a struggle between preserving their own personal safety and compliance with Manual Handling regulations versus fulfilling the rehabilitation ethos. Respondents described rehabilitation practice as a 'grey area' and identified a 'fine line' which marked the difference between the 'official line' on safe patient handling and the realities of handling rehabilitation patients.

'So really it's a grey area and no-one is really prepared to say, you know, yes you can do that but on the other hand they tend to say 'no, you have to assess the patient each time and take that risk.' And fortunately, we've been lucky, and I think it's because of the experience and technique, that people are going ahead.' (Ward Sister 2, GR)

Handling rehabilitation patients and assisting them with mobility and movement was viewed as inherently risky to the practitioner. Although all were at pains to emphasise that the patient would never be exposed to unnecessary risk, taking measured risk was seen as a necessary part of the patients' rehabilitation, allowing them the opportunity to try out physical abilities. Safe patient handling was viewed as an insufficient approach in rehabilitation, which maintained the patient at the same level, rather than increasing their abilities. Some respondents appeared to feel constrained by the 'official line' and emphasis on safety.

'If a patient comes in that can't walk, we have to get them to walk, if they are using the hoist all the time, we are never going to get them to walk...so it's a very fine line with rehab....sometimes you have to do things and you think I shouldn't be doing this, but there is no other way of doing it....this can't be doing me much good, but there is no other way of doing it. It's for the patient's sake, not our sake, but officially we should not be doing this.' (Registered Nurse 3, GR)

A number of staff appeared to 'know the right way' to do particular patient handling tasks, but chose to carry out an activity differently. One reason for this was because the practitioner did not view it to be in the best interests of the patient. For example, nurses talked about patients who could stand from a chair with two staff members if they were given 'a physical push'. They identified that if they followed the official guidance, the patient would have been hoisted or moved using a stand aid. This was seen as too 'extreme' and a move in the wrong direction for the patient. Instead, staff preferred to provide physical help for patients who were 'in between' – too good for the hoists, but not quite able to move using simple assisted standing techniques. In this way, staff accepted risk because it was for the benefit of the patient.

'I do not think in rehab you can keep patients totally safe. There has to be risks, otherwise you don't move them in bed all day because you are at risk of falling. Or you say, don't move from that chair! But it is just balancing that risk and as I say, I think that is what the policy is about, it's minimising risk.' (Ward Sister 1, GR)

Nurse respondents did not think that physiotherapists were governed by the hospital 'no lifting' ethos in the same way as themselves. They seemed to be of the opinion that although all practitioners had to address safety issues when handling patients, physiotherapists could 'do more' physical or manual handling than nurses if this was part of the patient's rehabilitation. For example, in the following extract, the ward sister implied that physiotherapists worked to a different policy to nurses. She states that *'because of their training, they are sort of allowed more leeway and, I think their intention is slightly different from ours'*. Similarly, the staff nurse perceived the physiotherapists to be working to a different remit: *'physios come under a different remit cos obviously that's their job...'* (Registered Nurse 3, GR)

This perception was reinforced by the physiotherapists who also suggested a difference between manual handling and therapeutic handling: For one physiotherapist, practicing rigidly to hospital policy would limit patients' rehabilitation opportunities. In this context, manual handling activities were justified by labelling them as 'therapeutic handling'. This type of handling was described as '*outside the rule book*' (PT2, CS1). For the second physiotherapist, the core purpose of her role was to take some level of measured risk to give patients that chance to improve their level of physical movement.

'if you really broke it down its like you are putting yourself at more risk to actually get the patient going.... it's a big risk – these are challenges we are facing – it's like we've go to get them sat on the edge of the bed and stood up and they are really tall and they are really big and really heavy but we have to do it cause that's my job and you can't not... It's our job – a major part of my job is to get someone who can't move themselves and stand up and transfer, that's my job.' (Physiotherapist 1, GR)

But physiotherapists, like nurses were aware of the ambiguity of their activities especially when then perceived themselves to be working beyond the official line. There was an underlying concern within many of the transcripts that the work of rehabilitation practitioners did not sit easily within the policy and might not be supported by the Trust if an incident were to occur.

'It is unseen practice that we do and it always worries you, it's always at the back of your mind – is this what we're supposed to be doing? because its rehab, you cannot escape this element of risk...I would say we do practice safe practice, I wouldn't say we were unsafe at all. The only place where I think we are perhaps more risky is when we are in treatment, when we're trying to push patients, trying to get what we want to achieve, it's the stuff that you're actually trained to do, you need to do hands on stuff with people, and that is when you're not actually using any equipment, and that is probably where the risk is more... ...we follow the guidelines to a point and utilise the equipment as its supposed to be done, but you're doing more manual handling, you're taking more weight than is the official line, you know.'

(Physiotherapist 1, GR)

This led a number of practitioners to the conclusion that the policy for manual handling was divorced from the reality of rehabilitation practice. For some practitioners, the policy had also had a negative effect on the rehabilitation process. When nurses and care assistants drew on the ‘no lifting’ ethos of the Trust, this meant that some were not willing to move and handle patients in a manner recommended by rehabilitation staff. In this way, the policy had changed the nature of care by driving nurses and care assistants to ignore patients’ needs for mobility –needs traditionally viewed as nursing needs and legitimate areas of nursing practice.

‘You’ll get nurses that say ‘well I’m not doing that the way you’ve just shown me, i.e. therapeutic way, because it’s poor manual handling and was not the way I’ve been shown to manually handle a patient. So I think you can use the manual handling policy as a way of not getting involved in therapeutic handling. I think some nurses especially aren’t keen to get involved in therapeutic handling because it’s ‘oh I was taught manual handling, I was taught the very passive way and I don’t want to injure myself’, which, you know, you can understand really but it doesn’t help the patients any.’ (Physiotherapist 2, GR)

4.4.3 Moving and Handling Training – A Technology of Power?

The staff interviewed had gained concrete experience of the Trust policy for manual handling through attendance at mandatory training sessions in moving and handling. Practices and techniques demonstrated during these training sessions established the ‘official line’ with regards to the handling of patients. Training was viewed as a good opportunity to learn possible new techniques on moving patients and about new pieces of equipment and also how to maintain safety. However, many respondents indicated a perception that the moving and handling training fulfilled the needs of the organisation but not that of the practitioner. It presented patients in simplistic terms, using non-complex examples with little focus on the inter-relationship between moving and handling patients and rehabilitation. The training demonstrated the organisations’ compliance to the legislation, but many practitioners did not feel it added any value to rehabilitation practice:

'because in the moving and handling training that we get from the Trust it tends to be basic, your bog standard patient. This is how you manage sit to stand, this is how you manage if they fall on the floor or if they are a bit wobbly. It doesn't tend to go into the complex or in-treatment.' (Physiotherapist 1, GR)

For the therapist below, the mandatory Trust training in moving and handling lacked sufficient focus on patients' rehabilitation needs. Training placed patients in a passive role and did not emphasise the active nature of rehabilitation practice.

Interview: 'So thinking about like, the policy, for moving and handling, for the Trust. How do you think that fits with the goals of rehabilitation?'

Physiotherapist: I don't think it fits very well. Obviously as part ... they always throw in the clause of 'you should talk the patients through something if they can physically do something themselves you should let them', so before you manually handle them you should do a little assessment and if they can do it themselves get them to do it themselves and they are always going to throw that in as an aside, but I think a lot of the manual handling policy is around protecting the employee and protecting their back, but it also sort of protects the patient, but it doesn't get them ... it doesn't always encourage the patient's rehab. It's quite passive and quite well, 'I'm going to do this to you' rather than, 'I want you to help me to do this that and the other.' (Physiotherapist 2, GR)

A number of participants identified the difficulties of applying the techniques taught during manual handling training to the types of patients admitted to the rehabilitation ward. Most patients needed more support than that discussed during training.

Interviewer: 'The moving and handling training. How does that relate to what you do?'

Occupational Therapist: It's very regimented to providing or facilitating good back care, you know, your basic moving and handling principles. Sometimes I feel, rightly or wrongly, that's not always realistic and you might have a completely unpredictable patient and you can try really hard to follow those moving and handling guidelines but it's just not going to work. In rehab we get a lot of unpredictable patients.' (Occupational Therapist, GR)

When asked, some nurses and care assistants professed that they had not read the hospital policy on patient handling. These staff were not concerned about whether they were able to comply with its requirements and did not feel that rehabilitation practice contradicted the policy. For other nurses though, the reality of carrying out essential nursing care fitted poorly with some of the techniques of safe patient handling. For example, trying to dress patients could pose significant difficulties as no equipment could get clothes on or off a patient.

Interviewer: 'Does the moving and handling training for the trust reflect your practice?'

Registered Nurse: I do agree that you shouldn't try to lift physically but sometimes its impossible not to, just even to sit a patient up in bed. The Moving and handling lady says just to move with the sheet. Well you can pull with the sheet but how do you get the pyjama jacket off? - its just impossible. I mean we have this man and my back was aching just trying to get his pyjama jacket off because he was a really big man, he was lovely, you could get him up with the sheet but you couldn't get his jacket off. I wish these moving and handling people would come and please show me how to do this because it's just physically impossible' (Registered Nurse 3, GR)

Finding themselves unable to apply the practices and techniques demonstrated during the mandatory training placed practitioners in a difficult position. They began to feel guilty about their practice, and unsure of whether they were complying with manual handling guidance. A number of staff raised the issue of litigation and 'courts of law' and worried that their patient handling practice might not be supported if an incident involving patient or staff injury occurred. The extract below sums up this anxiety:

'I say to them, what about a patient in rehab because we have to have the element of risk, we've got to let the patient do something, so they are going to be at risk, and they say 'as long as you're not going to hurt yourself or the patient', but when you sort of say 'well where do we stand with the cover?' they say, 'you should do what you are taught in your moving and handling sessions.' So really, we've got to take that risk with ourselves and the patients if we are going forward.' (Registered Nurse 6, GR)

Many of the respondents lacked faith that their employer would protect them if a patient sued as a result of a manual handling incident. The legal framework related to manual handling and the associated hospital policy was viewed as a potential threat, as opposed to a protective mechanism. Nurses were of the opinion that if they hurt themselves they would not be *'backed up in a court of law'*. Physiotherapy respondents also perceived the tension between ensuring safety and compliance with hospital no lifting ethos and the aims of and activities within rehabilitation practice – the need to stand someone up for example, or help them to walk. Methods of handling patients advocated within 'official' guidance on standing patients could not be applied to the patients admitted to the ward, who had much more significant mobility problems. This posed the same problems for physiotherapists as it did for nurses. However, physiotherapy respondents were able to describe ways to minimise the risk associated with standing these patients and the positions and 'hand-holds' they would use.

'The official way to stand a patient is a patient who can pretty much stand up themselves...but the patients we get are so dependent, this is where you actually get onto therapeutic handling, when you are looking at ways to treat them, you can't stand someone up the official way....what we do is come and assess them and see how bad they are....there's ways that we teach them to handle so you are handling more under the trunk wall, because you can't handle up into the armpits, so there are ways to support around the trunk and putting more effort around the hip and we'll do that between us. We try to stick to the guidelines for your neck or your back...its really important the way you handle the patient so you are not going to injure them, and then bringing them up...there is physical exertion on our part to get them up and then sometimes holding them up.' (Physiotherapist 1, GR)

4.5 Summary of Chapter

Nurses undertook a range of activities which were beneficial to patients' wellbeing and supported improvement in mobility and movement. However, nurses considered physiotherapists to be the experts in relation to mobility rehabilitation and deferred to them when decisions were made. Whilst therapists engaged in therapeutic handling, nurses did not, but undertook care handling. Longer term qualified nurses had

previously had greater involvement in patients' mobility rehabilitation, prior to the changes in Trust moving and handling policy. Staffing shortages, time pressures and the reality of patient care meant that nurses were aware of 'risk' in their daily work. Nurses admitted with some guilt that they were not able to eliminate all strenuous manual handling from their work despite using moving and handling equipment regularly. However, nurses accepted this was part and parcel of caring for patients.

Nurses and therapists alike desired an honest policy for moving and handling. It was argued that Trust Manual Handling policy ignored the realities of rehabilitation practice where some manual handling was essential. The annual moving and handling training sessions represented the 'official line' on moving and handling. It was perceived that working beyond the official line to engage in therapeutic handling put the practitioner at risk of criticism. Practitioners suggested that unless they could demonstrate that they had adhered rigidly to hospital manual handling policy they would not be supported vicariously by the Trust if a complaint was made and would not be awarded compensation if injured during the course of their work. Some nurses implied that fear of being blamed or criticised or of sustaining a back injury led others to avoid moving and handling patients.

CHAPTER 5

CASE STUDY 2 – REGIONAL SPINAL INJURIES CENTRE

FINDINGS

5.0 Introduction

This chapter draws on the 13 interviews carried out with staff working at the regional spinal injuries centre and the 25 hours of observational data collected. A wide range of issues were discussed by respondents during the interviews and a variety of patient handling activities were observed. This chapter provides an overview of the findings using verbatim extracts from interviews and observational data where appropriate to illustrate the sub-categories identified. Four Sub-Categories and related major codes were identified as detailed in table 15 below. This chapter will discuss each of the four subcategories and the related codes in turn.

Table 15: Case Study 2 Sub-Categories and Major Codes

Sub-Category	Major Codes
Facilitating Movement: Generalist and Specialist Contributions	Facilitating movement A physical job
Risk in Caring	Unacknowledged risk A duty to care
A Divided Team	The division of work Perceptions of the negotiated order
Interpreting the policy	Between a rock and a hard place Nurses aren't covered Compromising rehabilitation

5.1 Subcategory 1: Facilitating Movement - Generalist and Specialist Contributions

From the perspective of an outsider to spinal nursing, the nurses and care assistants working on the unit possessed a particular level of expertise and specialist knowledge which enabled them to care for patients with spinal injuries. Many of the patients on the unit had a range of complex needs including emotional and social needs. However, the physical care needs of this group of patients were also very significant. Nurses and care assistants contributed in a range of ways to patients' mobility rehabilitation and the work of the rehabilitation team itself.

5.1.1 Facilitating Movement

All of the spinal injured patients on the unit required substantial help with personal care. The work of care assistants and nurses was physically demanding and frequently involved rolling patients, physically helping them to get dressed or move from one place to another. Many patients required the same level of assistance day in day out which meant that there was much repetition in the work undertaken. Many of the patients had complex handling needs and episodes of sudden spasm posed a known threat to safe handling. It was clear from many of the interviews that the nurses and care assistants viewed the handling of spinal patients to be an area of expertise.

'It's a different kind of moving and handling, I think, to the rest of the hospital because our patients, if you're getting an elderly person out of bed, say with a hoist, they can move a bit you see. They can roll, they can get can get the sling under. Our patient, we have to completely move, so if you've got a tetraplaegic you've got to roll them to get the sling underneath and, once you've got them in the hoist then you get them into the chair, you've then got to get them in the right place in the chair. You've got to get them seated properly, because if you don't get them seated correctly they can get pressure marks, so there's a lot more, I think, plus we have a lot more moving and handling here and lifting, but we're not supposed to say lifting anymore are we?'
(Care Assistant 1, SP)

As the care assistant above identifies, patients' inability to assist with movement, often from the waist or neck down, made patient handling activities challenging. In the following example, the patient being moved has external fixators on both legs and a full torso brace to support an unstable spinal fracture. During the care episode, the care assistants adopt unsafe postures whilst trying to move the man. The care assistants verbalise that they ideally need another staff member to move the patient, but on this shift, they were one care assistant short.

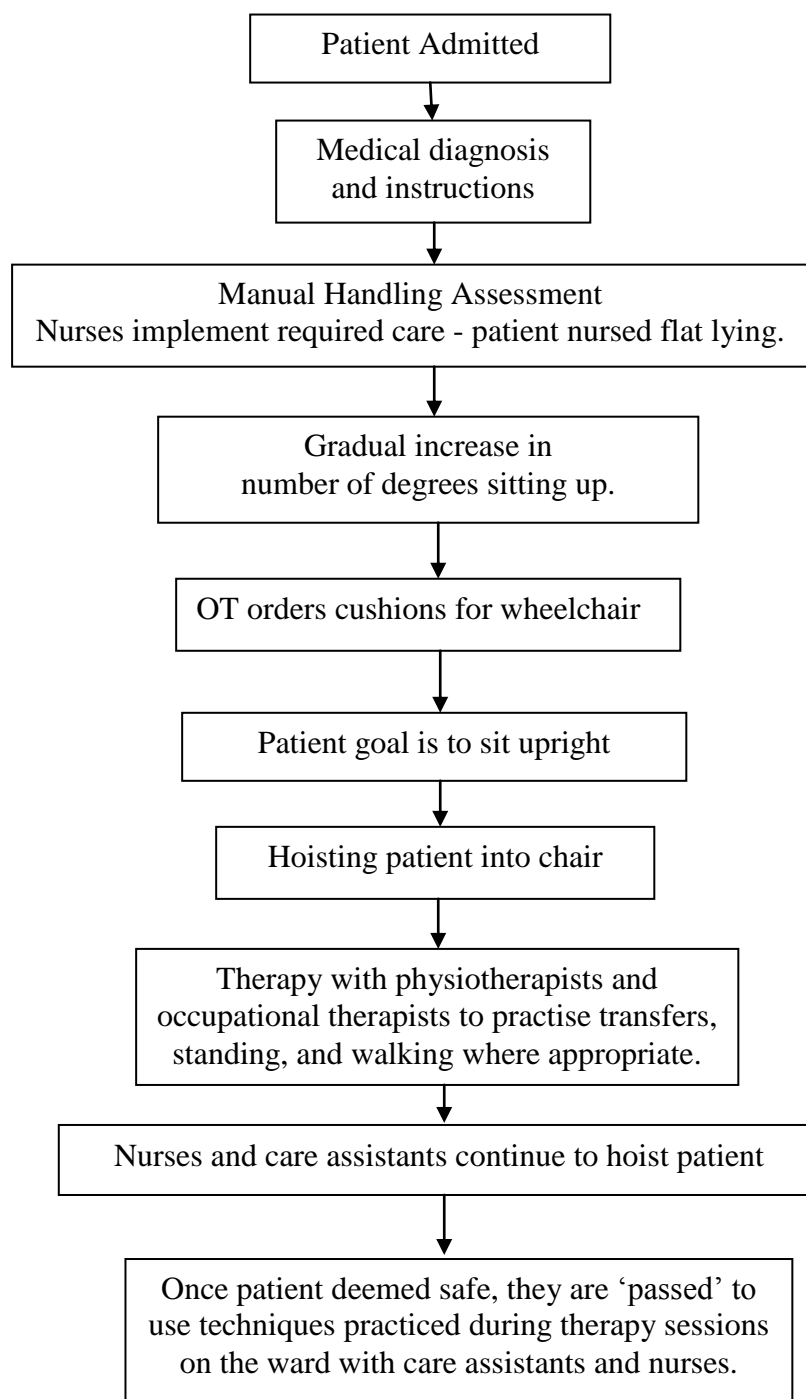
Box 4: Observational Extract 4: Case Study 2

Morning Care Episode – Getting man washed and dressed 24/5/07

The two care assistants have gone to another patient who is paralysed from the chest down. He has external fixators on both legs. One care assistant is leaning over the bed, supporting his leg and the external fixator – it looks very heavy. The other care assistant is pulling up his pyjama trousers – it looks a real strain. The care assistants say that the rolling is very tiring on their shoulders and wrists and fingers from pulling up clothes. The bed is sliding about even though the brakes are on. The floor is slippy. They are washing his hair now, bending over him and pouring water. Another care assistant mentions the wires under the bed inhibiting the rolling motion of the hoist. They are getting the patient dressed now, choosing his T shirt – they take him under the armpits, sit him up from lying to get him into a sitting position – it is not a good way to move him but the back brace is hard and solid and makes him wide across the back. They sit him forward again and put the front of his back brace on – he grimaces. Then they roll him in the bed with the brace on – his legs and their external fixators are separated by a pillow, but his legs flop over and they crash together. The sling is put under and he is rolled again. The care assistant says- ‘we could do with 3 people really’. It's now 12 o'clock and the lunches have arrived. The two care assistants have not stopped since 7.30 am.

From the interviews it was possible to identify a clear process through which medical staff, nurses, care assistants and therapy staff worked with patients to promote mobility rehabilitation. This process is illustrated in the diagram below.

Figure 4: Process of Promoting Mobility Rehabilitation



Beginning during the acute phase of the injury nurses and care assistants moved patients by log rolling and managed the patients needs whilst flat lying was required and later managed the patient's progression to sitting up. Nurses and care assistants were observed encouraging patients with their exercises and getting patients ready for

therapy sessions and appointments. Registered nurses also emphasised the importance of their 'pivotal' communication to other team members about how patients progressed with rehabilitation activities. Nurses and care assistants completed patients' activity charts, assisted them to get washed and dressed, carried out shower chair assessments and took great care to preserve patients' skin integrity. It was also important to be able to judge a patient's activity tolerance as they initially began to sit up in bed and chair after a long period of flat lying. Many of those interviewed also identified the importance of individualising the way they moved and handled patients based on personal knowledge of the patient's injury, spasm, pain and skin integrity.

'it's getting used to how all the different patients move and how much mobility they each have, because they are all individual and everything. You know, what you do for one you don't do for another and it's about getting used to what people can do.'

(Care assistant 3, SP)

Patient handling was intrinsically linked to skin care and prevention of pressure sores. Nurses turned patients to relieve pressure areas and checked the patient's skin. They also emphasised the importance of teaching patients how to relieve pressure and check their own skin using mirrors if possible and to communicate with nurses when positional change was due.

'We're mad on pressure area care because they can't feel. They can't tell you if they're uncomfortable or going numb or whatever. When we first start mobilising a patient into a wheelchair they'll increase the time hour by hour in the day and we check the skin all the time. If they have any marks, or any scratch or anything they won't get up until that's gone. They won't have any pressure on that area.'

(Registered Nurse 1, SP)

Promoting patient movement and improving the quality of movement was rarely observed to be the prime purpose of nursing. Facilitating movement was more likely to be a by-product of nursing care to meet another need such as to wash the patients back, change bedding or perform bowel care. However, on a few occasions nurses were observed helping patients to move and to relearn activities through an active,

function driven and encouraging approach. However, what was also apparent was that nurses lacked time to concern themselves with the quality of movement. The nursing focus was more related to whether the patient moved from a to b and achieved the functional goal, rather than how well they did it. The patient's comments in the fieldwork extract are illustrative of this.

Box 5: Observational Extract 5, Case Study 2

Conversation with Patient: 17/5/07

A patient engages me in eye contact and a smile. He knows who I am as I had introduced myself earlier and given him a research information sheet. He tells me that he has just started walking with his zimmer frame down in the gym with the physiotherapist. He is now allowed to walk up on the ward. He tells me that the main difficulty is lack of balance and altered sensation in his legs and slow muscles. Originally he was hoisted but then learnt to use the banana board. I ask him if the physiotherapist does things the same as the nurses. He says 'definitely not – the nurses have to move onto the next patient and can't wait while I take 15 minutes to transfer.' He says that the physiotherapists generally leave him to struggle for longer, make him work harder and are always looking at the detail – even if the transfer goes well, they will say 'no, do it again, you put too much strain on your shoulder.' I ask if the nurses do this. He says they don't, that they are just happy if the transfer goes ok – if you can get from one place to another. He says that they just don't have the time – he qualifies this and says, 'not in a bad way – they just don't have the time'. Later I ask a care assistant about this patient and his walking. She tells me she knew nothing about it. I wonder how nurses and care assistants can supervise a patient newly walking if they've had no briefing.

Many of the nurses and care assistants interviewed identified that there have been profound improvements in working conditions with the increased provision and use of patient handling equipment. However, some staff also alluded to the fact that because equipment could now be used, the challenges associated with handling patients had become less visible. From the data it appeared that care assistants bore the brunt of the physical labour associated with caring for patients with spinal injury.

5.1.2 A Physical Job

It was the care assistants who carried out much of the physical work in comparison to registered nurses (who had different roles to fulfil). On a number of occasions, the care assistants explained that they were short of staff on the shift which meant that each individual carer had a greater number of patients to look after. This had implications for their experience of fatigue. Staff were often late taking their breaks, frequently having worked 'hard' for 3-4 hours without a rest. Some care assistants had also worked long stretches (5-7 shifts in a row) or had done extra hours to cover for staff off sick. Late shifts were particularly tiring due to the tendency to have fewer staff on duty. During this shift, care assistants helped all patients out of bed for the afternoon, then assisted them to get them back to bed later on and towards the end of the shift also readied patients for bed.

Time pressures influenced the way in which care assistants worked. On a number of occasions they helped patients to get washed and dressed under an element of time pressure to ensure patients were ready on time for therapy appointments. When the pressure of time was a factor, this meant care assistants took fewer, shorter rest breaks and worked at a faster pace. The fieldwork extract below described a typical scenario.

Box 6: Observational Extract 6, Case Study 2

Memo: Awkward Work 23/5/07

Whilst I've been observing the nursing staff in action, I've seen many instances where they must move and handle awkward loads – patients legs, equipment for example, in very cramped spaces under some form of immediate time pressure (either ward, hospital or therapy schedules, patients' wishes or because of immediate needs, such as spasm). Care assistants do this without complaining, more in an accepting way – it is seen as just part of nursing work. Care assistants put up without having essential equipment. For example, not all of the beds on the unit are electric.

Physical care was carried out using the available equipment. Whilst this eliminated some of the physical lifting, such equipment could not remove all of the physical

labour associated with caring for patients with spinal injury. Whilst using the hoist once to move, wash and dress a patient might not be perceived as overly demanding, undertaking this process six or seven times a shift certainly was.

The observational data below demonstrate how the context of the care episode influenced how the work was undertaken. In this example, the care assistant felt under pressure because the patients were not happy. Patients had not been provided with any morning tea or coffee because the ward no longer had a housekeeper to do the drinks, answer the telephone or put away the stores. Some patients had not been able to wash or get dressed as the care assistants had been undertaking housekeeping duties. The two care assistants were working quickly because they were very much aware that the lunch trolley would be arriving soon. As I observed I felt that the care assistants were rushing and cutting corners and undertaking much physical lifting in the process of getting the patient dressed.

Box 7: Observational Extract 7, Case Study 2

Patient care – getting a patient dressed 16/5/07

None of the patients have had tea or coffee. Two care assistants have gone on a tea break (it is 11.30am). The other two have still got two patients to get up before dinner – one patient has asked three times now and is not happy – the care assistant is under pressure. They go to the first patient. He is lying in bed and needs to be dressed. Together the two care assistants lift up his shoulders and bring him into the middle of the bed – he can't help at all. They start to pull up his compression stockings, then his socks and then his trousers. It is hard work getting them on his legs as the patient cannot move them at all. Then they put his T shirt on – both arms through first and then they lift him forward using his underarms and bring the T shirt over his head. Then they roll him over at his knee and shoulder. His leg goes into spasm – it is pushing straight down and is rigid. The care assistant breaks the spasm by bending up his foot and pushing his leg up. They put then sling underneath him, then roll him again to get the sling through. They put the hoist under – it is difficult because the bed mechanism is in the way. The care assistant pulls the hoist out again and then tries again to put it in. They attach the straps of the sling to the hoist and he is raised up. The care assistant goes to get the chair whilst the other manoeuvres the hoist with the patient in the sling towards the chair. It is not lined up properly. They push the hoist to the side and he is lowered down into the back of the chair.

The care assistant stands in front of the patient and leans towards him, pulling him forward at the shoulders. Her knees are bent and she has a wide base. The other assistant pulls down his T shirt. Then they have a quick conversation. The more experienced care assistant wants the other one to hold the patient forward in the sitting position as she wants to get him sitting further back in the chair. She shoves at his knees with her hands and he goes back. She says it only works because he is on a Roho cushion and does not work with the flat cushions. I note the poor posture when the nurses are moving the patient's legs. They both have bent backs and straight knees.

Most nurses and care assistants acknowledged that whilst equipment did eliminate much of the physical lifting, spinal nursing remained a very 'physical job' where nurses frequently had to assist patients' legs on and off beds, log roll, get slide sheets and hoist slings under patients. This view was contrasted with that of senior nurses who seemed less concerned about the challenges of handling patients.

'The work is not taken out as much by using the hoists. Everyone seems to think that we are not manually moving people, because we have hoists. We are actually physically dressing them and everything and getting them in position to get them into the hoists and things like that, and then moving the hoists. There's still a lot of manual work involved.' (Care Assistant 3, SP)

Often, registered nurses and care assistants mentioned the need to undertake 'the little lifts' which were necessary to ensure the patient's comfort and safety. For example whilst a hoist would be used to transfer a patient from bed to chair, sometimes the patient needed further repositioning in the chair which, required a manual technique to be used. Whilst many of the nurses clearly knew about the principles of safe handling, often it was difficult to apply these. For example, because spinal patients cannot control their body temperature, they may need several layers of clothing that can be easily removed. This was difficult to achieve using equipment. Some nurses did admit to 'cutting corners' especially when they could not get enough staff for a transfer.

'I think obviously the aids that are brilliant; the slide sheets, the hoists, and we obviously use as much as we can, ... it's easy to be theoretical about things, and then in practice it doesn't actually work all the time. I just think it's impossible to say that

you don't lift... a tetra patient is sometimes, depending on the level of injury, is not free from a ventilator, so...once you get them up in the morning then you've got to dress them and you can only take them off the vent for a couple of seconds. So, I mean for instance, John, one of the patients - he likes to be warm, I mean he might have something like seven or eight layers on. On top! So you've got to detach, put in over the shoulders, and then obviously, because of the skin, you've got to get the clothes, the seams straight and you've also got to get the clothes straight at the back – you can't leave them mucked up!... I think personally, and most of the staff nurses agree with me, at some point you do end up lifting to a certain degree.' (Registered Nurse 2, SP)

Whilst it would be possible to avoid some of these 'little lifts' (N1) it seemed that nurses and care assistants generally decided it was in patients' best interests to carry them out.

5.2 Subcategory 2: Risk in Caring

Providing care to the patients residing on the spinal unit entailed risk to the nursing and support staff. However, some of the respondents interviewed felt that these risks were often not well recognised or acknowledged. Many of the staff talked of their experiences of back pain but reiterated their commitment to providing care to those who depended on them.

5.2.1 Unacknowledged Risk

A number of those interviewed implied that the risks associated with patient handling on the spinal unit were not always recognised. That is, risks went unacknowledged. Indeed, long time qualified nurses (longer than 15 years) voiced the opinion that 'nowadays, it's (patient handling) so much easier'(registered Nurse 9). These nurses had witnessed great changes in patient handling with the introduction of new legislation and new equipment such as hoists which had dramatically changed the provision of nursing practice. Some nurses seemed somewhat complacent about the risks associated with moving and handling because conditions had improved over the last 10 years - it was as if nothing more needed to be done. However, other nurses

pointed out that equipment did not rule out the regular need to physically lift the patient or part of the patient, such as their legs or torso. For the registered nurse below, patients' needs combined with the limitations of the environment, coupled with time pressures multiplied the effect of risk factors.

Interviewer: 'From your point of view, what do you think are the sort of main issues in moving and handling?'

Registered Nurse: Main issues. Safety. The main issue's safety to both patients and staff, because there are a lot of risk areas around, in our ward especially. Because it's not totally non-lifting policy, it's a minimal lifting policy, and, as you see, there's no space to get in and out with wheelchairs, to get them out with hoists. You've got wires everywhere. I also find it stressful sometimes. You know when you're on a time limit to get patients up for departments and you're dangling there with hoists and you're under the bed trying to get the wires over the hoist because the hoist won't go and the beds have to be a certain level to go in. It's just a nightmare.' (Registered Nurse 7, SP)

Some of the longest qualified nurses felt that newer nurses were more at risk of injury when handling patients because they 'had not been taught to 'lift' properly'. Some of the longer time qualified nurses felt they were no longer as strong and muscular as they had been because they no longer did so much lifting. This they felt put them at risk when working with other nurses or care assistants who were less likely to 'put their backs into it'.

Many nurses were critical of the design of hoists and beds. The bed mechanisms often impeded the movement of the hoist under the bed making the hoist cumbersome and awkward to use. Often nurses had to move the hoist backwards and forwards several times in order to fit the legs under the bed and in the confined space around the bed. Nurses and care assistants then adopted unsafe postures whilst repeatedly pulling and pushing a heavy load. Neither was there overhead tracking and so more physical lifting was required.

'The hoists are really awkward to move. I mean they have to be used because we can't lift people out of bed, but they're just so awkward. We have very little space.'

The hoists are quite wide, so you're moving exactly contrary to actually how they tell you to move. You're twisting and stepping back and leaning forward and doing all sorts of things that you shouldn't be doing. You take the weight on your legs because you don't bend with a hoist, but you're pulling it and you're taking all this force on your back and your shoulders. The hoist is heavy and then you have got a heavy patient in it as well.' (Registered Nurse 8, SP)

Nurses commented that it was often more difficult to move and handle patients in the morning and at the end of the day. This was because patients were fatigued and more likely to have spasm. Therapists did not assist patients at these times of the day despite being largely viewed as the experts.

'Yeah, and sometimes the physios do things better in the gym than they can in the ward, because again, when they're first getting up in the morning they might have spasm and fatigue, because they've just woken up, and then when they're going back to bed at night, again they're really tired because they've worked hard in the gym so the nurses get the strains from that.' (Registered Nurse 4, SP)

This linked across to another common perception which was the inevitability of back pain for nurses. A number of the registered nurses and support workers identified that back pain was a daily experience. Caring for patients with profound physical needs took its toll on these carers who were largely accepting of back pain as an occupational hazard.

'Most of us have sore backs, but it just goes with the job. But that's not necessarily just from getting them out of bed with the patients, that's just general, you know things that – you have to position them in the chairs, you've got to get down the back of the chair and pull them to the front and pushing, and really its wear and tear on your shoulders, your back. I think everyone feels it.' (Care Assistant 1, SP)

Both the registered nurses and care assistants argued that back pain was simply 'part and parcel of the job'

5.2.2 A Duty to Care

Although many of those interviewed spoke about having back pain and the challenges of moving and handling patients with spinal injury, there was a sense of vocation in the way these staff talked about their work. Despite the fact that care assistants often worked under time pressure, in confined spaces, using cumbersome equipment and had to take on awkward positions in order to move patients, they demonstrated compassion through their actions. However, it was also evident that if nurses and care assistants focussed only on their right to safe working conditions, the resultant patient handling decisions and activities selected would have impinged on patients' dignity and safety. Often, a dilemma existed between the nurse protecting her own safety whilst at the same time meeting the patient's care needs. Nurses were observed lifting patients' limbs and adopting unsafe postures during the process of providing care which were dangerous and put them at risk of injury. Often this was because the nurse was acting on instinct and seeking to relieve a patient's discomfort. However, in doing so, these staff put the patient's immediate needs above their own need for safety. As the registered nurse below identifies, there were certain requirements to the job of being a nurse which could not be avoided.

'But I think sometimes you've just got no choice, but you have got to lift. You've got to get the job done even if that's meaning holding somebody over, you know, on a regular basis day in and day out. I do think it has a strain on your back. I mean I'm really strong and I've never suffered with my back until I came here.' (Registered Nurse 2, SP)

In the care example below, the care assistant is observing whilst the patient attempts to transfer from his bed into his wheelchair. He has managed to dress himself, but needs to practice independent transfers. During the manoeuvre his leg goes into uncontrollable spasm and falls off the bed. The care assistant seeks to prevent the patient from sustaining a further injury, but in the process, lifts and bends quickly to break the spasm in the patient's leg muscles. Her first thoughts are how to protect the patient from damaging his limbs, not her own safety which she does indeed compromise.

Box 8: Observational Extract 9, Case Study 2

Patient care episode – helping a patient to transfer from bed to chair 24/5/07

The patient is paralysed from the waist down. However, using his upper body strength he has got up and is washed and dressed and is sat on his chair. He calls the care assistant over and says he wants her to just check his wheelchair cushion – he thinks it is the wrong way round. He manages to transfer himself out of the chair onto the bed but it is a struggle. He gets the banana board under his thigh and slides across but he falls backwards across the bed. His legs go into spasm – one leg is sticking up, the other is hanging down at an awkward angle. He tells the care assistant, urgently, that his leg has fallen down on the brake. She picks his leg up – it is very heavy as he is a big muscular man, tall and large framed. She looks at his leg to see if it is alright. She puts both his legs up on the bed – they're heavy, but she needs to get them up to break the spasm, at that moment in time she's thinking of him and how to stop the potential damage to his limbs. She goes to check the cushion and finds it is the wrong way round. He says 'no wonder I've not been able to get comfy these last 2 days.' He needs to get back in his chair. He manages to pull himself into a sitting position by grabbing onto his wheelchair, but even though the brakes are on, it moves. The care assistant is holding the chair down with her foot. His leg goes into spasm again – it is sticking out straight. The carer takes hold of it and pushes on his knee and holds his foot. She pushes it down onto the footrest of the wheelchair. She picks up his other leg and puts it in the wheelchair footplate. He manages to put the banana board underneath but it is difficult. He slides over on the board. The care assistant asks him if he can get the board out. He's trying but it's too far under. He lifts himself up and the health care assistant pulls it out.

5.3 Subcategory 3: A Divided Team

Teamworking between nurses, physio- and occupational therapists consisted of the sharing of verbal and written communications at the weekly multi-professional team meeting. All interviewees portrayed a working pattern that did not involve working alongside physiotherapists or occupational therapists in the provision of hands on

patient care. There was a clear divide, both geographically and professionally between team members and clear lines of work division.

5.3.1 The Division of Work

Work activities associated with the patient's rehabilitation were divided up between different members of the rehabilitation team. For example, nurses were responsible for skin care whilst therapists were responsible for 'therapeutic handling'. This involved teaching the patient how to successfully transfer from one place to another. Nurses were 'reliant' on the therapists 'telling' them what to do with patients in relation to movement and mobility rehabilitation. The occupational therapist described the difference in the patient handling activities carried out by therapists and the nurses. She also explained how this work system 'controlled' the process of mobility rehabilitation in order to provide the patient with a consistent approach to their rehabilitation:

'Well the difference is they're working with patients once the patient has reached a level of confidence, so they're (the patient) doing most of it themselves. If the patient is not capable then they are using lifting equipment....you get them to a point where they are more or less independent and only need minimal assistance, and that's where the nursing staff come in, because there is a danger if we're showing them how to do it one way and the nursing staff are showing them how to do it in a totally different way and that's why it is so important that we and the physios work so closely.'
(Occupational Therapist, SP)

She viewed her role to be that of coach and teacher. By providing manual support during movement her goal was to help patients through a transition phase from dependence to greater independence. That is, therapeutic handling was viewed as an active process of moving forward, which helped the patient to progress onto the next stage:

'I think there comes a point whereby a patient can do it themselves with a little bit of assistance. So, if you're teaching somebody how to reposition themselves they might just need that little bit of manual assistance while they are doing it. Now to me, that

is therapeutic handling. To get a patient to a point whereby they can do it independently...therapeutic handling is a process, you are going from stage to stage, whereas I suppose care handling is a single process' (Occupational Therapist, SP)

Physiotherapists and occupational therapists were perceived to have more time to work with patients in a controlled environment. There was no observed joint working between OT and PT on the ward or between nurses and therapists on the ward. The only shared working appeared to be the verbal communications. The following memo provides a flavour of one such multi-professional meeting. During the multi-professional meeting, nursing was only sparsely represented compared to the numerous physio- and occupational therapists.

Box 9: Observational Extract 9, Case Study 2

Observation of the multi – professional rehabilitation meeting 30/5/07

The report seems mostly the physiotherapist reporting what they have done. The nurse volunteers information on what the patient has been doing and also what the nurse have been doing for 8 of the 16 patients discussed. The OT makes requests of the nurses – to encourage the patient with washing and dressing (pt 11) and to ask if the patient has been wearing his orthoses (pt 10). Where the physiotherapist addresses information specifically to the nurses it is to warn them of a patient who cannot be transferred manually (pt 9). Where the nurse volunteers information, it is about how the patient is feeling (pt 15, pt 8), about the pts efforts to apply new techniques (pt 2) and to report on their activities with patients (pt 6, 10, 11, 13, 14 and 16). When one nurse reports that the nursing staff have been transferring a newly admitted patient and have worked on his functional activities, the physiotherapist doesn't say or ask anything. The patient has not yet been assessed by the physiotherapist.

The work of the therapists took place in the Therapist gym rather than on the unit. This meant that nurses often did not have a clear idea of what the patient's mobility rehabilitation consisted of or what activities were being undertaken, and certainly the nurses and care assistants had not observed these activities. Nurses were required to 'wait' until patients had been 'passed' or 'cleared' to do certain transfers before they

could begin to engage in those activities with the patient. However, the new techniques generally were not to be practised on the ward until the patient had been 'passed' to do so by the therapist. This was normally at a point when the patient could do the activity without specific coaching or staff intervention - practise in itself was no longer needed. That is, nurses were not asked to undertake planned practise with patients. On a number of occasions, nurses were not aware of what patients were supposed to be practising on the ward. In the extract below, the nurse describes the division of work.

'Well the physios are really sort of more based in the gym downstairs when it comes to mobilising the patient. The nurses really sort of take on the role, with regard to log-rolling and mobilising in the initial stages, and then when the patient is stable enough they'll start going down to gym and then the physios start work with them, you know if there is any chance of independence or ... and they'll start doing the transfers with the patients and walking, if that's possible. A lot of them go on a standing frame; even the ones with complete paralysis will go on a standing frame. We're not involved in that an awful lot and the physios aren't really involved in what we do up here, but we'll sort of get word from the physio that 'so and so can, they're allowed to start transferring up on the ward onto the bed.' And then we'll do that.'
(Registered Nurse 1, SP)

Whilst a number of nurses talked about encouraging the patient to wash themselves, or do their exercises, others viewed their role as mainly to get the patient ready for therapy (Care assistant 1 'Our job is getting them down to their departments on time, so that they get to OT and physio on time'). The division of work was signified by the different venues for where the work took place. The Occupational and Physiotherapists' offices and treatment rooms were geographically separate from nursing staff, based downstairs in the therapy gym, with their own offices. The nursing team was confined to the rehabilitation ward area on the second floor. Therapy staff did not undertake treatment in the patient bays or rooms. Many of the registered nurses interviewed suggested that this pattern of working was unusual and was not particularly helpful in facilitating their involvement in patients' rehabilitation. A number of nurses suggested the benefits of working closer working.

'Well we carry things on up here, and physio carries on down in the department and there's not a lot of transfer. We do dressing practice and stuff like that, but all the transfers are taught down in the department and instead of on the ward where they are actually transferring from the bed to the chair. So it could be a little bit more like staff coming up and we could get the patients dressed in the morning and the physios and OT's could come and get them out of bed and show them how to transfer and the staff would be present then instead of us having to go down to the department.'
(Registered Nurse 6, SP)

Being 'hidden away downstairs' (Registered Nurse 1) was perceived negatively. Some of the registered nurses interviewed implied that in comparison to their own work environments and work activities, the secluded nature of the therapy rooms offered a degree of comfort that they envied. Some of the comments suggested that therapists used this seclusion unfairly to avoid the more physical work required when undertaking patient care.

'They just plonk the patient back...they don't even put them in bed. We do. We do all the physical work. They don't do anything. They don't do any manual handling, as such.' (Registered Nurse 7, SP)

Observation of therapy sessions did not support these perceptions. However, none of the nurses or care assistants had spent time in the gym or treatment rooms and therefore knew little about what occurred in these spaces.

5.3.2 Perceptions of the Negotiated Order

Nurses were largely accepting of the teamworking arrangements, putting them down to poor staffing levels and historical reasons. The extracts below represent the public face of the team relations which were positive and supportive of each other and reflected the tacit understanding that loyalty was important within the rehabilitation team. However, the extract also suggests that teamworking was not organised to meet patients needs, but fitted with the preferences of those with managerial responsibility.

'Don't get me wrong, the physios are very good and, you know, they come up and they do their job and if you ask them anything there's no sort of problems between the two teams, but I just think ... it's obviously how it's run here, from a management point of view really. We wouldn't have any say in that anyway..... I think probably, like everything, it's probably down to staffing levels and I'm sure they'd love to come up and be more involved but to be fair to them they're not standing around doing nothing, but if you're not in that department, you don't know what's going on, so a lot of people think that they could do more, but I'm sure they are just as busy as what we are.' (Registered Nurse 2, SP)

Nurse interviews suggested that much of the role negotiation had taken place previously with no involvement of the nursing team. Nurses appeared to feel powerless to bring about change to the unsatisfactory working patterns. For example, one nurse stated:

'It's hard to influence other departments isn't it? You can influence nurses, but nurses can't influence another disciplinary really' (Registered Nurse 6, SP)

Some experienced nurses expressed dissatisfaction with the negotiated order and wanted to take more of a lead in the patient's rehabilitation. For example, by allowing patients to try out their abilities with assisted transfers, particularly if they had been admitted at a weekend, or over a bank holiday and were unlikely to see a therapist for several days. However, there was potential for the nurse to be rebuked if she did this. For example, the nurse below described communication within the multi-disciplinary team as sometimes 'hit and miss' with implications for the patient's rehabilitation:

'I think it can be a bit hit and miss at times, because if you're not on duty and it got missed or hasn't got handed over, a bit of miscommunication or whatever, and the patient says 'well I'm allowed to do it', and you go, 'but it's not been handed over to me', and they go 'but I've done it down there', and you feel that sort of and you want to say, 'I believe you' but it's not that, it's just that if we went and did the transfer and they haven't been passed then you're in trouble. So maybe it would be better...maybe

it would be good if someone was allocated to the patient to go down when they were doing their transfer. So you would know that it was done' (Registered Nurse 8, SP)

Some nurses resented the lack of teamworking between nurses, occupational and physiotherapist, believing the divide slowed down the patient's rehabilitation and removed opportunities for therapy carry over. A number of nurses suggested that they should go down to the gym to observe patient's activities. This would increase their confidence when working with the patients up on the unit, especially when information exchange was not always timely.

Whilst on the surface, the rehabilitation team was mutually supportive of each other, it was possible to identify areas of rehabilitation work which aroused team tensions. For example, a number of long time qualified nurses explained how their role in rehabilitation had changed in recent years, becoming much diminished in comparison to the roles of other 'therapists'. In the extract below, the nurse identifies competition for professional territory and ownership of aspects of the patient's rehabilitation. From the nurse's perspective, it was the OT who posed the greatest threat to her professional role in rehabilitation.

'I think patients learn an awful lot off the nursing staff, but lately, I just feel, over the last five years things have changed where the OT's get the credit for dressing practice but why does a patient have to have dressing practice once a week? Why can't, key workers do dressing practice? Why does it have to be OT's once a week? Why can't they have it every day? We wash and dress them every day, so I think it should be a nurses job, it used to be. And it used to be like, if a person, that is confident to teach them a transfer, why does it have to go through OT? Why can't we just show them how to do a transfer? It's all changed.' (Registered Nurse 7, SP)

Nurses also explained the importance of protecting the boundary line between nurses and 'therapists' in order to maintain their own sense of professional autonomy. The nurse below implied a tendency of unwanted or extra work to be 'dumped' onto nurses without reciprocity in return. This nurse felt it was important to maintain role demarcation to prevent other professionals from gaining 'control' of nursing activities and work. Whilst nurses would at times engage in role boundary blurring, this would

be for the benefit of the patient, rather than the therapist. In reality, the nurse felt that passive exercises were not a nursing priority, although one might argue that it would be a priority for the patient.

Registered Nurse: 'There should be more overlap when moving a patient, but it's got to be a two-way thing. The nurses can't be taking on things like movement, extra skills. The nurses could do that if perhaps the occupational physiotherapists could work more up on the ward, because it would free up more time. I don't think, in rehabilitation, it shouldn't always be 'that's your job and that's your job' but the done thing is that nurses take on extra roles and everybody else cuts back on roles

Interviewer: The passive exercises and the range of movement exercises, is that something nurses do here?

Registered Nurse: We tend not to do it, unless it's been specifically asked for from the physios or perhaps it's a bank holiday weekend and we know it's been a long time and no-one's moved their shoulders and stuff, then we'll actually do passive movements with them.

Interviewer: What's the reason for that then, not doing it, just out of interest?

Registered Nurse: I don't know. Probably time. Probably if we were to do it, as everything else, it'll become a nurse's responsibility. Like I say, we'll do it at a weekend and if there's a certain patient that you know is going to struggle if they don't get it done, we will do it as part of a bed bath and we'll just move his arms a bit or his legs, but as it's being the nurses responsibility to ensure that passive movements are done – we haven't got the time.' (Registered Nurse 5, SP)

Registered nurses also complained about their reliance on therapists to 'pass' patients enabling them to progress onto more independent transfers. The nurse below argued that the nurse as a professional should be given the freedom to decide whether they felt safe and competent to undertake a particular patient handling activity. For her, this arrangement undermined her professional autonomy.

'As nurses we should be able to use our own skills and expertise and say 'I feel safe and skilled enough to assist this patient in a transfer.' (Registered Nurse 4, SP)

As the fieldwork extract below indicates, registered nurses were capable of being active and function driven in their approach to rehabilitation. When nurses decided to work in this way and had the freedom to do so, they worked effectively with patients on rehabilitation goals.

Box 10: Observational Extract 10, Case Study 2

Fieldwork Extract: An active and function driven approach 23/5/07

Registered nurse is feeding back to another nurse about a new patient. She is saying he has done everything this weekend but needed to have a rest this morning. I asked what she did with him – ‘transfers on the toilet, from bed to chair, getting in the wheelchair’. As if to explain why he’d done so much with her she said ‘well he wasn’t gonna get any physio, and it was bank holiday!’ – she’s quite indignant at this. She relays to the other nurse that he ‘hasn’t been passed by physio yet’. She says that she goes with him to the toilet because of the pain – ‘so he got to the toilet, but I had to swing him back because he was in pain, but he’s incomplete. I altered his footplates and I’ve asked him to get a wedge because his pelvis is going forward’ - this conversation indicates to me that nurses could be more involved if given the chance.

The contribution of care assistants was poorly developed. Despite their key role in enabling patients to move and their many decades of experience, they were not involved in rehabilitation team discussions related to movement. None of the care assistants interviewed had spent any time down in the gym or in the pool. There was little role blurring and none had attended the multi-professional meetings and so had little insight into the activities of therapist’s nor opportunity to learn more about mobility and movement rehabilitation. This was despite the fact that they were the members of the nursing team most involved in patient handling. One health care assistant bluntly said ‘the staff nurses and auxiliaries don’t do physio’ (CA 1, SP) although she conceded that it would probably be good for patients.

Interviewer: ‘Do you think that the physios and OT’s have the same skills, sort of moving and handling wise?’

Care Assistant: No, I don’t really know because I’ve not had that much to do with them. I suppose it is very different really. I really don’t know, because I really don’t

know what they do.. I know they have different jobs and everything but I really wouldn't like to say who does more to do with moving and handling....We just go along with what we know they are up to, what stage they are up to, and everything, and we get told when they are not being hoisted anymore and when they're starting to transfer to slides and things like that. We just try to encourage them and help them, as best we can.' (Care Assistant 3, SP)

Although many of the care assistants were experienced and carried a great deal of responsibility for the physical care of patients, this contribution was not maximised as well as it could have been. Their status meant that they did not feel they were privy to all discussions regarding the patient's rehabilitation. Many felt this was detrimental to their ability to support patients' rehabilitation as the extract below suggests.

Interviewer: 'Would you like to work more closely with the physio and OT?

Care Assistant: I would because the session with the OT's and physios, when they teach patients to do their sliding board transfers, they come up to the ward and say 'so and so has passed for sliding board transfer', and you say 'okay fine', but how many people do they need? Do they need one person, 3 people - what are we actually doing for them? If we were actually downstairs, they could show us how they've taught the patient to do it. They could make it easier for the transfer of the patient. It happened this morning, with patient X, he was just being passed to do more transfers on the ward, and he was a bit anxious at first and we were like 'what do you want us to do?' And it probably looks, to him, that we don't know what we're doing because every patient transfers differently. And if we were to go downstairs on OT visits and they say 'right he can do this and he can do that'. It would make life a lot easier...' (Care Assistant 2, SP)

This was also the case for the Registered nurses who felt that they had no opportunity to develop their skills and knowledge relating to patient handling and mobility rehabilitation. One nurse described herself to be 'ignorant' of the physiotherapy role because of a lack of role overlap or skill sharing. For new staff to the unit, this was viewed as particularly detrimental to their ability to provided specialist care and rehabilitation.

5.4 Subcategory 4: Interpreting the Policy

Although a number of respondents reported that they had not read the Trust policy relating to moving and handling, it was interpreted largely as a policy which restricted nurses' involvement in therapeutic patient handling. Whilst it was acceptable for the occupational and physiotherapists to engage in manual patient handling during treatment sessions and later family carers during the rehabilitation process, it was accepted that nurses and care assistants were not 'covered' for this kind of patient care. This was a source of some tension as nurses felt that this reduced patients' rehabilitation opportunities unnecessarily.

5.4.1 Between a Rock and a Hard Place

A number of nurses were cynical about the hospital 'no-lifting' policy viewing this as a way of protecting the Trust and the organisation from liability, rather than providing protection for staff. By providing training to nurses and care assistants in safe patient handling, the Trust was perceived at one level to be shifting any organisational responsibility for safety firmly back with the individual practitioner. In the extract below, the nurse identifies the way in which the macro context for nursing work might influence nurses' behaviour and action. A sense of duty and loyalty to the service might lead to nurses taking risks with their own health and wellbeing.

'I think because of the way the Health Service is at the moment anyway, because of pressures, and money, and all the rest of it. I think the majority of nurses genuinely feel guilty to go off sick and I think, probably, the reason why they have so much sickness as well, generally, is because the pressure is on nurses in general, let alone in manual handling, just in general....making sure that we all go to these manual handling and risk assessments and all the rest of it. And I know there's a good reason why it's there, but I don't think that the nurses are that well looked after, but then the clever way of doing it is putting the onus on the nurse so that then if a problem does arise and you have the information, it's down to you. It's quite difficult really.'
(Registered Nurse 2, SP)

Nurses felt that they were often ‘between a rock and a hard place’. That is, needing to perform manual patient handling in order to deliver patient care whilst adhering to a ‘minimal lift’ policy. Whilst the rhetoric of the policy instructed nurses to avoid lifting, nurses felt that they had no choice but to do so. The reality of their nursing practice was that it would be impossible to deliver good patient care without an element of manual lifting. One nurse suggested that hospital managers were well aware of and complicit in this double standard. In this sense, the nurse implied that the Trust abused nurses’ ethic of care. The extract also indicates the confusion and ambiguity over what actions would be ‘covered’. The nurse admits that she would move a patient with less staff than ideally needed, against her better judgement and at the risk of personal injury, in order to prevent damage occurring to the patient. In this case, the conviction of the nurse’s moral framework, her sense of responsibility and duty to care for the patient has greater influence on decision making than the institutional mandate or an instinct for self preservation.

‘For somebody who’s on bed rest, quite a heavy patient who’s on bed rest with a new injury maybe, or someone who’s had a pressure sore. I mean he really should have three or four people who effectively should be lifting. Staffing levels are such, you know we have a lot of staff and you still are not ... you know ... you do it with just two. Now you have to do it because if you don’t move that patient they’re going to get worse pressure sores, but should anything go wrong I assume the Trust wouldn’t back you, because you’re taking that decision when I suppose you shouldn’t. So you’re stuck between a rock and a hard place really. You can either leave a patient who’s going to have pressure lesions, or you can move the patients hurt your back and drop them (laughing).’ (Registered Nurse 8, SP)

5.4.2 ‘Nurses Aren’t Covered’ (*in vivo code*)

Within the spinal unit it was accepted that that whilst nurses and care assistants would transfer patients with the hoist, the occupational and physiotherapists would be moving and handling patients very differently during therapy treatment sessions. The types of handling techniques used by therapists were described as ‘assisted transfer’ techniques where therapists could, with planning, take some of the patient’s weight. Over time, through the provision of therapy treatment sessions provided by

‘therapists’, the goal was to enable patients to gain greater independence to make the transition from assisted transfers to more independent transfers. In order to do this, patients needed practice, coaching and the opportunity to try new activities. Whilst therapists were ‘allowed’ to provide this therapy, nurses were restricted and were only able to hoist patients until they had been ‘passed’ to undertake more independent transfers. As the fieldwork extract below indicates, this was viewed as a way of protecting nurses from risk of injury. Whilst all staff were working towards the same hospital policy, some nurses and care assistants appeared to think that therapists had a different policy.

It was a source of confusion that OTs taught slide transfers down in the gym and yet nurses were not allowed to follow this through on the ward as they perceived that they were ‘not covered’. The nurse below explained how tensions within the rehabilitation team arose when patients’ relatives were taught to do assisted transfers, whilst nurses continued to be told that they were not ‘covered’. As the extract identifies, patient’s relatives were used as the benchmark for nursing practice – if relatives were being shown a transfer why should the nurse or care assistant not be shown? This approach equated the skills of nurses and care assistants with those possessed by lay people with no previous practical knowledge of moving and handling people.

‘It was really difficult ... just last year, because, obviously because of manual handling rules and nurses being covered, physios and OT’s could do assisted transfers mainly with tetraplegic, who need some assistance, but nurses on the ward weren’t allowed to do that because it wasn’t classed as a therapy session. So it was really difficult because the patient was never going to really improve that much because they were only doing it a couple of times, you know, in the physio session or the occupational therapy session, but if they were doing it on the ward and part of the daily basis you would see an improvement much quicker. So we had to overcome that and we done a risk assessment and written a protocol that if, what we basically said is, if the relatives has been shown to assist with transfers then the staff could also be shown, but it would have to be the OT would come up, show the staff, with that individual patient, this is how you would do this patient and then only the staff shown by the occupational therapists would do it, but it shouldn’t be like that.’ (Registered Nurse 4, SP)

This was interpreted by some nurses as a slight on the professional skill of registered nurses. For example, the nurse below suggested that little credence was placed on the nurse's assessment of the patient's handling needs, particularly if something went wrong whilst moving and handling a patient. In contrast, some nurses accepted the arrangements regarding the progression of patients as a logical way of protecting nurses from injuries that might be sustained whilst undertaking a complex patient care activity with which they may be unfamiliar.

Registered Nurse: 'They might be taught like a way down in occupational therapy and physio, but we can't do it up on the wards, with a manoeuvre they have been taught once or twice, but it's not done all the time.'

Interviewer: So, why if it's done in OT or physio can't it be done up here?

Registered Nurse: Because the nurses aren't covered for it now because of all the manual handling restrictions. If you hurt your back, because it's not a legal manoeuvre, you can't do it.' (Registered Nurse 6, SP)

Discussion with the OT revealed that difficulties interpreting the Moving and Handling policy for the Trust were not unique to the nursing team. Indeed, therapists also grappled with the tensions between staff safety and patient benefit and risk. Moving and handling was described as a grey area and an area of practice that require rigorous clinical decision making and professional judgement.

'I think it is a gray area and any time we have an issue around manual handling we do go back to the manual handling department and discuss it with them and you get the same answer: 'if you consider it in the patient's best interests to do it and you are confident, and feel safe to do it, then you do it. But it has to be your decision.' Now I say to all my staff, if you are not confident in manually handling that person, don't do it, don't put yourself at risk, but if you feel you are confident and you have the skills, and you want to do it, and it's in your patients best interests, that has to be your conscious decision. Unfortunately, we live in a litigious society and if you injure yourself because you've done something you shouldn't have done, well, contributory negligence is not always taken into account.' (Occupational Therapist, SP)

5.4.3 Compromising Rehabilitation

Some nurses felt that the emphasis on 'no-lifting' impinged on the patient's independence because they had less choice over how they were moved and handled. This was noted as an issue for community dwelling patients who were obliged to be hoisted rather than being able to move using sliding transfers because of the possible risks to community staff. Some staff felt that this limited patients' options in everyday living as they were not now provided with equipment such as monkey poles and bed ladders and relatives were not always taught the assisted transfer technique. This meant some patients would not be able to go on holiday as taking a hoist would not be feasible. One nurse also felt that although the emphasis on hoisting was safer for nurses, the job had become less satisfying since their role in teaching patients assisted transfers had been reduced. The nurse in the following extract identified the contradiction between the patient's right to make autonomous decisions about how they would be assisted and to take risks of their own choosing versus staff rights to work safely.

Registered Nurse: 'We had a couple of tetraplegics last year who we were doing an assisted transfer with...but case management said they had a real problem with it because when the patients went home and were expected to use hoists by care staff coming in, they were ringing up and saying 'they can't get me comfortable, they can't get me right' and she was saying 'well that's because they are not used to being in a hoist and you should have hoisted them here so they're used to being hoisted at home, because you're not being fair to them'. So that was their argument.

Interviewer: So what happened then?

Registered Nurse: We had to then start hoisting the patient.

Interviewer: And how did he feel about that?

Registered Nurse: He felt he went backwards in his rehabilitation and you know, I don't know whether it should come into it, but he was a young man, you know, and he really had an issue about getting in the hoist and the staff even had an issue with it because what we would normally do is sit him up and out the bed, but we were having to wait for the hoist' (Registered Nurse 5, SP)

Nurses with decades of experience recognised that practice was now safer, but were somewhat dissatisfied by the trade-offs that had been required – namely, losing the opportunity to teach assisted transfers. Whilst practice was safer for nurses, it was suggested that patients now received less rehabilitation and had less opportunity for independence. The occupational therapist also talked of the difficulty of ‘*striking a balance*’ between maintaining staff safety, patient safety and promoting independence. Whilst she could see the benefit of ‘*outlawing lifting*’, it had made the process of providing care, and promoting rehabilitation more difficult. In the extract below, she explains how repositioning a patient using a hoist became a significant event in terms of time:

‘If you want to reposition someone in the chair, for instance, you need to go and get a hoist, lift them up and lower them into the correct position. So that prolongs it, the process is not as quick, it’s not as convenient, but in terms of safety....’ (Occupational Therapist)

5.5 Summary

This chapter has discussed four subcategories and their related codes in turn. Spinal patients have complex physical, emotional and social needs. The data have exemplified the specialist and essential contributions of nurses and care assistants in meeting these needs. Nurses’ and care assistants’ roles in mobility rehabilitation were often, but not exclusively, focused on skin care and prevention of pressure ulcer formation. Observation of practice also revealed the very physical nature of care work, despite the regular use of hoists. Caring for spinal patients involved taking a daily personal risk to self, although staff did not feel that members of the senior management team recognised this. Respondents were at pains to explain that it was impossible to eliminate all of the ‘little lifts’ needed to ensure patients were comfortable.

A further significant finding related to the nature of team working which was characterised by division and seclusion. Nurses and therapists adopted distinctly different roles and activities and worked in separate geographical areas. Since different rehabilitation professionals did not work together there was limited

opportunity for knowledge or skill sharing to occur. Whilst some nurses were accepting of the negotiated order of teamwork, others felt that the divisions were artificial.

Most of the nurses and care assistants believed that they were not covered legally by the hospital policy to engage in therapeutic patient handling. To some extent, nurses' and care assistants' practices had been relegated to the status of non-expert or to the level of lay carer. Whilst nurses recognised the possible benefits of this approach to their safety, it was also a confusing scenario and incompatible with their specialist identity. Indeed, there was evidence of tension at the role boundary between nurses and therapists, competition for professional territory and perceptions of role encroachment.

CHAPTER 6

CASE STUDY 3 – STROKE REHABILITATION WARD

FINDINGS

6.0 Introduction

This chapter uses verbatim extracts drawn from the 13 staff interviews carried out on the stroke unit and short sections of observational data which were collected over a period of 18 hours. These data are used to illustrate and provide insight into the categories identified from the case study. Four sub-categories and four sets of related codes were identified as detailed in table 16 below. This chapter will discuss each of the four subcategories and the related codes in turn.

Table 16: Case Study 3 Sub-Categories and Major Codes

Sub-Category	Major Codes
Supporting mobility rehabilitation: nursing contributions	Empathy and care Collaborating with therapists Hoisting patients
Practical 'know-how' in therapeutic handling	Explanations of therapeutic handling The limits of 'know-how'
Safe systems of work	Err on the side of caution Putting up with second best
The delicately balanced team	Perceptions of each other Enjoying teamwork, wanting more

6.1 Subcategory 1: Supporting Mobility Rehabilitation – Nursing Contributions

Some interviews with registered nurses provided very little insight into the registered nurse's contribution to promoting patients' mobility rehabilitation. For example when one registered nurse was asked how she went about promoting patients' mobility rehabilitation, she was unable to think of anything apart from transferring the patient. For some respondents, it seemed that the language needed to describe their work and the rationale for particular interventions was lacking. Much of the emphasis was on the therapist's key role in leading this process through goal setting, and establishing instructions for how the patient should transfer. However, it was possible to identify a range of nursing contributions which could be viewed as beneficial to the patient's progress.

6.1.1 Empathy and Care

Many of the staff interviewed demonstrated real empathy with patients who had suffered a stroke and expressed a desire to show patients that they cared about them. A number of nurses identified the link between patients' mood and their ability to achieve their rehabilitation goals. The importance of forming a relationship with patients, motivating and encouraging, was emphasised as a way of facilitating the rehabilitation process.

Interviewer: 'Are there other things that you do that help a patient improve, mobility wise?'

Registered Nurse: Mobility wise. I think some of them... it's like most of them are depressed when they have a stroke, they just feel very useless and very disabled, but then you give them positive feedback. And some of them, because they won't try, and they are very, very depressed and they just give up. I think all you have to do is just give them positive feedback. Some of them just lost their self-confidence, but if they are given positive feedback they will do it. And they will trust themselves again and they will keep doing it until they can manage to walk again.' (Registered Nurse 4, SU)

It was also acknowledged that patients needed variety in their waking hours to prevent or at least offset the depression that many patients suffered as a result of the stroke.

One way of getting this variety was to ensure patients were able to ‘get off the ward’ as frequently as possible. The nurse below identified the boredom of being an inpatient and felt this was detrimental to their mood.

‘So we try to get them off the ward as much as we can really. Purely for their sakes. A lot of our patients go into, like, depression. There is nothing on here to stimulate them at all really. There is eighteen patients and there is about probably five therapists. They don’t see every patient every day. They do their best but it is just not realistic is it?’ (Registered Nurse 3, SU)

Nurses and care assistants reiterated the importance of helping patients to move about, identifying the risks to their future wellbeing without regular input. It was reported that on other wards, patients were left in bed for many days because of a lack of rehabilitation emphasis, a lack of knowledge and a lack of care for the patient. Whilst registered nurses identified their responsibility for carrying out falls risk assessments and devising individual patient management plans, it was the physiotherapist who was credited with leading the assessment of patients’ moving and handling needs (Ward sister , p4). As the ward sister identifies below, the physiotherapist was the key decision maker regarding how a patient should be transferred. Until instructions were given, nurses would move patients using the hoist, and concentrate on facilitating the patient’s bed mobility.

‘When the patients come from the Acute Stroke we don’t do any formalised moving and handling until they have actually been assessed by the physiotherapist. So the physiotherapist will come along ...assess the patient and say, “at the moment we think this patient should be moved via a hoist’...So we will start with hoist transfers... for getting in and out of bed. While they are actually on the bed we will actually do movement in the bed so that we are actually turning ... rolling them over in ... we all try and do it exactly the same way as we are taught in moving and handling is, bending the knee, putting their arm across the chest and then rolling them over to you and then vice versa to the other side. So we will do that and just to try and help encourage better bed mobility for the patient.’ (Ward Sister, SU)

Practical activities which registered nurses related to mobility rehabilitation included taking patients to the toilet, assisting patients to transfer and, getting patients in and out of bed. However, promoting mobility and facilitating progress in transfers was an indirect nursing activity, a sideline, rather than a prime activity. As the extract illustrates, the nurse's involvement in helping the patient to achieve mobility related goals occurred only when the occasion arose that the patient needed the toilet. It was the 'physios' who 'got the patient going', inferring that the physiotherapist was the individual who actively helped the patient progress towards rehabilitation goals, whilst the nurses 'just followed'. The nurse conceived her contribution to mobility rehabilitation as a simple act of helping the patient transfer, rather than viewing her contribution as instrumental to the process of recovery and rehabilitation.

'But as for mobility and transfers, we don't, the therapists are actually the first to assess them for that and we just... they actually do most of the transfers and unless they go to the toilet in the day, it is them that work on the transfers to be fair to them. We just transfer... we don't make them stronger in their transfers, we do it, but it is the therapists that actually work with them, with the transfers and get them going from, like, a hoist to a reach round, and then maybe a step round. We just follow what they have advised us.' (Registered Nurse 3, SU)

In many ways, it seemed that nurses underestimated the potential of their contribution to patients' mobility rehabilitation.

6.1.2 Collaborating with Therapists

Sitting down with the therapists and patient to set rehabilitation goals was an important activity. The types of goals mentioned included being able to transfer with two or standing with one to wash whilst sitting in a chair or mobilising to the toilet independently. Where goal setting was mentioned, it seemed that the therapist led this activity.

Nurses also made effort to 'carry-on' with the work that therapists had initiated with patients. This was largely through following the use of prescribed transfer techniques, 'specifications' and instructions over the weekend when therapists were not on duty

and during the day generally. For example, as the care assistant below explains, physiotherapists left instructions about how a patient should be transferred on a notice above the patient's bed.

Interviewer: 'So, helping them carry on from the therapy sessions, standing up and walking, whatever, is that written into care plans or do nurses have an idea, 'Right, I'm going to do that three times today' or is it anything that formal?

Care Assistant: No, not as such, but the therapists do put up on the board... because sometimes we can only transfer them from a chair onto another chair to wheel them to the toilet, then transfer them off that back onto that chair and then back into the wheelchair and back onto this chair. But then they get to the stage where they can actually mobilise with a Zimmer frame or a walking aid, and they'll put that on the board now, like 'Can walk with Zimmer...' (Care Assistant 3, SU)

As patients made progress in the gym with the physiotherapists, this was handed over to the nursing team to continue with. As well as transferring patients as per instruction, patients were also positioned in the bed or chair in particular ways to maximise patient comfort, sitting balance and to protect vulnerable joints. This also involved taking note of how well patients were managing to transfer using these techniques. Sometimes, nurses suggested when patients were ready to progress onto less intensive methods of support during transfers on the Monday morning when the therapists were next in.

'(The) physiotherapists are off for the weekend, so we have to continue what they have been doing from Monday to Friday... And on Monday, they will ask us a few questions, whether we struggled to do it, or we need to do something else that is easier for the staff or for the patient, or whether we feel that the patient is not ready to do these things yet.' (Registered Nurse 4, SU)

Filling the weekend therapy gap was seen as an important way of maintaining patients' progress in rehabilitation. It was also suggested that by increasing the consistency of approach in the team, the patient's opportunity to relearn good patterns of movement would be increased. However, it was also clear from the interview with

the ward sister that the availability of nursing staff affected what was achievable. For example, whilst physiotherapists' might stand a patient with three staff, this was not achievable on the ward because it was unlikely that three staff would be available at any one time to work with any one individual patient. Thus, the average staffing levels dictated the extent to which nurses could facilitate patients' mobility rehabilitation. It was not that nurses were not capable of undertaking assisted transfers – rather that staffing levels did not allow it.

Ward sister: 'If the therapists think that they are reasonably good at transferring then they will come to us and show us how they have done it first and then we will carry on and do it that way first of all. If they feel that they are not quite safe we will carry on doing hoist transfers and then they will carry on practising until the patient develops the skills to do it better. They will come and say to us, "Right you can start transferring Mr Such a Body with two." If it needs more than two then we don't tend to do it. The therapists will do it with more than two but ideally from a nursing point of view it has got to be with two. If it needs more then on the safety side they have to be hoisted...Because... staffing levels are very tight ... of an evening, of a night time it's reduced levels and if it's going to take three of you to get somebody into bed then it's safer for the patient really to be hoisted.' (Ward Sister 1, SU)

6.1.3 Hoisting Patients

Hoisting patients was a significant part of patient care. For patients with severe hemiparesis, being hoisted from bed to chair was viewed as the safest option for both patient and nurse. Being able to hoist patients was also an important way of preventing patients from developing the complications associated with being bed bound, such as chest infections, deep vein thrombosis and social isolation. Once the patient had been hoisted into a chair, they could access spaces beyond their bed, such as the outside. In this way, hoisting brought some freedom from the confines of the bed and the ward. It also enabled family members to become involved in the patient's road to recovery.

'A lot of them, like stroke patients, a lot of them have got weakness on the right or left side, so it takes two staff to move the patient in the bed, but through this machine that

we are using, hoist, we manage to hoist the patients up, each requires two assistants but it is a lot easier for us, so you don't hurt your back and it's safety for the patients and the staff... if you don't have a hoist you cannot even transfer a patient on to the chair...you know, you get chest infections staying in the bed the whole day, twenty-four hours, so when you hoist them on the chair it helps the lungs and it is a big change for them. It's the fact that we can put them in the wheelchair and you can wheel them outside, get some fresh air, in fact you can ask the family to be involved to wheel them out for a change. It makes a difference.' (Registered Nurse 4, SU)

Some nurses suggested that patients disliked being hoisted and would prefer to be transferred manually given the choice (S/N 3, p2). As the registered nurse below indicated, nurses tried to work towards patient preferences where possible. If patients verbalised a dislike for the hoist, nurses would try to build on patients' ability to transfer to maximise their chances of transferring using their own legs.

'I mean the patient themselves will tell you. They will tell you if they do not like the hoist and then we try to work on transfers then so they don't have to be hoisted. If they don't have to be hoisted, we don't hoist them.' (Registered Nurse 3, SU)

The nurse was keen to point out that on this ward, using the hoist was based on patient need. She suggested that on other, busier wards where there were less therapists available and less emphasis on a rehabilitation ethos, nurses would hoist patients for speed, convenience and safety. She was of the opinion that hoisting patients could be detrimental to their rehabilitation progress and should be avoided where possible.

Interviewer: 'Do you think the hoist is always the right approach?'

Registered Nurse: No, because I think you are taking away someone's ability to do things for themselves and I mean on some of the wards...some mega-busy wards and sometimes things like that are just overlooked and they are hoisted for quickness...I think things like that on general wards are overlooked. And therapists are not just next door where you can go and knock on the door and go "Can you just come and look at this patient?'" (Registered Nurse 3, SU)

On the other hand, the care assistant below identified that the hoist could be viewed as an important tool in the rehabilitation process.

'Well, I wouldn't say a hoist is rehabilitation. A hoist is a necessity, rather than rehabilitation. But to another extent, a secondary point, we are getting people out of bed, so then it could be classed as rehabilitation, we're not nursing people in bed. So we use that hoist to get somebody out of bed to sit them in a chair, and if need be' (Care Assistant 2, SU9)

Due to the staffing patterns on the ward, care assistants undertook the bulk, although not all, of the direct patient care. For example, in the morning, patients' needed help to sit up in bed, reach the toilet, eat their breakfast, and get washed and dressed. Patients might need help with standing, balance or walking with their frame.

Interviewer: 'Would you say then that you do more handling than trained nurses?

Care Assistant: We probably do more.

Interviewer: Right. And do you get as much training as the staff nurses?

Respondent: Probably more. Probably more from the therapist because they know we are more hands on. Not in a disrespectful way, but we do the washing patients, get them in and out of bed, transfer them from bed to chair, transfer them from chair to toilet, so we are doing more than ... and we normally show the staff nurses what we are doing, yes. We are always there to do it.' (Care Assistant 4, SU)

On some shifts, only one registered nurse was on duty with a team of care assistants to undertake the majority of the direct patient care. Under these circumstances, the registered nurse inevitably focused on certain fundamental priorities – in particular, ensuring that medications were given to patients at the correct time and to ensure patients were safe (S/N 5, p2). Registered nurses identified that they had to rely on care assistants in these conditions to give them information about the patient's ability, whether they were 'steady or unsteady,' their progress and how much supervision was needed for example. The care assistants were valued because they could be trusted to give a 'true picture' of the patient in order for the registered nurses to then hand over to the next shift or the therapists. Interviews with care assistants provided insight into

the wealth of experience and hands on skill that they possessed in relation to transferring patients, moving them in bed and using the hoist. However, like the registered nurses, care assistants also had many other duties apart from promoting mobility and movement and stated that the physiotherapist was the staff member with the greatest focus on this aspect of the rehabilitation process.

'I think because of the very job, we have different jobs (to physiotherapists), from just transferring patients, and we've got feeds to do and all sorts of drugs to put out, care plans to do...you know there's so many jobs that we have to do, making beds, giving out dinners, giving out teas.....giving out drinks, making sure that somebody is hydrated and so and so, taking people to the toilet, blah, blah... that they, the physios, can take longer because that's their job. It's specifically their job. Whereas we have numerous jobs.....and activities we have to do throughout the day. So we can't really take as much time with a patient as, say, the physios....they have more time.'
(Care Assistant 2, SU)

6.2 Subcategory 2: Practical 'Know-How' in Therapeutic Handling

In this ward, care assistants and registered nurses had been taught to varying degrees how to undertake a range of therapeutic transfers which could be used to move patients from the bed to the chair for example. These included the step round transfer, the reach round, and the pelvic transfer through flexion. This set the ward apart from others in the hospital as it also had its own therapeutic handling policy. This policy recognised and legitimated this type of patient handling activity as above and beyond those undertaken by nurses and care assistants elsewhere.

6.2.1 Explanations of Therapeutic Handling

Whilst all of the nurses and care assistants interviewed were supportive of the therapeutic handling transfers used on the ward, few were able to put into words what this involved. Only one care assistant (2) was able to offer a definition of therapeutic handling. He viewed it as handling which is of benefit to the patient, helping to develop the patient's balance, weight bearing, equilibrium and preventing the patient becoming over toned.

'Well, basically, therapeutic handling is therapeutic to the patient, the patient isn't struggling, we're getting a proper balance to that patient's needs. Obviously, if the patient isn't helping you then it's pointless. Because the patient needs to be helping us, and three people, there could be two nurses and the patient all working together. So, it's basically, it could be reach round to the left or reach round to the right, depending on which side the weakness is, or if there is a weakness. So, you need to get a proper weight bearing, we can get some kind of weight bearing to the weak side. Or not to too much over tone to the healthy side. They can get very over toned.' (Care Assistant 2, SU)

This fitted well with the definitions offered by the two physiotherapists who suggested that therapeutic handling had a number of components – moving a patient in a safe way, preventing unwanted complications (e.g. excessive tone), where the patient actively participates and can learn from the movement. The nurses interviewed were comfortable with therapeutic handling transfers and did not feel that these activities created undue physical strain for them. Therapeutic handling transfers were considered beneficial to patients who otherwise would be hoisted. From the perspective of the physiotherapists, it was important that patients experienced repetition of the therapeutic handling approaches.

'if you're moving someone therapeutically, you're enhancing that recovery so that they will function better....I know that if I could move them from A to B, handle them correctly, we would be able to promote more independence. On the other hand, if I have 90% of the time doing hoist transfers, then the patient will never learn any different, because it's the repetition that's needed.' (Physiotherapist 2, SU)

Nurses and care assistants were in agreement with this perspective. It was generally accepted that being hoisted eliminated patients' opportunities to develop strength in their own legs and to relearn balance and movement abilities. Therefore, using the therapeutic transfers recommended was very much valued.

Observational data revealed that many of the staff were adept at using the therapeutic handling transfers. On one occasion, a nurse transferred a patient whilst I was observing. Later the same day, the physiotherapist transferred the same patient whilst we both observed together. The nurse was pleased to see that her technique mirrored that demonstrated by the therapist. However, whilst this example provided evidence of the consistency which could be achieved in patient handling, other moments provided insight into the challenge of teamwork in the rehabilitation setting. In the section of observational data below (box 11), an experienced nurse (with 34 years of experience) transfers a patient. However, his commentary reveals how different practitioners may opt to undertake different transfers, depending on personal preference.

Box 11: Observational Extract 11, Case Study 3

Fieldwork Observation: Registered nurse transfers a patient (and later checks consistency of the manoeuvre against the physiotherapists transfer) 25/11/08

The nurse is going to move the patient from the wheelchair to chair. The student nurse is observing. The nurse explains that there are different types of transfer. ‘There is one where the patient puts his head towards your hip, but for this one I’ll be putting his head on my shoulder – its called a ‘through transfer’. He tells the student that the physios are using ‘reach round’ and that some nurses are actually using the hoist – he doesn’t say why. He says that as a night nurse, is really important to be able to transfer patients effectively and with confidence- ‘You’ve got to be able to go back to that patient and not think...oh no, you don’t want to be thinking of your patients as heavy.’ After the transfer he says ‘ that was just a basic transfer, sometimes the patient might be soiled and you’ve got to drop their trousers as well, or sort out pads. You’ve not just doing a transfer’ . The transfer is very controlled. The nurse takes hold of the patient’s hips and tells him he’s going to give him 3 little rocks and then he says to the patient to stand. It takes a few seconds for the patient to stand, but his legs gradually straighten. The nurse is blocking the affected knee, he has the affected arm secured. The patient is almost upright, he manages to move his affected foot round and the nurse sits him down. The nurse tells the student to put pillows under his arm to support the shoulder.

A later example illustrates how a care assistant chooses which transfer to use, based on her own level of confidence, her own preference and knowledge of the patient. Whether or not this created problems could not be ascertained in this study. However, differences in patient handling and inconsistency were certainly observed. In the extract below, a care assistant transfers a patient from chair to bed. She is somewhat in a hurry, thinking of the end of her shift at 9pm and tired from a long period of providing direct patient care. It is 8.45 pm and Mrs S wants to get into bed.

Box 12: Observational Extract 12, Case Study 3

The End of the Late Shift 10/12/08

8.45 p.m Care assistant goes to get Mrs S into bed. She looks up at the bed sign which reads ‘transfer with 2’. She says ‘she should be ok, I’ll see’. She says to Mrs S that she’s going to get her to stand up. The patient makes a good effort to stand by herself. Mrs S has stood up ok but she is not moving her legs or feet. The care assistant says ‘I’m just gonna give you a hug.’ She positions one hand on the patient’s upper back and one hand on her lower back. The patient puts her arms around the nurse’s back. The care assistant tells the patient to start to move her feet around. Slowly, the nurse manages to coax her round. Mrs S seems nervous and the care assistant says ‘trust me, have faith in me, I’m not gonna let you fall, put your hands down on the bed. Can you feel the bed behind you? Let go of me, put your hands down.’ The patient is reluctant but she does eventually put her hands down. The care assistant tells her to sit down on the bed. After a very brief pause, the care assistant tells Mrs S that she is going to stand her up again. Mrs S seems to have pain in her leg (probably because she has been sitting in her chair for almost five hours). She gets her stood up again and says ‘we’re gonna have a dance’ and she starts to rock her from side to side whilst giving her a bear hug. It doesn’t look that safe. The patient gradually rocks and steps to the side and the care assistant sits her down and lifts her legs up to the bed

6.2.2 The Limits of ‘Know How’

When asked about therapeutic handling, many of the nurses and care assistants seemed to take pride in the additional training they had received because it allowed them to do more with patients than on other wards.

‘Yes, in fact, I am quite proud that I work on these wards because we are being trained how to do it, to move stroke patients, we are shown how to do it. So, we’re special. The mandatory training for all the staff working in our hospital is different, but for us it is a special one.’ (Registered Nurse 4, SU)

Whilst the additional training was equated with ‘specialisation’ and specialist status, it was not clear whether knowledge of the therapeutic handling techniques actually made the nurses into specialists. Most respondents were clear in identifying that it was the physiotherapists who made the clinical decisions about which transfers to use, when to change the type of transfer being used and gave advice on what to do and what not to do. It was not clear to what extent nurses were familiar with underpinning theories of neuroplasticity and compensation and if and when each approach would be most appropriate. Some of the nurses interviewed had difficulty explaining the therapeutic transfer techniques, both how they were done and why they were done in that way. Whilst the staff nurse below felt that she could hoist a patient ‘with her eyes shut’, undertaking therapeutic transfers was more challenging and uncertain.

‘We have got a patient at the minute that is supposed to be doing like a step round, where they put their head on your hip, but he does not do it, he tends to stand up and he comes up and you can’t do that in that manoeuvre because he would pull me over with him. That’s how it’s done... when you see it... I can’t explain it, when you see it done, you will see what I mean. He goes like that... he leans forward and he puts his head on your hip here and you lean over the back of him and basically just grip his waistline like that and just manoeuvre him round....(and later) ... the hoist, I can do that probably with my eyes shut because that is something that we do a lot, we use the hoist. But it is all the different like... a step round, or a reach round, you move them to the... I am sure it is to the weaker side, you support the weaker side, that is the idea

of it, and then they can do some of the work with their better side.’ (Registered Nurse 3, SU)

Other staff nurses also identified gaps in their knowledge base in relation to therapeutic handling and desired greater insight into this aspect of their work. For example, the staff nurse below had not received training in therapeutic handling despite working on the ward for 2 years. When asked how she would explain the notion of therapeutic handling to a student nurse, she was unsure.

Interviewer: ‘If you had a student nurse on the ward and they said ‘oh what is therapeutic handling?’ , what sort of things would you try and get across to them?’

Registered Nurse: I don’t know, because I have never really...its just moving a patient safely because there are like three specific types of moving and handling, therapeutic handling, and its just deciding which would suit a particular patient.’ (Registered Nurse 5, SU)

Both the ward sister and lead physiotherapist discussed with frustration the fact that despite their best intentions of developing nurses’ and care assistants’ skills in patient handling, implementing in-service training was logistically difficult at the present time due to staffing vacancies and the priorities of meeting patients’ needs.

Interviewer: ‘The therapeutic handling, do you think that it’s easily taught to nursing staff?’

Ward Sister: It is to the staff that have already got experience at doing it because we do updates of it and sometimes you do tend to forget exactly how to do it if you are not consistently doing it, and it can be hard sometimes to teach a new person how to do it because they can’t quite get to grasps with what position they should be in and what position the patient should be in. And it can be a little bit difficult sometimes and I know we are at the moment overdue for our update so ... because the therapists have been really short as well as us it has been quite difficult.’ (Ward Sister, SU)

Because of these organisational constraints, for some of the more recently recruited staff nurses to the ward, there had been insufficient opportunity to develop the ‘know

how' required to feel confident in the therapeutic handling transfers that were so prized by the ward. Some staff had been taught formally on only one occasion. They had only had infrequent opportunities to practice techniques with patients. It seemed that expertise and competence came with regular exposure and practice.

'Yes, I wouldn't know how they move and handle down there (in the gym) but you will probably find that the therapists might move and handle different to the nursing staff as well because I don't think it is taught enough to remember, on here. I have only been taught it once and if you don't practise it every day, you basically just transfer the patients as safe as we can really, but like, Graham (Enrolled Nurse) has been here for years and he knows it like off by heart, you know the staff that have been here and done it all for years and years and years.' (Registered Nurse 3, SU).

This cursory approach to developing specialist knowledge left a number of staff lacking in confidence and competence. For the nurse below, additional skill and knowledge in therapeutic handling had since been gained from working with and observing the care assistants. However, this only allowed the nurse to 'pick up' the practical moves, rather than developing a sound grasp of the related underpinning theoretical knowledge needed to fully appreciate the intervention. A desire for 'proper training' seemed to be an essential ingredient for the nurse to be able to practice to her full rehabilitation potential.

'I have mainly picked it up as I have gone along....I have sort of picked it up as I have gone along....I would like proper training...to have the proper training on how to assess a patient and check a patient for the type of move that you might do. You know, so you can look at a patient and think, well what sort of move am I going to do with this patient' (Registered Nurse 5, SU)

Observational data and informal conversations with patients provided insight into the important role that care assistants played in patients' rehabilitation. In the two extracts below, patients identify that the capability of the staff member impacted on their own ability to move and mobilise. In the first example, the skill of the physiotherapist is identified whilst in the second, it is the care assistant who is singled out for praise.

Box 13: Observational Extract 13, Case Study 3

Patient Perspectives on Standing and Transferring

25/11/08 - I check with a patient to see if it is ok for me to observe when he makes his next transfer from bed to chair. He says it is fine and then out of the blue he states that 'some nurses are better than others'. I ask him what he means. He says that with some staff it is easy to stand up, but with others he can hardly get up. He says that the physios are good – 'there's one especially who is really good'. I ask what it is that makes her good – 'I don't know. She's a big lass, maybe she's stronger than the others'.

10/12/08 - I go to speak to Mr D who had a stroke. I have been observing his transfers in the previous few days. I ask how the transfers are going on. He says 'it depends how good *they* are'. I ask him what he means. He says 'some of them hold you different.' I ask him what he means. He says 'some of em, you can put your arm round their back and its better'. He points at a passing care assistant and says 'she's good'.

Although much emphasis was placed on the skills and knowledge of care assistants in relation to therapeutic handling, some members of this group too had difficulties developing their skills and knowledge. For example, the care assistant below reported having 'no time to stand and watch' the therapists at work and only few 'on the job' opportunities to learn about therapeutic handling.

Care Assistant: 'We handle them how we're taught to handle them. Now, how the therapists handle them in the gym, I don't know really...

Interviewer: You don't go in?

Care Assistant: We can do, but we really don't have time to go and stand and watch...we just don't have enough staff on the ward to go off and spend time in the gym' (Care Assistant 3, SU)

In contrast, another care assistant felt the on the job training system worked well with the therapists close proximity and regular presence on the ward enabling them to update the care assistants every few months (Care Assistant 4, p2).

6.3 Subcategory 3: Safe Systems of Work

A number of nurses and care assistants stated that lifting was banned and explained how they were now only able to ‘support’ rather than lift. They referred to the way things had changed in recent years in terms of the increased emphasis on health and safety. It was evident that staff were conscious of the importance of safety and of the need to follow safe systems of work. However, some of these systems were less than perfect.

6.3.1 Err on the Side of Caution

At times, there was some uncertainty over how best to move a patient if for example a physiotherapist had not been to assess the patient beforehand. When nurses and care assistants were faced with this uncertainty, many felt that the most sensible decision was to hoist the patient from one place to another. This was because it was generally perceived that it would be best to avoid the potential risk of an untoward event occurring. For example, if a patient fell or was injured or a staff member was hurt. The message presented by the staff interviewed was that they were obliged to follow the advice of the physiotherapist when moving patients and might be criticised if it was felt they had acted independently of that advice, should something go wrong.

Interviewer: ‘The hospital policy on moving and handling, does that have any effect on what you do here, would you say?’

Care Assistant: I think we’re exempt on some of the policies, because of the therapeutic moving and handling. Insurance-wise.

Interviewer: Right

Care Assistant: But you’ve still got to adhere to Health and Safety. So, really no, the policies don’t make a difference, but I think we have a little bit more leeway on the moving and handling, as far as insurance is concerned - Because we’re doing it day in, day out, day in, day out.

Interviewer: Yeah. So, if there was an accident?

Care Assistant: Well, if it was your fault and you were doing a procedure, moving and handling, that was not advised by the physios then I don’t think you’d have a leg to stand on. If somebody, say... we have boards at the back.....if that patient on his or

her door said, 'hoist transfer' and we didn't use the hoist, we did a manual transfer and we hurt ourselves then we wouldn't have a leg to stand on.' (Care Assistant 2, SU)

Thus, less experienced nursing staff practiced defensively, preferring to wait until the 'expert' had assessed the patient before intervening with mobility. Safety was a key priority for the nurses. Physiotherapists also agreed that nurses and care assistants should avoid taking risks when moving patients and should opt to use the hoist if they felt the patient's condition warranted this. Nurses' interviews also portrayed their ongoing awareness of the potential for injury to occur to themselves during the conduct of their daily work, but particularly when undertaking physical care activities. This awareness also increased their propensity to hoist patients in the face of uncertainty in the name of health and safety.

Encouraging nurses and care assistants to rely on the risk assessments and guidance provided by the physiotherapist regarding patient transfers had three key purposes. Firstly, it was suggested that following the physiotherapists' guidance protected both nurse and patient safety. This ensured that patient handling practices were underpinned by a well founded risk assessment. Secondly, it also ensured that recognised and trusted approaches to moving patients would be used, rather than approaches based on individual preferences and habits which might be dangerous to patient and nurse wellbeing. In this sense, this pattern of practice functioned as a way of controlling 'maverick' nurses and care assistants who might begin to work beyond the scope of their competence in patient handling. It was perceived that if a nurse was injured whilst moving a patient, she/he would be 'snookered' for not using a safe technique recommended by the physiotherapist and would be unable to claim compensation. It was also suggested that it would be possible for the patient to file a private prosecution of the nurse/carer if it could be shown that the patient had been moved in way which was not advised by the physiotherapist.

Interviewer: 'Do you think that people ever put their own safety at risk to give that patient the chance?'

Ward Sister: I think some people do and we have had to go back to them and say, look, for safety and mainly the patients and their own safety they are not to do it. It has to be done the correct way. Because injury wise, if they hurt themselves and they are not doing it appropriately, then they are snookered. They can't claim anything at all and the patient could then take out private prosecution on that Support Worker or Nurse for actually doing it on their own when it's advised that it's done with two. So we do try and put it to Support Workers because there are a number of Support Workers who will try and do that bit further, and say, "Well, you know, they managed it this day on their own." But formally they should be doing it with two and that's what we would always advise, if they have been assessed by the therapist as doing it with two.' (Ward Sister, SU)

Thus, following the guidance of the physiotherapist was established a standard expectation of a rehabilitation nurse or care assistant.

6.3.2 Putting Up with Second Best

A number of the care assistants were disgruntled that they had to work with equipment that was not necessarily the best. For example, ceiling fixed tracking hoists were used in other hospitals on rehabilitation units. The care assistants felt that these would be of value on their ward. They found the physical demands of hoisting patients tiring because often they had to move furniture out of the bed space and lift wires under the beds out of the way (*'you have to lift the wire up under the bed, yes, so you are battling with the wires under the mattress'* Care Assistant 5, p2). For this reason, some care assistants expressed a preference for manual transfers over hoist transfers for their ease and speed (Care Assistant 5, p3)

Interviewer: 'What effect do the patient's movement problems have on nursing care?

Care Assistant: Well, it can be quite bad at times, especially with a hoist, because you've not got much room round the beds to hoist in and out, so you're constantly moving chairs out of the way before you can even get to the bed, and then you've got wires under the bed what you've got to bend down and hold up while the other one tries to put the hoist under. But once you've got the patient in the hoist, the hoists are so heavy to manoeuvre, because they don't glide, you've really got to pull while one

holds the patient in the hoist so they don't swing about, because you have to pull it with a bit of force to actually get the... the wheels don't seem to glide if you know what I mean? It takes a lot on your shoulders and your arms. So, can you feel that...Even though they're electric hoists, it's all the manoeuvring. Yeah, it's quite hard.' (Care Assistant 3, SU)

Knowing that safer systems of work existed elsewhere caused some resentment as it was felt that the lack of tracking systems was probably due to cost (Care Assistant 1), p3). This belief was reinforced by the fact that some of the hoists had been bought with charitable funds and the view that the Trust was limited on what it could or would purchase (Ward Sister 1). One care assistant who had worked for over five years on the unit described the physical and tiring nature of the work which was both repetitive and often awkward. She explained that it was not necessarily the patient transfers that were demanding, but other more amorphous aspects of the work. However, whilst they carried out much of the physical manual labour, care assistants were not able to exert power to ease work conditions.

'The type of patients we have, I don't think it really matters what manoeuvre you're doing with them. It's still tiring on your body when you're doing it day in day out, day in day out. My shoulders are really bad at the moment now and they have been for quite a while. I find it more so when the patients are in bed and you're washing them in bed, and a lot of them, you see, you've got to really sit them up to try and get their pyjamas off, their pyjama top, and with that affected side, they can only move one side, and some of them, their upper bodies are really stiff and you're constantly trying to manoeuvre them forward so you can get the pyjamas off their back. And I find that really hard now. It's just years and years of work, years and years of wear and tear' (Care Assistant 3, SU)

In a similar line, another care assistant described the struggle that was involved in rolling up deflated air mattresses and packing them back into the storage bag and moving it to a storage area.

6.4 Subcategory 4: The Delicately Balanced Team

Throughout the interviews, one of the most common comments was that the physiotherapists were always there and could be easily accessed being 'just next door'. Although patients received much of their therapy in the gym and off the ward, physiotherapists were a constant presence and appeared to be keen to engage with nurses and care assistant regarding how best to transfer and position stroke patients. Being available to demonstrate techniques and close proximity gave nurses and care assistants confidence in the team and a sense of coherence (Care Assistant 1, p5).

There seemed to be very few tensions within the multiprofessional team. The existence of a 'therapeutic handling policy' maintained an orderly pattern of working which had been developed in response to the needs of the rehabilitation team. However, whilst experienced nurses and care assistants seemed satisfied with the level of teamworking, some of the comments made by recently qualified nurses working on the ward suggested that teamworking and skill sharing was more of an illusion than a reality. Skills and knowledge did not pass by diffusion from therapists to registered nurses despite their daily presence on the ward. This was probably because therapists and nurses did not work together with patients.

6.4.1 Perceptions of Each Other

From the interviews with both the care assistants and nurses, the physiotherapist was placed squarely in the role of expert in relation to patient handling. The physiotherapist held responsibility for assessing patients, deciding on the way they should be moved and handled, helping to solve patient handling problems, training the nursing team and deciding on which equipment to order. Analysis of the physiotherapy interviews affirmed their perceived 'jurisdiction' for all aspects related to patient handling. There was no hesitation in claiming ownership of this aspect of rehabilitation practice and it was clear that this was part of a reasonably comfortable negotiated order. The extract below illustrates this aptly:

'We will be the ones to initiate how patients should transfer and the nursing staff carry that forwards...we dictate really on what we think is best for the patients and definitely, they are happy for us to take the lead...we are the experts in therapeutic handling' (Physiotherapist 1, SU)

Nurses in return were happy to accept instructions and orders from the physiotherapist about how to move and handle patients, to carry forward their work and to be 'trained' by them. Interviews suggested that much of the boundary work had been done and the formal policy on therapeutic handling had legitimised nurses' contribution to mobility rehabilitation. Table 17 below provides a detailed insight into the way that nurses and care assistants perceived their role and that of the physiotherapist.

Table 17: Perceptions of Co-Workers

	Care Assistant Interviews	Registered Nurse Interviews	Physiotherapy Interviews
Comments About nurses	<p>‘We do movement and handling day in day out’ ‘We are trained by the physiotherapists’</p> <p>Will hoist patients if not yet assessed by physiotherapists</p> <p>We will ask if we have a problem</p> <p>Nurses rely on us to do the care work</p> <p>‘We show the staff nurses what we are doing’</p> <p>‘We do assess ourselves’(1)</p> <p>‘Practice over the weekend’</p>	<p>‘We just transfer, we don’t make them stronger’ (3)</p> <p>‘We just follow what they’ve advised us’ (3)</p> <p>Request input – ‘we think they are ready...just come and watch them’ (3)</p> <p>‘We will carry on’ (4, Sister)</p> <p>‘We will give a few facts on Monday’ (4)</p> <p>Don’t get time to go to the gym</p>	<p>Nursing staff ‘carry forwards’</p> <p>Nurses must take responsibility for own practice</p> <p>Assess at a ‘low level’</p> <p>‘Err on the side of caution which is a good thing’</p> <p>‘Happy for us to take the lead’</p> <p>‘nurses do assess ‘but by rights it should be the therapist’</p> <p>Standards of transfer high, positioning not as consistent</p>
Comments About physiotherapists	<p>‘They will advise us differently’</p> <p>Does the ‘in-depth assessment’</p> <p>Know the correct moves – give ‘specifications’</p> <p>The therapists show us what to do – ‘they grab you and say right, this is what we are doing’</p> <p>We don’t get to work with them</p> <p>Has ‘more time’ to work with patients</p> <p>Does ‘treatment sessions</p> <p>Gets the equipment</p> <p>Gives instructions – ‘tells the trained staff’</p> <p>Practices with patients</p> <p>Lets nurses know when patient is ready to progress</p> <p>Puts instructions on the board</p> <p>Comes into nursing handover</p> <p>‘The therapists have the book’</p> <p>‘They hand over every time we can actually do something different with patients safely’</p> <p>‘They use all sorts’</p>	<p>Come and assess</p> <p>Update the patients board</p> <p>‘Will come and show us’ (3)</p> <p>‘Make patients stronger’ (3)</p> <p>‘Work on the transfers’ (3)</p> <p>‘Get them going’ (3)</p> <p>Keep practising (sister)</p> <p>‘Decide what’s best for them’ (3)</p> <p>‘Decide whether they can be mobilised, if they are safe’</p> <p>‘Do the therapeutic handling’</p> <p>‘Lead the goal setting’</p> <p>‘Teach us with a patient’ (sister)</p> <p>Teach students nurses</p> <p>Have knowledge of the equipment (sister)</p> <p>‘ask us a few questions’ (4)</p>	<p>‘We the therapists suggest an ideal’</p> <p>Give nurses ‘simple instructions’</p> <p>‘We will dictate’</p> <p>‘We are the experts in therapeutic handling’</p> <p>Therapists the change agents – ‘us, as therapists, engaging the staff in it’</p> <p>Emphasis on relearning, less so on compensation</p>

Where occasional tensions were alluded to, this was largely put down to a lack of time which lead to differences in prioritisation. For example, the physiotherapist below

hints that nurses and care assistants might not always prioritise therapeutic handling approaches as high on their agenda as the physiotherapy team would like.

'I think sometimes within rehab it can feel that we, the therapists, suggest an ideal and maybe the nursing staff feel from a time perspective or priority, they may think, we have not got many staff, we have got to get this done...So, it is often around time constraints with the nursing staff. And probably as well, the main emphasis on both jobs is different – what they see as their main priority we do not see as our priority. I think that is sometimes where we clash abit.' (Physiotherapist 1, SU)

Some of the interviews suggested that care assistants felt that it was the therapists which held control of the equipment that was used on the ward. Not only were they perceived to have all the equipment in 'their' room, the physiotherapists also kept 'the book' through which new equipment could be identified, sourced and ordered. There also appeared to be competition for resources between nurses and therapists.

'they are all in the gym this equipment, all this new fangled stuff that we should have on here – just all of a sudden it appears – where have they (the physio) got that from and why haven't we got one on here.....we need wheelchairs, we need all sorts, but we do not get them. They (the physios) keep the new ones in the gym and they keep the old ones here which is abit unfair.....we have no new things really...sometimes you do feel like the poor relation' (Care Assistant 4, SU).

6.4.2 Enjoying Teamwork, Wanting More

Many of those interviewed were keen to work more closely with physiotherapists to provide hands on therapy. However, this was not viewed as an achievable goal because of the low nursing, care assistant and therapy staffing levels. A number of respondents remembered how this had once been the normal mode of operation.

'See, at one time, we used to work... I mean I'm going back years ago, we used to work like the therapy staff would work with the nurses and do a therapy session together with one of the patients. Which I thought was pretty good as well. Because,

sometimes, you'll get a patient what will do things for the physios, but when it comes to us doing it they can't do it. So if they know we've watched them do it... so it's a bit of motivator as well sometimes I think.

Interviewer: So that changed though, did it?

'Yeah. It seemed to change really. I don't know why really. It's probably because we went so short-staffed and they went through a phase of being so short-staffed.'

(Care Assistant 1, SU)

Shared working appeared to be a long gone luxury that had begun to fade into memory. The following extract illustrates how the lack of shared working prevented the sharing of skills and skills and knowledge between therapists and nurses. Not only was there a lack of opportunity to spend time in the therapy gym, but neither could staff contribute to home visits for example.

'When a patient goes up to the gym, I want to see how they do it, how they do the patient in the gym but we don't have time to do it. That's right. Yes. Even there, you just need to ... I want to see them, how they do it in the gym, like, what exercises have they been doing in the gym. ... some of them do standing exercise, or, I don't know what else, just moving really to them. But I want to see it, if I only get time, I want to see the physiotherapist with the patient doing the therapy in the gym (Registered Nurse 4, SU).

There appeared to be a number of logistical barriers to developing the team. For example, members of the therapy team were transient, due the nature of staff rotations. Therapy staff did not work at the weekend and arrived on the ward from 9 a.m on wards. For nurses, there were significant variations in the dependency level of patients admitted. This impacted on the pace of work and at times, limited nurses' and care assistants' availability to assist with rehabilitation treatments and programmes. The physiotherapists below had been instrumental in attempting to introduce weekend physiotherapy staffing. However, because of low therapy staff and a lack of funding, the initial pilot had not yet progressed despite the need for a seven day service having been identified. From her perspective, much more joint working was needed as a way of improving patient care.

'I think it's a two way thing really. I think that perhaps we're not as flexible as we should be. Because we only work certain hours of the day...I do feel that a lot of the issues could be addressed by doing joint washing and dressing with the nursing staff, by actually working different times of the day...they probably have more problems getting people back into bed than we do, but we're not there to get them back into bed.' (Physiotherapist 2, SU)

6.5 Summary

Nurses and care assistants recognised the contribution they made to the prevention of complications associated with immobility. Providing patients with physical care of their body and eliminatory needs prompted nurses to engage in transfers and mobilisation, although this was a sideline rather than the immediate priority. Nurses built rapport with patients as part of the therapeutic milieu. Hoists were essential to the provision of nursing care, much of which was provided by care assistants. Practical 'know how' in therapeutic handling was demonstrated through the nurse and care assistant's ability to undertake three therapeutic handling transfers which the physiotherapist had taught members of the nursing team. A specific therapeutic handling policy had been constructed to legitimise this contribution. Nurses equated these additional skills as evidence of their specialised status. However, not all nurses were confident with these skills.

Nurses and care assistants were conscious of the risks associated with their work. Nurses erred on the side of caution in the absence of a physiotherapy assessment having been completed. Nurses thus practised defensively to avoid a possible incident in which they would be criticised.

The physiotherapist was perceived as the expert in relation to moving and handling both assessing patients' needs, deciding how they should be transferred and training the nurses. Most of the nurses and care assistants seemed to be satisfied with the negotiated order. Only care assistants mentioned that they were sometimes the last to know about changes in patients' status for example. Time constraints and staffing problems posed barriers to shared working between nurses and care assistants and the

physiotherapy team. In addition, a lack of nursing time limited nurses' ability to engage in any level of therapy carry over. This was exacerbated by therapists' work hours which differed to the nursing shift patterns.

CHAPTER 7

SYNTHESIS OF FINDINGS AND PRESENTATION OF THE GROUNDED THEORY

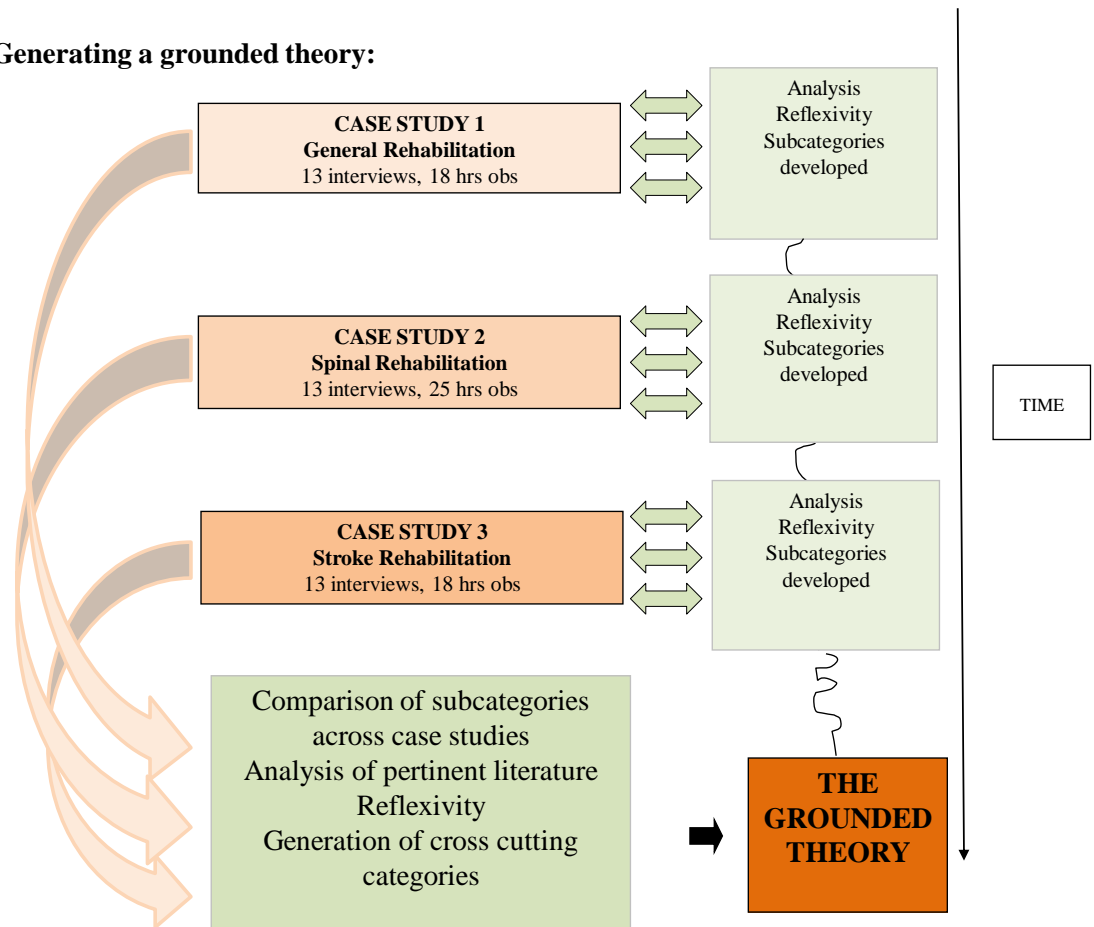
7.0 Introduction

This study addressed three objectives. Firstly, it sought to describe hospital based nurses' and care assistants' actual contributions to patients' mobility rehabilitation. The second aim was to explore how these activities contributed to rehabilitation teamwork. Finally, the study examined the impact of NHS patient handling policies on the process of assisting patients with mobility rehabilitation and the involvement of nurses and care assistants. The study was conducted in three settings – a general rehabilitation ward, regional spinal injuries unit and a stroke rehabilitation ward. A set of findings was generated for each case study.

By comparing the findings generated from each setting exploring the similarities and differences between them, it has been possible to identify cross cutting categories arising across the three settings. This process is illustrated overleaf in figure 5 (page 180). This chapter provides a discussion of the cross cutting categories in the context of the wider literature. The categories identified included '*promoting mobility: an embedded activity; A to B transfers; the negotiated team; a context of risk; interpretations of the official line*' and '*feelings of dissonance*'. Table 18 (page 184) provides an overview of these.

The chapter then defines the core category, 'safe to care, care to keep safe', which provides the hub around which each of the cross cutting categories can be integrated. The relationship between the core category and cross cutting categories is represented diagrammatically in figure 6 (page 211) to illustrate the grounded theory as a whole.

Figure 5: Generating a grounded theory:



7.1 Exploration of the Cross Cutting Categories:

In this section, the individual cross cutting categories are discussed in relation to the literature to set the current study in context. A more comprehensive summary and comparison of the categories by case study setting is provided in appendix 20 (pages 279-184). Appendix 20 details the main open codes, major codes and subcategories for each case study to illustrate how together, these informed the development of the cross-cutting categories presented here.

7.1.1 Promoting Mobility: An Embedded Activity

The first consistent category spanning each of the three case study settings was labelled 'promoting mobility: an embedded activity'. 'Promoting mobility' was labelled as an 'embedded activity' because it often occurred as a result of the

provision of help with washing and personal care such as shaving and grooming, dressing, re-positioning the patient for comfort and pressure area care. In order to provide this type of care, nurses and care assistants frequently needed to manoeuvre patients either by rolling, sitting up, or supporting patients using pillows. This was achieved often using their own hands and physical strength, or using slide sheets, hoists or transfer boards if manual help was overly strenuous or risky to the patient. In this way, promoting mobility was an activity which was embedded within other rehabilitation nursing activities.

Within the literature rehabilitation nursing care has been described similarly as the 'maintenance care' that is the vital bedrock upon which the rehabilitation process and its interventions can be overlaid (Waters and Luker 1996). This maintenance role has also been described as 'routine,' or comprising 'basic care'. Kirkevold (1997) more eloquently describes it through her description of the nurse's 'conserving' function. This involved nurses maintaining patients' normal functions, preventing complications and protecting from harm. Like this description, nursing care in this study tended to be driven not by rehabilitation goals but by a need to prevent patient problems and to get patients ready for therapy.

Wade (2005b) makes a distinction between rehabilitation 'treatment' and rehabilitation 'support/care'. Rehabilitation treatment is defined as any intervention that leads to a sustained change in the patient's situation whilst 'care/support' is described as interventions that are needed to *maintain* the patient's situation. The data gained from this study suggests that the contribution of the nursing team lies somewhere in between these two poles. Whilst both nurses and care assistants viewed nursing as therapeutic in itself, it was seen to be distinct from the 'therapy' associated with 'therapists'. Nursing care comprised the before and after of therapy, it was the preparation for therapy and the care after therapy. In all of the rehabilitation settings studied, nurses and therapists were involved in a symbiotic relationship. Without the input of nurses and care assistants, therapy sessions undertaken by therapists could not occur. However, without the input of the therapists, the patient's rehabilitation progress would not be as goal focused and strategic. This was because rehabilitation nursing interventions appeared to be ad hoc, rather than intentional.

In the present study it was observed that some nurses focused much more on rehabilitation goals than others. Previous authors have also identified nurses' variable contributions to rehabilitation role enactment. Based on their observational study of stroke patient care Pound and Ebrahim (2000) write that *'the physios reported that they would only give information to nurses who they knew would use the information. There were clearly some key nurses that physiotherapists used as channels of communication, chosen not on the basis of their seniority, but because they were known to follow a rehabilitation philosophy'* (p1441). It is of interest to explore why this anomaly might arise.

Scott (2007) proposes that nurses are governed by an internalised 'regulative ideal' that shapes and affects the way in which the nurse both views her work and carries it out. The individual has internalised a certain idea or belief about how things are done, practised or, how one should behave. As a result, one will always strive to behave in such a way that does not conflict with this standard. It is possible that two nurses may work in the same workplace but hold different internalised 'regulative ideals' and may therefore 'enact' their role differently.

An individual nurse's or care assistant's 'regulative ideal' may be formed and shaped by many sources of influence. For example, role enactment is effected by the process of occupational socialisation (Kneafsey 2003), the agents of which are those influential role models from whom novice nurses learn, in addition to the process of education. Within the rehabilitation setting, each individual nurse is likely to have experienced variations in pre-registration and post registration education programmes, previous work experience, and experiences of teamwork. These varying influences on the occupational socialisation process may well shape and determine the nurses' perception of her 'expected role behaviours' i.e. the activities and responsibilities that are perceived to be important in daily work performance.

These are two specific gaps within the sphere of rehabilitation nursing. At present the expected minimum standard of nursing practice in relation to mobility rehabilitation consists of: completion of falls risk assessments, referral to the physiotherapists and a 'safe' handling approach. This standard is taught in mandatory moving and handling training. There is currently no standard of education in rehabilitation for registered

nurses. In addition an important gap has been left by the discontinuation of English National Board accredited rehabilitation nursing courses. My observations revealed that longer time qualified nurses 'enacted' their role with rehabilitation patients differently to their more recently qualified counterparts. The two groups of staff seemed to be governed by a different set of regulatory ideals. Indeed, more recently qualified nurses are more likely to have been educated following an acute care model (Long et al. 2002b, Nolan and Nolan 1999). There may also be few positive rehabilitation nursing role models or staff who display expertise in rehabilitation practice (Pryor 2005).

As such, many registered nurses newly recruited to rehabilitation settings will learn how to 'enact' their role from care assistants whilst 'on the job' (Long et al. 2002b). This may help to explain why very little difference could be discerned in relation to registered nurse's and care assistant's responses to patients' with mobility and movement problems. This finding resonates with those of Pryor (2005) who identified that registered and enrolled nurses were provided with little guidance or role modelling on how to differentially use their skills.

Table 18: Summary of the Cross Cutting Categories Derived from the Combined Findings of Case Study 1, 2 and 3

Category	Description
Promoting mobility: an embedded activity	Within the provision of rehabilitation nursing care, patients were often assisted with personal and physical care. This often required nurses and care assistants to help the patient to move, roll, transfer or stand, in order to achieve this. These activities had the potential to contribute to the patient's mobility rehabilitation.
A to B transfers:	There were distinct boundaries in the patient handling activities that nurses/care assistants and therapists engaged in. Nurses and care assistants mostly restricted their handling approaches to A to B transfers whilst therapists engaged in 'therapeutic' handling.
The negotiated team:	The physiotherapist was considered the expert in relation to moving and handling and mobility rehabilitation whilst nurses viewed themselves, in comparison, as non-experts. Therapy work was viewed as distinct from the rehabilitation care provided by nurses and care assistants. Therapy and nursing work was divided geographically and professionally.
A context of risk:	Nurses and care assistants worked in a context of risk. They responded to risk in different ways: by risk assessing; avoiding risk; deferring to experts and accepting risk.
Interpretations of the 'official line':	The 'official line' regarding patient handling was presented to practitioners via annual mandatory moving and handling updates. Some practitioners resisted the official line, others were resigned to it, whilst a latter group abdicated from a role in promoting mobility.
Feelings of dissonance:	Practitioners experienced feelings of dissonance when the legislative focus on self preservation competed with their internalised rehabilitation ethic. The rehabilitation ethic accepted the need to take some measured risks to enable patients to progress. Being confined to A to B handling was therefore a source of frustration for some. Other nurses experienced dissonance because they felt that hospital policy required them to avoid unnecessary patient handling. These nurses argued that it was impossible to eliminate all patient handling and were anxious that their practice would be judged as non-compliant.

7.1.2 A to B Transfers

There were distinct boundaries in the patient handling activities that nurses/care assistants and therapists engaged in. Nurses and care assistants mostly restricted their handling approaches to A to B transfers whilst therapists engaged in ‘therapeutic’ handling. A to B transfers served a crucial purpose in enabling patient care needs for personal care, elimination, pressure area care and the act of eating and drinking to be successfully achieved. It was important that these kinds of transfer could be carried out at speed, with minimal disruption and discomfort to the patient and with safety. Safety was of prime importance as nurses and care assistants could be required to carry out numerous patient handling activities in short spaces of time at certain times of the day such as first thing in the morning, at mealtimes, after lunch, at tea time and later when patients got ready for bed. Nurses and care assistants were conscious of the risk of sustaining an injury and the rhetoric of ‘no-lifting’ was ever present. This meant that safety concerns, rather than rehabilitation goals, tended to dictate the way in which patients were handled by nurses and care assistants.

These findings are reminiscent of the results of an ethnographic study conducted by Reed and Bond (1991) over twenty years ago. The study explored nurses’ assessment practices in care settings for older adults, taking a particular focus on mobility. A key finding was the use of a ‘dichotomous classification’ system which described patients mobility status as either ‘mobile’ or ‘immobile’ with further assessment depth restricted to guidance on how to transfer the patient such as ‘two nurses to stand and transfer.’ The study concluded that nursing care reflected a ‘managerial rather than a therapeutic approach’ whereby the focus was not to improve or maintain the current mobility status, but to ‘accommodate immobility within ward routines’ (p59). More recently, Burton’s (2009) study of two Canadian stroke units identified tension between nursing and physiotherapy staff in relation to the application of ‘therapeutic transfers’ (p90). Therapy staff were reportedly more comfortable with the concept of risk taking when moving and handling patients, compared to their nursing counterparts who were driven by a safety approach.

In contrast to nurse’s descriptions of their own handling practices, physiotherapists and occupational therapists in the present study described their transfers and handling

techniques as ‘therapeutic’. This type of handling was not driven by an immediate care need but was aimed at improving the quality of the patient’s movement, their strength or balance or at increasing their ability to move independently. It was a kind of handling that generally occurred in the rehabilitation gym rather than at the patient’s bedside. It could involve the therapist taking some of the patient’s weight either through supporting a patient in a leaning position, or a sitting position or in assisting a patient in a standing position for example.

Case study three was somewhat different to case studies one and two in that the nurses and care assistants worked to a ‘therapeutic handling’ policy. This new policy had been developed to enable nurses and care assistants’ to ‘carry-over’ from therapy activities, through the provision of consistent therapeutic patient handling practice. In this way, nurses’ and care assistants’ involvement in therapeutic handling was legitimized, as was their knowledge, role and status as rehabilitation practitioners (Marias and Street 2008).

Previous studies have highlighted the value of nurses ensuring continuity of care in rehabilitation settings, both by carrying over from other members of the multi-professional rehabilitation team and role blurring - particularly in relation to the integration of mobility skills into daily nursing care activities (Long et al. 2003). Over a decade ago, Pound and Ebrahim (2000) identified that ‘a key tenet of the rehabilitation philosophy is that nurses liaise with therapists about patients’ treatments and carry over what is learned in therapy to the everyday activities of the ward’ (p1439). Authors such as Hajben-Schoenmakers et al. (2009) suggest that nurses and support workers could build additional activities, traditionally viewed as ‘therapy activities’ into nursing care as a way of increasing the time that patients spend engaged in therapeutic activity. Tseng (2006) highlights the importance of range of motion exercises whilst Miller (2010) argues that constraint induced therapy, treadmill training and gait orientated training could all be considered legitimate nursing concerns.

None of these activities were observed in the case study settings. Few nurses or care assistants spoke of a distinct role in therapy carry-over or were observed to be engaging in therapy carry over activities. However, observations confirmed the

practice of some nursing interventions to promote mobility identified in Kneafsey's (2007) systematic review. This included the nurse undertaking moving and handling risk and falls assessments, developing relationships with patients which would theoretically support the rehabilitation process, using splints under the direction of occupational therapists, using motivational and teaching skills (long time qualified staff only) and positioning patients for comfort. However, there was no evidence of isotonic exercises, range of motion exercises or structured walking programmes. The main direct contribution to mobility rehabilitation appeared to be the nurse undertaking A to B transfers with the patient, within the context of providing rehabilitation nursing care.

One might question whether the ideal of 'therapy carry over' is possible to achieve if nurses and care assistants are not present to observe and participate in providing therapy treatment sessions. In addition, nurses may feel reluctant to intrude on another professional's area of competence (Svensson 1996) and may avoid appearing to be challenging. Indeed, although the nursing role in therapy carry-over in case study 3 was well conceived it was evident that some nurses and care assistants had gained insufficient experience and tutorage to develop confidence and understanding of the rationale for and use of the therapeutic handling approaches, or even to describe their practice.

7.1.3 The Negotiated Team

Although nurses and care assistants recognised their key role in assisting patients with mobility and movement during the process of care delivery, apart from one or two exceptions, they did not consider themselves to be experts in relation to mobility rehabilitation or therapeutic handling. Whilst nurses and care assistants perceived a need for action in relation to patients' mobility rehabilitation, decision making was viewed as the domain of the physiotherapist. Nurses felt they lacked the discipline related knowledge to justify making decisions regarding mobility rehabilitation. This finding echoes the conclusions of earlier studies. Previous research (Nolan 1997, Long et al. 2002, Kneafsey and Haigh 2009) identified nurses' perception that a deepened knowledge and skill relating to mobility rehabilitation would be beneficial to patients. Other studies have identified the propensity of nurses to attribute

physiotherapists with the status of expert whilst viewing themselves as non-experts (Pryor 2008, Waters and Luker 1996, Dalley and Simm 2001).

Wade (2005a) identifies the inadequacy of current rehabilitation practice in describing fully the nature of rehabilitation interventions and calls for a more specific rehabilitation vocabulary. Care assistants and registered nurses in this study seemed to find it difficult to articulate what they did specifically in relation to mobility rehabilitation. Descriptions of their role were scanty and lacked in-depth explanation. Like the nurses in Kneafsey and Haigh (2009) survey, nurses involved in this study were also unfamiliar with terms such as 'therapeutic handling', 'rehabilitation handling' or 'treatment handling'. Mobility rehabilitation and other terminology were not at the fore front of their consciousness. However, it was an activity in which these staff members engaged on a daily basis. Liaschenko (1995) argued that language can contribute to the development of nursing theory and the further progression of nursing. This study adds strength to this position and suggests that without a specific vocabulary to articulate the nature of nursing interventions, little clarity can be achieved and the importance of nursing strategies may remain unrecognised.

Nurses' imprecise explanations of their role may indicate that nurses and care assistants drew on tacit knowledge to undertake their work. Tacit knowledge may be ambiguous and difficult to draw out and has been described as an 'untapped resource' (Meerabeau 1992). Nurses' inability to articulate their role in mobility rehabilitation may also indicate that nurses and care assistants viewed the moving and handling of patients as a routine activity. Direct observation identified that it was an activity carried out regularly throughout the day and was often delegated to care assistants being generally considered 'basic nursing care.' Ascribed as such, it was conceivably viewed as an aspect of patient care not requiring the skills of a registered nurse. It is proposed here that by assigning the activity of patient handling to 'routine status', registered nurses were able to conserve time and mental energy by then delegating this aspect to the care assistant's sphere of work. This process of 'automation' meant that the moving and handling of patients then became a daily reference point in the care assistants day which required little conscious thought and could be undertaken automatically (Greenberger 1998).

Waterworth (2003) identifies that some routines take priority over others. For example, the routines of higher status health care workers will come before those of less 'important' staff. This was observable in rehabilitation settings as nurses rushed to get patients ready for therapy indicating the 'status' of the therapists. Like the nurses in Johnsson et al's. (2005) study, nurses perceived a lack of time to assist patients with mobility. The expectation that nurses would engage with therapy carry over and integration was viewed as unrealistic. Thompson's (2008) exploration of nurses' level of research utilisation, found that 'busywork' consumed so much time it caused nurses to feel powerless over aspects of their practice. As a result, nurses developed strategies to protect their time. Waterworth (2003) also identified that nurses' time management strategies included avoidance tactics, giving selective attention, delegating to others and short cutting. It is suggested here that busy nurses in rehabilitation settings 'avoided' full involvement in mobility rehabilitation by delegating to others. By giving only 'selective attention' to mobility rehabilitation and placing it outside their professional sphere of work ('abdicating') nurses gained 'extra time' for activities perceived to be more pressing and essential to the role of the registered nurse. These culturally acceptable and normative behaviours allowed nurses to cope with time shortages and stress and benefited the overall performance of the whole nursing team (Zisberg et al. 2007, Thompson 2008).

Therapy work was generally viewed as distinct from the rehabilitation care provided by nurses and care assistants and there were few examples of role overlap or shared working. Therapists undertook teaching and coaching during therapy sessions in the therapy gym. Once the patient had achieved the new skill then nurses and care assistants could incorporate it into the patient's daily routine. Thus, nurses and care assistants' roles had little focus on patient coaching. Tyson et al's. (2008) observational study to explore the content of therapy treatment in acute stroke settings, although small-scale, lends support to this finding. Thirty-six physiotherapists recorded their activities during therapy treatments with five patients, on five consecutive occasions using a validated recording tool. This revealed that teaching others how to help patients comprised a mere 4% of their time. Similarly, the present study found that care assistants involved in this study had little insight into the treatments and activities which would typically occur during therapy treatment sessions, never having spent time directly observing therapists' work. It is therefore

unsurprising that some care assistants in this study felt they lacked sufficient skill and insight to maximise their contribution to therapy carry over work, despite being given delegated responsibility for it.

The potential for discord and role conflict between nurses and physiotherapists within the rehabilitation team has been suggested as a distinct possibility within the literature. Pryor (2008) identified the haphazard nature of collaboration and the fact that team members rarely worked to common rehabilitation goals. Nurses were described as marginalised and segregated from the social world of the team. Tseng (2006) suggests that conflict may arise regarding professional territory and role expansion. However, the data collected for this thesis did not support this on the whole.

Relations within each of the rehabilitation teams were generally harmonious. Norms of practice were well established and there appeared to be an understanding over what could and could not be 'negotiated'. For example, nurses were able to request the input of therapists to reassess a patient, to suggest moving and handling strategies or to give advice regarding patients' particular problems. Physiotherapists also occasionally offered help with activities traditionally considered within the nursing domain – for example, helping a patient to access the toilet. However, it was evident that there were some aspects of rehabilitation practice that were non-negotiable.

In each of the case study settings, the team member identified with the status of 'expert' in relation to physical rehabilitation did not alter, but was automatically known to be the physiotherapist. Teamwork practices maintained and supported the superiority of the physiotherapist to make clinical decisions about patients' mobility and movement, over nurse's ability. In addition, in case study 1 and 2 nurses (with few exceptions) would only engage in A to B transfers. Therapeutic handling practices were clearly outside of their role boundary. Indeed, therapist led negotiations with nurses and care assistants aimed at encouraging additional therapeutic handling activities were not observed. In this way, the mode of teamwork in relation to mobility rehabilitation appeared to be entrenched and static. It accepted and maintained a clear division of work which was manifest through strict boundaries in the kinds of patient handling activities in which nurses and therapists engaged.

Thus, although role boundaries are not necessarily fixed, but are socially constructed and amenable to alteration, for some nurses and therapists, activities relating to moving and handling and therapeutic handling appeared to be non-negotiable. Kreiner et al. (2012) identifies that role boundaries can be made 'strong' and impermeable by the role holders. The extent to which a role boundary is permeable or impermeable determines whether activities from one domain will be integrated into, or excluded from the role holders domain. It was evident that some nurses and therapists maintained strong role boundaries, clearly identifying 'therapeutic' patient handling practices as outside of nursing roles and inside of therapists' roles. Others on the other hand, allowed role boundaries to be more permeable, and allowed integration of additional activities.

Despite this, across the three case studies similar areas for improvement in teamworking were identified by some nurses and therapists. In all sites, nurses and care assistants described a desire to work more closely with the physiotherapist in order to gain greater understanding of their role and interventions and how these could be carried forward. Some nurses and care assistants seemed to feel that they were deliberately excluded from knowledge of therapy by the working practices that therapists adopted, such as undertaking all therapy sessions away from the patient's bedside. However, all nurses and therapists were of the view that it would be impossible to develop the nursing role further or incorporate additional responsibilities, given the existing workload and the policy restrictions which were felt to impinge on their scope of practice. In this respect, there was little room for negotiation between nurses and physiotherapists in relation to patient handling and mobility rehabilitation, even if so desired. Attempts to change practice were viewed as futile.

Overall, there was only minor evidence of tensions within the rehabilitation teams. Three particular triggers were evident. Some nurses perceived that physiotherapists were reluctant to become involved in patients' personal care activities and in helping patients to access the toilet. Long et al. (2002) and Pellat (2003) also identified nurses' desire for reciprocity by having physiotherapists help with aspects of nursing

work. The second trigger was observed only twice and involved two long term qualified nurses. These nurses expressed difficulty fulfilling their desired role in rehabilitation. They suggested that their attempts at a fuller involvement in therapeutic activities were stifled by other team members' limited conceptions of nurses' as rehabilitators, and the impermeable professional role boundaries thus constructed (Kreiner et al. 2012). Other studies too have suggested that role protectionism may inhibit the sharing of profession specific roles and skills (Gibbon 1991, Long et al. 2002).

The third trigger to team discord related to the role of care assistants within the rehabilitation team. The present study identified that although care assistants were instrumental in providing patients with daily care, and supporting rehabilitation plans, a number interviewed expressed the view that they were not involved fully or were 'the last to know' about changes in patients' rehabilitation status. Observations also revealed the lack of opportunity that care assistants had to attend multi-professional team meetings and the preference for therapists to communicate directly with qualified nurses. Other studies have also identified this issue. For example, Atwal et al. (2007) action research study into older adult rehabilitation processes in a UK general rehabilitation ward found that therapists relied on nurses and care assistants to implement therapy carry over. However, care assistants perceived that they were not actively involved in decision making regarding patients' rehabilitation.

The concept of 'negotiated order' provides a useful theoretical lens through which to interpret the relations between nurses and physiotherapists and care assistants. Watson (2003) defines negotiated order as '*a pattern of activities which emerge over time as an interplay of the various interests, understandings, reactions and initiatives of the individuals and groups involved in an organisation*' (p36). The theory of negotiated order was originally developed by Strauss (1978) and argues that it is the individual micro-level interactions and negotiations between people that generate and maintain social order within organisations, rather than formal structures (Reeves et al. 2009). Through the process of negotiation, decisions are made about who should do what, how it should be done, when it should be done and how much of something should occur (Svensson 1996).

In the present study, the negotiations and non-negotiations between nurses and physiotherapists were a reflection and manifestation of the wider social arena. Strauss (1963) termed this the 'negotiation context', of which the rules, policies, laws, normative proscription, ideology, and dominant prevailing discourses comprise a key part. It is therefore valuable to attempt an explanation for the non-negotiated aspects of patient handling practice and to explore the factors and forces that have worked to create and sustain the work patterns so evident across the three case studies.

In this study, nurses and physiotherapists preserved the rules of practice. That is, they were active in the process of maintaining and recreating a particular order (Svensson 1996). This seemed to be because these patterns were in some way of benefit to both groups and therefore worth protecting. By being able to defer assessment and decision making roles to physiotherapists, nurses were able to manage the flow of work and postpone certain activities until the patient was seen by the physiotherapist. This created an opportunity and method of time management. Placing the physiotherapist in the role of expert could also be viewed as a way of easing the nurse's work burden. Nurses were able to justifiably abdicate responsibility for this aspect of care planning and care delivery. Clear role divide also removed the need for nurses to renegotiate the boundary between the 'no-lifting' legislation and the goals of rehabilitation. By placing the physiotherapist in the role of rehabilitator, nurses were no longer required to lead problem solving, make clinical decisions or consciously focus on maximising patients' mobility.

This self preservation strategy may have developed as a way of reducing nurses' sense of vulnerability to injury and litigation. In this way, subservience and 'distancing' (Pryor 2008b) from the challenges associated with patient handling decisions may have constituted a form of protectionism. Placing the physiotherapist in the role of expert also provided nurses with a means of determining and proving nursing care to be safe and defensible in an era of increased litigation.

Allen (1997) argues that the division of labour is a dynamic process whereby occupational roles are not concrete, but are actively negotiated within a system of work. However, in her study, negotiation between doctors and nurses was limited, largely because these staff groups worked in different locations and at different times.

This resulted in a 'non-negotiated order' in the settings studied. In the present study, nurses' desire to work more closely with physiotherapists had not been translated into a negotiation in any of the case study sites. There may be many barriers to negotiations, particularly those which could potentially lead to changes in practice.

Often, subtle variations in the micro-context of the workplace led to differences in team functioning. For example, factors such as: the staffing of the rehabilitation teams, nursing workloads, level of patient dependency, the sense of time, and degree of reliance on care assistants, all had a bearing on how nurses' and others' worked. For example, when nursing teams were staff depleted, care assistants and registered nurses alike were forced to adopt a task focused approach to patients' care, dispensing with the rehabilitation focus or therapy carry-over activities. Therapy team members accepted the inevitability that 'rehabilitation activities' would be neglected when nursing staff numbers were low. Likewise, when therapy staff numbers were suboptimal, therapists' aspirations to share skills and knowledge with nursing colleagues were scaled down.

This has been identified elsewhere. For example, Suhonen et al's (2009) integrative review of the literature identified key obstacles to the provision of individualised care. From nurses' perspectives and despite their best intentions, individualised care could be compromised by organisation-centred values. These values focused on the needs of the organisation and tended to over-ride individual patients' requirements. The most frequently noted difficulty in the literature reviewed was inadequate staffing which led to a shortage of nurses, an 'impoverished' skill mix, excessive workload and stress and limited supervision of care.

The simple absence of therapy staff in the early morning, later evening and weekends also limited to the extent to which it was possible for nurses to communicate and problem solve with therapy colleagues in relation to specific patients. In addition, the physical rehabilitation environment also had an impact on teamwork patterns. This is also noted in Sinclair et al's. (2009) ethnographic study of rehabilitation teamwork which found that physical and structural separation between nursing and physiotherapy presented challenges to inter-professional teamwork. Specifically,

because therapy rooms and offices were located away from patients bays, discussions relating to patients were often relayed to nurses after the event.

Similarly, the macro-context of negotiation may also influence the way in which participants work. Whilst the analysis presented here is based on observations made at the micro level of rehabilitation teams, the foundations for the teamwork arrangements observed in relation to mobility rehabilitation had been laid at the macro level – at the level of EU legislation, UK Health and Safety law, the professions of nursing and physiotherapy and through the policies developed by the employing health care organisations. For example, within the settings studied, the varying interpretations held by nurses, care assistants and physiotherapists regarding the hospital policy on moving and handling, created a barrier to negotiations relating to mobility rehabilitation activities.

From interviews with the longer time qualified nurses, it was clear that they had experienced widespread change over time in their roles and responsibilities in relation to patient handling. These nurses had been affected most by the changes since the 1992 legislation (HSE 1992). In contrast, newly qualified nurses did not have a historical perspective or a sense of ‘we used to do that.’ Longer time qualified nurses had, to some extent, been forced into a new order. For nurses who did not wish to relinquish control of moving, handling and assessment and decision making roles, the new order caused some frustration and resentment towards physiotherapists.

7.1.4 A Context of Risk

Observation of nursing work and staff interviews quickly revealed the many risks associated with providing nursing care within the rehabilitation context. The main sources of risk cited by the nursing teams was the lack of time to spend on activities, feeling rushed and staff shortages. Long shifts and fewer staff per shift meant that less staff undertook the patient handling activities and this repetition was the cause of much complaint, rather than the patient handling itself. Menzel et al. (2004) identifies the inherent risk to nurses’ physical wellbeing, associated with many aspects of rehabilitation nursing care. In case study 2, the nurse manager seemed to be unaware

of the physical strain being experienced by the care assistants on the ward suggesting a weakness in the integrity of the safety culture (Feng et al. 2008). Research by De Ruiter (2008) offers a perspective from the USA and uncovers the complexity of patient handling for nurses. Similarities between this and the current study could be found particularly the way in which frequent interruptions, the need for speed in decision making and in throughput influenced how patient handling decisions were made and activities undertaken.

Within this study, these very factors (lack of time and staff) were cited as important reasons to restrict nurses' practices in patient handling to A to B transfers rather than requiring nurses to engage in fuller involvement in therapeutic patient handling. In contrast, there was no apparent feeling that physiotherapists should similarly restrict their activities. None of the nurses and care assistants interviewed identified physiotherapists as at risk of injury. This inaccurate perspective may be promoted by physiotherapists themselves who may also wish to view themselves as immune to injury. Campo and Darragh's (2010) qualitative study revealed that for the physiotherapists' interviewed, their professional identity was bound to an image of strength and athleticism, combined with expertise in musculoskeletal health. This lead them to underplay or hide musculoskeletal pain in order to maintain clinical credibility.

Often, the provision of rehabilitation care entailed risks which could not easily be removed that were intrinsic to the type of care being provided. For example, there was no piece of equipment that could be used to wash a bed bound patient, help to put compression stockings on, put a patient's clothes on, place slings beneath patients' bodies, manoeuvre a hoist or shift furniture. Each of these activities created strain and fatigue. In particular though, care assistants complained that using cumbersome and poorly designed equipment was tiring and caused aches, pains, hand, wrist and finger discomfort. Hoists were heavy when a patient was suspended, they were difficult to move within the confines of the bed space and were often easily trapped under the bed mechanisms. Slide sheets were criticised for hurting fingers and wrists with repeated use. Observation also suggested that care assistants found it difficult to facilitate patients who were semi-dependent to move up the bed and arise from chairs. Helpful equipment such as handling belts, patient hand blocks and bed ladders were not

observed. Risks such as these were a permanent feature of the work, the environment, the patients and the equipment. Menzel et al. (2004) identify that whilst equipment may reduce compressive forces within the spine, there has been limited research to explore the extent to which stress is transferred to other body parts when equipment is used.

In order to adapt to these risks, nurses attempted to practice as safely as possible undertaking risk assessments for moving and handling, using equipment and adopting safe postures. When nurses described their role in patient handling, safety in handling was foremost in their minds. For some more recently qualified nurses and care assistants the main concern regarding mobility rehabilitation was to ensure that patients could be transferred safely from place to place, without injury to carer or patient. These practitioners were satisfied with a care and maintenance role and demonstrated little interest in a fuller involvement in 'therapy' activities. Enabling patients to get to the toilet, find a comfortable position or sit safely were achievements in themselves. The outcome of this position was however, a patient who was 'maintained' at a constant level rather than benefiting from a consistent rehabilitation approach. This perspective positioned nurses in the 'safe to care', maintenance role, rather than a rehabilitation role. This was identified as one way of 'avoiding risk' - an approach to patient handling which eliminated manual 'lifting'. This focus on safety made it difficult for nurses to engage in therapeutic handling and many nurses actually believed that they were forbidden to do so in any case.

Although many of the risks associated with their work could not be controlled, one element that nurses and care assistants could manage was the extent to which they moved and handled patients, minimising the frequency of handling interventions. Another way of controlling the risks associated with patient handling was to defer to the physiotherapist regarding key decisions such as how to transfer a patient or mobilise them. Following the instructions of the physiotherapist was perceived as a way of ensuring that nurses and care assistants selected safe transfer methods and did not place themselves in unnecessary risk.

It is argued that the management of organisational risk is most effective where there is open communication which in turn increases workers' trust in the internal

organisational risk management processes (Conchie and Burns 2008). Whilst nurses were aware of risks to themselves resulting from their work and used strategies to minimise these, many of the respondents seemed to largely accept these daily risks without question, viewing aches and pains as 'just part of nursing'. It was evident that the practitioners interviewed had little confidence that these risks would ever be addressed or reduced. Rather, staff accepted that they would just have to carry on. Nurses also felt that their practices would be scrutinised and most likely criticised if a patient, colleague or they sustained an injury associated with patient handling, but that little recognition would be given to the challenges associated with care work. Thus, although a rhetoric of safety existed, this did not permeate completely into the world of practice.

7.1.5 Working with 'The Official Line'

The 'official line' regarding patient handling activities was presented to practitioners via the annual mandatory moving and handling update sessions they attended. Official training sessions such as these were largely viewed as an opportunity to update pre-existing skills and to ask questions regarding particular difficulties within the workplace. These sessions also served to remind staff of the importance of risk assessing and risk avoidance and specifically, of adhering to the Trust policy for Manual Handling and Patient Handling.

One view of hospital manual handling policies is that they constitute a key mechanism for ensuring a culture of safety within the organisation. In the UK, the Health and Safety Commission (1993) describe safety culture as a combination of the values, competencies and actions of workers' towards safety, viewing each of these factors as contributing to the effectiveness of safety measures in place. In this study, many of the care assistants and registered nurses admitted that they had not read the patient handling policy. These staff believed that attending the mandatory training was sufficient. In this way, mandatory training was the 'mouthpiece' for the policy and was readily acceptable within the 'oral culture' of nursing (Scott 2007).

Nursing staff described patient handling equipment in positive terms, and were observed to use it frequently to eliminate unnecessary patient handling. Although a

perception exists that the over use of patient handling equipment may lead to inhibition of the patient's rehabilitation (Nelson 2008), only experienced and long time qualified nurses and therapists expressed this view. Care assistants and more recently qualified nurses did not appear to hold this opinion. Indeed, a recent study by Ruzsala and Musa (2005) suggested that the use of handling equipment has become more acceptable to therapists working within rehabilitation. These authors showed that although therapists had some concerns, equipment was used frequently to complement therapy treatment sessions. In contrast, Tyson et al's. (2008) study of stroke physiotherapy highlights an entrenched preference of physiotherapists to use manual facilitation techniques.

Marias and Street (2008) identify that policies may be created in isolation from the work context and may not reflect the complexity and 'messiness' of practice. In the present study, nurses appeared to respond in three different ways to the official line on patient handling presented during mandatory training: The first response was to '*resist*' the policy. Some nurses felt that the moving and handling policy for the Trust did not take into account the realities of rehabilitation nursing. In their view, it was impossible to eliminate many risks, and detrimental to patient rehabilitation to eliminate all of them in any case. These nurses (and the therapists in case study one in particular) wanted an honest policy that would allow them to be open about the patient handling and mobility related activities they engaged in during the process of helping patients.

These staff resisted the 'official line' and continued to engage in occasional manual transfers such as front assisted standing and transfers. In some situations, these were felt to be more therapeutic than the 'safe' transfers using hoists and slide sheets, advocated in training sessions. In these circumstances, nurses felt that such practices left them open to criticism from others. Consequently, they did not broadcast their participation in Bobath influenced techniques, or encourage others to follow suit.

When 'no-lift' policies were initially introduced into NHS Trusts and the RCN promoted the no-lift message, this was quickly absorbed into the oral culture of nursing. Although the literature now promotes a 'minimal handling' or 'safer handling' message (de Castro 2004), practitioners still measured their own activities

against the original 'no-lift' mantra. They seemed to feel guilty and anxious when they admitted that they did lift and did at times support patients' weight (albeit partially) when providing care. Whilst most interviewed viewed the policy as important and relevant, practitioners felt intimidated by it, rather than supported. The perceived dissonance between the 'official line' promoted during mandatory training sessions and the realities of rehabilitation practice led to some rehabilitation staff feeling alienated from the employer and the wider organisation.

A second group of staff responded to the official line on patient handling by becoming '*resigned*' to it. These nurses and care assistants were concerned that if an incident occurred where a patient was injured during a transfer, and they had used a manual approach or had not followed the physiotherapists' advice, that the Trust would not support them in 'a court of law'. The Trust policy was viewed as an institutional weapon that could be used against them, or at least could be used to deny them compensation if they were unfortunate enough to be injured at work. This anxiety meant that although some of the practitioners wanted greater involvement in patient handling and physical rehabilitation, they were resigned to the restrictions on their involvement and gave up former levels of involvement in such activities.

The final group '*adopted*' the Trust policy and the rhetoric of 'no lifting' to the extent that they avoided participating in mobility rehabilitation activities where possible. In this way, they had effectively abdicated any responsibility for this aspect of the patient's recovery, preferring to situate this part of practice in the domain of the therapist.

Healthcare has seen an increase in litigation relating to negligence and accidents (Lilleyman 2005) and a culture of blame in the NHS has been documented (Waring 2005). As a result, there has been an increase in effort within the NHS to develop and implement effective risk management strategies (NHS Litigation Report 2010). This has largely been achieved by urging practitioners to avoid known risks and hazards. It has also been identified that the standard of performance required to meet the practitioner's duty of care has become more demanding. Young's (2009) analysis of court proceedings suggests that a 'doctrinal' shift in attitudes towards health care staff can be detected. He suggests that judges are more likely to question the decisions

made by clinicians as the traditional deference to health care staff has been eroded within society. It is thus suggested that the growing emphasis on risk avoidance, a fear of being blamed, combined with the increase in litigation, has had the effect of deterring some nurses from engaging fully with mobility rehabilitation activities. Indeed, moving and handling has become associated with negative associations, including the risk of back injury and the risk of being blamed in the face of an accident (Kneafsey et al. 2003). It is possible that nurses who lack confidence in their skills and abilities may well distance themselves from this aspect of patient care and rehabilitation.

The staff observed generally conformed with safety norms in patient handling given the right circumstances (staff, time, resources). However, contradictory norms also exist in nursing and some norms may take precedence over others (Marias and Street 2008). For example, all nurses recognise the need to 'cope' with the patient caseload whatever the circumstances. Nurses must work to ward routines and get through the work to support the effective functioning of the nursing, medical and therapy teams. Thus nurses may dispense with certain norms and adopt others, depending on the circumstances. For example, in this study, at busy times nurses did cut corners in patient handling for increased speed (i.e. engaging in manual patient handling to move patients up the bed, or transfer from bed to chair) and did relinquish involvement in additional 'ideal' rehabilitation activities, focusing instead on minimum standards to ensure patient safety.

Thus, whilst an espoused ideal for nursing practice may include the prioritizing of mobility rehabilitation and nurse led therapy activities, at busy times, this activity may be dispensed with in favour of other more dominant norms. Through the process of normalization, specific, acceptable standards are maintained and reinforced. If the individual fails to conform to expected norms, little punishments are inflicted to highlight failures (Marias and Street 2008). It was not evident that nurses were judged, nor judged each other negatively for failing to engage in mobility rehabilitation. Rather, it was accepted as an inevitable, normal and logical option given the work situation. In contrast it is suggested here that individual nurses would be judged harshly if they failed to keep up with the pace of work, thus disrupting the efficiency of the whole team.

Gibson (2001) examined the role of texts in creating cultural representations and reproduction in relation to nurses and medication error. Similar parallels can be observed within the literature relating to nurses and patient handling. Much of the literature stems from EU and Government policy, management bodies (e.g. Hospital Management Boards) regulatory bodies (e.g. NMC 2008), researchers and from educators. Each of these types of literature presents a version of 'reality' and set of rules and expectations against which nurses are judged.

An underlying theme within the literature is for the need for nurses to be governed, assessed and educated. Nurses are positioned as non-compliant with moving and handling rules (Cornish and Jones 2009, Hignett 2005, Swain 2003), as lacking in skills and knowledge (Crompton and Bannister 2002, Kay and Glas 2011), as requiring training in equipment use (Barnes 2007), as victims of back injury (Lim et al. 2011), as the subjects of research (Jones et al. 2005), and as givers of care (Jones et al 1998, Forster et al. 1999). Rarely are nurses presented as experts in their own right in relation to patient handling. Only a minority of articles represent an alternative discourse or reflect the views of rehabilitation nurses (e.g. Mutch 2004, Mitchell et al. 2005, the RCN Rehabilitation and Intermediate Care Nurses' Forum 2002 and De Ruiter 2008).

The impact of this is that nursing practice is conceived and reported on in particular ways whilst other ways of thinking about rehabilitation nursing are excluded. According to Gibson (2001), discourses have the power to create meanings whilst obscuring or obliterating others and also delineate how nursing identities and practices are construed. A requirement for risk avoidance and patient safety reflects the legal and professional mandate to which nurses' compliance is expected. This compliance is enforced through EU and national laws that emphasise the legal weight of hospital policies relating to patient handling. Nurses must be responsible and will be held accountable for their actions. The nurse is governed and under surveillance and the discourse for moving and handling also provides a mechanism for wielding disciplinary power. Nurses' practices are audited and nurses police each other (Cook 2006) undermining a culture of trust and replacing it with an illusion of control. Nurses are reminded of their legal duty to risk assess, to use safe systems of work, to

avoid manual lifting and the possibility that they will not be compensated should they be injured through their own actions or inactions. Furthermore, should a patient be injured, the nurse may be accused of 'contributory negligence' (Pellat 2005). In such a context, with such weighty responsibilities, it is unlikely that nurses will direct their attention to an expanded role in mobility rehabilitation.

The dominant discourse relating to patient handling has established certain safety norms in relation to nurses' patient handling practice against which individual practitioners can be judged (Feng et al. 2008). Over the last decade, views on moving and handling have changed with a movement away from the 'no-lifting' stance towards greater acceptance of the individuality of each care situation, requiring a new focus on 'safer handling' or 'minimal handling' within a work context which supports a climate of safety (Mark et al. 2007). Indeed, this study has revealed a number of important safety values in relation to patient handling. All practitioners knew of the importance of risk assessment, of using equipment, of consulting with experts. All staff valued the hoists and used handling equipment where possible. However, the study also revealed that the now out-dated rhetoric of 'no-lifting' continued to be a pervasive influence. The continued presence of this 'rule' or 'norm' in nurses' consciousness has dangerous implications.

The extreme application of the 'no-lifting' rhetoric may cause nurses to avoid moving patients, leading to essential patient care needs being neglected. Indeed, even if 'safe principles' in load handling are applied, the nurse who chooses to reposition or turn a patient or assist them to stand and walk is at higher risk of back injury than one who chooses not to (Mark et al. 2007). At the other extreme, over-zealous and dogmatic 'no-lifting' messages may alienate practitioners who find this stance incompatible with an ethic of care. For example, Barnes states (2007) 'it is the function of equipment to lift, not the function of the nurse.' Clearly, this statement pays scant recognition to the 'extraneous and unpredictable factors that often complicate' patient handling activities (Hignett and Richardson 1995, p221).

7.1.6 Feelings of Dissonance

This study threw light on a number of ethical dilemmas which arose for nurses and care assistants in relation to patient handling decision making and the process of mobility rehabilitation. Often, these dilemmas lead to uncomfortable feelings of moral conflict. For example, some staff reported an inner conflict between the legislative requirement for self preservation versus the internalised care ethic of the practitioner. Whilst staff knew it was important to avoid unnecessary manual handling and necessary to use patient handling equipment, nurses, care assistants and therapists alike often found this to be impossible. This was because speed was frequently important within the immediate moment in time. A typical example related to the patient who desperately needed to access the toilet. Often, the quickest and most effective way to move the patient was to use their own manual strength at that immediate moment in time.

For these staff, within the practitioner-patient relationship it was not morally acceptable to leave patients who were uncomfortable or poorly positioned or desperate for the toilet to go and fetch a hoist or stand-aid. This may be partly explained by the fact that patients on rehabilitation wards are vulnerable. As well as illness and often pain, patients are also separated from previous sources of support and comfort derived from their familiar surroundings, friends and relatives (Stabell et al. 2006). The relationships and 'emotional connections' that patients may develop over time with nurses, care assistants and therapists may therefore be critical to supporting the patient's rehabilitation and recovery (Wegener 1996). Genuine relationships may also be important in maintaining the patient's dignity, particularly as he or she may have experienced profound loss of previous levels of physical function, autonomy and control over their own destiny. It is within the context of this close relationship that a range of ethical dilemmas may occur.

Practitioners were motivated by their internalised moral sense of duty to protect patients' dignity and wellbeing. This included giving patients the chance to test out their own physical abilities by standing or transferring with manual support rather than using a hoist. In these moments in time, practitioners weighed up the risk to

themselves of sustaining an injury as a result of the manual handling event, compared to the risk of the patients' dignity and wellbeing being harmed. Often, the decision opted for involved taking a measured risk. This course of action was perceived to be most consistent with their internal sense of duty to the patient – their ethic of care.

This kind of decision making has been identified elsewhere. For example, Stabell et al. (2006) argues that when faced with frailty and illness, health care staff may be motivated to act in certain unexpected ways. He goes on to state that 'confrontations with vulnerability, pain, suffering and subjective hurt generate specific moral reasons for helping a person, and strengthen the force of interpersonal attention' (p244).

The data from this study suggested that practitioners' ethic of care related to the sense of moral obligation or duty to act in a particular way towards patients, within the context of a carer-to-patient relationship. Within practitioner-patient relationships there exists a certain level of shared understanding of how each should relate to and act towards the other (Doane and Varcoe 2007). In relation to nursing work, qualified nurses' work towards a strict moral code which dictates the nature of the relationship and to which nurses are held accountable (NMC 2008). Unregistered care assistants also work from within a particular moral framework. Whilst there is no written 'code of practice' for care assistants, one might argue that paid carers work towards a common understanding and set of lay expectations and stereotypes of how members of a 'nursing team' should, and will act. Part of this expectation and value system includes a desire to help others and the expectation from patients that this will be so – that the figure of 'nurse' will provide 'care'.

In this study, it was noticeable that when nurses and care assistants moved and handled patients, this was often at times when patients were in pain, semi-naked, soiled, needing to eliminate and thus vulnerable both physically and mentally. In these circumstances, it was neither practical, nor desirable for care assistants to attempt to engage in therapy carry-over activities such as exercises or movements. The focus was on maintaining privacy, dignity and comfort. This differed to the occasions when therapists moved and handled patients who were at those times, clean, dressed and groomed prior to their interventions. Certainly, this influenced the relationship between patients and nurses and meant that it differed to the relationship that patients had with therapists.

Other sources of moral conflict also arose. For a number of nurses and therapists, the reliance on hoists to move patients was viewed as detrimental to patients' wellbeing, inhibiting the rehabilitation process and their progress towards independence. Staff felt that the dominant safety emphasis in relation to patient handling meant that they were able only to contribute to maintenance rather than to rehabilitation. Waterworth et al. (1999) also identifies that a dissonance may arise for the nurse if she is placed in a position of having to prioritize certain tasks 'in ways that run against the current of nursing ideas about holism and individualised and interpersonal care' (p166) or if the nurse feels that patients' needs are placed in secondary position to the goals of the organisation. Cooke (2006) noted how ward sisters 'clung' to a personal and professional ethic of care, but often felt that this ethic was being undermined. Certainly, some staff in this study felt that patients were being disadvantaged as a result of an unrealistic organisational policy. It was this difference between the nurse's internalised normative disposition regarding rehabilitation practice and the more limited 'actual role behaviours' demanded by the employing institution that had the potential to cause cognitive dissonance for the nurse.

Other nurses identified that some staff had taken a concern with safety to the extreme. Having become so focused on avoiding personal injury, these staff neglected patients' comfort needs and their need for help with movement and mobility. As a result, patients were left in bed unnecessarily. From this perspective, and for patients at least, the policy had perhaps had unintended consequences and had changed the nature of nursing practice for the worse.

Although presenting a view from a different Continent, De Ruiter (2006) also identifies a raft of ethical dilemmas which occur because of the conflicts which may arise between preventing nurses and care assistants from injury, maintaining patients' autonomy and minimizing patients' pain and discomfort. De Ruiter calls this the 'grey zone' and describes this as situations where whichever action the nurse takes, could lead to a negative outcome. For example, the nurse may experience conflict over whether to reposition a patient manually, or to use a hoist. On the one hand, if the nurse opts to use a hoist selected on the basis of a patient handling assessment, she may know that this will cause a particular patient pain, fear or lead to de-motivation

and hopelessness. On the one hand, if the nurse or care assistant chooses to reposition a patient manually, she may sustain a personal injury. This scenario, repeated over time will lead to the nurse experiencing moral distress.

7.2 The Core Category: Care to Keep Safe – Safe to Care.

Analysis of the body of data enabled a core category to be developed to describe and explain how nurses and care assistants contributed to patients' mobility rehabilitation. The core category was entitled 'Care to Keep Safe – Safe to Care.' The following section explains the core category, and the inter-relationship of the cross cutting categories.

Nurses viewed their role to be primarily the caregiver who would keep the patient safe rather than the practitioner who would focus on the patient's mobility rehabilitation (Care to keep safe). Nurses and care assistants suggested that limits to their skills and knowledge restricted them to a 'care handling' approach. Without specialist knowledge, there was a sense that engaging in therapeutic handling or other mobility rehabilitation activities could cause additional risks to the patient or themselves – hence, nurses and care assistants were 'Safe to Care' but were not safe to engage in therapeutic handling activities.

The categories which form the building blocks of the grounded theory all contributed to the focus on safety which pervaded nurse's practices'. For example, in the process of providing rehabilitation care, nurses attempted to prevent problems and responded to patients' needs as they arose, in order to maintain safety. Nurses and care assistants were aware of risks to patients and themselves arising from the environment, their treatments and nursing interventions. Nurses and care assistants tried to avoid unnecessary risks and used moving and handling equipment liberally. Mandatory training in moving and handling was viewed as useful by focusing on safe practices in patient handling and promoting a 'no-lifting' message.

One way of ensuring patient safety regarding patient handling was to defer decision making to the physiotherapist regarding how the patient should be transferred, mobilised and positioned. Nurses used this system to demonstrate that 'due process'

had been followed, and to be sure that their practices were appropriate. Nurses were aware of the possibility that their skills in patient handling and mobility rehabilitation may not be as comprehensive as the designated experts. Nurses felt well able to care safely for their patients but were generally less certain of how to promote mobility rehabilitation.

The way in which work was divided was viewed by some as a protective approach. Taking patients to the gym was seen as safer because the patient was then able to be treated in a predictable environment with more than one therapist present to assist to the patient. The boundaries in patient handling were also suggested as a way of maintaining staff and patient safety. By restricting nurses' and care assistants' involvement in patient handling to the less complex, more predictable transfers, it was perceived that the risk of injuries resulting from an unpredictable event were reduced. It was argued by the therapists interviewed that this also protected patients from non therapeutic patient handling practises which might even cause patient injury. By inference, this suggested that nurses were not perceived to be sufficiently skilled or knowledgeable to engage in therapeutic handling and mobility rehabilitation without putting themselves or the patient at risk. In contrast, nurses were deemed sufficiently skilled to undertake A to B transfers in order to keep the patient safe and to meet care needs.

To summarise the grounded theory as a whole, nurses contributed to patients' mobility rehabilitation through a '**care to keep safe**' approach. Nurses' were conscious of the need to prevent potential problems such as pressure sores, malnutrition, infections and of course, falls. Through the provision of **rehabilitation nursing care**, nurses helped patients to get washed, dressed, to eat and drink and meet eliminatory needs. In doing this, nurses also assisted patients to negotiate **A to B transfers** to get from one place to another. This allowed patients to gain some mobility and movement practice and to engage with activities of living. The nursing focus was not on improving the quality of patients' movement, but on safe transfers to enable other care needs to be met.

Whilst care assistants and registered nurses spoke of a desire to work more intensively to assist patients with movement and mobility, a number of factors stopped this from

occurring. Both the work context and the nurse's and care assistant's skills and knowledge base restricted these ambitions and left many with the feeling that under the circumstances, they were only 'safe to care.' Indeed, within the context of the 'negotiated team' nurses perceived themselves as **non-experts** in mobility and movement, lacking in skills and knowledge, compared to the physiotherapists. This led some to take a back seat in relation to this aspect of rehabilitation practice, rather than taking on a leadership role. Divided work practices also increased the mystique associated with physiotherapy treatments and intervention, further reinforcing their expert status and supporting their role as the most suitable decision maker in relation to the patient's mobility rehabilitation. Nurses' interpretations of hospital policy and 'the official line' also led to the perception that nurses (but not physiotherapists) should, for safety's sake, follow a 'no-lift' approach. Nurses also worked in **context of risk** resulting from a lack of time, lack of staff, cumbersome equipment and a lack of confidence regarding their own knowledge base.

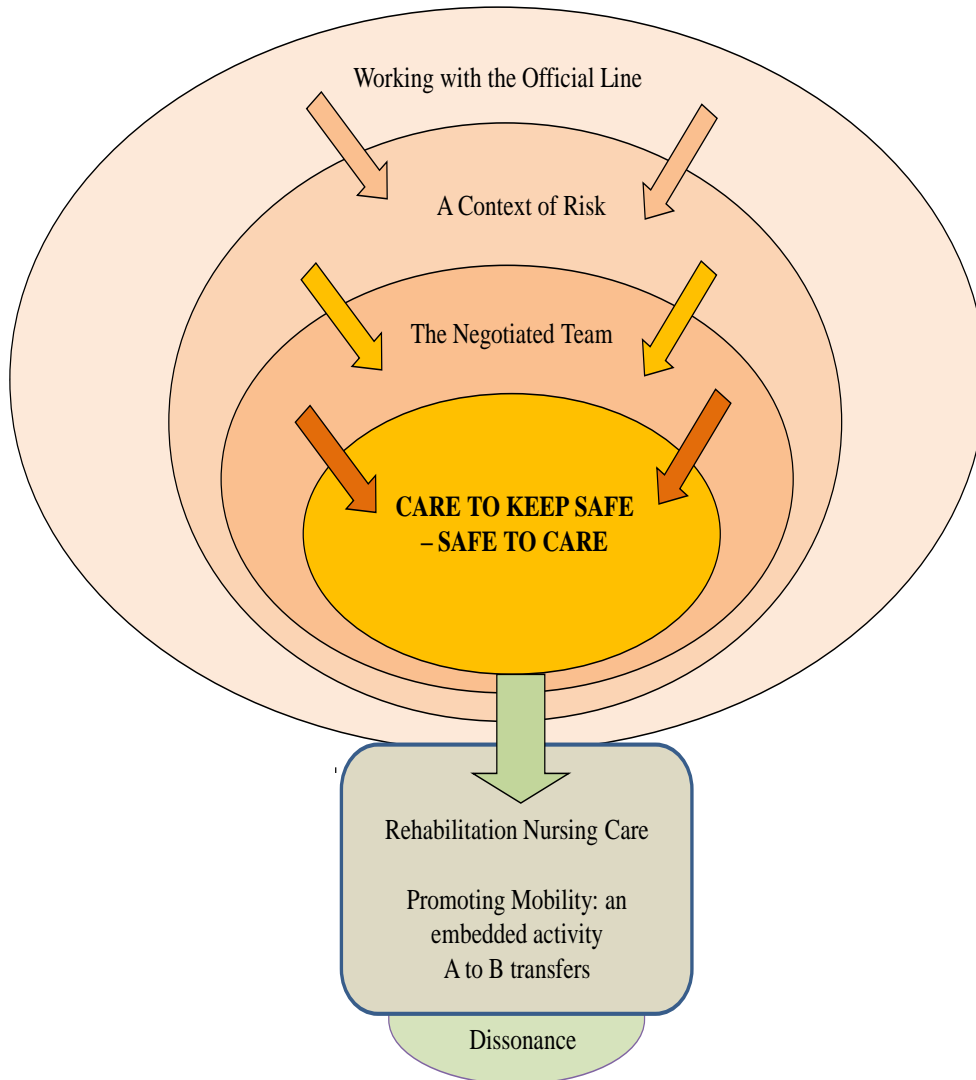
For nurses who subscribed fully to the philosophy of rehabilitation and believed in the importance of close teamworking, skill sharing and the need for continuity in the patient's rehabilitation, this situation caused **feelings of dissonance**. These nurses felt that patients' rehabilitation was delayed by artificial role divisions and that the nurse's potential contribution to the rehabilitation process was unreached. This limited patients' potential freedom and rehabilitation outcomes. Other nurses experienced dissonance as a result of the differences in how patient 'care' was enacted in practice and with how 'care' was described or interpreted in policy. For example, nurses felt that hospital policy relating to patient handling required them to avoid unnecessary handling. However, these nurses argued strongly that it was impossible to eliminate all patient handling, as the 'caregiver-patient' relationship demanded and required nurses to undertake many 'little lifts'. This made nurses and care assistants anxious that their practice would be judged as incorrect, which led to them feeling alienated from the hospital policy.

7.3 Chapter Summary

This chapter has drawn together the findings from the three individual case studies which were carried out in a general rehabilitation setting, a spinal injuries unit and a

stroke rehabilitation ward. A set of cross cutting categories which span the three case studies has been identified and discussed in relation to the wider literature. The chapter culminated in a description of the core category for the grounded theory which was entitled 'Care to Keep Safe – Safe to Care.' The core category can be used as the key concept around which to structure and consider each of the other categories.

Figure 6: A Grounded Theory to Describe and Explain Nurses' and Care Assistants' Contributions to Patients' Mobility Rehabilitation.



CHAPTER 8

CONCLUSIONS AND IMPLICATIONS

8.0 Introduction

This study has culminated in the production of a set of findings and the development of a grounded theory to describe and explain nurses' and care assistants' contributions to patients' mobility rehabilitation. A core category was established, described as 'Care to Keep Safe – Safe to Care'. This chapter concludes the thesis by answering the three initial research questions posed at the start of the thesis. The second section of the chapter explores the implications of the study. The final section evaluates the quality of the research, its contribution to knowledge and its limitations.

8.1 How Do Nurses and Care Assistants Contribute to Patients' Mobility Rehabilitation ?

The core category, entitled 'Care to Keep Safe – Safe to Care', can be used to describe and explain the nursing and care assistant contribution to patients' mobility rehabilitation. The core category identified the nursing focus to be the primary *care* and safety of the patient, rather than the rehabilitation of the patient. Nurses and care assistants sought to prevent potential problems in relation to mobility and movement; they did not want patients to fall, they did not want patients to develop pressure ulcers and did not want to worsen the patients' muscular condition (e.g. tone, spasm). This focus on care was driven by the dominance of a pervasive discourse of safety. This stemmed from multiple sources such as professional guidance, legislation, institutional policy and academic literature. Whilst concepts of care and rehabilitation are not mutually exclusive, the 'safety' messages propagated through these avenues took precedence over and competed with the underpinning philosophy of rehabilitation.

Nurses and care assistants contributed to patients' mobility rehabilitation through the provision of rehabilitation nursing. Rehabilitation nursing care ensured that patients' essential needs were met (e.g. nutrition, hygiene, elimination, positional changes). Usually, this required the completion of A to B transfers which sometimes provided patients with chance to practice their mobility. Nurses supported the provision of physiotherapy by ensuring patients' daily needs were met to enable them to participate in therapy sessions. Nurses' and care assistants' contribution to mobility rehabilitation did not reflect the range of potential activities and specific interventions identified within the literature, and tended to be generalist rather than specialist. Much patient handling and 'care' work was undertaken by care assistants. Care assistants worked at speed and did not receive education to support them in their rehabilitation role. Their activities were not observed to be supervised or directed by registered nurses. The study did not identify significant differences in registered nurses and care assistants' approaches to patients' mobility rehabilitation.

Although many nurses recognised the potential benefits of an increased nursing focus on activities to support mobility rehabilitation, a range of contextual factors meant that this aspiration was unmet. The work environment was characterised by staff shortages and perceived time pressures. Nurses and care assistants also felt they must not 'lift' and must limit the extent to which they engaged in manual handling (and by default, patient handling). Nurses and care assistants also suggested that limits to their skills and knowledge restricted them to a 'care handling' approach. Without specialist knowledge, there was a sense that engaging in therapeutic handling or other mobility rehabilitation activities could cause additional risks to the patient or themselves. Physiotherapists were essentially viewed as safer and better qualified to lead the patient's mobility rehabilitation. Indeed, the most significant barrier to nurses and care assistants developing an extended role in relation to mobility rehabilitation appeared to be the entrenched teamworking practices observed in the case study settings.

8.2 How Do Nurses' and Care Assistants' Activities to Promote Patients' Mobility Rehabilitation Contribute to Rehabilitation Teamwork?

The study aimed to examine how nurses' and care assistants' mobility rehabilitation activities contributed to rehabilitation teamwork. In doing this, the study was concerned in particular with the interplay between nurses and physiotherapists and less commonly, the occupational therapist. What this study established is that a clear negotiated order existed which dictated who did what in relation to mobility rehabilitation and how team members would interact with each other regarding this. Overall, it seemed that there was only limited teamwork between nurses, care assistants and physiotherapists in relation to mobility rehabilitation

Nurses and care assistants concentrated their efforts on keeping patients safe and on enabling patients to meet immediate needs associated with daily living such as reaching the toilet, eating, washing and dressing and getting from one place to another. This often required nurses and care assistants to move a patient from A to B. These activities were essential to the patient and in relation to teamwork, allowed therapists to then engage the patient in tailored therapy sessions.

Whilst nurses and care assistants engaged in A to B transfers, therapists undertook therapeutic handling. The division of work between nurses and therapists meant that nurses and care assistants had few opportunities to increase their skills, knowledge and insight into therapy activity. Nurses and care assistants had limited knowledge of the activities occurring during therapy sessions and none had attended a therapy session since qualified or employed in their respective posts. Neither were nurses or care assistants observed working with physiotherapists and patients together. Rehabilitation work was divided geographically, professionally and temporally. These factors reinforced nurses' perceptions of themselves as non-experts whilst physiotherapists were perceived as experts.

The negotiated order in place created benefits for both nurses and physiotherapists. Since physiotherapists had been elevated to the role of expert within the organisation, nurses were able to step back from assessment and decision making in relation to mobility and moving and handling. This conserved nurses' time and protected them

from the potential of being criticised for making a mistake, injuring a patient, being sued or being injured. Preserving the physiotherapist's dominant role in this aspect of the patient's rehabilitation also imbued the rehabilitation process with professional credibility.

The accepted status of the physiotherapist as expert and the nurse as non expert meant that nurses and care assistants were content to accept that there were distinct differences, boundaries and restrictions to the patient handling activities in which they could engage. Nurses and care assistants became further distanced from their responsibility for mobility rehabilitation. Only long time qualified experienced nurses questioned this division of work and sought to retain engagement in mobility rehabilitation.

The data collected did not indicate that nurses in the case study settings assumed a strong leadership role in relation to the rehabilitation teams. In case study one, physiotherapy team members appeared most articulate in relation to the development of rehabilitation team processes. Although the matron of the medical directorate was mentioned by ward sisters, this role was not focused on developing the rehabilitation team. In case study two, clinical leadership was provided by an occupational therapist. In case study three, the Stroke Consultant was clearly of great importance in providing clinical, research and rehabilitation leadership. The lack of nursing leadership within the sphere of rehabilitation constitutes a significant barrier to developing the nursing contribution to patients' mobility rehabilitation. The importance of empowering and supporting ward sisters/change nurses has been identified in the recent literature as a matter of significant concern (Sawbridge and Hewison 2011, RCN 2009). In the present economically pressured health care environment, the combined impact of efficiency measures and high consumer expectation means that nurses are now subject to extremely close professional scrutiny and critique. As a result, the need for nursing leadership becomes increasingly important lest the profession of nursing loses its central position in the health care arena.

8.3 What Impact Do NHS Patient Handling Policies Have On Nurses' and Care Assistants' Contributions to Mobility Rehabilitation?

All nurses and care assistants attended mandatory training in patient handling. The focus of these sessions was on safe handling and the importance of adhering to load handling policy. Training was valued as it provided updates on how to use equipment. Many nurses and care assistants had not read the hospital moving and handling policy. Mandatory training comprised the mouthpiece for the policy. Nurses' and care assistants' perception of risk and the response to risk were influenced by the mandatory training in manual handling and presentation of the 'official line' therein. Some respondents suggested that nurses in other settings responded to risk by avoiding patient handling.

For long time qualified nurses, following the 'official line' on patient handling led to feelings of dissonance. These nurses did not believe it was fully possible for them to promote physical rehabilitation if they were confined to a care handling approach. Nurses who responded to the 'official line' by 'abdicating' from responsibility for mobility rehabilitation did not seem to experience conflict between the policy and their role in the rehabilitation ward.

Whilst the 'no-lifting' mantra remained at the level of nurses' and care assistants' consciousness, physiotherapists, by virtue of their expertise, were perceived to be exempt from this norm. This added confusion to nurses' and care assistants' interpretations of Trust moving and handling policy, perpetuating an assumption that physiotherapists worked to a different set of rules.

Although all nurses used equipment frequently to move patients, it was not possible to eliminate all of the 'little lifts' needed to position patients comfortably. Nurses were habituated to difficult working conditions and accepted that these could not be changed within the current NHS. Thus, although nurses were supportive of a safety culture, they remained disadvantaged by their working conditions and the employer which colluded in this double standard.

Participants were largely of the opinion that their employer would not support them in a court of law if they or a patient were injured during a patient handling episode. Practitioners suggested it would be more likely that they would be criticised for engaging in unnecessary manual handling.

8.4 Implications for Practice

This study identified that an important impediment to rehabilitation nursing practice was staffing and skill mix inadequacies. When nursing team complements were suboptimal, rehabilitation approaches were essentially abandoned. Thompson (2008) argues that the effect of being ‘too busy’ means that nurses perform those activities deemed essential to direct patient care. In the present study, it is possible that whilst nurses and care assistants viewed ‘safe’ patient handling as essential to the provision of nursing care, activities related to mobility rehabilitation were perceived to be less vital. These activities were not part of the ‘norm’ and nurses and care assistants did not expect to be held accountable if they were omitted. It would seem that greater clarity is needed regarding the activities rehabilitation nurses and care assistants can and should engage in, in order to maximise patients’ rehabilitation. Without a specific toolkit of activities that are ready at hand for nurses and care assistants to utilise, a specific role in mobility rehabilitation is easily overlooked or takes second place to other activities. What is important is that intentional strategies are implemented to promote patients’ mobility rehabilitation, rather than the reliance on an ‘ad hoc’ approach. However, these will only become a reality with adequate staffing, skill mix and staff knowledge.

Registered nurses and care assistants may view the moving and handling of patients as a routine activity. Whilst routines may be adaptive and enable efficient working they may also be a hindrance to the provision of individualised nursing care. The entrenched nature of routines means that they cannot easily be changed despite new circumstances. Nurses’ and care assistants’ conception of patient handling as a routine activity is incompatible with it becoming an area of nursing speciality because it will not be given the attention it needs to be developed to its full potential.

Service providers need to re-examine how they wish nurses and care assistants to work. Current institutional arrangements do not enable nursing teams to work easily in a rehabilitative manner. As Liaschenko and Fisher (1999) noted, ‘nurses have shown themselves to be astute observers of what work they are paid to do and what work they are not paid to do’ (p32). If nurses and care assistants do not perceive that the institution expects them to work rehabilitatively, or does not enable this to occur, staff will focus their attention elsewhere. Whilst safety in care cannot be compromised, rehabilitation approaches (which often take longer e.g. coaching) may be perceived to be expendable in the context of time pressure. In a climate where throughput and efficiency is valued, spending additional time on mobility rehabilitation may not be viewed as a priority. Measures of dependency and staffing ratios should be scrutinized to ensure that coaching and supportive activities are achievable.

An entrenched culture which places primacy on the expertise of the physiotherapist regarding all decisions mobility related, leads to registered nurses’ declining to assume a leadership role in this sphere of practice. Nurses who lack confidence in their own expertise, skills and knowledge regarding mobility rehabilitation are likely to defer to physiotherapists, resulting in scant engagement with mobility rehabilitation. With so few physiotherapists and the dominant role of nurses and care assistants in providing day to day care for rehabilitation patients, this is a crucial window of opportunity that is not maximised.

The distinct division of work and spatial separation between nurses and therapists in the rehabilitation settings bore no resemblance to literature on role sharing and blurring. Nursing and physiotherapists rarely worked together during the week and therapists did not work at weekends. The effect was to limit any scope for knowledge transfer or skills development between practitioners. Newly qualified nurses had few rehabilitation role models to identify with as mostly, patient care was delivered by care assistants. If rehabilitation teams truly wish to work towards patient focused rehabilitation goals, members of different professional groups will need to work more closely together with the patient. To enable this, artificial role barriers need to be deconstructed.

The study found that registered nurses and care assistants undertook very much the same activities in relation to mobility rehabilitation. This observation suggests that care assistants have assumed some of the direct patient care roles traditionally associated with nursing roles. Although the study did not set out to compare the roles and contributions of these two staff groups, only two main differences were observed. Registered nurses completed the falls and moving and handling assessment and attended rehabilitation team meetings. In contrast, care assistants did not attend the multi-professional rehabilitation team meetings yet carried out more of the patient's direct care. This meant that although care assistants were often more instrumental in the patient moving from place to place and were potentially well situated to implement rehabilitation interventions, they had few formal opportunities to report on patients' progress, to influence the goal setting process or gain insight into the rehabilitation programmes planned for specific patients.

This finding has implications for rehabilitation practice. If the aspiration of the multiprofessional rehabilitation team process is for patients to experience well coordinated and consistent therapy, it is vital that all team members are fully grounded, involved and skilled in rehabilitation principles and practice. A reliance on unregulated care assistants to deliver the majority of direct patient care may mean that this is not the case and there are implications for quality. Without regulation, there are no nationally agreed standards of education, nor a code of conduct. Not all care assistants will have accessed National Vocational Qualifications in care nor have received sufficient work-based rehabilitation specific education, supervision or mentorship (Hand 2011).

It is vital that this valuable group of care workers are recognised for their contribution and supported to continue to improve the rehabilitation opportunities for patients in hospital. For example, care assistants should be fully involved in team communication processes, rather than being excluded from team meetings and case conferences. At the same time, it is essential that registered nurses working in rehabilitation practice continue to positively influence the patient's rehabilitation and be recognised for this, lest they are substituted for 'cheaper' labour. As boundaries between groups of health care workers shift further, it is essential that skill mix

decisions are made on the basis of how best to meet patient's needs, rather than cost cutting measures.

Nurses' and care assistants' perceptions of hospital moving and handling policy may need to be challenged. It is possible that misinterpretation of the policy stemming from the reliance on 'oral transmission' has meant that some nurses have lost confidence in their role and responsibility in relation to patients' mobility rehabilitation needs.

Although messages relating to patient handling have changed in recent years, taking into account patient choice and dignity with a 'safe handling' approach now advocated, the highly influential and initially helpful 'no-lifting' mantra continues to echo in the oral culture of nursing. This echo from the past may inhibit current nursing contributions to mobility rehabilitation. At its worst extreme, nurses may avoid moving and handling patients, leading to patients' needs being neglected. More realistic messages must continue to be promoted. Whilst one would not argue against a focus on patient and staff safety, it is important that the core values of a rehabilitation approach are also reaffirmed. The importance of mobility and movement to patients' wellbeing should be emphasised and strategies to promote mobility should be incorporated into education courses and practice settings.

Current discourse identifies the high status of the 'patient safety movement' (Richardson and Storr 2010). Nurses are viewed as ideally placed to lead this agenda to improve quality in health care. The phenomenon of 'hospital induced deconditioning' in older adults could sensibly be identified as a source of hospital induced iatrogenesis. In this light, low mobility in older adults could be the target of nurse-led patient safety initiatives. This would redirect the nursing focus from an 'avoidance' approach, towards an active role in implementing intentional strategies to promote mobility.

Some respondents believed that hospital policy stifled their contribution to rehabilitation and failed to reflect the realities of rehabilitation work. Indeed, policies do exist in some national health organisations which dictate that nurses should not engage in therapeutic handling. It is vital that policy makers explore with

practitioners the nuances of practice and ensure that these can be encompassed within the policy. If this is not achieved, practices may become stifled and secretive and staff may become alienated from the organisation.

The negotiated order between nurses and physiotherapists relating to movement and mobility has implications for nursing practice and nursing knowledge. Whilst elevating the status of the physiotherapist and accepting a subservient position in the hierarchy of professionals relieves the nurse of one area of responsibility, it also limits her/his role, and professional agency. By being passive, the nurse loses responsibility for assessment and decision making regarding moving and handling and mobility and therefore has less influence within the rehabilitation team. For nurses to increase their involvement in mobility rehabilitation, a number of changes would need to occur. The negotiation context of the rehabilitation team would need to become more progressive to enable nurses, care assistants and physiotherapists to work much more closely together regarding patients' mobility rehabilitation.

The boundary line in relation to patient handling needs to be re-examined and should remain flexible, dependent on the practitioner's level of knowledge, skill and experience and the patient's need for mobility rehabilitation. That is, for patients who require additional structured support, nurses and care assistants should be encouraged and enabled to do this within the scope of their professional practice and accountability.

The profession of nursing has retreated from a role in mobility rehabilitation. Rather than being the result of the actions of individual nurses (at the micro-level of the rehabilitation team), the cause of this retreat stems from the response of the nursing profession (at macro-level), to manual handling legislation. Eradicating unnecessary manual handling and increasing the use of handling equipment has been aimed at complying with health and safety legislation. The potential effect of reducing back injury also meets another important target for the profession - retaining members and increasing recruitment. This goal is congruent with the needs of health care employers. As a by-product, it may also reduce costs incurred by compensation and litigation claims arising from manual handling injuries.

A perhaps unintended outcome of these developments however, is that the profession of nursing has turned its attention away from a commitment to physical rehabilitation, delivering this sphere of rehabilitation practice into the domain of physiotherapy. The result is that nurses working in rehabilitation risk becoming deskilled. It is vital that nurses are supported to keep pace with emerging evidence on ways to support mobility in order to prevent hospital related deconditioning in older adults. Although current teamwork practices may serve the needs and requirements of the nursing and physiotherapy professions and health care organisations, it may not serve the needs of patients. Lack of role and skill sharing and joint working between nurses and therapists may well slow down the rehabilitation process.

Strong leadership will be needed to change elements of the non-negotiated order of current rehabilitation practice. Innovation in practice often requires a change in behaviour such as stopping or modifying current practice, and changing views and beliefs. Any attempt to alter practice will be dependent on the functioning of the entire rehabilitation team (and the sub-teams within it). Leadership and management support will be essential in presenting a rationale for change, in increasing the level of shared focus of the team(s) and in encouraging open communication and problem solving (Holleman et al. 2009). In particular, whilst it is understandable for nurses' default to the role of non-expert in relation to mobility rehabilitation (whilst attributing the role of expert to the physiotherapist), this is not helpful to patients' rehabilitation. More in-depth conversations and interactions are needed between nurses and physiotherapists, to enable the responsibility for maximising patients' rehabilitation potential to be better shared. Individual nurses and care assistants need to take on a much stronger role in supporting and promoting patients' rehabilitation. This will open up the potential for nurses to begin to drive the implementation of intentional evidence based mobilisation programmes advocated in the literature (Hoijsben-Schoenmakers et al. 2009).

The role of the ward sister or charge nurse has the potential to make significant contributions to leadership within hospital rehabilitation settings. These post holders will be influential by setting standards and by acting as rehabilitation nursing experts and role models. The supervision and monitoring of care provision will also be increasingly important in ensuring quality is upheld, given the close surveillance

currently applied to the profession. As efficiency measures are implemented within health care organisations, ward sisters/charge nurses will need to be able to analyse patient flow, dependency levels, care needs and workload using recognised assessment tools. Being able to present rational arguments for sufficient staff and skill mix will be essential if innovations are to be implemented. The ward sister/charge nurse should also be central to creating a culture of learning and development where ongoing constructive feedback is provided to rehabilitation team members. To achieve these aspirations however, these crucial individuals must have time and space to actively lead, rather than being counted in regular staff numbers and becoming embroiled in daily patient care (Kendall-Raynor 2011, RCN 2009)

8.5 Implications for Research

Further research is required to examine whether the grounded theory presented here is reflected in other rehabilitation settings. This would establish the relevance of this study more widely.

The current evidence base offers little guidance to hospital based nurses regarding mobility rehabilitation. A weak and incoherent evidence base and lack of clear guidance on how best to promote mobility rehabilitation contributes to nurses paying only limited attention to this aspect of patient need. Updating Kneafsey (2007) systematic review which explored the content and quality of the evidence regarding nurses' interventions to promote mobility rehabilitation, would be beneficial, taking a more specific focus on those key interventions identified by Miller et al. (2010) (described on page 30).

Future studies should also identify the most effective contributions that nurses and care assistants could make to promote patients' mobility, within a range of different rehabilitation settings and varying models of rehabilitation teamwork. For example, whilst walking and exercise programmes may be of benefit to patients, research is needed to identify the most effective combinations of these interventions with the greatest impact on patients' outcomes. Questions such as 'what work best, how much intervention is needed and who can deliver the intervention?' must be asked. Taking those activities identified by Miller (2010) as a starting point, comparison studies

could be developed to compare the impact of different ‘doses’ of intervention to identify the optimal level of input required to affect patient outcome. Once the most effective strategies have been identified, feasibility studies are then needed to evaluate how these can be translated into practice and who would be best able to implement them.

Whilst the negotiated order suited the needs of the organisation and the routine of care, it was unclear whether the negotiated order met the needs of patients. This question could not be answered by the present study but indicates a need for further research to explore patients’ experiences of patient handling and mobility rehabilitation.

Nurses and care assistants argued that time pressures interfered with the rehabilitation process. This led to some nurses experiencing moral distress. Future research should explore how staffing ratios impact on the proportion of time nurses and care assistants spend coaching and interacting with patients and the impact on patient outcomes. Future research should also explore what effect risk aversion has on nurses’ level of engagement with patient handling and mobility rehabilitation activities.

In the settings studied, care assistants delivered much of the patient’s direct care. It would be of value to examine more closely how care assistants contribute to multiprofessional rehabilitation input. Further research is needed to explore what educational support care assistants most need for this role.

Participants identified that using equipment to move patients caused a range of discomforts. It is important to examine from nurses’ perspectives how using equipment impacts on wellbeing. Close working with manufacturers could also ascertain whether design improvements and new technologies could improve equipment comfort and usability.

8.6 Implications for Education

The extent to which the nurse follows a rehabilitation philosophy will influence whether he/she values a role in promoting patients' mobility rehabilitation and the extent to which intentional strategies are employed to do this. Many of those interviewed seemed content with a maintenance role and showed little interest in fuller involvement in therapy activities. Whilst workplace pressures may hinder nurses from engaging in rehabilitation activities, nurses should have access to education to provide further insight regarding the specific contributions that they could make to the therapeutic milieu and patients' rehabilitation goals.

Nurses' pre-registration education in relation to the handling of patients focuses primarily on handling to maintain safety. Little or no attention is given towards strategies to promote mobility rehabilitation. This is because the main avenue via which nurses receive education regarding patient handling and mobility rehabilitation is via mandatory training in manual handling. The purpose of this training is to ensure adherence to moving and handling policy. If nurses are to engage in a fuller role in rehabilitation, specialist education is needed to support the application of evidence based approaches to rehabilitation practice and specifically mobility rehabilitation.

As McKenna and Hasson (2004) note, a difficulty for registered nurses is that they are held responsible for care that they do not provide or supervise. Although registered nurses are responsible and accountable for planning, implementing and evaluating nursing care, much of the hands on delivery is delegated to care assistants. At present, this part of the workforce does not have a clearly defined training. As recently advocated by Randall (2011), it is vital that this valuable staff resource and the wealth of experience and skills encompassed by this group is properly harnessed and further developed. Care assistants working in rehabilitation settings should receive applied education and training in rehabilitation processes and practices.

Nursing lecturers may be ill equipped to teach nurses beyond the boundaries of a care handling approach, being uneducated themselves regarding therapeutic handling and movement. Discipline specific knowledge that has largely been encompassed by the physiotherapy profession and removed from nursing curricula may need to be

reincorporated into pre-registration nursing education programmes. Nurses need to be taught about the motor relearning approach, functional rehabilitation strategies, and ways to implement walking and exercise programmes as well as keeping abreast of current research developments in the field.

8.7 Evaluation of the Study

Since the reflexive turn in the 1960s, doubts have been raised about the relevance of evaluating qualitative studies using the traditional criteria of validity, reliability and generalisability (Annels 1999, Altheide and Johnson 1994). However, numerous authors do provide guidance on ways to assess qualitative research (e.g. Brewer 2000, Hammerseley 1992, Seale 1994). Lincoln and Guba (1999) established four criteria for assessing the trustworthiness of naturalistic studies: credibility, transferability, dependability and confirmability. The following section considers the quality of the present study in relation to these dimensions. It also clarifies the contribution to knowledge that this study has made.

8.7.1 Evaluating the Trustworthiness of the Study

The credibility of a study relates to the extent to which the descriptions offered within the study are believable, sufficiently vivid and recognisable to those familiar with the field of study (Beck 1993). Credibility may be assessed by examining whether; prolonged involvement within the field took place; whether observations were consistent; whether data were triangulated; whether member checks were undertaken and whether a reflexive account is provided (Lincoln and Guba 1999).

In this study, great care was taken to establish rapport with the research participants and several visits were made to the sites before data collection occurred. Data collection took place over a period of weeks to enable me to ensure that observations were consistent and could be led by the ongoing process of analysis and constant comparison. This ensured that theoretical sampling approaches could be incorporated into the fieldwork. The collection of interview and observational data also made triangulation possible and provided further opportunities for constant comparison and allowed for the possibility of ‘converging lines of enquiry’ to emerge (Yin 1993,

p98). Each interview participant was sent a copy of their transcript with a letter asking for any comments or queries. At the conclusion of fieldwork, a summary of findings was drawn together and sent to the case study settings. A request for feedback and comment was made though none was received. Throughout the study, a reflexive approach was taken. This enabled me to take into account my own prior life experience and perspectives and the way in which they might influence data analysis and interpretations derived therein.

Charmaz (2006) recommends that the ‘credibility’ of grounded theory studies should be evaluated by examining the logic and conceptual ordering within the analysis processes. This study moved through a systematic process of open coding, focused coding, conceptualising and theory building (p79). The achievement of conceptual clarity was also assisted through the development of relational statements (appendix 14, page 264) and a ‘situational analysis’ approach (appendices 15 and 16, page 267-8). Together, these processes enabled the study to achieve a high level of abstraction, in order to generate both a set of findings and a grounded theory with the ability to provide an understanding and account for the findings.

‘Transferability’ relates to whether a study is repeatable within a new context and so examines the nature of sampling and whether a comprehensive explanation of context is provided. By providing a description of the settings (p87), details of the sample characteristics (appendix 10, page 257) and observational data (appendix 9, page 254) and copious raw data within the thesis, readers will be better able to discern the relevance of the data for themselves and their work setting. The extent to which the case study findings can be generalised was maximised by undertaking three case studies with justification for the selection of each to enable analytic generalisability. The reliability of the study was enhanced by drawing on a case study protocol which structured my activities in the field whilst allowing scope to respond to the emergent nature of grounded theory. This also allowed me to maintain a case study database. The case study protocol included the guiding research questions, information sheets, consent forms, interview and observational schedule, previous fieldwork notes, memos and reflexive comments.

The dependability of a study relies on there being clarity about decisions being made during the study, that data collection and sampling is rigorous and that the categories and conclusions drawn from the data presented are clear. For each case study site a clear audit trail was created to provide clarity regarding how data were used to generate major codes and categories (see appendix 21, page 280). It was also important to provide a clear explanation of how data were analysed (see figure 3, page 79) and how codes and categories were derived (see appendices 11, 19 and 20, pages 259, 272 and 274)

Deciding the overall confirmability of a study is achieved by analysing the previous three criteria. My own evaluation of the study indicates that this research was methodologically credible resulting in a set of findings of relevance and interest to nurses, therapists, educators and policy makers.

8.7.2 Contribution to Knowledge

The uni-professional nature of previous rehabilitation research has been criticised. It is argued that within the context of a multi-professional team, it is not possible to disentangle how the interventions of one staff group affect specific patient outcomes. This is because the patients' recovery will be influenced by the combined contributions of the whole team (Wade 2005). However, whilst this perspective is acknowledged the specific focus on registered nurse and care assistant contributions to mobility rehabilitation can be justified.

Whilst many authors have promoted the idea that nurses could and should engage in an extended range of rehabilitation activities, there has until now existed little good quality evidence regarding how this has been translated into practice. Although a number of studies have attempted to describe the nursing contribution to rehabilitation processes in general, none has focused specifically on mobility rehabilitation. There is also a paucity of research examining the contribution of care assistants to the rehabilitation process. This study has been able to explore what nurses and care assistants actually contribute to patients' mobility rehabilitation. It has also been able to explain the reasons for the patterns observed in nursing work practices. In addition, the study has allowed for comparisons to be made between what is espoused in the

literature regarding what nurses should do to assist patients' mobility and what actually takes place in the naturalistic hospital setting. The findings of this study have been used to develop a detailed set of implications and recommendations for rehabilitation practice, nursing education and research.

8.7.3 Study Limitations

This study was based on the assumption that social reality does not exist independent of human action, but is created through the interaction of individuals with each other, with society and within structure. Thus, research outputs are not a direct reporting of the respondent's reality, but a 'rendering, one interpretation among multiple interpretations, of a shared or individual reality' (Charmaz 2000, p523). This alone may be considered by some to be a crucial limitation to the quality of this study.

This study was focused on hospital based nursing and so cannot speak for the activities of nurses and care assistants working within community services. Their activities and interactions with the wider rehabilitation team may be very different. It is also not possible to be certain that the findings of this study reflect the activities of nurses working in other hospital rehabilitation environments. Although there was no reason to believe that the case study settings were peculiar or significantly atypical, it is possible that the negotiated orders exposed and patterns of working described in the study sites were unique to only these three rehabilitation units.

A final comment is required on the apparent separation that has developed in this study between the provision of physical and psychological care in relation to mobility rehabilitation. Many studies have highlighted the importance of registered nurses' interpersonal skills, which enable them to listen effectively, empathise and build trusting relationships with patients, thus empowering patients to actively participate in their own care and treatment (Larsson et al. 2007). For example, Sahlsten et al's. (2009) study of patient participation, involving interviews with twenty Swedish patients highlights the importance of nurses 'knowing' the patient and building co-operative relationships in order to reinforce their self care ability. Whilst the present study focused on *physical* rehabilitation, this was largely because of what was happening in practice, which directed what was observed. The grounded theory

presented herein is based on empirical data, rather than espoused theories of nursing care. Minimal observational data was collected to confirm the registered nurses' role in providing emotional and psychological support or the utilisation of interpersonal skills to promote patient participation in rehabilitation. Only in the stroke unit data (case study 3) did this theme arise with any clarity.

The current study does not seek to undermine the importance of psychological care, particularly in relation to the development of the therapeutic milieu. Indeed, part of the registered nurse's role in mobility rehabilitation should be to blend the provision of psychological care with physical care in order to generate a climate of trust and autonomy which promotes the patient's participation. It was perhaps beyond the scope of this study to capture all that occurred in relation to mobility rehabilitation, given the complex nature of the nursing role. It is possible that because the initial observational schedule devised did not specifically draw attention to observing the nurse's contribution to emotional care, that I overlooked nursing activities of this nature.

The lack of emphasis within the grounded theory on nurses' use of interpersonal skills to provide psychological care perhaps confirm the conclusions of previous research exploring service user perspectives. These studies have revealed that patients often perceive that nurses' lack the time to stop and talk, listen and build therapeutic relationships (Long et al. 2001, Attree 2001). This study did not explore the experiences of patients or their family members. It may be that their view on the rehabilitation process is very different to that described and explained in this study. The patient voice may tell a different story of how movement and mobility is regained, indicating a need for further research.

8.8 Final Conclusion

This study was based on the underpinning assumption that nurses and care assistants do contribute to patients' mobility rehabilitation in some shape or form. However, the nature of this contribution remained unclear. This study therefore examined the processes in which nurses and care assistants engaged in order to assist patients. It sought also to gain an understanding of the factors which influence the way in which

nurses and care assistants contribute to mobility rehabilitation. The findings of the study confirm that nurses and care assistants do indeed make important contributions to the process of rehabilitation and in assisting patients to become mobile again after illness and trauma. This contribution generally involved helping patients to achieve A to B transfers, rather than other specific approaches to mobility rehabilitation. Clear differences between the roles and interventions of registered nurses versus care assistants regarding this sphere of practice were not identified.

It is argued within this thesis that at the present time, nurses and care assistants lack the knowledge, skills and awareness to extend their role in relation to mobility rehabilitation. In addition, although an enhanced role in mobility rehabilitation could theoretically encompass structured therapy carry-over activities and other intentional strategies, nurses and care assistants work in an environment which is not conducive to such accompaniments. As well as a lack of time to implement supplementary interventions, present teamworking arrangements and role boundaries between nurses, care assistants and therapists do not support further developments in rehabilitation nursing. Significant changes in both the micro and macro context for practice would need to occur to enable nurses and care assistants to engage more fully in the processes of mobility rehabilitation. The now limited attention given to this aspect of the hospitalised patient's recovery could be viewed as a source of iatrogenic harm (Wade 2009).

A number of factors limit nurses' desire, willingness and ability to take decisions and plan specific interventions regarding patients' mobility rehabilitation. First and foremost, nurses have limited formal or work based opportunities to learn and gain knowledge about mobility rehabilitation. The perceived expertise of the physiotherapists and relative non-expert status of the nurse by comparison limits the nurse's willingness to make decisions. Nurses' fear of sustaining a musculo-skeletal injury, the concern that they may place the patient at risk, and anxiety about being blamed for an untoward incident, also inhibits nurses from making decisions relating to patient's mobility rehabilitation.

The dominant discourse in relation to nurses' patient handling activities revolves around the concept of 'safety.' This powerful movement and its associated rhetoric,

alongside the entrenched nature of negotiated orders in rehabilitation, have created and shaped a version of nursing work where there is little room for a role in promoting mobility rehabilitation. Nurses and care assistants are acutely aware that they must avoid risks and protect patient safety. These requirements reflect the legal and professional mandate to which their compliance is enforced through the application of hospital policies for patient handling. Registered nurses must be responsible and will be held accountable for their actions. In this environment registered nurses will be unlikely to focus their efforts on expanding their limited role in mobility rehabilitation.

Much of the patient handling work observed was routinely undertaken by care assistants. Patients were moved, or practised mobility as a by-product of other care activities. Given this, it is not surprising that registered nurses were not observed to engage in coaching the patient specifically with movement and mobility. For the care assistants, their only education for this aspect of practice came from mandatory moving and handling training and the experience they gained in the workplace. Their role in implementing rehabilitation programmes and making decisions about patients' mobility rehabilitation was not transparent. In addition, physiotherapy tended to occur in gyms or behind curtains and rarely involved nurses or care assistants. A work context characterised by divided work practices and delegation of activities to care assistants will not support registered nurses engaging in a structured approach to mobility rehabilitation or an extended role in therapy integration. The implication for patients is that their rehabilitation potential may not be fully achieved.

Appendix 1

Literature Search and Review Methods

The literature search and review were largely carried out after research fieldwork had been completed. The literature review chapter presented within this thesis was constructed on the basis of a 'systematised approach' to literature searching and reviewing. Traditional narrative reviews are now viewed as biased and 'subjective' sources of evidence, as they are 'largely constructed using selected materials to support pre-existing conclusions (p1).' (ScHARR 1996). Whilst chapter 2 does not claim the status of a 'systematic review', particular efforts have been made to strengthen the validity of the conclusions drawn from the review.

Brette and Grant (2003), identify 6 stages to a literature search including clarifying the search question; identifying important components for searching; translating concepts into terms used by the database; identifying synonyms used to describe the concepts; combining terms; and reviewing results. Four key questions shaped the literature review as follows:

1. What is known about the role of the nurse in relation to rehabilitation?
2. What is known about the nurse's contribution to multi-professional rehabilitation teamworking?
3. What is known about the nurse's contribution to therapeutic patient handling activities and mobility rehabilitation?
4. What is the legislative, policy and professional context for mobility rehabilitation and patient handling activities?

The search strategy involved searching a range of sources. Medline (1980-2010), CINAHL (1980-2010), AMED (1990-2010), and dissertation abstracts were searched. Other grey literature was also searched for via the PhD Thesis Index and National Research Register. Subject experts were contacted to identify research in progress or grey literature. A range of professional organisations were accessed such as the Royal College of Nursing and the Chartered Society for Physiotherapy, the American Association of Rehabilitation Nurses, and the Australasian Rehabilitation Nurses Association. In many ways the search strategy resembled a snowball sampling

approach (Greenhalgh and Peacock 200). That is, the search strategy developed according to the requirements of the study and responded to the literature already retrieved.

Although one disadvantage of searching both Medline and Cinahl is the identification of duplicates a dual approach was preferred as Medline is suggested to have a higher sensitivity and Cinahl is thought to have a higher positive prediction rate (Brazier and Cecily 1994). Used together, it was envisaged that the sensitivity of the search process would be maximised. That is, a high percentage of papers would be detected initially, even though a number of these may be inappropriate, to eventually yield a maximum number of relevant retrievals after filtering.

Identifying Key Terms/Subject/Mesh Headings:

The search strategy aimed to maximise retrieval of relevant documents and minimise retrieval of irrelevant documents (ScHARR 1996) to attain a balance between high recall and high precision. As such, a combined search of free text terms (those assigned by the author and located in the title or abstract) and subject headings (assignment by the database indexer) was used. Mesh headings were used to lend greater focus to the search. To account for variations in the indexing approach of different databases, individualised search strategies were developed for each source.

A set of key terms and synonyms were identified to search for the population (e.g. rehabilitation nurses, nurses, nursing staff, gerontological nurses, elderly care nurses) using wildcards and truncation as appropriate. A range of terms were then identified regarding patient handling activities (e.g. patient handling, manual handling, patient lifting, therapeutic patient handling, rehabilitation patient handling, transferring, patient handling policies, no-lifting policies, therapeutic handling policies) and mobility rehabilitation activities (e.g. positioning, passive exercises, walking, movement, mobilising, mobilizing, gait, muscle tone, physical therapy, physiotherapy). Terms were also identified to search in relation to teamworking (e.g. teamworking, team-working, multi-professional, inter-professional, interdisciplinary, transdisciplinary, role blurring, role sharing, rehabilitation teams). Terms were grouped using OR and then the different sets of terms were combined with AND.

Some limits to the database searches were applied, mainly to retrieve only English language papers referring to adult rehabilitation practice.

Types of evidence included:

Systematic reviews have traditionally focused on quantitative research and commonly set minimum study quality thresholds which define the weakest design acceptable within the review (Khan et al. 2003). However, for the purpose of this literature review, it was decided that all studies relating to the research question would be included, irrespective of the type of the design. It is recognised that informational literature informs the practical decisions which people make on a daily and longer term basis (May 1993). These literature also provide potentially important representations of the reality of practice and 'received wisdom' within the professional world of nursing (Scott 1990). As such, evidence from professional bodies were also accessed.

Retrieving articles:

For a literature review to draw conclusions based on the highest quality evidence available, standardised processes should be used to select studies from the large volume often identified by the search (Glasziou et al. 2001). As such, the titles and abstracts of search retrievals were scrutinised to identify whether they related to the search question (relevance). Articles were identified as either being included in the review, excluded from the review, or requiring further consideration. Potentially relevant papers were then accessed from the library, or via inter-library loans, read and checked against the inclusion and exclusion criteria shown below (Glasziou et al. 2001). No articles were rejected on the basis of research design alone.

Inclusion criteria and Exclusion Criteria:

To be included in the review, the evidence needed to be relevant to one of the four initial literature search questions. It also needed to be written in English and published since 1980. Research studies using both qualitative and quantitative methods were included as long as they in some way informed a discussion in relation to the search questions. Papers about community nursing roles in relation to rehabilitation were excluded as these were not deemed to be relevant to the hospital focus of the study. The study focused on adult, general nursing and articles relating to

wandering behaviours of dementia patients were therefore excluded. Articles referring to exercise and physical activity in a health promotion rather than rehabilitation context were also omitted. Papers relating to falls and falls prevention were also excluded as these were not deemed directly relevant to the search questions.

Appraisal Process

Unstructured appraisals of evidence may lead to over-critical assessments or over-enthusiastic endorsements of study quality (Glasziou et al (2001). As such, all included papers were subjected to a structured appraisal using quality checklists to identify the strengths and limitations of research located (ScHARR 1996). Whilst critical appraisal tools help to ensure the research process is transparent and structured, readers must still employ their own intellectual capacities during this process (ScHARR 1996). It is also accepted that whilst such tools reduce some elements of bias, the reader's assessment of study quality will still ultimately be a subjective judgement (Long and Godfrey 2001, 2004).

A validated critical appraisal tool for quantitative and qualitative research designs was used (Health Care Practice Research and Development Unit 2001). This tool contains six sub-sections: study evaluative overview; study, setting and sample; ethics; group comparability and outcome measurement; policy and practice implications; and other comments. Critical appraisal was used to identify the extent to which the design, conduct and analysis reduced sources of bias and maximised validity and reliability.

Appendix 2: Summary of research studies reviewed exploring the place of nursing within the rehabilitation process (in chronological order)

Author/ Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Reed (1993)	To examine how nurses assessed the mobility needs of elderly patients	Observation of nurses' assessment practices and interviews with 34 nurses. 14 observations per ward from 7.30 am until 9.30 pm. 3 care of the elderly wards in one hospital. Observations recorded on a checklist to specify nurses' activities.	Nurses valued physiotherapy as it was seen to 'help them' with nursing work. Nurses lacked knowledge of physiotherapy and a clear divide existed between the nursing and physiotherapy roles. Team tensions emerged related to physiotherapy hours and lack of weekend cover.	Extensive data collection. Focus of data collection was on nurses and the views of physiotherapists were not sought. These would have added a further dimension to the study findings. However, on their own the findings shed light on teamworking relations.
Ellul et. al. (1993)	To explore how patients in rehabilitation wards spend their time when not being attended to by therapists.	All (n=51) patients surveyed on four wards in one rehabilitation facility. Patients observed every half hour between hours of 8 am and 5pm. 3 observers and inter-reliability check carried out. 4000 observations completed. Intervention programme designed – consisted of activities and exercises.	In pre-test phase, patients spent 70% of time engaged in non-rehabilitation activity. Post-intervention saw a 55% increase in the time patients spent engaged in 'on the ward rehabilitation activities. Identifies the difficulty in retaining a change in practices, due to staff turnover and difficulties implementing activation programme due to porters' refusal to transport patients.	Half hourly observations mean that some activities would have been missed, having taken perhaps 5, 10, 15 or 20 minutes to complete during the 30 minute window of observation. 'Talking to staff/relatives/patients' and 'nursing procedures' classified as non-rehabilitation activities. Rehabilitation activities related to physical activities revolving around movement.
Strasser et. al. (1994)	To explore staff perceptions of key aspects of the rehabilitation process	Survey of 113 staff from inpatient teams. Three outcomes measures used: Ward Atmosphere Scale; the Group Environment Scale; and the Interprofessional Relations Scale	1 in 5 staff felt that colleagues were defensive about their professional expertise and judgement. Half of participants felt that other professionals encroached on their territory.	Use of validated outcome measures an effective means of collecting empirical data amenable to statistical analysis. Quantitative nature of study design means that it is not possible to gain insight into the reasons for the results. US study.

Author/ Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Brillhard & Sills (1994)	To identify the roles and responsibilities of registered nurses and rehabilitation technicians in one rehabilitation facility.	Work diaries, n=6 RGN's and n=4 rehabilitation technicians over 58 shifts for RGN's (44 day, 14 evening) and 59 shifts for technicians (32 day, 27 evening)	Direct patient care encompassed almost 50% of registered nurses time, indirect patient care involved up to 38% of the time and 6-9% of time spent on unit maintenance.	Small sample size, study conducted in the USA. Diaries relied on self report and self timing of activities. It is possible that recording was not accurate. Recordings by both groups differed – more evening shifts documented by technicians. Comparisons therefore not appropriate between groups.
Waters & Luker (1996)	To explore team members' understanding of rehabilitation.	Qualitative, interview based case study of two rehabilitation wards for elderly patients, involving 56 staff interviews.	Nurses not perceived to be the driving force of rehabilitation. Nursing work was identified as falling into four categories: general maintenance; continence; prevention and management of pressure sores and 'carry-on' work	Insightful and rich in detail. Sample included nurses from a range of grades and positions, as well as therapy and medical staff. However, data is context specific. No detail is provided regarding the ward settings which comprised the 'cases', thus limiting the generalisability of the results.
Kirkevold (1997)	To develop a theoretical perspective on the role of nursing in stroke rehabilitation.	Based on a number of research studies in stroke care nursing, but one in particular which involved observation of direct care and interviews with nurses on one unit over a three month period	Describes four therapeutic nursing functions: Interpretive function: helping patients/family to understand ramifications Consoling function: emotional support Conserving function: maintaining normal functions, preventing complications Integrative function: helping patients to integrate learned activities into daily activities.	The ideas presented in the paper are unique and clearly presented, including a critique of previous research. However, the paper accessed does not elaborate specifically on the data set from which the theoretical perspective presented is derived. For example, the stroke setting itself is not described, nor the sample characteristics or number of interviews.

Author/ Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Newall (1997)	To investigate the types of rehabilitation activities occurring on a rehabilitation ward and to examine changes in patients' behaviour post intervention.	Five, one week observational periods conducted over 2 years with 67 patients' observed. Total of 3447 observations completed. Observations initially completed hourly and then half hourly as some activities were being missed.	Patients on average spent 43 minutes with therapists (9% of day). New rehabilitation environment led to a decrease in the amount of time patients' spend by bed-side or gazing passively. 31% of the 'working day' spend on 'basic care and ADLs' (washing, dressing, eating, drinking, mobility) and contact with other staff (eg nurses and doctors). Less than 1% of time spent on 'therapy homework'.	Good levels of inter-rater reliability. Rehabilitation equated with therapy and therapists, disregarding nursing contribution. Reliance on observation alone may mean that interpretations derived from the data are inaccurate. Results context specific but indicative of potential to increase patients' engagement in meaningful and beneficial activities.
Jones et. al. (1998)	To examine whether a teaching package can improve nurses' knowledge of and practices of positioning of stroke patients.	Non-equivalent control group design. Conducted on 2 stroke rehabilitation wards and 4 general medical wards randomly allocated to either E or I groups. 116 nurses included and completed questionnaires and 38 patients observed for positioning.	Significant differences between the registered nurses in E and C groups in knowledge of stroke and positioning post intervention. Also significant improvements in 8 elements of patients' positioning post intervention on the E wards.	Well designed, adequate sample size, groups similar for important variables, wide range of data collection measures and valuable results achieved. Some gaps in data collection. For example, 674 observations recorded for E group and 326 for C group. May limit the external validity of the study. Feasibility of the enhanced nursing role not discussed.
Gibbon (1999)	To examine the processes occurring within rehabilitation team conferences for stroke patients	Observation of team conferences (3 in a stroke rehabilitation unit and 2 in an acute stroke unit), 111 observations of patient progress discussions.	Greatest contributor to team conference was the physiotherapist and nurse ward manager. Physiotherapists most frequent decision makers. Nurses' fulfil leadership and brokerage role. Identifies that 'team members do not share equality of status and power, but this is part of the rhetoric of teamwork' (p248)	Findings are illustrative though context bound to the two teams studied. Use of the recording schedule limited the opportunity to undertake qualitative observations which may have yielded further understanding.

Author/ Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Hill & Johnson (1999)	To find explanations and patterns in neurological nursing from the perspective of nurses	Interviews with 9 registered nurses working on a specialist neuro-rehabilitation ward.	Three themes identified: Nursing interventions directly related to patient care (promoting independence, routine nursing tasks, management of patient care, counselling of patients). Staff turnover influences nurses' practice. Nurses' beliefs about their role - jack of all trades, 24/7	Findings are believable and have since been confirmed by other studies. However, only a small scale study confined to one study setting. Interviews limited to 40 minutes and may have therefore been quite superficial. Findings limited to the level of description rather than explanation.
Dowswell (2000)	Aimed to identify what factors led to a stroke patient's positioning being adjusted and who was involved in achieving the change in position?	Pre-test, post test one group design. Physio-led training programme for nurses re mobilising, positioning and handling. 27 bed rehabilitation ward. Time sampled, non-participant observation of patients' position. 2288 observations pre-intervention, 2267 post-intervention.	Patient spent on average 26% of time in poor position. A slight decrease in poor positioning post-intervention. The specific a deliberate changing of patients' position by nursing staff in order to improve it was a rare event.	Conducted on one rehabilitation unit and so findings may relate to the quality of nursing care and nurses' knowledge in that specific setting. May therefore not be generalisable. A lack of contextual information regarding setting (eg staffing levels and educational intervention). The effect of poor positioning is not made clear.
O'Connor (2000a)	To identify the patterns of nursing care delivered in stroke units	Survey of stroke units (n=43), visits to 21 and interviews with 90 Registered Nurses	Identified nurses' interventions in care delivery to be related to two themes: Direct care (general care, specific care, rehearsal care) Continuity care: care given as a function of nurses' 24 hour presence. Also discusses the 'mode of care' – facilitative interventions plus non-interventions	Sample size extensive and study results confirm and reflect findings from previous studies. However, only a convenience sample was used as only those present on the day were interviewed. It is possible that this sample did not therefore include the most 'experienced' nurses. The focus of the study is also on 'beliefs' rather than observed events. Views of patients and carers not accessed and so the 'patterns of care' described cannot be confirmed. Limited to stroke care.

Author/ Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
O'Connor (2000b)	To determine the nature of nursing intervention in the rehabilitation of stroke patients	Interviews with 90 nurses from 21 stroke units	Identified 6 themes which encompassed nursing interventions: Focus of care - patient placed at centre stage; Outcomes of care – patient choice important; Direct care – aimed at achieving goals through maintenance, care and rehearsal ; Specific care – care of relatives, psychological care, continence, handling and positioning; Continuity of care, Model of care, Context of care – safe and supportive atmosphere	As above
Singleton (2000)	To describe nurses' perspectives on their interventions to encourage clients to self care in a short term rehabilitation unit.	Ethnographic study of 4 registered nurses working in a 39 bed rehabilitation unit. Data collected over 6 months via participant observation, informal interviews (n=4) and one to one interviews (n=8). USA	5 categories represented how nurses encouraged clients in caring for themselves: Co-ordinating and involving others in carrying out patients' care Talking and communicating with clients Assessing, observing, using trial and error Teaching clients, staff and families Reinforcing with clients	An in-depth study which allowed exploration of nurses' practice and beliefs. However, no description of the setting or the number of hours of observation. Although data is rich, it is possible that the findings are so specific and unique to the four individuals included that they will not translate well to other nurses and settings.
Burton (2000)	To describe nursing practice in stroke rehabilitation	Analysed 35 reflective accounts, provided by 13 rehabilitation nurses working on a 24 bed rehabilitation unit, plus one focus group (n=4).	Three categories to describe nursing role in rehabilitation: Nurse as provider of care (doing, providing and educating); Facilitator of personal recovery (helping, comforting, teaching, working with family/patient); Manager if multi-disciplinary provision	Good description of the rehabilitation unit. Findings verified post-analysis by group of 4 nurses who participated in a focus group. Retrospective information provided by nurses may well have limited validity. Nurses' desire to portray themselves well may mean that the written reflections did not reflect reality - 'espoused practice.'

Author/ Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Booth et. al. (2001)	To identify and compare patient-nurse interaction and patient-occupational therapist interaction.	10 stroke patients selected from stroke unit. Observations of 2 morning care sessions with 10 patients – one with the OT and one with the nurse.	Most frequently used style of interaction between the patient and OT and nurses was supervision. OT's used prompting /instructing and facilitating movement to a greater extent than nursing staff (significant difference in approach)	Data set rather restricted and generalisations cannot be made as findings context bound to small number staff and one setting. However, novel research method that could be applied to other research problems. Observations conducted by a physiotherapist selected because he was neither a nurse, not an OT and would not be affected by professional bias. However, may have held preconceived ideas of the role/activities of OTs and nurses.
Dalley (2001)	To investigate nurses' perceptions of physiotherapists as members of the rehabilitation team.	Semi-structured interviews with 8 nurses drawn from a potential sample of 18 nurses working in two rehabilitation wards in UK hospital.	Physiotherapists' viewed as experts, with a clearly defined role, focused on mobility and function. Patients observed to behave differently for physiotherapists compared to nurses. Physiotherapy knowledge valued but not always available. Some nurses resented task delegation from physiotherapists. All nurses felt that physiotherapy skills could be useful to nurses such as mobilising patients, manual handling, passive exercises and exercise routines. Nurses felt that physiotherapists lacked insight into the demands on nurses and nurses' autonomy in decision making.	Purposive sampling allowed staff with a range of grades and levels of experience to be included. Findings provide valuable insight though cannot necessarily be generalised. Sample very small, though in-depth data gained. The views of physiotherapists themselves not sought which would have added a useful dimension to the results.

Author/ Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Pryor & Smith (2002)	To systematically explore the role of registered nurses working in rehabilitation in Australia.	Qualitative in-depth interviews with 13 registered nurses, on 3 occasions.	Seven domains of practice identified: The rehabilitation approach; The teaching and coaching role; Observation, assessment and interpretation; Administering and monitoring therapeutic interventions; Management of rapidly changing situations; Management, advocacy, and co-ordination; Monitoring and ensuring the quality of health care practice	Interviews approximately 2 hours long indicating depth and sufficient discussion. Interviews were not taped however potentially limiting the quality of the information recorded. Data relies on self report rather than observation of practice. Results descriptive rather than explanatory.
Pryor (2002)	As above	Interviews with Australian registered nurses, n=13 individual interviews, 2 focus groups (n=8 and n= 21)	The paper focuses on one domain of practice 'the rehabilitation approach' which reflects the 'how and why' of nursing practice, rather than the 'what' - the 'style' or 'way' of doing nursing.	As above
Long et. al. (2002)	To identify nurses' actual and desired contributions to meeting rehabilitation patients' needs.	Ethnographic study 49 clients recruited, all interviewed once, plus 21 carers. Interviews with nurses and MDT members (n=88), observation of nursing practice (360 hours) and expert workshops (involved 74 people)	Identified 6 interlinked rehabilitation nursing role: Assessment; Co-ordination and communication; Technical and physical care; Therapy integration and carry-on Emotional support; Involving the family Barriers to role: time, teamwork, skills, knowledge and resources.	Large scale data collection. Conducted in a range of settings in one geographical area of the UK. Data triangulation pointed to coherence across the data increasing the generalisability of the results. Expert workshops also used as a means of authenticating the findings.

Author / Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Long et. al. (2003)	As above	As above	Several factors limited the effectiveness of rehabilitation team working. Nurses had varying perceptions of their role in rehabilitation. Some contrasted the ambiguity of their own role with the perceived role clarity of therapists. Many nurses did not feel their rehabilitation contribution was valued. Role boundaries between nurses and therapists varied with overlap between the different disciplines in some settings. Occasional tensions arose when professionals felt their role was encroached upon. Resource issues limited the rehabilitation approach and nature of teamworking.	As above.
Pellat (2003)	To explore how nurses and patients perceive the nursing role in spinal cord injury	Qualitative interviews: 14 RGNs and 14 patients participated in semi-structured interviews.	Four categories regarding perceptions of the nursing role: the bedrock of rehabilitation; making the transition from acute care philosophy to rehabilitation philosophy; nursing as low profile; caring and nursing power	Purposive, rather than convenience sampling adopted to include both experienced nurses and patients. However, sample derived from only one unit limiting generalisability. No indication given on topic guide for interviews.
Routasalo et. al. (2004)	To describe registered nurses perceptions of geriatric rehabilitation nursing	Survey: Questionnaire distributed to registered nurse in Denmark (n=200), Finland (n=200) and Norway (n=200). Overall response rate of 65%	Nurses did not make a distinction between nursing and rehabilitation (62-75%) All nursing work regarded as rehabilitative (66-88%), nursing helps in the provision of physiotherapy (58-93%), most nurses believed that rehabilitation nursing is aimed at helping patients to move (79-89%), Danish nurses showed most agreement that rehabilitation nursing involves conscious risk taking (67%)	Questionnaire design process involved pilot, revisions and tests for face validity and sensible process for translation. Test for internal consistency reported. Good response rate achieved. Only nurses' perceptions were collected and these must be interpreted as such. Further research needed to observe actual practice.

Author / Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Burton & Gibbon (2005)	To examine the impact of an expanded nursing role providing continuity care to stroke survivors and carers in the community post hospital discharge.	Clinical trial: Specialist nurse visit 2 days after discharge, to include a holistic assessment and follow up visits (n=87) compared to normal care (n = 89)	Intervention associated with improved patient perceptions of general health at 12 months, reduction in negative emotional reactions and perceived social isolation, reduction in deterioration in physical independence.	A unique, and partially successful attempt to link nursing inputs to patient outcomes. However, the author report that the trial was somewhat smaller than anticipated, making it more difficult to achieve sufficient power in the results or detect statistically significant results. Missing data at 3 and 12 months also affected analysis. Also identified is the likelihood that formal outcome measures may not be sensitive enough to detect small improvements in patients' outcomes.
Kvigne et. al. (2005)	To explore nurses' descriptions of the nursing care and rehabilitation of hospitalised female stroke survivors	Phenomenological study involving interviews with 14 Norwegian rehabilitation nurses	Nurses focused mainly on functional and practical aspects of women's situation Rehabilitation was viewed from a professional rather than patient point of view Rehabilitation nursing care was mainly gender neutral.	Reliance on interview data may have limited the scope of the findings. Observation of nurses' practice may have revealed a wider range of activities, or revealed tacit knowledge and understandings in relation to gender and care after stroke. Results derived from two locale in Norway which may have implications for generalisability.

Author / Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Pryor (2007)	As above		'Role ambiguity' identified as a key concern for rehabilitation nurses. Three factors contributed to role ambiguity. Nurses learnt on the job, the roles of registered and enrolled nurses were not discriminated and there was difficulty articulating the registered nurses role in rehabilitation.	
Barecca & Wilkins (2008)	Explore the perceptions', and feelings of nurses' providing care to people admitted to a stroke rehabilitation unit.	Phenomenology, n=8 nurses	6 key themes: nurses enjoyed providing care to stroke survivors; they described their role as pivotal to the rehabilitation process; nurses found it difficult to let patients struggle; lack of time and resources were viewed as a hindrance to their ability to apply a rehabilitation approach to nursing care; nurses felt their rehabilitation role was devalued by others.	Rich data but transferability limited due to small sample size, and also from a Canadian setting. Sample composed of 8 volunteers out of a potential sample of 49 staff in the unit, so those included likely to have a particular interest in rehabilitation nursing.
Pryor (2008a)	To explain how nurses contribute to inpatient rehabilitation.	Grounded theory design, observation and interviews with 53 nurses working across 5 rehabilitation sites.	Nurses contribute to outpatient rehabilitation by coaching patients to self care. Dividing and divided work practices between allied health and nursing limit the extent to which nurses can contribute. Segregation of nursing staff and perceptions of role ambiguity meant nursing and allied health staff rarely worked together. Nurses largely responded to this by distancing themselves from teamworking issues.	An in-depth study conducted across multiple sites and utilising a rigorous set of data collection methods. However, data not collected from patients or therapists which means that findings cannot be challenged or corroborated. In addition, differences between registered and enrolled nurses' strategies were not explicitly explored. The grounded theory approach did not allow the effectiveness of nurses' interventions to be studied.

Author / Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Pryor (2008b)	As above	As above	Three factors contributed to segregation as a contextual condition for rehabilitation nursing: lack of acknowledgement of nursing's complex role: rehab patients and acutely ill patients; divisive work practices: separation in work environment, therapy timetabling, nursing continuous multiple patient load; discontinuous teamwork: ambiguous use of terminology, fragmented team communication, ineffective co-ordination of patients care.	As above
Pryor & O'Connell (2008)	To develop a grounded theory of nursing's contribution to inpatient rehabilitation.	Grounded theory design, observation and interviews with 53 nurses working across 5 rehabilitation sites.	Nurses viewed the primary purpose of rehabilitation to be: facilitating patient self care and increasing independence, helping patients to cope with disabilities and preventing readmission to hospital. Nurses subscribed to 4 over-arching principles: rehabilitation is a continuous process; rehabilitation requires active participation; rehabilitation is goal directed; rehabilitation requires multi-professional teamwork.	As above.
Pryor (2009)	To develop a grounded theory of nursing's contribution to inpatient rehabilitation.	Grounded theory design, observation and interviews with 53 nurses working across 5 rehabilitation sites.	Identified nurses role in 'coaching patients to self care' and therefore as an 'agent of change' . Coaching patients was a three phase activity involving: easing patients into rehabilitation; maximising patient effort; providing graduated assistance ('doing for patients', 'standing by' for patients', and 'providing no assistance.' (similar to Jesters' model of 'enlightened withdrawal' of support in rehabilitation nursing)	As above.

Author / Year	Study Aim	Study Design and Method	Main Findings	Evaluative Comments
Kneafsey & Haigh (2009)	To explore nurses' views on the handling and moving of rehabilitation patients	Questionnaire survey, 3205 questionnaires distributed, 501 returned (response rate of 15.6%)	Nearly all nurses valued their role in promoting mobility rehabilitation. And felt confident in their patient handling skills. Respondents valued physiotherapy and were committed to teamwork in relation to patients handling. 77% reported that 'no-lifting' policies were in place in their workplace. Almost half felt that manually assisting patients was more beneficial than using equipment to move patients.	Poor response rate a limit to generalisability as those who responded are likely to be more interested in the topic than those who chose not to reply. Data relies on nurses' perceptions only, rather than actual practice. However, results provide insight into a neglected area of nursing practice.
Pryor & Buzio (2010)	To describe nurses' experiences and perceptions of a rehabilitation nursing practice development project conducted in one inpatient 38 bed rehabilitation ward in Australia	Implementation of a two phase practice development (PD) project. Phase 1 = two module rehabilitation nursing education programme. Phase 2 implementation of nursing intervention known as 'rehabilitative milieu therapy' for inpatients. Interviews with 21 nurses in three rounds over a period of approx. 1 year	Key finding: The PD project fostered a change in culture and enabled nurses to enhance inpatient rehabilitation through the increased engagement of patients and nurses. Identified key building blocks to the success of the project to be positive staff attitudes towards the project and to rehabilitation and senior nurse support. Nurses led patient activities and production of patient education material provided a 'vehicle for enabling and authorising rehabilitation nursing practice' (p983) and providing identify and authority in the rehabilitation process and the development of further expertise. With high patient acuity however, nurses were less able to engage in patient teaching and coaching activities and were more likely to 'do for.'	Findings derived only from staff interviews and no observation of practice or interviews with patients and carers. These sources may have yielded valuable data. Generalisability limited as practice development project undertaken in only one setting. However, the results maybe useful to other nurse managers seeking to stimulate change in ward based practices. Limited explanation of the tensions which arose between registered and enrolled nurses regarding role blurring and how these were resolved. Good example of practice interventions that may be implemented with no further cost, relying instead in change of working practice. Sufficient detail provided re sample and setting.

Appendix 3:

Finding a field-work location - questions discussed over the telephone with ward managers of potential fieldwork sites.

Introduction: Spend time explaining the project – purpose of project is to explore the following research questions:

- To describe nurses' and care assistants' contributions to patients' mobility rehabilitation.
- To examine how nurses' and care assistants' mobility rehabilitation/patient handling activities contribute to rehabilitation teamwork.
- To explore the impact of NHS patient handling policies on nurses' and care assistants' contributions to mobility rehabilitation.

Progress so far:

National questionnaire survey sent to 3205 nurses. 501 nurses returned their questionnaire. The questionnaire was designed to find out about nurses views on how to meet rehabilitation patients' moving and handling needs and promote mobility and movement. Now following up on the 36 who said it was ok to contact them again – you indicated in the survey that you would be willing to be contacted again – does that still stand? Trying to find a field work site where a therapeutic handling policy is being used.

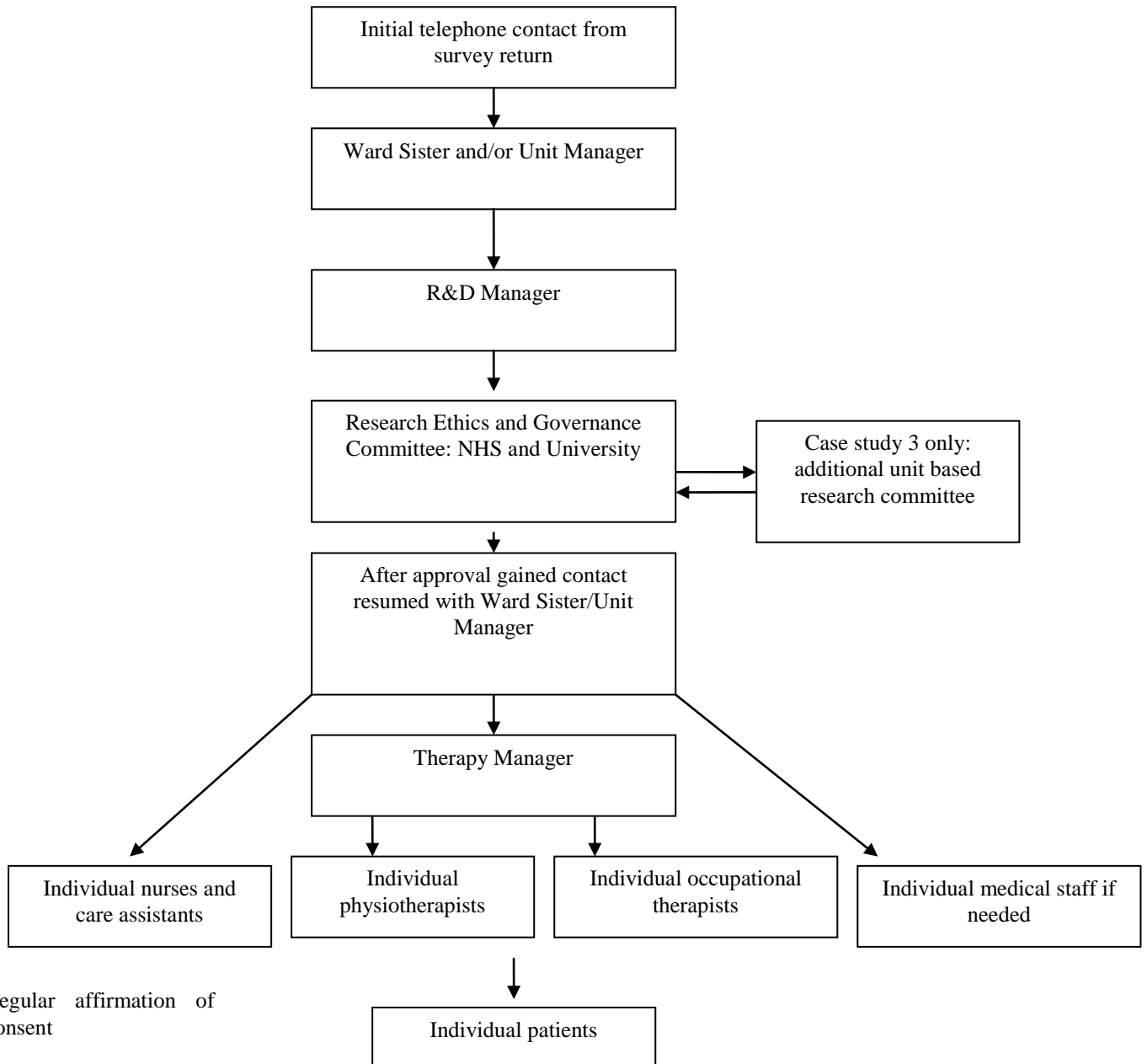
Scoping questions:

- Where do you work?
- What type of patient?
- What type of teamwork?
- Does your place of work have a special therapeutic or rehabilitation handling policy?
- If yes, please can you send us a copy?
- Ask person to describe policy
- Does your place of work use an innovative approach to meeting rehabilitation patients' handling needs?
- Have you/your colleagues had any special education relating to rehabilitation patient handling?

Thank the individual and ask if it is ok to contact again.

Appendix 4:

Negotiating access to the fieldwork settings.



Appendix 5

Information Sheet for Rehabilitation Practitioners

Study title: Exploring Nursing Approaches to Rehabilitation Patient Handling

You are being invited to take part in a research study. This information sheet tells you about the research. Let us know if there is anything that is not clear or if you would like more information. *Thank you for reading this.*

Background to the study

Helping patients with mobility and movement is a challenging aspect of nursing practice. Often, this activity raises issues about staff safety and skill sharing amongst nurses, physio- and occupational therapists.

What is the purpose of the study?

The study aims to explore nurses' beliefs about and practices in relation to rehabilitation patient handling. It will look at nurses' usage of mechanical aids and manual techniques to move and handle rehabilitation patients and the skills and knowledge needed to undertake this part of nursing care. It will also explore the effect of patient handling policies and team-working on patient handling practice.

Where is the study taking place?

The study is taking place in up to six different rehabilitation sites, both hospital and community based. Your place of work is one of these settings.

Why have I been contacted?

We are inviting rehabilitation practitioners who work in the chosen study settings to take part in this study. We hope that by speaking to staff about how they help patients with mobility and movement, and by observing clinical practice, we can learn more about rehabilitation patient handling.

What does the study involve?

We are carrying out interviews with rehabilitation practitioners. Interviews will last up to one hour and will be held at a time and place to suit the individual. We would like to tape record the interview to save time on note-taking. The interviewer will ask about patient handling, the use of mechanical aids and manual techniques to move and handle patients, team-working and the skills and knowledge needed to make clinical decisions about patient handling.

We are also planning to observe clinical practice, looking at how patients are helped with mobility and movement. The researcher will visit the ward/unit on approximately three occasions and will observe practice for up to four hours at a time. The observational period will not be focused on specific nurses – the researcher will try to observe any instances where patients are being helped with mobility and

movement. This may involve many nurses and many patients over the four hour period.

The purpose of this study is not to identify unsafe practice. However, if at any point unsafe practice is observed or is about to take place, the researcher will intervene to protect both nurse and patient. The ward manager would be informed of the event.

What will happen if I agree to take part?

We would like to invite you to take part in an interview. We may also wish to observe the patient handling activities you are involved in if you are on duty when we come and visit and talk about it afterwards. This would take around 5 minutes. We will only observe patient care with your consent and that of the patient. Patients will be also be provided with an information sheet and the researcher will seek their consent prior to observation taking place. After your interview we will send you a transcript for your approval.

Will the information I give be confidential?

We will not report the names of people who did or did not take part in this project. Your involvement and any information that you provide will be kept confidential although you may discuss the study with your colleagues if you wish. Interview tape recordings will only be heard by the researchers and will be locked securely in a cupboard and kept for 10 years before they are destroyed.

Do I have to take part?

We will only involve you in the project with your permission. We will provide you with a consent form to read and sign to show you understand what the project involves and agree to take part. However, you do not have to take part and can refuse to participate even after you have signed the consent form. You do not have to give reasons and this will not reflect badly on your work.

What are the possible benefits of taking part?

There are no real benefits to you in taking part in this study. However, the information provided by this study will help us to learn more about helping patients to move.

What are the possible risks of taking part?

There are no risks in taking part in this project.

What will happen to the results of the research study?

The results of the study will be published in a report which will be available on request. This will be held both by the University of Salford and by the RCN Rehabilitation and Intermediate Care Nurses Forum.

Who is organising and funding the research?

The study has been funded by the RCN Rehabilitation and Intermediate Care Nurses' Forum.

Who has reviewed the study?

The study has been reviewed by the University of Salford Research Ethics and Governance committee, and peer reviewed by RCN Rehabilitation and Intermediate Care Nurses' Forum members alongside two University researchers. (NB To be added once achieved – COREC approval and Research Governance approval)

What happens if you have a problem with this research?

If you have a problem with the conduct of this research, please contact,

Rosie Kneafsey

tel [REDACTED] email [REDACTED])

Thank you for considering taking part in this study.

Appendix 6

Information Sheet for Patients

Study title: Exploring Nursing Approaches to Patient Handling

This information sheet tells you about a research study which is looking at how nurses and other staff help patients to walk and move about.

Background to the study

When people are poorly or are recovering from an illness, nurses and other staff such as physiotherapists often spend time helping the person to walk and move about. There are many different ways of helping people with this activity and this is what the study is looking at.

What is the purpose of the study?

The study is going to find out about how nurses use equipment and manual moving skills to help people who are recovering from illness to move and walk. The study will also look at what happens in real life when nurses and other staff help people to walk or move about.

Where is the study taking place?

The study is taking place in a number of hospital and community rehabilitation settings. The place where you are being cared for now is one of these settings.

Why have I been contacted?

The staff working here are helping with this study. They have agreed to let the researchers watch how they help people to walk and move about. The researchers will be visiting on about three occasions and will stay on the ward for up to 4 hours at a time. Because you need help with walking and movement, a researcher may sometimes be present when this help is being given to you. This would only be for a few minutes however whilst you are being provided with support.

What will happen if I agree to take part?

We would like to ask your permission to observe the nurses and physiotherapists when they are helping you to move or walk. This would only be on a few occasions for a few minutes at a time. The researcher will only be visiting on three days (insert date.....).

We may also want to look at the records that have been kept about your rehabilitation to find out more about how the staff have planned your care.

Will the information I give be confidential?

We will not report the names of people who did or did not take part in this project. Any information that you volunteer will be kept confidential. You can talk to your friends or relatives or the staff about the project if you want to.

Do I have to take part?

We will only observe the nurses as they help you if you give your permission. We will provide you with a consent form to sign to show you have agreed to take part. However, you can refuse to take part even after you have signed the consent form. You do not have to give reasons and this will not affect your care.

What are the possible benefits of taking part?

There are no real benefits to you in taking part in this study. However, the information provided by this study will help us to learn more about helping patients to move.

What are the possible risks of taking part?

There are no risks in taking part in this project.

What will happen to the results of the research study?

The results of the study will be published in a report which will be available on request. This will be held both by the University of Salford and by the RCN Rehabilitation and Intermediate Care Nurses' Forum.

Who is organising and funding the research?

The study has been funded by the RCN Rehabilitation and Intermediate Care Nurses Forum. It has been checked by a recognised ethics committee.

What happens if you have a problem with this research?

If you have a problem with the conduct of this research, please contact,

Rosie Kneafsey

tel [REDACTED] email [REDACTED])

Thank you for considering taking part in this study.

Appendix 7

Patient consent form

Patient Identification Number:

Project Title: Exploring nursing approaches to patient handling

Name of Researcher:.....

Please initial box

1. I have read and understand the information sheet for the above study and have had chance to ask questions.
2. I understand that taking part is voluntary and that I can refuse to help at any time, without giving reasons and without my care being affected.
3. I understand that a researcher may observe what nursing and other staff are doing when I am being given help to walk or move about.
4. I agree to my care records being reviewed by members of the research team.
5. I understand that any information that I give will be kept confidential and that I will not be identified in the final report.
6. I agree to take part in this study.

Name of Participant

Date

Signature

Name of Person taking
consent

Date

Signature

1 for patient; 1 to be kept with research notes

Appendix 8

Staff consent form

Staff Identification Number:

Title of Project: Exploring nursing approaches to rehabilitation patient handling

Name of Researcher:.....

Please initial box

1. I confirm that I have read and understand the information sheet dated
(version) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time,
without giving reasons and without my work being affected.
7. I understand that I may be asked to take part in a tape-recorded interview which will be
transcribed and analysed by a member of the research team.
8. I understand that a researcher may wish to observe my activities when I am helping
patients to walk or move about.
9. I understand that my participation in this study will remain confidential and that it will not
be possible to identify me from the final report.
10. I give permission for quotations from my interview to be used in any subsequent
publication
11. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

1 for staff member; 1 to be kept with research notes

Appendix 9

Detailed break down of observational data collected at each of the three fieldwork sites

Case study 1 : Observed Patient Handling Events

Type of Patient Handling (n=number of events)	Practitioners involved
Hoisting a patient (1)	2 care assistants and patient
Helping a patient walk (5)	Assistant practitioner and patient Registered nurse and patient Care assistant and patient Physiotherapist and patient Physiotherapist and patient
Helping a patient transfer (2)	Two physiotherapists and patient Student and patient
Sitting a patient up (1)	Registered nurse and patient
Helping a patient stand (4)	Two physiotherapists and patient Care assistant and patient Two physiotherapists and patient Student and patient
Wheeling a patient (4)	Care assistant and patient Care assistant and patient Registered nurse and patient Registered nurse and patient
Conversations about patient handling or mobility (4)	Physiotherapist and Care assistant Care assistant Care assistant 1 handover
Episodes of joint working (0)	
Total: 21 instances of patient handling in 18 hours of observation, conducted between the hours of 7.30 and 4pm over 5 separate days.	

Case study 2 : Observed Patient Handling Events

Type of Patient Handling Event (n=number of events)	Practitioners involved
Hoisting patient from bed to chair (1)	Two care assistants
Washing and dressing a patient in bed involving: <ul style="list-style-type: none"> • Removing night clothes • Rolling patient • Sliding patient • Putting on clothing • Hoisting • Positioning in chair (4)	Two care assistants on each of the 4 occasions
Manual lift to reposition patient in chair (2)	Two care assistants on both occasions
Sitting a patient forward in bed using under the arms as leverage (4)	Two care assistants on each of the three occasions
Sliding patient onto pat slide and padded phileslide and over onto shower trolley (1)	Three care assistants
Rolling patient off pat slide and across onto bed from the shower trolley (1)	One registered nurse and one care assistant
Pulling patient up the bed using bed sheet (1)	One registered nurse and one care assistant
Picking up a patients limb and repositioning it (2)	One care assistant on both occasions
Supervising a patient doing an independent transfer (1)	One care assistant
Putting on anti-embolic stockings (4)	One care assistant on each of the four occasions
Supervising a walking patient (1)	One care assistant
Conversations related to moving and handling (4)	Registered nurse to registered nurse Rehab specialist nurse to staff nurse Registered nurse to care assistant Registered nurse to physiotherapist
Therapy treatment session (3)	Two occupational therapy treatment sessions One physiotherapy treatment session
Total : 25 instances of patient handling in 25 hours collect over 5 days between the hours of 7.30 and 4pm (conversations not counted)	

Case Study 3: Observed Patient Handling Events

Type of Patient Handling Event (n=number of events)	Practitioners involved
Supervising a walking patient (4)	One care assistant One registered nurse One care assistant One student
Conversations related to moving and handling during handover (2)	Registered nurse to registered nurse Ward sister to nursing team
Therapy treatment session (1)	Two physiotherapist
Manually standing a patient up and transferring: <ul style="list-style-type: none"> • From chair to wheelchair (1) • From wheelchair to chair (1) • From bed to chair (4) 	One physiotherapist Enrolled nurse Student, two care assistants workers, one enrolled nurse.
Total : 11 instances of patient handling in 18 hours of observation, collected over five days between the hours of 7.30 and 4pm (conversations not counted)	

Appendix 10: Interview Respondent Characteristics

Case Study 1

Respondent Code	Role	Years Worked in Speciality	Band
N1	Registered Nurse	6 months	5
N3	Registered Nurse	12 years	5
N4	Registered Nurse	2 years	5
N6	Registered Nurse	5 years	5
WS1	Ward Sister (Registered Nurse)	24 years	7
WS2	Ward Sister (Registered Nurse)	11 years	7
M&H Co-ordinator	Registered Nurse	5 years	? G grade
TAP	Therapy Assistant Practitioner	11 years in rehab, 2 years as TAP	Not known - foundation degree
CA 2	Care Assistant	10 years	NVQ2, band 3
CA 5	Care Assistant	6 years	NVQ2, band 3
OT	Occupational therapist	6 years	Senior 1
PT1	Physiotherapist	7 years	Senior 1
PT2	Physiotherapist	4 years	Senior 1

Case Study 2

Respondent Code	Role	Years Worked in Speciality	Band
N1	Registered Nurse	7 years	5
N2	Registered Nurse	4 years	5
N3	Sister (Registered Nurse)	25 years	6
N4	Sister (Registered Nurse)	17 years	6
N5	Ward Sister (Rehab Nurse Specialist)	19 years	6
N6	Registered Nurse	18 years	5
N7	Registered Nurse	12 years	5
N8	Registered Nurse	3 years	5
N9	Senior Sister (Registered Nurse)	21 years	7
CA 1	Care Assistant	7 years	NVQ2, band 3
CA2	Care Assistant	2 years	NVQ2, band 3
CA3	Care Assistant	2.5 years	NVQ2, band 3
OT	Occupational therapist	32 years	Therapy Manager, band unknown

Case Study 3

Respondent Code	Role	Years Worked in Speciality	Band
N1	Registered Nurse	4 years	5
N2	Registered Nurse	2.5 years	5
N3	Registered Nurse	1.5 years	5
N4	Registered Nurse	4 years	5
N5	Registered Nurse	2 years	5
WS1	Ward Sister (Registered Nurse)	6 years	6
CA1	Care Assistant	34years	NVQ3
CA2	Care Assistant	13 years	NVQ2
CA3	Care Assistant	5 years	NVQ2
CA 4	Care Assistant	4 years	NVQ2
CA5	Care Assistant	10 years	NVQ2
PT1	Physiotherapist	18 months	Band 7
PT2	Physiotherapist	15 years	Band 8

Appendix 11:

Example of the line-by-line coding process of interview data Case Study 1

Interview Statement:	
<i>'With the mobility, we do find sometimes, they will do it for the physios because they think that's the physios job, but not for us. They think, you're a nurse, you should be doing it, you know, fetch me the commode. But we're like, 'no, you need to walk to the toilet. When the physio's not here, we're carrying on with what we think.'</i> (Staff Nurse X)	
Line-by-line Coding : Development of open codes	
<i>'With the mobility, we do find sometimes, they will do it for the physios because they think that's the physios job, but not for us. '</i>	'do it for the physios' Recounting patients' perceptions Recounting patients' behaviours Impact on nurses
<i>'They think, you're a nurse, you should be doing it, you know, fetch me the commode. '</i>	Expectations of nurses Stereotypes Nurses 'do for'
<i>'But we're like, 'no, you need to walk to the toilet.'</i>	Encouraging mobility Patient education
<i>'When the physio's not here, we're carrying on with what we think.'</i>	Standing in Carrying on Making assessments

As this example demonstrates, a very large number of codes are initially generated through the open coding, using a line-by-line approach. These codes are called 'open codes.' Once an interview transcript has been read and analysed using line-by-line coding, a list of all the open codes generated is drawn up. This list is kept at the front of the interview transcript for ease of cross referencing.

The second phase of coding is called 'focused coding.' Here, the open codes that seem to be most prominent or informative in relation to the research questions are selected for further exploration and are elevated to the status of a 'major code.' Once a major code has been selected, work then progresses to describe and delineate the code until it is fully suggested/saturated by data.

The next stage is to identify links and patterns between major codes. Codes that are similar or closely related are grouped together under the umbrella of a category heading. The category heading is chosen to represent the group of major codes. This is conceptualising.

**Example of the line-by-line coding process with observational data
Case Study 3**

Observational Fieldwork Extract: Case Study 3 December 10th 2008	
<p>The two care assistants go to see patient R. He is tired and wants to get into bed. The care assistant moves the bed nearer to the patient, whilst he is sat in the chair. She blocks his knees but then decides they'll get his T shirt off first and put his PJ top on. They take it off his good side first and then over his head and then off his weak arm. Then they put his clean T shirt on – weak arm first, then over his head, and then off his arm. Then care assistant goes to stand him up. She blocks his knees and he puts his arm around her back. She grasps around his middle and tells him to rock 1,2 and 3 and then 'stand tall'. He is still bent quite a lot in the middle but he steps around and sits on the bed ok. They lie him back and pull down his tracksuit. He has a red mark on his knee from his catheter tube. She undoes the strap of the tube and then cuts off the net pants and pad. She puts his arm brace on for the night.</p>	
Line-by-line Coding : Development of open codes	
The two care assistants go to see patient R. He is tired and wants to get into bed.	Checking on the patient Ascertaining what patient wants
The care assistant moves the bed nearer to the patient, whilst he is sat in the chair.	Assessing the space Changing the space
She blocks his knees but then decides they'll get his T shirt off first and put his PJ top on. They take it off his good side first and then over his head and then off his weak arm. Then they put his clean T shirt on – weak arm first, then over his head, and then off his arm.	Using technique to undress Knowing about hemiparesis Preventing shoulder damage
Then care assistant goes to stand him up. She blocks his knees and he puts his arm around her back. She grasps around his middle and tells him to rock 1,2 and 3 and then 'stand tall'.	Standing a patient up Blocking the knee Preparing to move Instructing the patient Knowing how
He is still bent quite a lot in the middle but he steps around and sits on the bed ok.	Stepping round
They lie him back and pull down his tracksuit. He has a red mark on his knee from his catheter tube.	Undressing Assessing the skin
She undoes the strap of the tube and then cuts off the net pants and pad. She puts his arm brace on for the night.	Taking action to reduce pressure Applying splints

Appendix 12

Key analytic questions to prompt analysis of observational and interview data

Key analytic questions to probe and organise the data (Corbin and Strauss 1998, Charmaz 2006)

Sensitizing questions: What is going on here? Who are the key actors involved? How do they define the situation? What is its meaning to them? What are the various actors doing? Are their definitions and the meanings the same or different? How do things/events/people change over time and in different circumstances? What patterns can be seen in the data? What are the key processes in play? Who is acting/interacting with whom? (coding for process) Why is the action/interaction changing or staying the same? Are actions/interactions aligned or misaligned? What are the consequences of actions/interactions on other actions/interactions?

And further questions from Charmaz (2006):

From whose point of view is a given process fundamental ?

Whose view is marginal?

How do the observed social processes emerge? How do participants actions construct them?

Who exerts control over these processes? Under what conditions?

What meanings do different participants attribute to the process? How do they talk about it? What do they emphasise? What do they leave out?

How and when do their meanings and actions concerning the process change?

Theoretical questions: what is the relationship between one concept and another? How do events and actions change over time? What are the larger structural issues and how do these events play into or affect what I am seeing? What does this case tell us about the others?

Practical and structural questions: which concepts are well defined and which are not? Where, when and how do I go and gather more data for the evolving theory? Is my developing theory logical?

Appendix 13

Example of Constant Comparative Analysis – Case Study 2

Memo: Case Study 2 16/5/07 Physical Labour

Observation of Care Assistants highlights the physical nature of their role in caring for people with spinal injuries. Providing help with washing, dressing and positioning is physically strenuous even when using hoists and slide sheets. However, the Ward Sister's view is that working conditions are so much better now and have improved dramatically in the last 20 years. She does not seem overly concerned at the physical nature of the job, whereas I am taken aback. I want to explore this further with Registered Nurses : Do RN's share the same views as the Ward Sister or Care Assistants?

Memo: Case Study 2 23/5/07 Moving and Handling Equipment – Panacea or Red Herring?

Observation of patient handling events reveals that the most patient handling is carried out by care assistants, rather than RN's. However, interviews with RN's also point to the physical strain experienced by nurses as a result of their caring role. Being tired and achey is compounded by staff shortages, lack of rest breaks, time pressures and all the 'little lifts'. Nurses also report that hoists are hard to manoeuvre and heavy and awkward in cramped spaces. Looking at the literature, there is very little acknowledgement that using equipment may lead to injury itself. However, Menzel (2004) identifies that most nursing activities in rehabilitation settings entail some kind of musculo-skeletal risk. Once of the case assistants implies that because they do have some equipment, managers overlook the physical nature of the work – patient handling equipment viewed as a panacea but perhaps it is actually a red herring? It would be interesting to find out how physiotherapists view their work.

Memo: Case Study 2, 24/5/07– Comfortable Seclusion

Today I observed the physiotherapist working with a patient. The difference in working conditions in comparison to care assistants and registered nurses is stark. The physiotherapist spends a full hour working one to one with the patient with no interruptions, mobilising joints, pressing on muscles and using the hoist. She does not rush and takes care with what she is doing. However, I do note that some of the positions she works in seem awkward.

Memo: 24/8/07 Comparing the data from case study 2 with case study 1

‘I shouldn’t say it, but there is physical lifting on our part’ (physiotherapist)

Comparing these data with the findings from case study one reveals some definite similarities. Observation of registered nurses and care assistants revealed the ‘context of risk’ within which care work occurs. Nurses, care assistants and therapists report ‘dealing with the here and now’ in order to meet patients needs and make ‘guilty admissions’ that manual handling does happen. Practitioners know what ‘the official line’ is on patient handling – that lifting should not occur. However, many of those interviewed describe situations where they have to support the patient’s weight because there is no piece of equipment that can replace human hands and dexterity. Whilst all those interviewed can honestly say that they use handling equipment, they cannot honestly say that they do not lift. There is a sense of division between trainers and policy and the reality of practice. The policy is at odds with the process and purpose of rehab.

Appendix 14

Relational statements developed between emerging categories

One way of taking forward the analysis has been to examine the relationships between the different major codes and categories. This approach has been used to develop a set of eight relational statements. These comprise of six explanatory relational statements and two inferred relational statements.

Explanatory Relational Statements

The division of work leads to particular perceptions of expertise:

The division of work between nurses and therapists meant that nurses and care assistants had few opportunities to increase their skills, knowledge and insight into therapy activity. As a result, nursing staff and care assistants had limited insight into the work of therapists and the content of therapy treatment sessions. Therapists were also perceived to possess greater autonomy than nurses, being able to move freely between different geographical locations as they pleased and being able to adjust the size of their patient caseload depending on resources and their working hours. In this way, rehabilitation work was divided geographically, professionally and temporally. These factors reinforced nurses' perceptions of themselves as non-experts whilst physiotherapists were perceived as experts. Only a few 'maverick' nurses perceived themselves to also be experts in patient handling and rehabilitation practice.

Boundaries in patient handling are reinforced by perceptions of expertise

The accepted status of the physiotherapist as expert and the nurse as non expert meant that nurses and care assistants were content to accept that there were distinct differences, boundaries and restrictions to the patient handling activities in which they could engage. Whilst physiotherapists engaged in therapeutic handling, nurses and care assistants were involved largely in A to B transfers. Nurses and care assistants become further distanced from their responsibility for mobility rehabilitation. Only long time qualified experienced nurses questioned this division of work and sought to retain engagement in mobility rehabilitation.

Responding to risk by deferring to experts reinforces perceptions of expertise

One way in which nurses responded to risk was to defer to experts. This in turn reinforced the status of the nurse as non expert and the physiotherapist as expert.

The widening and firming of boundaries in patient handling is incongruent with some of the core principles of rehabilitation practice, leading to nurses experiencing internal moral conflict.

Long time qualified and rehabilitation experienced nurses with a historical perspective found it frustrating accepting the firmer and wider boundaries between the roles of nurses and physiotherapists in relation to mobility rehabilitation. This caused frustration and internal moral conflict because these nurses felt they were letting patients down.

The firming and widening of boundaries in patient handling increases the division of work.

As the difference between what nurses and care assistants undertake in relation to mobility rehabilitation increase, there is greater need to separate out the rehabilitation work.

The core values of rehabilitation nursing care may clash with the messages promoted within mandatory manual handling training: the source of the 'official line'. This may lead to internal moral conflict.

Rehabilitation nursing care has as its core a concern with promoting patients' independence and wellbeing. The messages promoted in mandatory moving and handling training often relate to self preservation and the prevention of harm to self. The conflict between these two sets of values may cause nurses to 'resist or adapt' the 'official line' promoted within mandatory training. It may also lead to nurses accepting risk to themselves in order to fulfil their internalised ethic of care for the patient.

Inferred Relational Statements

Nurses' responses to risk are heightened by the mandatory training and the explication of the 'official line'.

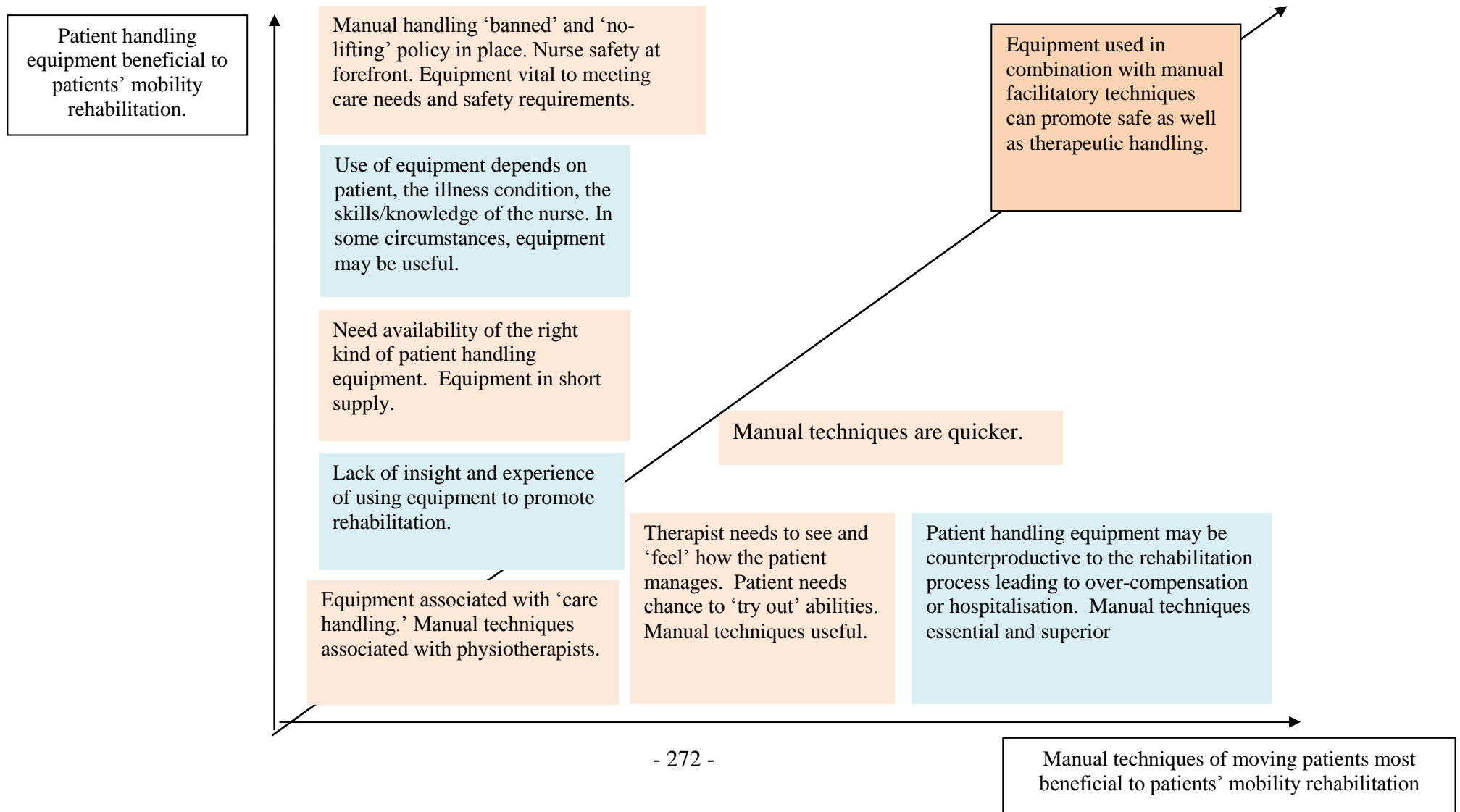
When nurses engaged in patient care and patient handling manoeuvres, they were well aware of the possible risks to themselves. This perception of risk and the response to risk were influenced by the mandatory training in manual handling and presentation of the 'official line' therein. Within this training practitioners were urged to risk assess and avoid risk wherever possible. This increased the likelihood that once nurses have identified risk, they will seek to avoid it and distance themselves from the source of the risk by referring to the 'expert'. The result is that nurses will increasingly distance themselves from patient handling and mobility rehabilitation.

Nurses who respond to the 'official line' by 'adapting and abdicating' from responsibility for mobility rehabilitation do not experience moral conflict.

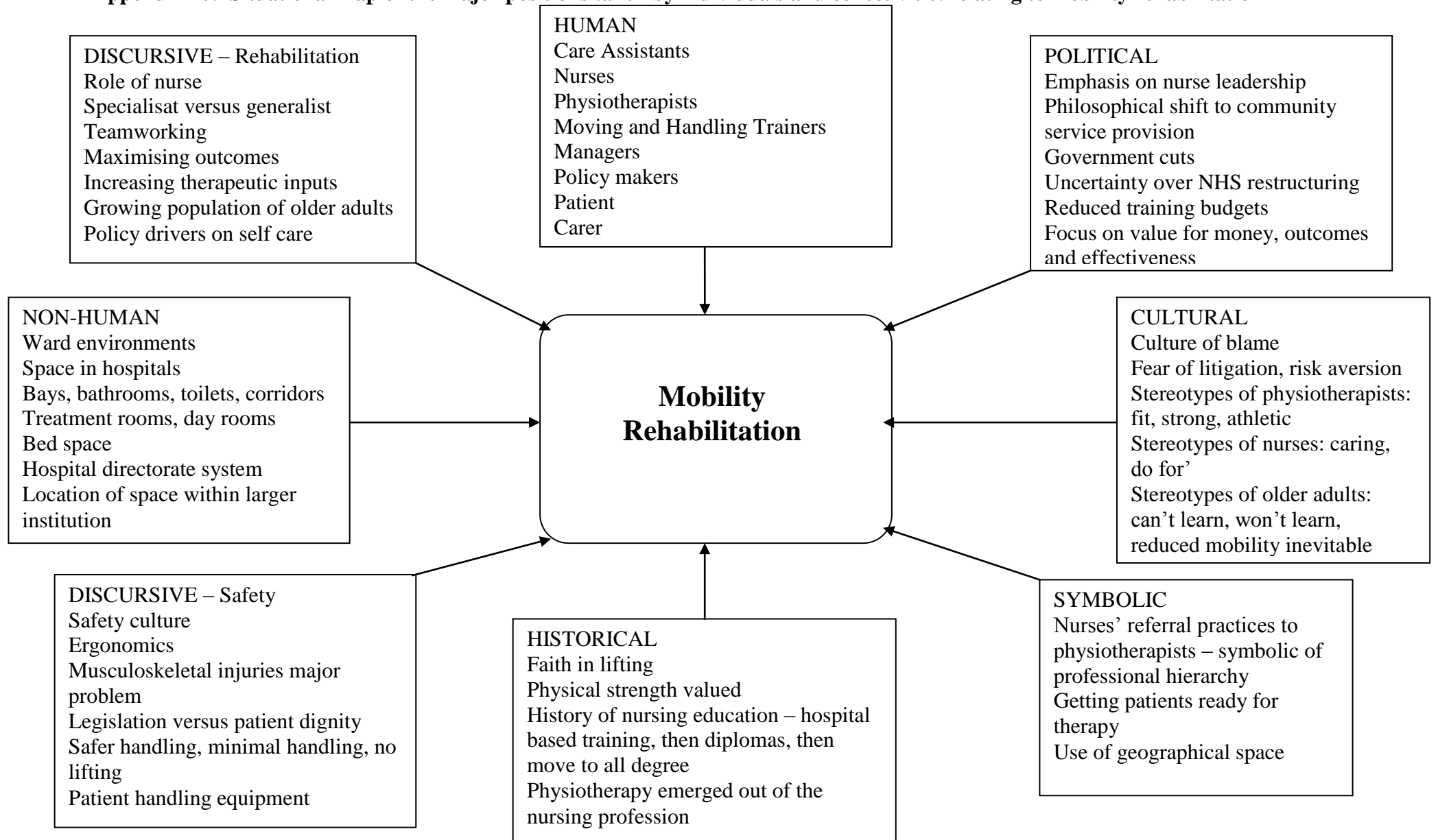
Nurses who respond to the 'official line' by 'adapting and abdicating' from responsibility for mobility rehabilitation are less likely to experience the moral conflict which is derived from a concern that they are neglecting their rehabilitation responsibilities. In this way, nurses who distance themselves from a role in mobility rehabilitation protect themselves from feelings of failure or criticism for not fulfilling this additional duty. That is, if a responsibility is not claimed, one cannot be held accountable for it.

Appendix 15: Example of a positional map to set out the major positions taken in relation to the use of patient handling equipment during the process of promoting mobility rehabilitation

(Associated major codes from across case studies: manual handling happens; a physical job; approaches to patient handling; nurse's aren't covered)



Appendix 16: Situational map of the major positions taken by individuals and collectivities relating to mobility rehabilitation



Appendix 17

A REFLEXIVE APPROACH – Early memo on developing rapport

When I introduce myself to staff, I state clearly that I have a role in teaching student nurses patient handling and doing research. I explain the perspective I am coming from – that moving and handling patients can be difficult, that equipment can be heavy and that policy guidance on patient handling might not always seem helpful. I have used my own experience as a practising nurse and as a teacher to develop a connection with the nursing team, to show that I possess an awareness of the issues they face. I want to be seen as both an insider (with some knowledge and insight) and an outsider (naïve, to be taught and shown) but definitely not as an expert, auditor or manager who would judge their standards of practice. Being pregnant has created many sources of discussion between myself and the nursing staff, particularly when morning nausea threatened my ability to undertake observations and conduct the interviews. In many ways, this has created a link between myself and the participants through gender and motherhood. Adopting a constructivist approach has meant that it has been important to maintain a sense of reciprocity with participants making a conscious effort to question my own judgments, question my right to judge and the potential for power imbalances to skew data collection and interpretation. I have worked flexibly when planning interviews with participants, fitting in with ward routines, even conducting one interview at 5.30 am. I have reinforced to participants that if patients' need care at the time of the interview that this should be prioritised. Frequently interviews had to be cancelled and rescheduled because of this.

Appendix 18: Using Memoing To Drive Theoretical Sampling – Case Study 1

This example demonstrates how data collection leads to memoing and plans for further theoretical sampling.

Memo: April 2007 Questioning the Relevance of Moving and Handling Training

Today I have been looking at past memos and fieldnotes to look for connections and links between them. I came across two previous fieldnotes that seem to fit together:

17/10/06 Fieldwork Note: I met with the ward sister to go over a few plans with the research. Whilst we are chatting, she said *'the nursing staff come back from M&H training with their head in their hands because it's just not the real world.'*

12/4/07 Fieldwork Note: I have carried out an interview with a staff nurse. When I turn off the tape, she suddenly says: *'I'm in the moving and handling training and I think, what is the point of this? You're not teaching me anything I don't already know. They're all healthy, the volunteers – how does that relate to our patients?'*

Based on the similar nature of the views expressed by the two nurses above, one might question the relevance of mandatory M&H training for rehabilitation nurses. As such, it seems necessary to seek out an alternative and perhaps contrasting viewpoint. This may be obtained from the Moving and Handling Trainer for the Trust.

Plan: Contact trainer and arrange for an interview if willing. Try to ascertain her views on the value of mandatory training for rehabilitation nurses. (Booked for the 18th April 2007)

June 2007: Memo Following Interview with M&H Trainer

The interview with the M&H trainer confirmed a belief that using the hoist with rehabilitation patients only 'maintains' them at the same level, rather than promoting progression. The trainer feels nurses lack the necessary skills and knowledge (of A&P, treatment, normal movement, Bobath techniques) to be therapeutic through handling. This means that nurses focus on promoting 'safety'. She does not perceive that hospital policy contradicts with the underpinning principles of rehabilitation. However, her interview also clarifies for me that the purpose of mandatory training is

not to teach about rehabilitation. Rather, the focus of the training is on safety.

Plan: Interview physiotherapists and ascertain whether it is possible to apply 'safe' principles to handling spinal patients on the unit and the value of mandatory training. Ascertain views on nursing contribution to mobility rehabilitation.

Appendix 19

Saturating major codes to develop the over-arching category 'Role Demarcation' – Case Study 1

Category: Role Demarcation
Major Codes:
Physiotherapist as Expert Nurse as Non-Expert Encouraging Mobility Role Boundaries and Acceptable Boundary Transgressions
<p>Major Code: Physiotherapist as Expert</p> <p><u>Preliminary Open Codes:</u> Faith in the physio, mystique, infallible, decision maker, expert, protector of nurses, therapeutic, assessor, advisor</p> <p><u>Respondent Comment:</u></p> <ul style="list-style-type: none"> • 'They look at it in more depth and we are very much guided by them of what they want, very much led by the physios' (Ward Sister 1) • 'We'll do the very first assessment and advise how this patient should be handled, and we will advise our nurses and work with them on that' (Physiotherapist 1) • 'Nurses are supposed to take on board our advice and recommendations' (Physiotherapist 2) <p><u>Observation Note:</u></p> <p>12/4/07 I go to observe the physiotherapist treating an old lady who I have observed the nurses only hoisting. The physio says that her goal is to get the patient to achieve banana board transfers. I am very sceptical as the patient has been totally dependent on the nurses. Amazingly, I watch as she is coaxed from the electric chair across the banana board to the plinth. She then works on pelvic exercises using a large ball. The physio says that the nurses will need to keep hoisting her until she can manage the banana board unaided. I can't help thinking this may be beyond her reach and I only ever see the nurses hoisting after this.</p>
<p>Major Code: Nurse as Non-Expert</p> <p><u>Preliminary Open Codes:</u> a stop-gap, always in a rush, deal with here and now, perceived lack of skills/knowledge, defer responsibility, basic level, basic assessment, care handling, a to b transfers, keep patients safe, essential care needs</p> <p><u>Respondent Comment:</u></p> <ul style="list-style-type: none"> • 'We'll walk them to the toilet and back, so that's part of the practice, unless its too dangerous for us to practice. There are some things that we wont do that the physio's will. We are getting them out of bed to go to the toilet, not to see what they can do' (Registered Nurse 4) <p><u>Observation Note:</u></p> <p>26/4/07 The student nurse has just struggled to coach and assist a patient with Parkinson's to stand up from the bed and transfer to the chair. The patient almost falls. The student tells the staff nurse. She says 'well I got him up on my own yesterday and....' She pulls a face and her silence implies that she had similar difficulties. Later I go and talk to the physiotherapists about he problems the nursing staff are having getting him to stand. She is surprised to hear this as his sit-to-stand practice with her has been 'fine'. She later says ' I can actually get him to stand</p>

with minimal support, just a finger tip on his shoulders to guide him up, whereas some of the nurses will manually help him up and he will use the nurses as a pivot.'

Major Code: Encouraging Mobility, Promoting Rehabilitation

Preliminary Open Codes: Encouraging, maintaining, walking, transferring

Respondent Comment:

- 'Obviously, we try to keep the patients as mobile as we can' (Ward Sister 2)
- 'Make sure they know how to use the frame properly, and you take it slowly, you do a couple of steps and if you don't think he is steady, then you put the chair behind him' (Care Assistant 6)
- 'There is somewhere in between when patients get to a certain level, we liaise with the nurses and they will promote some level of therapeutic handling in every transfer, which is when they are too good for the hoist but still need physical help to transfer.'
(Physiotherapist 1)

Observation Note:

25/4/7 It is 7.30 am. A patient is buzzing. Registered nurse goes to the patient and says 'do you want to sit up for breakfast?'. The nurse uses the electric bed to raise the patient up but at the same time puts her arm under the patients axilla. She says 'try to sit yourself forward.' The patient pulls on the bed sides and the nurses arm.

The morning is progressing and it is 9.30 am. The care assistant goes to see a patient and asks her if she wants a wash. The care assistant tells me that the patient can actually do alot for herself, but she forgets and leans back '*so you're constantly having to remind her – lean into your frame, your leaning back.*'

Major Code: Role boundaries and acceptable boundary transgressions

Preliminary Open Codes: The weekend effect, professionals' priorities, role blurring, role boundaries, negotiated practices, different but complementary, carry-on role

Respondent Comment:

- 'The nurses are allowed to use their initiative as long as they are confident to do it and the patient is confident. The we will proceed with it and hand back to the physios that this patient was able to do this at the weekend' (Ward Sister 2)
- 'If we've got time and we know the patient's status and they're walking and they say to me 'can you take them for a little walk', well then I would.' (Registered Nurse 1)
- 'The handling and moving – it's down to the physios' (Care Assistant ?)
- 'They work at a slower pace, they've got to assess the patient, but they do it professional. If I was stood watching them, or helping a patient to move or something,, it's boring to me. I prefer to be with the patient, hands on and do everything, but that's how they do their job – but we continues at weekends....but it's quite a different role.'
(Care Assistant ?)

Observation Note:

26/4/07 The care assistants have been busy working in pairs to get all the patients up, washed and breakfasted. The care assistant wants to get another patient up but she can't find anyone to help her. She sees the physio on the ward and almost apologetically asks her to help, justifying this by identifying that 'all the others are on a training course.' This is the only example I've seen of care assistants ALMOST working together with a patient. However, at that moment a care assistant comes round the corner and the first one says 'it's ok, I'll do it with X now.'

Appendix 20: Tables to show the main open codes, major codes and subcategories for each case study and to illustrate how together, these informed the development of the cross-cutting categories discussed in chapter 7

Cross Cutting Category 1: Promoting Mobility - An Embedded Activity

C.S	Open Codes	Major Codes	Sub-Categories	Cross Cutting Category
1	Keeping patients mobile, zimmer frames, hoisting, turning, helping to walk, transfers, ‘doing for’, avoiding heavy handling, variable level of attention to mobility, helping, encouraging, keeping patients safe, teaching, noticing patients mood, preventing pressure ulcers, DVT, risks associated with immobility, falls assessment, patients expectations – nurses as doers, caring for different patients with different needs, being busy, reliance on care assistants, lack of time	Encouraging Mobility Within Context of Nursing Care	Encouraging Mobility: Variable Contributions	Promoting mobility – an embedded activity
2	Judging activity tolerance, managing flat lying, managing spasm.	Facilitating movement	Facilitating Movement: Generalist and Specialist	
	Busy care assistants, time constraints, doing all the ‘little lifts’, physical and personal care work delivered by care assistants, working under time pressures, fewer rest breaks, using appropriate equipment, but not possible to eliminate all manual lifting eg repositioning in chair, difficult to apply principles when putting patients clothes on.	A physical job		
	Pain control, bowel care, teaching self care, skin care, changing bedding, putting clothes on, medications, observations, preventing complications, personal, intimate and physical care of the body, prepare for the new day, readiness for therapy.	Nursing care: specialist and generalist (collapsed into main category)		
3	Recognising importance of mobility, taking to toilet, sitting patients up, therapeutic transfers, transfers a ‘sideline’ to nursing care, using prescribed transfer techniques, assisting patients to transfer, registered nurse role limited by staffing levels, support workers crucial, forming supportive relationships to underpin the rehabilitation process, washing a dressing.	Empathy and Care (necessitating transfers)	Supporting Mobility Rehabilitation	
	Hoisting for safety, prevention of complications.	Hoisting for safety.		
	‘Sitting down’ with therapists to set rehabilitation goals, ‘Carry-on’ work.	Collaborating with therapists.		

Cross Cutting Category 2: A to B Transfers

C.S	Open Codes	Major Codes	Sub-Categories	Cross Cutting Category
1	Safety (for nurse and patients) a prime concern, safety dictates decision making, perception that physios work under a different remit., A to B transfers and ‘therapeutic transfers’ differ and are done by different professional groups: A to B: safety of movement, standardised, everyone, speed and safety and prime concern, minimum standard for the patient, achievable with the limited skills set of existing staff. Therapeutic handling: Quality of movement: skilled, expertise, specialist, requires certain ‘condition’ to occur (p22), rehabilitation goals prime focus.	Different Approaches to Patient Handling: A to B or therapeutic	Encouraging Mobility: Variable Contributions	A to B Transfers
2	Assisted transfers done by therapists, different transfers and handling techniques used during therapy, therapists take weight, therapists focus on progression towards greater transfer independence, nurses need to be protected, protecting patients from injury, hoisting for safety, care assistants bear the brunt	Assisted transfers or hoisting for safety (later collapsed into the division of work)	Divided Practices in Patient Handling	
	Nurses are restricted to hoisting, nurses wait until patients ‘passed’ by therapists, therapists work to a different policy, nursing expertise is challenged, nurses’ autonomy is reduced, nurses not valued, care assistants are under-developed	Perceptions of knowledge and expertise		
3	Defining therapeutic handling: handling that is of benefit to patient, about balance, weight bearing, equilibrium, tone. Combines a focus on safety, with patients’ active participation and learning from movement., therapeutic handling transfers not a cause of physical strain, benefits to patients, gives chance for patients to develop strength, balance and movement.	Explanations of therapeutic handling	Practical ‘Know-How’ in Therapeutic Handling	
	Practical ‘know how’ in therapeutic handling, nurses taught ‘therapeutic transfers’, used under physio direction, pride in skills, specialisation, theoretical gaps in knowledge, lack of language to describe, lack of training/practice to develop competence and confidence – ‘no time to stand and watch’, a desire to know more.	The limits of ‘know how’		

Cross Cutting Category 3: The Negotiated Team

C.S	Open Codes	Major Codes	Sub-Categories	Cross Cutting Category
1	Difficulty articulating role, 'we used to do more', nurses are non-experts, nursing assessments preliminary, nurses focus on moving and handling needs, not quality of movement, physiotherapy assessments 'full', physio assessments lead to goal setting, physios focus on facilitating improvements in quality of movement, physiotherapist as expert, decision maker and specialist, physio instructs nurses, nurses know little about the 'full assessment', perception of nursing skills/knowledge gap, no opportunities for role development, negative impact on patients' mobility rehabilitation	Non Experts and Experts in Rehabilitation Handling	Role Demarcation	The negotiated team
	Joint working with patient's problem driven, nurses do not attend therapy or gym, little knowledge of what therapy entails, lack of shared language, physiotherapy assessment the 'baseline', nurses may make a 'judgement call', nurses expected to 'carry-on' in relation to patient transfers, limits to the carry-on role	Role Boundaries and Accepted Boundary Transgressions		
2	Care assistants and registered nurses receive no formal training or education relating to rehabilitation processes, no shared working, nurses role 'diminished' by the professional expansion of others, OT and physiotherapists taking responsibility for decision making whilst registered nurses losing professional autonomy, Therapy occurs in the gym, comfortable seclusion	Excluded from Knowledge (collapsed into perceptions of knowledge and expertise) and later 'perceptions of the negotiated order'	A Divided Team	
	Nurses' status: rehabilitation expert or lay carer? Support workers and nurses get patients 'ready' for therapy, Therapists 'pass' patients for transfers and make decisions regarding transfers, nurses need protecting, patients need protecting.	Controlling Patient Handling Processes (collapsed into the division of work)		
3	Physiotherapist as expert with jurisdiction for assessment and treatment plans regarding mobility/movement, nurses working at the level of common sense and practical – non-expert by comparison to physiotherapist (use of lay/tacit/procedural knowledge). Perceived to possess sufficient procedural knowledge to be rehabilitative, registered and unregistered nurses happy to accept instruction from physiotherapist,, care assistants - the last to know.	Rehabilitation Experts and Nurses with Specialised Skills (Collapsed into 'perceptions of each other')	The Delicately Balanced Team	
	Mutual desire to work more together, barriers to team and skills development, work patterns.	Enjoying Teamwork, Wanting More		

Cross Cutting Category 4: A Context of Risk

C.S	Open Codes	Major Codes	Sub-Categories	Cross Cutting Category	
1	Staff shortages, increased speed of work, being rushed, ensure routine tasks achieved, lack of patient handling equipment	A Context of Risk	Risk: Inherent, Essential and Accepted	A context of risk	
	Being rushed, rehabilitation approach dispensed with for the 'do for' approach, deal with the 'here and now', risk taking, , meeting patients' immediate urgent needs, maintaining comfort,.	Dealing with the Here and Now			
	Manual handling valued: gives patients chance to try out movement abilities, comfort, immediacy threat of retribution, fear of being blamed, fear of criticism, mismatch between training in M&H and real life, hoists cumbersome and tiring, impossible to eradicate all aspects of manual handling from care work, inherent risk.	Guilty Admissions: Manual Handling Happens			
2	Risks inevitable, risk not always recognised, limitations of the environment, time pressures, risk multiplied, patient handling risk greater early morning and late evening, absence of therapists, hoists cumbersome, hoists incompatible with beds, hoists cause strain, lifting unavoidable despite equipment	Unacknowledged Risk	Risk in Caring		A context of risk
	Inevitability of back pain, daily experience of back pain, vocation in nursing, compassion in caring despite challenges, balancing own right to safety with ethic of care, taking risks to help the patient.	A Duty to Care			
3	Err on the side of caution because 'lifting in banned.', hoist to avoid risk, obliged to follow expert advise, defensive practice, 'always the potential for injury'.	Err of the Side of Caution	Safe Systems of Work		
	Outdated equipment, hoists cumbersome and time consuming, belief that saving costs put before staff safety.	Putting Up with Second Best			

Cross Cutting Category 5: Interpretations of ‘The Official Line’

C.S	Open Codes	Major Codes	Sub-Categories	Cross Cutting Category
1	Manual handling training represents the ‘official line’, training fulfils the needs of the organisation to comply with legislation, ‘official line’ difficult to apply to practice, dissonance, fear of criticism, fear ensures compliance.	Mandatory Training: A Technology of Power	Interpreting the Policy	Interpretations of the official line
	Working beyond ‘the official line’, risk later criticism, litigation threat, vulnerable to the policy, questioning whether Trust would support staff in case of a claim, application of blame.	Policy: Protection or Threat?		
2	M&H policy protects Trust from liability, policy does not protect staff, training shifts responsibility for safety from organisation to nurse., double standard – Trust abuses nurses’ ethic of care, impossible to provide good nursing care without some manual handling but this is not recognised.	Between a Rock and a Hard Place	Interpreting the Policy	
	Nurses ‘are not covered’ to do assisted transfers, physiotherapists are covered, obligated to follow therapists’ advice in case of a claim.	Nurses’ Aren’t Covered		
	Nurses’ restricted to ‘safe’ transfers (often hoist) to protect nurses safety, hinders rehabilitation, reduces patients’ practice time. ‘No lift’ mantra leads to avoidance, reluctance to handle patients leads to deconditioning, an ethic of care: a commitment to helping the patient and taking some risks to do this, limitations of the official line, best interests of the patient, choose to avoid hoist despite risk, accept some risk to self.	Compromising Rehabilitation		
3	Nurses and support workers taught three specific ‘therapeutic handling transfers’, assessed as competent, These transfers recognised by the Risk Management Committee as a ‘variance’ to the trust safer Handling of Loads Policy.	Therapeutic Handling Policy:	Specific Policy:	

Cross Cutting Category 6: Feelings of Dissonance

C.S	Open Codes	Major Codes	Sub-Categories	Cross Cutting Category	
1	<p>Internalised professional moral obligation, desire to maintain patients' dignity and freedom, competing principles, patients' needs for rehabilitation versus need for personal safety. 'The rehabilitation ethos – an ethic of care': commitment to helping the patient and taking some risks to do this. Limitations of the official line, considering best interests of the patient, avoiding the hoist even though this is more risk free option, accepting some risk to self, altruism, 'rule book' inhibitive. 'Safe' approach detrimental to patients' recovery, maintenance is neglect, paradox of consequence – policy has changed the nature of nursing practice with possible detriment to patients' rehabilitation, option to ignore patients' mobility needs.</p> <p>Moving and handling policy does not reflect rehabilitation reality, eliminating 'all risks' incompatible with rehabilitation, measured risks needed, physiotherapists work to a different policy, physiotherapists can 'do more' manual handling, tension between safety, compliance and rehabilitation goals and activities.</p>	<p>Impact of the policy on the rehabilitation ethos</p> <p>Changes in handling practice: looking back</p>	<p>Interpreting the Policy</p>	<p>Feelings of dissonance</p>	
2	<p>Vocation in nursing – compassion in caring despite challenging workloads and time pressures. Balancing own right to safety with the need to fulfil their sense of moral duty to care. Impact on patient handling decisions is to take some risks to help the patient. Team divide detrimental to patients' rehabilitation, slows process, reduces patients' quality of life. Loyalty and duty to the patient, risk taking and putting patients' needs before own. Emphasis on 'no-lifting' impinges on patients' rehabilitation and later quality of life and independence.</p>	<p>Compromising Rehabilitation</p>	<p>Interpreting the Policy</p>		
3	<p>Err on the side of caution because 'lifting is banned.'</p> <p>Defensive practice because 'always the potential for injury'.</p>	<p>Err on the Side of Caution</p>			

Appendix 21

CASE STUDY 1 AUDIT TRAIL

Subcategory 1: Encouraging mobility: variable contributions

Major Code: Encouraging mobility and movement	
Interviews with Registered Practitioners	Interviews with Care Assistants
Assessing, do first assessment, the basic assessment – WS2, N1, N4, N6 ‘See how they are’ – N3 Encouraging , keeping mobile – WS2 Keep patients safe, ‘safety comes first’ – N4 Hoisting, caring, maintaining – M&H co-ordinator Liaise with us, tell us, follow what we say - PT1, PT2, OT1	Commitment to patient – CA6 ‘See what patient can do’ – CA1 Carry-over ‘if we have time’ – AP2
Observational Data: 12/4/07 Walking patient to the toilet, hoisting patient into bed (maintenance), handover reports about mobility 25/4/07 Sitting a patient up in bed, walking with a patient, taking a patient a bowl for a wash, helping patient stand, wheeling a patient	

Major Code: Different approaches to patient handling	
Interviews with Registered Practitioners	Interviews with Care Assistants
‘Always in a rush’ , differences in handling – N4 Care versus therapeutic handling’ – WS1 Focus on safety – WS2, M&H co-ordinator Basic transfers – N1 Care handling, not therapeutic, A to B – PT1, PT2, OT1	A to B – CA1 Always in a rush – CA1 Different types of assessment – CA2
Observational Data: 15/3/07 – ‘different ethos’ in handling – M&H Co-ordinator 25/4/07 Physiotherapist coaching a patient on the plinth	

Subcategory 2: Role Demarcation

Major code: Non-experts and experts	
Interviews with Registered Practitioners	Interviews with Health Care Assistants
Nurses do 'a basic assessment'- WS2, N1, N3, N4 Nurse maintains, 'does for' – N4 Faith in the physios, physios are experts – M&H co-ordinator, WS2, N1, N3, N6	Faith in the physios – CA2, AP2 Lack of skills, experience, knowledge
Observational Data: 12/4/07 Observation of physiotherapy treatment session – specialist and lengthy input 26/4/07 Student assisting a patient to stand, my conversation with OT/PT	

Major code: Role Demarcation and Accepted boundary transgressions	
Interviews with Registered Practitioners	Interviews with Care Assistants
Nurses have to make 'a judgement call' – M&H Co-ordinator Distinct role boundaries – N1, N3, N4, WS1 Advocating more role blurring – PT1, OT1 Negotiated working practices – WS2	Deciding, using own judgement - CA2, CA1 Fill the weekend gap – AP2 Different but complementary – CA6
Observational Data: 12/4/07 Care assistants helping all patients transfer from bed to chair, washing , dressing, using hoist – morning routine - role demarcation 12/4/07 OT helping patient with washing and dressing – query with care assistant over 'red patch' on sacrum – 'I don't know, I'm not a nurse' states the OT 25/4/07 Lack of communication of physiotherapy treatment and goals to nurses 25/4/07 Two physiotherapy treatment sessions 25/4/07 Missed opportunity for shared working	

Subcategory 3: Risk: inherent, essential, accepted

Major code: Dealing with the ‘here and now’	
Interviews with Registered Practitioners	Interviews with Care Assistants
Deal with the here and now – WS2 Meeting patients’ immediate needs – PT1	Do what they can depending on staff - CA2 ‘By the time you’ve looked for a hoist’ - CA6
Observational Data: 12/4/07 Making ‘male and female bays’ – rushing to meet organisational demands	

Major code: A context of risk	
Interviews with Registered Practitioners	Interviews with Care Assistants
Justifying the need for manual handling - WS1, WS2 Inherent risk due to patient population and purpose of ward – P1, PT2, OT1 Taking risks essential – WS1 (N1 – avoids risk)	Having to take risks because of lack of time, staff, equipment – A2, CA2, CA6
Observational Data: 12/4/07 Physiotherapy treatment session – ‘she’s one we really struggle with’ – strain for physiotherapist 12/4/07 A lack of essential patient handling equipment	

Major code: ‘Guilty admissions’: manual handling happens	
Interviews with Registered Practitioners	Interviews with Care Assistants
Manual handling ‘inevitable’ – N3, N4 Accepting risk – WS1, WS2	Accepting risk to self – CA2, CA6, A2 Some patients ‘in-between’ – too good for hoist, not good enough alone ‘No lifting’ approach not practical – CA’
Observational Data: 12/4/07 Observing difficulties with patient transfers for nurses, care assistants, student nurse	

Subcategory 4: Interpreting the policy

Major code: Changes in handling practice – looking back	
Interviews with Registered Practitioners	Interviews with Health Care Assistants
Equipment can hold patients back – N3 Historic perspective, ‘the tide has changed’ – WS2, PT1, N6 Valuing equipment – WS1	‘No lifting’ approach in place now, but it’s not practical – A2, CA6
Observational Data: None	

Major code: Impact of the policy on the rehabilitation ethos	
Interviews with Registered Practitioners	Interviews with Health Care Assistants
Abdicating responsibility – N3 Contesting the policy N3, PT1, OT1 Patients need rehab – N3, N4 – ‘don’t follow the rule’ The gray area – N3, N4, WS2 Patients can’t always be ‘wrapped in cotton wool’ – M&H co-ordinator Missed opportunities for rehab	Patients need rehab – CA2 Reality versus rhetoric - CA6
Observational Data: Fieldwork Note 17/5/07	

Major code: Mandatory training – a technology of power	
Interviews with Registered Practitioners	Interviews with Health Care Assistants
The official line, working beyond the official line, questioning the ‘line’ – PT1 M&H training, the ‘bog standard patient’ – PT1,PT2, OT1 Limited impact of policy – N4 – about safety Fearing litigation – WS2, N6	‘In a court of law ‘ – CA2, CA6
Observational Data: None	

AUDIT TRAIL - CASE STUDY 2

Category 1: Facilitating Mobility Rehabilitation

Major Code: Facilitating Movement with Spinal Patients	
Interviews with Registered Practitioners	Interviews with Care Assistants
<p>The special needs of spinal patients: N1 – p2, 3, 4, 5, 13, N2 – p3, 12, N4 – p12, N5 – p2, 17, N7 – p5, N8 – p3, 4, 6</p> <p>Facilitating movement: N1 – p2, 6, p10, N2 – p14, N4 – p2, 7, N5 – p7, 9, 14, 15, 18</p> <p>N7 – p8, N8 – p6</p>	<p>Special needs of spinal patients - CA 1 – p2, CA 2 – p2</p> <p>Facilitating movement CA2 – p2,3,7</p>
<p>Observational Data:</p> <p>16/5/07 Getting Man with complex needs washed and dressed</p> <p>16/5/07 Care assistant is 'present' whilst patient tries new techniques Conversation with patient</p> <p>23/5/07 Reporting on patients progress to other team members</p> <p>23/5/07 Active and function driven nursing approach</p>	

Major Code: A Physical Job	
Interviews with Registered Practitioners	Interviews with Care Assistants
<p>Nursing auxiliaries bear the brunt: N8 – p1, N9 – p10</p> <p>Care as physical: N2 – p2, 3, N7 – p3, N4 – p8</p>	<p>Care as physical: CA 1 – p9, CA 2 – p2, 3,4, 8, 9</p> <p>CA 3 – p2, 6</p>
<p>Observational Data:</p> <p>16/5/07 Helping with shower, rolling patient</p> <p>16/5/07 Care assistants working in confined space, repetitive movements</p> <p>16/5/07 Care assistants washing patient, using equipment, but still have to lift – awkward space and equipment</p>	

Category 2: Risk in Caring

Major Code: Unacknowledged Risk	
Interviews with Registered Nurses	Interviews with Care Assistants
Struggling with equipment. Little lifts all the time: N2 – p4, 7N4 – p11 N6 – p4, N7 – p2, 3, 16, N8 – p10 Inevitability of back pain: N2 – p2,5	Lifting unavoidable: CA 1 – p3, CA 2 – p3, 9 CA 3 – p2 Inevitability of back pain: CA1 – p4,5, CA2 – p3,4,5
Observational Data 24/5/07 Helping a patient transfer from bed to chair - patients legs go into spasm, care assistant protects patient from harm, but is herself endangered 16/5/07 Care assistants provide essential care but unsafe postures are inevitable 24/5/07 Poorly designed equipment, unsafe postures, providing essential care	

Major Code: A Duty to Care	
Interviews with Registered Nurses	Interviews with Care Assistants
‘You can’t not do it’, ethic of care, a risk I’m prepared to take: N2 – p4, 5 N6 – p5, N7 – p6, N8 – 11, 12 ‘the little lifts’: N6	Lifting unavoidable – CA1, p3
Observational Data: 16/5/07 Using the Golvo, care assistants rushing so patient makes his appointment - a ‘wacky shift’ as short staffed 24/5/07 Care assistants under pressure, no housekeeper	

Category 3: A Divided Team

Major Code: Perceptions of Knowledge and Expertise	
Interviews with Registered Nurses	Interviews with Care Assistants
<p>Excluded from knowledge: N1 – p19, N2 – p9 N7 – p9 Perceptions of the negotiations: N1 – p8, 9, 10 N2 – p9, 10, N3 – p4, N5 – p6, N6 – p6, 7, 8 N7 – p9, 10, 14, 17 Nurses' status – expert or lay carer: N4 – p6 N5 – p5, 6, N6 – p9, 11, N7 – p7, 14</p>	<p>Excluded from knowledge: CA 1 – p12, CA 2 – p5, 6, 10, 12, CA 3 – p3, 4, 5 Perceptions of the negotiations: CA 1 – p10 CA 2 – p6, 7 Nurses' status: expert or lay carer</p>
<p>Observational Data: 17/5/07 Conversation with patient – nurses and physios do things differently 30/5/07 Multi-professional team meeting – transgression of occupational boundary</p>	

Major Code: The Division of Work	
Interviews with Registered Nurses	Interviews with Care Assistants
<p>Role blurring not a priority: N4 – p6, 7, 13, N5 – p8, 10, N1 – p7, N6 – p11, N7 – p9, N9 – p14 Comfortable seclusion, 'nurses don't see what happens': N1 – p6, 7, 8, N2 – p9 N8 – p15</p>	<p>CA 1 – p5, 6, 10, 11 CA 2 – p7, 9, 11 Comfortable seclusion: CA 1 – p5 CA 2 – p5</p>
<p>Observational Data: 24/5/07 Observation of OT treatment session 24/5/07 Observation of physiotherapy treatment session 24/5/07 Observation of physiotherapy treatment session</p>	

Category 4: Interpreting the Policy

Major Code: Between a Rock and a Hard Place	
Interviews with Registered Nurses	Interviews with Care Assistants
‘Lip service to nurses’ safety’, interpretation of policy: N2 – p6, 11, N3 – p2, N4 – p17, N5 – p5, 10, N6 – p2,3, N8 – p5, 11, 12 Compromise to rehabilitation, making compromises and being compromised: N3 – p1, 2, 12, N4 - p3, N5 – p11, 12, N6 – p2, 12, N9 – p6	Interpretation of policy: CA 2 – p6
Observational Data: none	

Nurses Aren’t Covered	
Interviews with Registered Nurses	Interviews with Care Assistants
Lay carer, rather than specialist handler: N3 – p3, N4 – p17, N5 – p5, 6, N7 – p17, N8 – p5 ‘One rule for us, one rule for them’ – N5, p2	Hasn’t read policy – CA2
Observational Data: Fieldwork memo 17/5/07	

AUDIT TRAIL - CASE STUDY 3

Category 1: Mobility Rehabilitation – Nursing Contributions

Empathy and Care	
Interviews with Registered Practitioners	Interviews with Care Assistants
Empathy, care, taking patients to toilet: N3, N4, N5, WS1 Indispensable backbone, reliance on care assistants: N3, N5 Movement in bed, rolling, washing: WS1	Mobility trajectory: CA3 M&H activities, stand, steps, transfers: CA5 Rapport: CA2 Care assistants more ‘hands on’ – CA4
Observational Data: 26/11/08 Registered nurse and students give patient a bed bath, then transfers patient into chair 10/12/08 Two care assistants wash a patient in bed 10/12/08 Care assistant walks with a patient to toilet 10/12/08 Care assistant walks with a patient down the ward 11/10/08 Care assistant washes patient in bed and transfers her out into chair	

Collaborating with therapists	
Interviews with Registered Practitioners	Interviews with Care Assistants
Communicating, making a judgement call, carrying on for physiotherapists: N4 Promote the rehab message, do transfers, request input: N3 ‘Carry on ‘ from therapists: WS1	Follow the ‘specifications’ of the physiotherapist and OT, symbiosis, proximity of team members, verbal updates, carryon at weekend: CA2, CA3, CA4
Observational Data: 10/12/08 Care assistants reading patients transfer instructions 11/12/08 Ward round	

Hoisting patients	
Interviews with Registered Practitioners	Interviews with Care Assistants
Start with hoist transfers: N4, WS1, N3 Valuing equipment use: N5 Hoisting for speed, hoisting because of dependency: N3	Hoist invaluable in early days, hoisting therapeutic: CA2 Extra work of using a hoist: CA1, CA4, CA5 Preference for manual handling: CA5
Observational Data:None	

Subcategory 2: Practical Know-How in Therapeutic Handling

Explanations of Therapeutic Handling	
Interviews with Registered Practitioners	Interviews with Care Assistants
Pride in being trained: N3, N4 Know the moves, but not the rationale: N5 Explaining therapeutic handling: PT1, PT2	Pride in additional skills and knowledge, explaining therapeutic handling: CA2, CA4
Observational Data 26/11/08 Observation of physiotherapy treatment session 10/12/08 Two care assistants transfer a patient from chair to bed using therapeutic transfer – two examples	

Developing and Retaining Know How	
Interviews with Registered Practitioners	Interviews with Care Assistants
Exposure, 'we just follow': N3 Limits of knowledge: N3, N5 Training, behind with training: N4 Easy to forget if not doing it: WS1 Nurses have 'know-how' rather than expertise: PT1	Training done by therapists, learn on the job, no time to stand and watch: CA2, CA3, CA4
Observational Data: 25/11/08 Registered nurse transfers a patient and later checks consistency of the manoeuvre against the physiotherapists transfer. 25/11/08 Patient's perception of nurse skill versus therapists' skill in handling 26/11/08 Patient's perception of staff skill in transfers	

Subcategory 3: Safe Systems of Work

Err on the side of caution	
Interviews with Registered Practitioners	Interviews with Care Assistants
Caution, health and safety, preventing injuries, potential for injury, physical demands: N3, N4, WS1, N5 Must follow physio advise or would 'be snookered' : WS1 Priority is to keep patients safe: N5	Lifting is banned: CA1
Observational Data: None	

Putting Up With Second Best	
Interviews with Registered Practitioners	Interviews with Care Assistants
Reliance on charitable donations: WS1 Acknowledging gaps in knowledge, lack of organisational support: N5	Acceptance of physical labour, risky activities: CA2, CA3 Safer systems of work exist elsewhere: CA1, CA3 Poor equipment design: CA4
Observational Data: None	

Subcategory 4: The Delicately Balanced Team

Perceptions of Each Other	
Interviews with Registered Practitioners	Interviews with Health Care Assistants
Physiotherapist is the decision maker, advisor, 'shows the nurses', does the full assessment; N3, N4, WS1, N5 Physiotherapists affirms jurisdiction for mobility rehabilitation, nurses have tacit knowledge: PT1, PT2 Transfers goods standard, positioning less consistent: PT1	Control and access to equipment lies with therapists: CA1, CA4 Training done by therapists: CA2, CA3 'No time to stand and watch': CA3 Learn on the job: CA4 Therapists have more time: CA2 Care assistants the last to know: CA4
Observational Data: None	

Enjoying Teamwork – Wanting More	
Interviews with Registered Nurses	Interviews with Health Care Assistants
Benefits to patients: N3, WS1. N4 Logistical barriers to TW: PT2	Desire for close teamwork, lack of time: CA5 Reminiscing about 'better days' :CA1
Observational Data: None	

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