International Journal of Orthopaedic and Trauma Nursing (2015) **19**, 24–35

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International Journal of Orthopaedic and Trauma Nursing

www.elsevier.com/locate/ijotn

Improving the experience of hip fracture care: A multidisciplinary collaborative approach to implementing evidence-based, person-centred practice

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KEYWORDS
Geriatric Medicine;
Orthopaedics;
Culture;
Communication;
Evidence-based practice

Abstract ***Background:*** Hip fracture care is well supported by national guidelines and audit that provide evidence of safe interventions and an improved process. In the drive for organisational efficiency, complications have been reduced and length of stay shortened. Prioritising targets and performance alone can lead to poor multidisciplinary communication that potentially omits the psychosocial needs of older people recovering from hip fracture.

Aim: To explore a multidisciplinary collaborative approach to implementing evidence-based, person-centred hip fracture care.

Design: Collaborative inquiry.

Methods: Sixteen clinical leaders ($n = 16$) from different disciplines, working with older people with hip fracture at different stages of the care pathway participated in eight two-hourly facilitated action meetings. Data collection included strengths and limitations of the present service, values clarification, clinical stories, review of case records and reflections on the stories of three older people and two carers.

Results: Hip fracture care was driven by service pressures, guidelines and audits. The care journey was divided into service delivery units. Professional groups worked

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http://dx.doi.org/10.1016/j.ijotn.2014.03.003

independently resulting in poor communication. Time away from practice enabled collaboration and the sharing of different perspectives.

Conclusions: Working together improved communication and enhanced understanding of the whole care experience.

Implications for practice: Enabling teams to find evidence of safe, effective person-centred cultures requires facilitated time for reflective practice.

Editor comments

It has long been recommended that the care of the patient following hip fracture requires well coordinated multidisciplinary effort in order to ensure that it is both effective and patient-centred. Even so, it is often felt that such an approach is not as well executed in practice as it is sold in theory and that true collaboration can be restricted by the professional culture in the care setting. This important study helps practitioners, leaders and managers to begin to understand the drivers and the inhibitors that need to be overcome before real progress can be made in making the intentions of multidisciplinary care a reality for this vulnerable group of patients.

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Introduction

The national quality strategy provides direction for the delivery of best quality care that is person-centred, safe and effective (Scottish Government [SG], 2010). In hip fracture care there are national standards, evidence-based guidelines and abundant data from a national audit (Clinical Standards Board for Scotland [CSBS], 2002; NHS National Service Scotland [NHS NSS], 2005, 2008; NHS Quality Improvement Scotland [NHS QIS], 2004; Scottish Intercollegiate Guidelines Network [SIGN], 2009) that help demonstrate a measurable impact in terms of reduction in preoperative delay, length of hospital stay and functional ability (Currie and Hutchison, 2005; NHS NSS, 2005). However, despite early surgical fixation, many of the frail older people with hip fracture are unable to regain their pre-injury level of function and independence (Cooper, 1997; Koval et al., 1997; Olssen et al., 2007a; Sirkka and Branholm, 2003) and many are at risk of poor outcomes (Hart et al., 2002; Magaziner et al., 2000).

Recovery following hip fracture has tended to take a restorative approach, providing safe physical recovery through standardised care pathways (British Orthopaedic Association [BOA], 2007; Crotty et al., 2010; Eastwood et al., 2002; Egol et al., 1997; Giaquinto et al., 2000; Koot et al., 2000; Olssen et al., 2007a). At each stage of the care journey, older people meet many different disciplines, specialities and agencies (Askham, 2008; Boockvar et al., 2004; Olssen et al., 2007a; Tierney and Vallis, 1999; Tierney et al., 1998). The presence of an identified leader and caring behaviours of staff were valued and contributed to the experience in a variety of ways (Hallstrom et al., 2000; Hommel and Thorngren, 2003; Huby et al., 2004; Nahm et al., 2010; O'Brien and Fothergill-Bourbonnais, 2004). The older person's perspective of hip fracture has been explored in terms of the individual knowledge and zest for life; the pain; the struggle to move; the need for help with activities of daily living and coming to terms with the decline in physical function (Archibald, 2003; Olssen et al., 2007b; Ziden et al., 2008). However, there is little convincing evidence that guidelines alone improved overall experience of care (Atwal and Caldwell, 2002; Cameron, 2003; O'Connor, 2005).

The culture of hip fracture care can be complex and there can be discrepancies between actual practice and declared protocols at almost every stage of the pathway (Tierney, 1997; Tierney and Vallis, 1999; Tierney et al., 1997). The difference in values between quality improvement processes, evidence-base practice and person-centred practice can tug practitioners in different directions creating stress and confusion in the workplace (Cuthbert and Quallington, 2008; Tutton et al., 2007; Walsh et al., 2011; Woodbridge and Fulford, 2004) potentially hindering the delivery of safe, effective person-centred practice (Christie et al., 2012; Edvardsson et al., 2009; Rycroft-Malone et al., 2002, 2004b; Titchen and Manley, 2006).

Collaboration between multidisciplinary teams in Orthopaedic and Geriatric Medicine can improve quality and reduce cost (Atwal and Caldwell, 2005; Beaupre et al., 2005; Cameron et al., 2000; Christmas

et al., 2003; Handoll and Parker, 2006; Healee et al., 2011; Koval and Cooley, 2005; Oliver, 2005, 2008; Watters and Moran, 2006) but can also be fraught with difficulties (Atwal and Caldwell, 2002; Taylor et al., 2010; Tierney and Vallis, 1999). In some cultures, developing facilitative leadership roles has helped improve communication between care providers across the care journey, so increasing satisfaction (Hardy et al., 2006; Hickman et al., 2007; Manley et al., 2005, 2008; McCabe and Timmins, 2006; Watters and Moran, 2006). This support enables healthcare practitioners to identify different ways of tackling challenging issues (McCormack and Garbett, 2003; Walsh et al., 2011) and to experience implementing research into day to day work (Manley and McCormack, 2004; Rycroft-Malone, 2004a, 2004b; Rycroft-Malone et al., 2004a).

Aim

To explore a multidisciplinary collaborative approach to evidence-based, person-centred hip fracture care.

Method

Collaborative inquiry sits in the evolving paradigm of human inquiry that values adult education, participation, democracy and transformative learning (Bray et al., 2000). The approach is underpinned by the combination of critical theory and the concept of life-world (Habermas, 1978); the action orientated approach to learning from experience (Mezirow, 2000) and the humanistic psychology of person-centred practice (Rogers, 2004). The process draws on the practical use of language used in a shared experiential context (Guba and Lincoln, 2005) and develops new understandings known as 'living knowledge' that is useful to the participants in their everyday working lives (Reason and Bradbury, 2001).

Ethics

Ethical approval was sought from the University Faculty Research Committee [UFRC] and Ethical Governance Committee [EGC], the Local Research Ethics Committee [LREC] and then the Research and Development Department of the Health Board. The invitation to clinical leaders, patients and carers to participate was supported with written information. Written consent was obtained at the start of the study and verbally at each stage of the study. It was emphasised throughout that participation was voluntary and participants could withdraw at any time without repercussions.

Sample

Sixteen clinical leaders, three patients and two carers volunteered to participate. The clinical leaders were from different disciplines, were knowledgeable in the field of hip fracture care and were in a position to influence others. The patients were over 65 years of age and had experienced and recovered from hip fracture. The carers were over 18 years of age and cared for a family member who had experienced hip fracture.

Researcher's role

The researcher role involved creating a safe, trusting environment; valuing experience and encouraging reflection and action (Bray et al., 2000). Care was taken to deal with stress immediately and directly by addressing issues as they arose.

Data collection

The data was collected during eight two-hour action meetings and is presented in three main stages: introduction; story telling and reflection on patients' and carers' stories.

Stage 1 – Introduction

The background to the study was explored and ground rules were agreed. Experiential learning approaches were used to enable the group to realise how attitudes, values and behaviours may be preventing change in practice (Burnard, 2002; Manley and McCormack, 2004; Mezirow, 2000; Sharp, 2005). The strengths and limitations of the hip fracture service at different stages of the care pathway were identified. Developing a set of shared values and beliefs about hip fracture care ensured that individual experiences, concerns, values and differing points of view were received by all members of the group (Brydon-Millar, 2008; Dewing, 2007). Developing a shared vision gave direction and provided a basis for evaluation (Dewing, 2007).

Stage 2 – Story-telling

Participants provided evidence in the form of a story of their experience in practice and their understanding of safe, effective, person-centred hip fracture care. Story-telling enabled participants to share their experience whilst hearing the experience of others (Bray et al., 2000). One healthcare and one social

care case record was explored and new shared criteria for person-centred record keeping was developed by the group.

Stage 3 – Reflection on patients and carers stories

The patients and carers participated in semi-structured interviews to tell their stories of the journey from injury through to getting home. Clinical leaders reflected on excerpts from these stories and identified their learning.

Analysis

Content analysis (Cohen et al., 2000) was used to develop themes and sub themes from the data sets that included: meeting notes and transcripts, interview transcripts, flip charts, reflections and evaluations.

A creative interactive person-centred workshop enabled the participants and their managers to work together to review the data and to develop a framework of the risks, actions and outcomes of person-centred practice. To enhance rigour, this same workshop was repeated with a group of practice development nurses and again with a group of healthcare lecturers.

The themes and sub-themes from this framework were then linked together using a conditional matrix (Miles and Huberman, 1994). An immersive process of listening helped develop a deeper understanding of all the data collected (Waithe, 2007). Finally, applying stages of critical reflexivity (Mezirow, 2000) enabled the development of key theoretical messages. Fig. 1 shows the Haiku, traditional Japanese poetry (Toyomasu, 2001), chosen to help capture the meaning of the 'lived experience' of developing practice in hip fracture care.

Limitations of this study

This longitudinal study was carried out in one Health Board. Time away from the clinical commitments for participants had to be justified and initially there were fiscal demands in terms of backfill. Due to clinical commitments not all the clinical leaders were able to participate as fully as they would have liked. Withdrawing support at the end of the study was very difficult as the input was valued and needed to continue.

Results

There are four main phases to the findings of this study: What it was like; overcoming the risks together; thinking differently and, finally, the enhanced experience.

What it was like

Each stage of the older person's journey following hip fracture care was managed by a large multidisciplinary team. There was a rapid journey from the accident to the emergency department where a '*dedicated radiographer takes an X-ray for a quick diagnosis*' *(Flipchart [Fc] 1)* and '*liaised with theatre if required*' *(Fc1)*. There were surgeons '*proficient at the hip operation*' *(Fc1)* and anaesthetists '*who*

Promoting person-centred practice			
Phase 1 Risks	**Phase 2 Actions**	**Phase 3 Actions**	**Phase 4 Outcomes**
Negative culture Top down driven by policy Risk tick box quick fix			
Hierarchy rules Telling taking punishing Getting row again	Leadership teamwork Expertise experience Dynamics values	Respect uniqueness Individuality Positive regard	Listened to informed Being true to self and others Honest realistic
Fast Austin Moores They are going to get more through Depersonalised	Vulnerability Find space, taking time to think Being together	Active listening Respect reciprocity Helping each other	Motivate involved Patient as team member good Same goal solutions
Frustration anger Doubtful it will ever change Powerlessness escape	Shock anxiety Acknowledging fear Feels overwhelming	Safe, never alone Team feelings are important We are people too	Little things matter Refreshed enlightened insight Uniqueness valued
Repetition lack of continuity poor communication	Many obstacles Aha! Able to challenge Soon to move forward	Empathy insight Seeing person not injury Targets are not concern	Choice gives confidence Personal priorities Flourishing pathway
Researchers reflections			
Conflicting values When care is reduced to tasks The person is lost	Stronger positive Light is beginning to shine Things can be better	See through personís eyes Understanding awareness Othersí perspectives	Interactive group Reflective time, develops Knowledge of practice

Fig. 1 Haiku developed to illustrate the story of developing practice in hip fracture care.

are willing to do slightly sick patients' (Fc1). There was pharmacy input for '*review of patient medications and the management of poly-pharmacy issues' (Fc1)*. There were '*two case planning meetings per week' (Fc1)* involving *'a multidisciplinary team discussion regarding patient participation and awareness'* (Fc1). There was '*good community liaison between hospital and home*' (Fc3). However, the focus was very much on professional work rather than the person being cared for.

In acute care the care pathway document based on the national guidelines was used to guide the care-giving process. Various risk management tools, perceived to be management initiatives, were added to the patient's records and resulted in unwieldy files.

'*The problem is that the care pathway, in order to incorporate everything, has got to be so big and complicated and then you've got extra bits of paper on top of it*' (6.454 Geriatrician).

The type of prosthesis used to fix the hip fracture was perceived to be important. There was a need to balance best surgical practice with the financial restraints and individual patient's needs in terms of physical ability. Rather than referring to people the conversation was about the 'prosthesis'.

'*. . .if they come from a nursing home they will automatically be thinking Austin Moore's.. . .. . .which is a perfectly good procedure for someone who they don't think is going to go very far on the outside. . .*' (1.174 Theatre nurse)

'*. . .the SIGN guidelines recommend bi-polar for all patients rather than Moore's*' (1.192 Physio 2).

The group laughed together about the speed in which everything was carried out; the focus was on the beds rather than individual needs.

'*I mean, they do their operations and they try to get them here as quick as they can*' (4.480 Theatre nurse) [laughter];

'*I've been on that side and I know how it works; We're laughing because it just sums it up so beautifully*' (4.484 Rehabilitation Nurse 3).

'*the bed managers come on and put the pressure on the ward staff*' (6.1385 Surgical Nurse).

So those delivering the care created a language that depersonalised the situation and those being cared for to '*risk assessment*', '*prosthesis*', '*quick fixes*' and '*transfers*'.

The organisation was described as being '*byzantine in structure*' (Evaluation [Ev] 8 Geriatrician). The system was over-elaborate with many levels and positions that were impossible to make sense of. The cause of the problems was perceived to be governmental in terms of lack of resources.

'*Money is the driving force*' (Ev8 Physio 1).

'*I feel that funding/bed crisis/number crunching on the organisation are one of the main causes of all the problems*' (Ev8 Community Nurse).

Alarmingly, the drive to manage risk and monitor performance was not improving care as it had intended to do but creating a culture of fear.

'*Big people. . .. . .Big people up there*' (5.501 Radiographer).

'*So everything is about risk management. . .but it's also about watching your back, protecting yourself*' (2.340 OT3).

'*Pressure from above means, we, as a team cannot function efficiently*' (Ev8 Community Nurse).

The perceived lack of control and involvement led to a lack of autonomy which was at odds with individuals' professional status. There was a lot of anger and frustration with the system.

'*[There is] frustration about the inability to influence the bigger picture*' (Ev8 Physio1).

'*The system frustrates me greatly. I hate how the organisation thinks targets are more important than patient care, particularly when they fix the statistics to meet targets anyway! At what cost!*' (Ev8 Social worker).

There was sense of striving for the best but finding that the system was not helping.

'*I already do try to think of the patient in making decisions involving disruption e.g. ward moves, clinic visits but the system often overrides me*' (Ev8 Geriatrician).

'*I am keen to change to improve things but feel limitations in power*' (Ev8 Physio 2).

'*Mostly we want the same things for patients but feel powerless to change the bigger structure of the whole system*' (Ev8 Social worker).

There were strengths in the multiprofessional team working but there were concerns about communication. The conflicting experiences mixed messages, '*lack of joined up-ness*' (*Fc4*) and '*lack of continuity*' (Fc4) were creating confusion and a lack of understanding (Fig. 2).

The tactic of focussing on the wider agenda allowed the team to deflect difficult issues. Time was wasted gathering information from different places.

The system was trying to be cost-effective and efficient but was having difficulty doing so.

'*Lots of people are trying to give good care but we are hampered by a fragmented system and need for reassessment and repetition due to poor communication/documentation – individuals are isolated*' (Ev8 Geriatrician).

To cope with the conflicting demands the healthcare professionals become emotionally detached and depersonalise the situation. Feelings and emotions appear to be ignored. This increased stress and defence mechanisms were used to cover up the anxiety and discomfort of trying to meet the conflicting demands. The whole organisation at every level appeared to be lacking awareness and understanding. These hidden feelings, the communication difficulties and the resulting lack of understanding were impacting on care delivery.

Overcoming the risks together

Listening to the release of feelings and emotions from the group was not easy. There appeared to be much hidden knowledge and understanding that needed to be uncovered and used effectively. Focussing on finding shared meaning of evidence-based person-centred practice helped this process. There was a stark comparison between the values underpinning person-centred practice in terms of '*empathy, trust, understanding needs and building relationships*' *(Fc4)* and the '*guidelines, targets, standards, goal setting and measurement*' (Fc5) required of the evidence-based practice and performance agenda. The group suggested that perhaps '*more caring and less measurement may be better*' *(Ev2)*. By working together and building trust through understanding the group were able to share their expertise, experiences and values and in turn build up their group strength to recognise the challenges ahead.

Initially, the enormity of the change felt overwhelming. There was a feeling of desperation.

'*What we have to change feels impossible in the face of bed pressures/lack of resources/the huge organisational issues; there is so much work there is to do on the negatives*' (Ev3 g).

'*Feels overwhelming; don't know how this will end*' (Ev3f).

'*Will this actually change anything?*' (Ev3e).

Expressing and acknowledging these feelings together enabled the group to reflect.

'*There are clinical time restraints and it is not easy to be away from team*' (Ev3b),

'*time is luxury*' (Ev8 Physio1).

'*At the same time there is a lot of wasted time that*

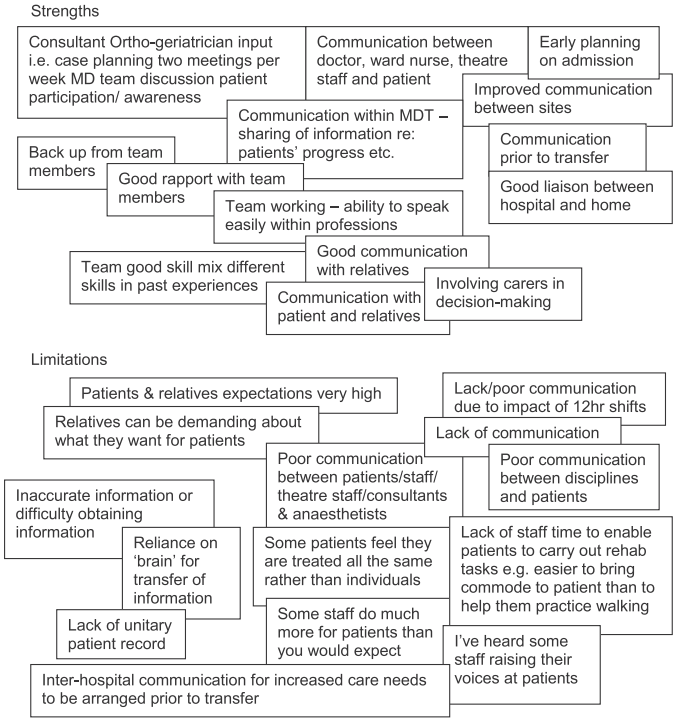

Fig. 2 Communication issues highlighted as strengths and limitations.

could be used better' (Ev2).

It was beginning to dawn that there were some really small ways that big issues could be addressed. The records were focussed on medical diagnosis and treatment; there were results of investigations, nursing care plans, actions and evaluations and risk assessments, many of which were incomplete. This was a big shock that helped the whole group realise that they all had a part to play in making sure their practice and record keeping matched their understanding and beliefs about evidence-based, person-centred practice.

They could see that the challenge was not only to bridge the gap between acute and primary care but to bridge the gap between the expectation of the national standards and what was actually happening in practice. Working together they created shared criteria for person-centred records (Fig. 3).

Thinking differently

Demonstrating understanding of the situation created trust and reduced stress. Meeting and working together had helped in

'*Developing stronger relations with other members of the team and gaining greater understanding of their working pressures*' (Ev3c, Ev8, Rehabilitation Nurse 3).

The group were valuing each other's skills, strengths and professional knowledge.

'*The team is more diverse than I realised*' (Ev8 Dietician).

'*The team worked well together*' (Ev8 OT1),

'*everyone is enthusiastic*' (Ev8 Physio2).

'. . .*aiming for best care for the patient*' (Ev8 Community Nurse).

The space to share ideas had freed the group of some of the obstacles that may have been contributing to the negativity that potentially develops when working alone within a critical environment.

'*I enjoyed having time and opportunity to discuss and share*' (Ev3d).

'*I feel I have voice*' (Ev1).

'*There is freedom of speech and discussion*' (Ev1, Ev2).

'. . .*realising everyone has difficulties*' (Ev1g)

'*there are lot of positives in what we do*' (Ev1);

'*good things happening in the service*' (Ev1).

There was a sense of belonging and acceptance that they could work together as a team. The strength of their shared learning was evident as they

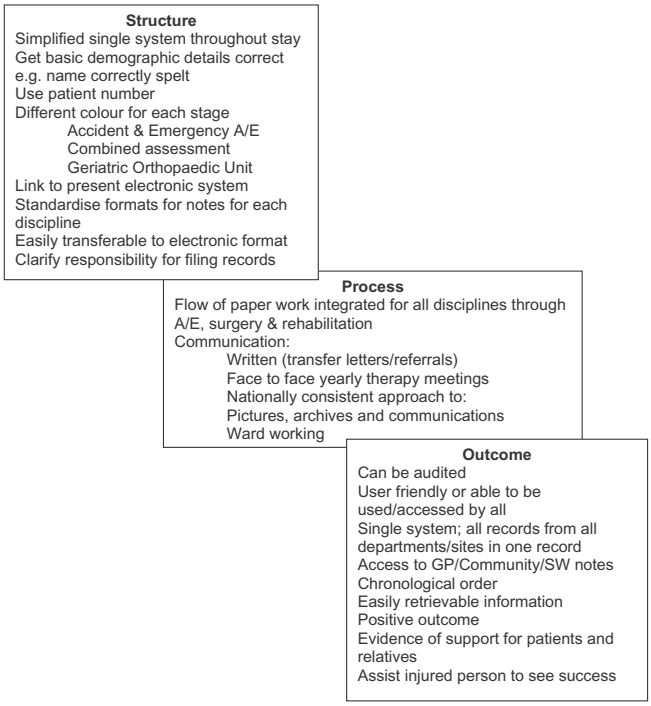

Fig. 3 The wish lists for a unified person-centred record focussing on structure, process and outcome.

recognised the need to move away from profession specific work to an interprofessional approach involving all disciplines with the older persons' experience as the focus.

The team had developed awareness of themselves and each other and had better understanding of the support that working together could bring.

'*This has given me greater understanding of the shared frustrations we have and shared motivation to do a good job*' (Ev8 OT3; Ev8 Community Nurse);

'*support from other members of the team, sharing experiences*' (Ev3e);

'*I enjoyed having time and opportunity to discuss and share*' (Ev3d).

The team chose to reflect on excerpts from the stories told by the patients and carers. The details of these stories are reported in another paper. Seeing the whole picture, they acknowledged the diversity of experience and highlighted some of the difficulties experienced in the journey to recovery following hip fracture.

'*We have learned lots about the patient journey and now understand this better*' (AR8 Dietician).

'*It shows how complex a journey can be from place to place and you know, quite complex things might happen to the person*' (6.675 OT3).

'*Increased awareness that patient may find things more important than I would; NHS targets are not concern to patients*' (AR8 Physio 2).

The enhanced experience

By reflecting on all these experiences, the older peoples' and carers' voices had been heard. As a result, the team awareness of the hip fracture experience was heightened. The team felt comfortable, refreshed and enlightened. They had recognised the complexities of the journey following hip fracture. They could see the small things that they could change that would make a difference to the patients' and carers' experience.

Welcoming, accepting and knowing the best way to do something gave reassurance and feelings of safety which made a big difference to patients and carers. It was important to get to know the people to enhance the experience for this vulnerable group of patients and to have some continuity of care between the care settings.

'*We need to spend more time with them and sit and talk with them*' (AR8 group reflections).

'*See if anything can be done to make it easier for them to make the transition from hospital to home*' (Ev8 Rehabilitation Nurse 3).

The team recognised the need to know and understand each other and the patients for whom they cared. One way forward was to give information and to check understanding.

'*Patients need to understand rationale. We need to ensure we are communicating effectively; we need to check understanding*' (AR8 group reflection).

The team developed a better understanding of the people they were caring for. They were no longer the '*hip fracture*' or '*the prosthesis*' but people with interesting lives, responsibilities and hobbies.

'*Older people still enjoyed activities, were still able to participate or reminisce. It was important to see the patient as a whole person with a life beyond hip fracture care*' (AR8 group reflections).

Having time for reflection, the clinical leaders had stopped hiding behind the facade of the workplace pressures, responsibilities and busy duties. They were now able to see the whole picture and were more in tune with the contributions that each discipline brought to the whole experience.

Discussion

The national hip fracture guidelines (SIGN, 2009) and standards (CSBS, 2002), generated from knowledge dominated by the positivist paradigm, provide systematically collated clinical evidence as a guide to improving the quality of care (Olssen et al., 2007a). The implementation of these standards and guidelines were reinforced by the national audit (NHS NSS, 2005, 2008). This resulted in the service delivery being driven by risk management, evidence-based practice and targets. This approach was accepted as safe and effective practice but there were risks in that the 'softer' caring aspects of the recovery process were being overlooked (Godfrey and Townsend, 2008). The dominant evidence-based perspective, along with the government performance targets, was expecting the practitioners to behave in a way that unintentionally deprived the older person of their dignity.

At each stage of hip fracture care, healthcare professionals with a variety of specialist experience, knowledge and expertise work independently delivering care within their remit. This led to each discipline driving their own knowledge-based goals and priorities and also contributed to the fragmentation of the patient's treatment and care. Findings of a fragmented service in care of older people were

not unusual (Askham, 2008) but in this study this appeared to have an adverse impact on the perceived quality. There was little evidence of integrated care.

As other studies had found; care pathways were not enabling the different disciplines to work effectively together (Atwal and Caldwell, 2005) and had little impact from a patients' satisfaction point of view (Olssen et al., 2007a). Individual professions identified more with their professional than their interprofessional colleagues, thus retaining their individual professional identities. The focus was on professional priorities rather than the person being cared for.

The favoured leadership style was control and delegation that conflicted with the co-ordinated clinical pathway approach that required different disciplines to contribute equally (Atwal and Caldwell, 2005). There was poor communication between the managers who were trying to meet the performance targets and the multidisciplinary team who were trying to deliver the care. Previous studies showed a lack of understanding between disciplines of each individual's contribution to the whole pathway of care (Atwal and Caldwell, 2005; Cameron, 2003). There appeared to be enormous differences between individual, team and management expectations in terms of goals and outcomes for the journey of care as well as many problems in the system (Tierney, 1997; Tierney and Vallis, 1999; Tierney et al., 1997). Influenced by the technical structural–functionalist view, which is blind to feelings and emotions (Walsh et al., 2011) this workplace culture was creating tensions. To cope with this, the team had become emotionally detached, depersonalised the situation, rationalised their actions and blamed the system.

In a workplace of scrutiny, audit and review creating a safe environment for reflection and learning was paramount and drew on previous practice development work where leadership and facilitation crossed traditional care boundaries (Hickman et al., 2007; Manley et al., 2005, 2008). Involving participants from different settings helped overcome the natural divisions inherent in organisational structures and to ensure a continuous focus on the care pathway for the older person and those close to them.

There was a feeling of doom and despondency experienced by individuals in the group. Problems were perceived to be external to the group and, initially, there was no evidence of a desire to change. The uncertainty, fear, anger and frustration created stress and it didn't seem to be getting better. From a person-centred perspective this was the evidence of the first stage of the change process (Rogers, 2004).

Discussing clinical stories in this mutually supportive way was essential in helping to break down perceptions of 'us and them' and reducing scapegoating and blame by sharing humanity and in recognising similarities rather than differences. Participating in a supportive environment where the group did not have to take the initiative enabled them to express the overwhelming nature of change (Burnard, 2002; Rogers, 2004). Through working together and building trust the group were able to share their expertise, experiences and values and in turn build up their group strength to recognise the challenge ahead. The time no longer felt wasted; instead it was perceived to be a valuable support. Developing ethical awareness in action challenged the complexity of individual autonomy versus collective action (Brydon-Millar, 2008). The freedom of discussion removed obstacles that were contributing to poor communication. The group developed as a team; thinking differently, seeing each other's perspectives and demonstrating more order in their thoughts and actions.

Reflecting on excerpts from the patients' and carers' stories of each stage of the journey to recovery following hip fracture continued the person-centred focus and highlighted some of the difficulties experienced in the journey to recovery following hip fracture. Many of these difficulties were not new and had been recognised in national policy and reported in other research studies (Askham, 2008; Boockvar et al., 2004; Nahm et al., 2010; Tierney et al., 1998). The implementation of this participatory collaborative process enabled the multidisciplinary group to see the whole patient journey, to share understandings, and to become a team. This supported the suggestion that a multidisciplinary model of care could result in an improvement in the care of older people with hip fracture (Christmas et al., 2003; Handoll and Parker, 2006; Oliver, 2005).

Conclusion

By creating a positive learning environment, the team had an opportunity to work across boundaries, to develop shared values and to find evidence of these in practice. There was a need to continue the facilitated time out in order to further develop this collaborative multidisciplinary approach to hip fracture care.

Contributions

Concept and design JC.

Analysis and interpretation JC, MMac, CC, GM-S.

Draft of paper and critical review JC, MMac, CC, GM-S.

Approval of final version JC, MMac, CC, GM-S.

Conflict of interest statement

There are no known conflicts of interest.

Funding source

The Centre for Integrated Healthcare Research funded this study.

Ethical approval

This manuscript contains a statement that the work has been approved by the appropriate ethical committees, institutional review board or other relevant bodies within the institution(s) in which it was performed and that subjects gave informed consent to the work.

Acknowledgements

The authors would like to thank the older people, carers and healthcare professionals who participated in this study; the Centre for Integrated Healthcare Research for the funding and the other academic staff who gave their time and support in the initial stages of this development.

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