

A Study on Patient Experience of Moving and Handling in Hospitals

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Declaration

I declare that the work in this thesis is my own unless where otherwise stated.

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Abstract

Aim: The aim of the study is to develop a theory of factors that influence the patient experience of being moved and handled in hospitals.

Background: The implementation of manual handling policy has been publicly criticised in community settings, but there is little knowledge of the in-patient experience. This study sought to discover the in-patient perspective on this aspect of care in hospitals.

Methodology: A constructivist grounded theory approach was employed. Theoretical sampling technique continued until data saturation was reached. Constant comparative analysis was used to produce a theory from categories and themes.

Conduct: Eleven patients from two rehabilitation hospitals participated in semi-structured interviews. Most participants had recent experience of the acute hospital setting.

Findings: Participants did not distinguish moving and handling as a discreet element of care, but rather perceived it as an integral part of care delivery. Participants described how the manner of care delivery was more important than the mechanics. The analysis of data indicated that expectations of care grew through the recovery process and capacity to influence the delivery of care also increased. The emergent theory linked Maslow's 1943 theory of self-actualisation, patients' expectations of care and their capacity to influence care. Capacity to influence care moves through stages, from yielding when physical needs are greatest, to asserting when there is a need for autonomy.

Conclusion: The study theorised that as patients move through stages of recovery, their expectations of care and their capacity to influence care increases. This can provide understanding of patient motivation and opportunity for nurse support.

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Chapter 1. Introduction

'Manual handling' is the term used in occupational health and safety organisations and safety legislation to describe manual labour at work. It applies to any use of bodily force (for example, lifting, pushing, pulling, throwing) by the worker to move a load (Manual Handling Operations Regulations 1992 (as amended 2002)).

'Moving and handling' is the term more commonly used in the health and social care industry to describe the manual handling of people and the training of the workforce in the necessary skills (Hares and Wanless 2018). This introductory chapter firstly describes the need for control of manual handling risk (Section 1.1) and subsequently the challenges of implementing the regulations when the 'load' is a person (Section 1.2). These sections outline the regulatory framework and effects of manual handling upon healthcare workers, then provides background indicating that the patient experience of being physically assisted in hospital, may not be commensurate with patient choice.

1.1. The Regulatory Background

Health professionals need protection from manual handling risk. The Health and Safety Executive (HSE) identifies that they have a higher than average prevalence of work-related musculoskeletal disorders compared to the general United Kingdom (UK) workforce (Health and Safety Executive 2019). The annual HSE survey shows a prevalence rate per 100,000 employees of 1380 for 'Human Health and Social Work Activities', compared to 1160 for 'All Industries' and can be contrasted, for example, with the rate of 910 of those who work in 'Education'. General practitioners surveyed by the HSE identified manual handling activities as the major causative factor for those experiencing musculoskeletal disorders at work. The high rate of ill-health and the need to comply with the regulations, prompted the Royal College of Nursing's (RCN) recommendations that care organisations develop 'Minimal Lifting Policy' documents specifying that lifting people be avoided in all but life-threatening circumstances (RCN 1996). UK hospitals implemented these 'no lift' policies to comply with the RCN's interpretation of the regulations (Monaghan et al. 1998). The guidance has been reviewed several times and currently uses the term

'moving and handling', more accurately reflecting the definition of 'manual handling' in the regulations that incorporates aspects such as pushing and pulling, not exclusively lifting (RCN 2019). There is a widespread enduring belief that "healthcare professionals should not physically lift patients" because the regulations prohibit this form of manual handling people (Todd et al. 2014, pp.6).

The Manual Handling Operations Regulations are precise in the definition of a load (Reg. 2) and includes "any person and any animal." There is no ambiguity, the handling of people is subject to the regulations. The schedule to the regulations defines ergonomic factors that should be assessed relating to manual handling operations. These factors are: the nature of the task, the individual capability of the handler, the physical characteristics of the load, and the hazards present in the environment. The regulations do not prohibit lifting people, but a person is a load and the load must be assessed before manual handling is undertaken.

The HSE provides guidance on the regulations (HSE 2016). This includes a risk filter with guideline weights under which the load should not require detailed assessment. The guideline weight for a female handler lifting at the optimal height (near the waist) is 16 kg. The figure for a female is used here as the majority of the nursing workforce are women (NHS Scotland Information Services Division 2019). An additional handler adds only 30% of the combined capacity due to additional risks in team handling, for example, equal distribution of the load and coordination of movement. The guidance suggests a weight of 25 kilograms is acceptable for two female handlers, well below the weight of most adults. Weights above this guideline figure require further assessment to reduce risk, mechanising the task is generally recommended. Government statistics focus on body mass index rather than weight. These statistics reveal that 65 percent of adults in Scotland are overweight, with 29 percent categorised as obese or very obese (Scottish Government 2018a). A large team of handlers would be required to lift even an underweight adult, yet the HSE (2016) advise that "Teams of more than four members are unlikely to work unless managed very carefully" (p.36). The heavy weight and other risks presenting in an adult

person as a load (for example bulk, no secure handholds, likelihood of shifting during the manoeuvre) could be interpreted as a legislative ban on lifting. The adoption of 'no lift' policies may have been a useful heuristic to assist nurses and other health professionals in decision making, but these policies are sometimes unreasonable when put into practice.

1.2. Loads with Rights

The interpretation of the regulations as a lifting ban can adversely impact on those being cared for and may deny them human rights. Local Authorities adopted blanket 'no lifting' policies and threatened to withdraw care if clients refused to use a hoist for carers protection (Mandelstam 2005). In some instances, Authorities insisted that clients would be better cared for in care homes, threatening to separate families (Cunningham 2002). An elderly man was found guilty of attempted manslaughter when he tried to kill himself and his wife who suffered from Alzheimer's disease (Dimond 2000). His suicide note blamed a social worker and the care company that had threatened to withdraw the carers who visited three times daily unless he accepted a hoist into the house. This ultimatum was described in the Guardian newspaper as "the straw that broke the camel's back" (Kelso 2000). Dimmond (2000) argues that this is a breach of Article 2 of the Human Rights Act 1998 (HRA), the right to life.

Additional HRA Articles that Dimmond claimed no lift policies could invoke are:

- Article 3, Right to freedom from inhumane or degrading treatment or punishment,
- Article 5, Right to liberty and security,
- Article 8, Right to dignity and family life.

An English civil court case regarding the handling of people involved two adult sisters reliant on carers to move (R v East Sussex County Council 2003). This landmark legal decision has become referred to in manual handling literature as the 'East Sussex case' (Mandelstam 2005). Presiding Justice Munby determined that the needs of the person being cared for had to be assessed against the rights of the workers. He found blanket 'no lifting' policies to be unlawful as they had potential to breach Article 8 of the Human Rights Act 1998, the right to dignity and a family life. The East Sussex case indicates that being

reliant upon others to move can affect a person's lifestyle and relationship with society. The East Sussex case ruling was considered to have implications for the rights of hospital in-patients versus the rights of nurses to be safe at work (Fullbrook 2004).

The judgement that restrictions being imposed on how a person is moved is potentially a breach of Human Rights should also be considered in terms of patient rights. The Patient Rights (Scotland) Act 2011 enshrines the need for a patient focussed service. Section 3.2(c) of the Act specifies that healthcare must *“allow and encourage the patient to participate as fully as possible in decisions relating to the patients' health and wellbeing.”* The implication of this being that the patient should be a partner in planning how aspects of care are delivered. There is an expected standard of patient and public involvement, how NHS Boards in Scotland perform against the standard is monitored (Scottish Health Council 2010). The right of patients to participate in decision making, supplements their human rights to dignity and a family life.

Experiences of service users in non-hospital environments, such as the East Sussex case in community care, has led to much discussion on the impact of moving and handling care implementation. A report on children and young people with disabilities' experiences of manual handling in Scotland, found that poor work practice may breach children's rights and could be harmful to child welfare (Paton 2008). One child described the embarrassment she felt going to the toilet at school. The child would be wheeled down the main corridor in her wheelchair by a teaching assistant, followed by another assistant pushing a mechanical hoist. She felt humiliated that her personal care needs were made visible to all her schoolmates. The report made several recommendations to the Scottish Government. It suggested changing statutory instruments such as the Manual Handling Operations Regulations and including specifications that people should not be treated in the same way as inanimate loads (p.70). Other recommendations of the report were for organisations to establish clear lines of responsibility and employ practices to ensure that a risk adverse culture does not override individual preferences.

At the opposite end of the age spectrum, Taylor et al.'s (2014) ethnographic study observed older adults in care homes. This study on mobility observed and interviewed 15 residents for 20 months. They reported that the care home residents were unaware that they had any choice in how they mobilised. If offered physical help from a carer to rise from a chair, the resident would simply allow it. The study concluded that the acceptance of assistance in the perceived absence of choice impacted on residents' mobility and quality of life. The findings of this small-scale study require further support to assess if they can be generalised across the care sector.

Investigating and documenting the experiences of people receiving mobility assistance in a variety of settings (at home, in school or in care facilities) provides important insights on the effect of that care on an individual's rights and autonomy. Listening to the personal experience of those being cared for also generated recommendations for improving how care is delivered. This study wishes to examine the patient experience of moving and handling in hospitals.

1.3. Moving and Handling in Hospitals

Few analytical studies of patient groups needing assistance to move in hospitals were found in the course of this study. Most of the available literature is presented from the perspective of investigations on the occupational health and safety of nurses. In his review of back pain in nurses, Pheasant (1997) indicates that some nursing specialties have a higher than average prevalence of acute back pain. The annual prevalence for acute back pain in these areas was higher than for all nurses in general (19 percent): 'General Medicine' (37 percent), 'Geriatrics' (34 percent) and 'Orthopaedics' (34 percent). Pheasant described that these specialties also involve a high instance of manual handling.

The correlation between back pain and manual handling activities (Pheasant 1997, HSE 2019) indicates nursing specialties where moving and handling patients might take place. This helped to identify locations where there are patients who regularly experience being aided to move by caregivers. The only widescale UK study focussed on identification of in-patient groups that need

'lifting' I was able to find was an outdated survey conducted by Bell (1984), there seems to be no recent similar explorations. Bell surveyed 725 wards in 83 hospitals of an NHS Board in Scotland and an NHS Trust in England. Of the 13,107 in-patients at that time, 28 percent required 'lifting' (n=3,629). The study defines the largest single specialty group as 'Geriatric' (38.7 percent), followed by 'General Medicine' (12.5 percent), 'General Surgical' (8.1 percent) and 'Orthopaedics' (5 percent). A recent survey in the United States (Kayser et al. 2020) found that only 3.7% of patients in Acute hospitals used hoists but this is not comparable because of differing legislative requirements. Kayser et al. (2020) noted that in those States with lifting legislation, patients were 59.8% more likely to have used lifts. Legislation in relation to manual handling is in its infancy in the United States, whereas it has been statute in the UK for almost three decades. The specialties identified by Bell (1984) are similar to those identified as the working areas of nurses who suffered onset of acute back pain related to the handling of patients.

The intent of this study is to explore the experience of patients moved and handled by healthcare workers in hospitals; factors perceived as relevant, and whether impact on rights, mobility and self-determination exists. Before describing the development of the research aim, I will outline my clinical background and why I chose this topic to study.

1.4. Clinical Background

My background is as a Registered Mental Nurse and I became involved in delivering moving and handling training to nursing colleagues in 1992. A large NHS Community and Mental Health Services Trust offered me a secondment as a specialist Moving and Handling Adviser in 1996, and I have specialised in this and allied themes since (for example, reducing exposure to risk factors of work-related musculoskeletal disorders). I began working in the acute hospital setting in May 2000 covering two large acute and two rehabilitation hospitals. I gained additional professional qualifications and have maintained these through continuous professional development as a Chartered Member of the Institute of Ergonomics and Human Factors, Chartered Member of the Institution of Occupational Safety and Health and Advanced Member of the National Back

Exchange. I have some small previous experience in conducting interview-based studies (Murty 2010).

My most recent post was from 2010 to 2019 managing the Moving and Handling Service for a Scottish NHS Board. In addition to managing the training and advisory service, I functioned as a nurse consultant advising upon, for example, staff referrals from occupational health, building design, risk management and litigation. This role included working with healthcare professionals in the hospital and community. If the patient assessment was complicated and multifactorial, a referral was made to me, mainly from moving and handling team members and clinical staff. The complexity of cases rarely related to physical handling, but to the balance between patient right of choice versus staff safety. Patients sometimes were adamant that they wished to be moved in a way that put themselves or staff at risk and breached regulations; but heavy-handed enforcement could lead to a discontent patient, family and involvement of local politicians. I was often able to find the origin of the concerns and recommend a compromise that reduced risk. Every case that required my intervention was in the primary care setting. I became curious to why I was not called upon to negotiate between patients and caregivers in the hospital setting.

1.5. Summary of Introduction

This chapter outlines that interpretation of the Manual Handling Operations Regulations regarding the moving and handling people has sometimes conflicted with people's rights. Court cases, studies, the media and government reports indicate some discontent with moving and handling practice. In hospitals the study of moving and handling has mainly been from the perspective of occupational health and safety. My experience of working in this field led to curiosity upon the patient perspective on moving and handling.

There is evidence that patient experience is positively associated with clinical safety and clinical effectiveness (Doyle et al. 2013). In examining the patient experience in this area, we can therefore reflect upon outcome measures in the safety and quality of moving and handling patients. There is support for this from Tucker and Adams (2001) who investigated the literature to produce a model of

patient's evaluation of care. They found the terms satisfaction and quality to be interchangeable. By studying the patient experience of moving and handling, we can learn how to improve the quality of that experience

Before selecting the precise research questions and methodological approach to this study, a review of the existing literature on patient experience of moving and handling in hospitals was carried out. The term 'caregiver' will be used where different disciplines have been involved in the research papers, for example, nurses and physiotherapists. The review of the literature prior to designing the study is explained in the following chapter.

Chapter 2. Literature

This chapter firstly provides an outline on the theme of patient experience in the literature. Section 2.2. describes a scoping review of the literature related to patient experience of moving and handling in hospitals. Subsequent sections discuss the content of the papers identified and other related studies before identifying gaps in current knowledge.

2.1. Patient Experience

This work began with a brief review of patient experience to provide a general understanding of this subject before narrowing the literature search to the precise topic being addressed (moving and handling).

In the first edition of *The Patient Experience Journal*, Wolf et al. (2014) conducted a synthesis of the literature to seek a definition of 'patient experience'. They found no agreed definition in common use. Elements they found in the literature that formed patient experience included a focus on patient expectations, on individualised care and an alignment with patient centred principles.

Person-centredness is a requisite for individualised care and is an aim of nursing care and a focus of nursing research (McCormack and McCance 2016). The concept of person-centredness developed from work of the psychologist Carl Rogers (1951) who concluded that a person can only grow through positive regard from others. Terms describing the concept vary including client-centred, user-centred and patient-centred (Scholl et al. 2014). Scholl et al's review also summarised the literature as finding the term 'fuzzy' and 'elusive', whereas McCormack et al. (2015) found there to be a growing common language on person-centredness. Despite any vagueness in definition, there is no doubt that the semantic nature of all terms and descriptions puts the person at the centre of care and deserving of consultation.

'2030 Nursing: A Vision for Nursing in Scotland' describes 'personalised care' and defines it as nurses "working with' people, finding out what is important to

them then using all their skills and experience to help them achieve their goals” (Scottish Government 2017 p.16). The concept of ‘working with’ rather than ‘ministering to’ seems the heart of person-centredness in nursing and is widely described in the literature (McCormack and McCance 2016; Chapman 2017). The move towards more person-centredness in nursing has grown steadily since Florence Nightingale first considered how nurses should care for patients (Paparella 2016). It is evident in Nightingale’s writing that she acknowledged patient needs and concerns, her remedy was to advise nurses on how they may best deliver care (Nightingale 1860). The continuum of change has been to see patients more as partners in care. The Health Foundation’s (2016) framework for person-centred care outlines the main principles, being that a person must be treated with dignity, compassion and respect, and for the care to be personalised, coordinated and enabling. In keeping with the nature of person-centredness it must also be considered that patient expectations are not generic, and that they are particular to the person. Expectations of care can only be discovered and met by engaging with the individual.

Health and Social Care organisations in Scotland strive to discover what is important to service users by employing strategies such as ‘What matters to you?’ (Health Care Improvement Scotland 2019). Service users are asked this question to focus quality improvement interventions. Linder-Peltz (1982) found patient prior expectations to be the social-psychological aspect most linked with satisfaction with care received. By discovering what the person’s expectations are, nurses can help meet them or recalibrate them to be more realistic if necessary. Factors shaping patient expectations constantly change dependent upon the information available to them, for example the increased use of the internet to obtain medical information (Wolf 2017).

Research has been ongoing to find common elements shaping patient experience and assisting in measuring outcomes. One organisation conducting such outcome measures is The Picker Institute, where they describe their vision as “The highest quality person centred care for all, always” (Picker Institute 2019a). The institute developed and validated a survey of patient experience

consisting of 15 questions (Jenkinson et al. 2002). The questions asked about anxiety, pain control, family involvement, but mainly about the level of information provided. The questions drew upon previous health and business research into customer satisfaction, but the cost of common ground may have been a loss of finesse. An example of this is a paper cited in the development of the Picker questions that outlines nuances such as people with chronic conditions tending to have lower satisfaction levels (Sixma et al. 1998). The Picker survey is an annual measure and provides a snapshot of organisational performance at that time. The surveys can be contrasted for improvement or decline in patient experience related to the questions asked. The quantitative data on its own cannot reveal the reasons for change and organisations will need to make further investigations.

The original 15 questions of the survey (Jenkinson et al. 2002) were condensed further by the Picker Institute and Harvard University to eight principles of patient centred care that were adopted as The NHS Patient Experience Framework (NHS National Quality Board 2012). In a precise format the framework outlines eight elements critical to the patients' experience of NHS Services. This framework has since been superseded by 'Our shared understanding and ambition' (National Quality Board 2015). Condensing the definition of patient experience even further to "what the person experiences" and "how that made them feel" (p.8). The brevity of this definition encapsulates the term 'patient experience' and is easy to understand.

It appears that patient experience is particular to each individual in each hospital situation. The phenomenon of experience can only be understood by obtaining information from the patients themselves. In the next section a more targeted approach is taken to review the literature pertinent to patient experience of moving and handling in hospitals.

2.2. Scoping Review

In undertaking a study, Creswell (2014) recommends clarity around the key terms of population, phenomenon and focus for research. In this study the areas identified are:

- Population = Hospital Patients
- Phenomenon = Experience
- Focus = Moving and Handling

A mind-map of the terms Hospital Patients, Experience, Moving and Handling and Qualitative studies ('experience' being the phenomenon of interest) was drawn up, with all related terms forming the basis for the literature search. All terms resulting from this mind-map and forming the search are provided in Appendix 1.

The purpose of this literature review is to:

- appraise the current knowledge of patient experience of being moved and handled in hospital;
- identify themes that have influence upon the experience;
- identify gaps in the knowledge base.

A scoping review seeks to examine the nature of existing literature on a topic and identify any gaps. This differs from a systematic review where the aim is to critically appraise the literature and answer a specific question (Munn et al. 2018). A scoping review fits best with the purpose outlined above. The scoping review of the literature was conducted following the process used in the reporting method PRISMA, explained by Moher et al. (2009) and the Prisma Scoping Review Checklist (Tricco et al. 2018). The PRISMA approach ensures that a review of the literature follows standardised guidelines. This method details the number of articles found and at what stage they are discounted. The PRISMA flowchart is provided in Appendix 2 as a map to the evidence and provides details on the number of articles found and how they were reviewed, in the later stages it gives the reason why full-text articles were rejected.

Five databases were searched (CINAHL, Medline, Embase, Cochrane Library and HMIC) using the terms derived by mind-mapping the subject headings: Hospital Patients, Experience, Moving and Handling and Qualitative studies. Other sources of literature searched included the archives of moving and handling journals: The Column, Journal of the National Back Exchange (UK) and the International Journal of Safer People Handling and Mobility.

The next section summarises the findings of the scoping review.

2.3. Summary of the literature

There were very few studies found relating to the patient experience of moving and handling in hospital. An initial 85 studies were screened against the inclusion and exclusion criteria detailed in Appendix 3. Papers that involved moving and handling outwith hospital settings were initially excluded. These groups are not part of those identified within the 'in-patient' population.

All studies involving hospital in-patients' experience of manual handling is included in the final selection. Only seven articles met this criterion, the included articles are summarised in Appendix 4. The results indicated that some data were collected in the form of questionnaires and rating scales. The use of the term 'qualitative' in the search strategy may have excluded articles that examined the patient experience using numerical data. The search was repeated removing 'qualitative' terms. No new articles were discovered that related to patient experience of moving and handling in hospitals.

The seven studies were assessed using the CASP checklist for qualitative studies (Critical Skills Appraisal Programme 2014, Appendix 5). Use of a checklist helps make reviewers more aware of the research practice used in the papers, and CASP is a widely used example of such checklists (Dixon-Woods et al. 2007). Additional checklists considered included NICE (2012) and COREQ (Tong et al. 2007). There is commonality throughout the checklists with similar questions being asked of the methods and findings. CASP was chosen for the literature review for reasons of familiarity and ease of use.

Quality issues arising from the use of the CASP checklist included:

- generalisability relating to very low sample size of patients interviewed (n=3) in Luz and Echternacht (2012). Three participants is a low number of participants even for qualitative research. Participants defined as 'patients' all had long-term conditions, but their age range was between

60-95 and they were cared for within a 'long-term institution' meaning that there was limited care experience as a context to this research;

- Alamgir et al. (2009) studied the use of ceiling hoists in 19 acute hospital and longer-term hospital settings. The patient group that they chose to interview came from just one complex care setting (spinal injuries, neurological disorders) not reflecting a range of hospital experience;
- transferability relating to geographic and economic reasons with Luz and Echternacht (2012) from Brazil. Their recommendations are common practice in Europe where very few patients experience using the older equipment that they describe. The wording of this paper is also disjointed at times which may reflect presentations of the findings in a second language;
- Kjellberg et al. (2004) did not use patients to recount their experience, but used two nurses and a physiotherapist to role play and answer questions; therefore, accounts may have participant bias;
- Ruszala and Musa (2005) collected patient opinion but did not report it in detail or via verbatim accounts (only two sentences in the published article). It is unclear from the stated objectives of this study why the researchers decided to interview patients for their experience of transfers. Objectives centred on evaluating the effectiveness of mechanical aid use in physiotherapy rehabilitation which is a narrow aspect of moving and handling;
- The setting for data collection of Luz and Echternacht (2012) appeared inappropriate and may have led to the finding that hoist design should include a feature that stopped patients rotating in the sling during transfers. The picture provided shows the patient being moved in a large empty space like a therapy room; the need for movement and constant repositioning would have been more apparent had the transfer taken place at the patient's bedside, with the space constraints and obstacles therein making a need to avoid collisions (constraints that were observed in practice by McGuire et al. 1996);
- Interviews with patients did not seek depth of experience but mainly sought rankings on scales in the studies by McGuire et al. (1996),

Kjellberg et al. (2004), Pellino et al. (2006) and Alamgir et al. (2009). The structure of these interviews did not allow for probing of participants' responses, and therefore could be regarded as a superficial understanding of participants' experiences (Ogden & Lo 2012). Alamgir et al. (2009) did allow participants to provide additional comment to their ratings and from a thematic analysis of the 12 patient interviews were able to identify reasons they preferred ceiling hoists. All 12 interview participants had long-term conditions but were not diverse in terms of the settings that the participants were cared for and therefore did not completely reflect the acute hospital in-patient population;

- Three studies sought statistical significance for their findings, all exploring probability (Kjellberg et al. 2004; Pellino et al. 2006; Alamgir et al. 2009). Kjellberg et al.'s (2004) participant sample was least representative consisting of 3 health professionals role-playing patients; a positive aspect was that the participants took part in two types of assisted transfer 102 times for each of the transfers providing a wider range of variables in technique. Pellino et al. (2006) predicted that 'Twenty manual transfer ratings and 10 mechanical transfer ratings were needed to achieve a power of 0.95 with a significance level of 0.01' (p.7); 12 patients reported comfort and security in the manual transfer and 27 in the device group, a disparity with their predicted requirements. It is clear from their paper that the personnel assisting in transfers may have participated in tasks more than once, but not if this also applied to patient participants. Alamgir et al. (2009) confined testing for significance to the statistical data on ceiling hoist use and incidence of adverse patient outcomes such as falls and pressure ulcers; they may also have felt their sample of 12 patients with long-term conditions was not representative as described above. For quantitative results the use of 3, 30 and 12 samples would be seen as very low for use in statistical analysis. Therefore, the results could not be generalised to the in-patient population.

All of these articles have features making them worthy of inclusion. The most relevant being the desire to explore patient experience of moving and handling in hospitals.

Appendix 6 identifies the main themes this review distilled from the studies. Summarising these, the themes are Safety, Acceptance of Mechanical Aids, Skills and Knowledge of Caregivers, Comfort and Person-Centred Care. Each theme is explored in the next section.

2.4. Themes in the Literature

Themes in the literature were identified by first reviewing the aims of the studies to pinpoint the primary focus. Additional themes appeared in the findings and recommendations of the papers reviewed. The themes presented here are ordered by the number of papers that explored the theme, from highest (all studies) to lowest (two studies).

Safety

Safety was the dominant theme in the literature with all papers exploring aspects of safety and security. The safety of caregivers was considered by McGuire et al. (1996) and Ruzsala and Musa (2005) in relation to postures adopted when assisting in transfers with action recommended to reduce postural extremes. Patients however generally felt safe in hoists (McGuire et al. 1996; Ruzsala and Musa 2005) and secure when using mechanical lifting devices as measured by rating scales (Pellino et al. 2006; Alamgir et al. 2009). The exception is Luz and Echternacht (2012) where the only information provided is from a patient who feared using the hoist. Luz and Echternacht interviewed three patients but only reported the feelings of one and did not explain whether this was a shared opinion or not. Pellino et al. (2006) found that patients felt safer with a lateral transfer device than being transferred manually, a mean rating of 4.68 on a seven-point Likert scale for mechanical transfer compared to 2.5 for manual assistance of nurses. The patients' general feelings of security contrast with McGuire et al. (1996) findings that nurses believe patients find lifting devices unsafe. The finding that there are contradictory perceptions of safety between nurses and patients questions the transferability of Kjellberg et al.'s (2004)

research approach, where three health professionals role-played patients to report feelings of security during assisted transfers. Coulter Smith et al. (2016) emphasised risk assessment of patient handling activities to reduce risk of injury to the patient.

In summary, safety of the caregiver as well as the person being moved and handled appears to be essential in any moving and handling risk assessment and within every moving and handling action. However, research is sparse on understanding exactly what this means from a patient experience perspective. What is known from the poor-quality research evidence available, based on Likert scale responses from a small sample and a small group of participants within a neurological area, is that there is poor understanding of what the term 'safety' means to participants, how that is perceived as an aspect of care, and what actions could be taken to improve the perceptions and feelings of safety through any moving and handling actions.

Acceptance of Mechanical Aids

Patient acceptance of mechanical aids was the second most prevalent theme with all but one of the papers (Coulter Smith et al. 2016) considering this aspect. Patients accepted the necessity for mechanical aids (McGuire et al. 1996; Ruzala and Musa 2005; Pellino et al. 2006; Alamgir et al. 2009). Luz and Echternacht (2012) is again the exception, where the patient they reported as scared in a hoist refused to use one. The general acceptance of mechanical aids was contrary to nurses' assumptions that patients did not want to use them (McGuire et al. 1996). Patients accept the necessity for mechanical aids and equipment was regarded desirable to assist independence and necessary for rehabilitation (Ruzala and Musa 2005).

It is clear from the papers that most patients accept the use of mechanical aids, but what remains unclear are factors that contribute to patients' acceptance. Only Alamgir et al. (2009) provided further information, a thematic interview analysis of why ceiling hoists were preferred to mobile hoists. Knowledge of the factors that contribute to patient perception of mechanical aids could further

assist to increase their acceptance. If a patient is scared to use a hoist as described by Luz and Echternacht (2012), what provokes fear of hoists? The fear of hoists is an area that has not been examined in existing literature.

Skills and Knowledge of Caregivers

Patients' experience when explored was often contextualised by staff need for safety, education and competency. Recommendations of studies relate to the need for training and skills (McGuire et al. 1996; Kjellberg et al. 2004; Pellino et al. 2006; Alamgir et al. 2009; Coulter Smith et al. 2016); better equipment design (Luz and Echternacht 2012) and changes in professional practice (Ruszala and Musa 2005). It also appears that patients are more satisfied if moved by a caregiver who is more skilled in performing the transfer (Kjellberg et al. 2004; Almagir et al. 2009). There has been insufficient research to state this unequivocally, findings from both papers account for only 15 people providing values on rating scales. This is a low number for quantitative statistical significance (Biau et al. 2008). Kjellberg et al. (2004) was the only study that sought to identify correlation between caregivers' technique (skill) and ratings of safety and comfort (small positive associations). To standardise their approach the methodology used two nurses and a physiotherapist to role-play patients. The limitations of using healthcare workers in this role-play are acknowledged by the researchers, for example, nurses' perceptions can be contrary to those of patients as described by McGuire et al. (1996).

From these papers it appears that skills and knowledge of caregivers is a relevant factor in moving and handling interactions with patients. The papers leave a gap in the knowledge in what forms patient perception of skilled and knowledgeable assistance in moving and handling transfers.

Comfort

The comfort of patients when being assisted with transfers seemed an adjunct to safety. McGuire et al. (1996) describe interviewing patients regarding 'safety and comfort' of mechanical aids; 70 percent of patients found them comfortable and a further 20 percent were neutral. Kjellberg et al. (2004) asked participants

to rate 'safety and comfort'. Comfort was measured using a scale of -4 (very uncomfortable) to 4 (very comfortable) with a median value of 2 being reported by those role-playing patients. Those role-playing patients were fit, healthy adults of working age and their perceptions of comfort could differ from older infirm adults. Pellino et al. (2006) asked patients to rate feelings of 'comfort and security' on a seven-point Likert scale; comfort using the mechanical lateral transfer device rated higher than being manually assisted by nurses (mean 4.5 versus 2.5).

From these papers it would appear patients do not generally experience discomfort using mechanical devices and may even find them more comfortable than manual assistance. The selection of this topic by the researchers does not indicate if this factor would have been of great significance to the patients themselves. If comfort is of importance to patients, the reliance on rating scales does not provide an opportunity to examine in depth the aspects that contribute to patient comfort.

Person-Centred Care

The reliance on rating scales in some of these studies could mean that the person-centredness of interventions was not considered unless additional methods of data collection were used. McGuire et al. (1996) and Almagir et al. (2009) also conducted semi-structured interviews with only McGuire et al. (1996) considering aspects of person-centredness such as information given to patients. Pellino et al. (2006) did not seek consent from patient participants stating that "the patients implied consent by answering the questions" (p.6). This relates to the research methodology rather than the moving and handling activity but contrasts with a recommendation of McGuire et al. (1996) that written consent should be obtained from patients before even electing to use mechanical aids. Coulter Smith et al. (2016) had the most person-centred approach being focussed on the moving and handling needs of a specific client group, older people with osteoporosis in acute hospitals. They found that moving and handling care may focus on the immediate presenting acute illness, but also needs to consider the patient history.

In summary, the person-centredness of moving and handling interventions has been little explored. It is not known how the assistance to move in hospital compares to patients' perceptions of what is in their best interest. Only McGuire et al (1996) considered the adequacy of information currently provided on moving and handling assistance, it remains unknown what information patients may find useful and when best to provide this.

The scoping review indicates the extent of existing knowledge on patient experience of moving and handling in hospitals. The findings of these studies were compared and contrasted with other literature found when the search was expanded to include literature not specific to the acute hospital setting or patient experience.

2.5. Expanded Literature

Themes in the literature relating to people's experience of moving and handling but not involving hospital patients, or where this was not the focus of the research, were excluded from the search strategy. The focus of this study is on patient experience of moving and handling in hospitals, and the literature review initially focussed on research in hospitals. When that search did not retrieve much evidence, the search was expanded to other care settings to identify additional perspective on being moved and handled. Some reports from the wider literature did describe additional facets or measures of the moving and handling experience.

Knibbe et al. (2012) studied acceptance of mechanical assistance by 'patients' at home and in care-homes. They found that patients' acceptance of equipment grew over time. Immediately after introduction of a hoist, 25 percent of the 81 patients that they interviewed felt positive about the equipment. This figure rose to 61 percent after repeated use with seven percent retaining negative views (32 percent neutral). This study supports the scoping review finding that there is a general acceptance of mechanical aids (McGuire et al. 1996; Ruzsala and Musa 2005; Pellino et al. 2006; Alamgir et al. 2009). Another aspect Knibbe et. al (2012) report is perceived skills and knowledge of caregivers using the hoist.

Perceptions of caregivers' skills became more negative when the patients became more familiar with transfers, with 23.5 percent of caregivers having skills perceived as 'bad' at introduction and 45.7 percent several weeks later, although the hoists themselves were viewed more positively. The changing patient perception over time of mechanical aids or handlers' skills has not been investigated in the hospital setting. It could be argued that in a hospital setting the type of moving and handling equipment used is more liable to change as the patient's condition improves or deteriorates, whereas in the settings studied by Knibbe et al (2012) the patient condition is more stable and changes likely to be more gradual.

Knibbe et al.'s (2012) methodology was more explorative of the patient experience than any of the studies conducted in hospital. The use of semi-structured interviews and open questions provided participants opportunity to comment upon their experience of using lifting equipment. While interviews were analysed into stages of change, this approach did glean additional information from participants pertinent to the experience. Comments reported on introduction to lifting equipment included concerns that the battery would fail, the hoist would not support the patient's weight or might topple over. These fears provide insight to aspects that may also apply in hospital if patient participants are provided the opportunity to discuss the experience.

Boakye-Dankwa et al. (2017) studied care homes with skilled nursing services in 203 sites (USA). The research team undertook an integrated cross-sectional analysis of factors including employee and resident satisfaction, safety and quality of care. Resident satisfaction was ascertained by obtaining the facilities results in response to an annual national survey tool developed by the National Research Corporation (private company) and clusters developed between the various factors. They found facilities with greater resident satisfaction and care outcomes to also have a better safe resident handling program performance. However, safe handling was not the only linked factor and others included higher employee job satisfaction, retention and engagement. The safer handling program may have contributed to these outcomes, but the extent remains

unclear. There have been studies linking employee retention and satisfaction to safer handling (Foschen et al. 2005) but there is no detailed investigation of safer handling linked to hospital patient satisfaction.

Owen and Fragala (1999) reported on reducing nurses physical stress when transferring residents in nursing homes. A sliding aid was used to transfer patients from chair to bed or vice-versa, rather than a gait belt (a belt applied to the resident's waist with handles for those assisting). Residents were asked to rate comfort and security scored 0 (very comfortable/secure) to 7 (very uncomfortable/insecure). The sliding devices rated a mean score of 0.75 for comfort compared to 3.71 for the gait belt; and 1.16 compared to 3.42 for safety. The authors caution that there was a small number of responses as many residents lacked capacity to report. Twenty-four responses came from six residents using the sliding devices and seven ratings from five residents using gait belts. The methods used in this study are like those employed in hospitals by Pellino et al. (2006) and Alamgir et al. (2009) to measure comfort and safety in hospital transfers. Owen is a contributory author in Pellino et al. (2006). The findings in nursing homes and hospitals are shared, with more specialised equipment being more positively rated (Pellino et al. 2006; Alamgir et al. 2009). The strengths of using rating scales is that the data can easily be ranked, and numerical values compared showing that patients perceive x more positively or negatively than y. A weakness is that the reasons for preferences remains elusive without further study.

Taylor et al.'s (2014) ethnographic study in nursing homes was previously reported in chapter one (section 1.2.). Residents perceived they had no choice in accepting assistance to move from chairs. The authors concluded that this impacted upon the residents' mobility and autonomy. There has been no similar study conducted in the hospital setting.

An additional study in the hospital setting was conducted by Hobbs et al. (2007) who reported that the use of dedicated 'lift teams' increased positive outcomes in hospitals. This study was not included in the scoping review as the focus was

upon staff satisfaction and wellbeing, however patient and family satisfaction were included in the list of metrics. A lift team would attend the patient when they required to be moved or repositioned using mechanical equipment. The findings on patient experience was not reported other than “Patient and family satisfaction are expressed on a daily basis via one to one conversations, letters, and patient satisfaction surveys” (p 51). There are no measures or patient comments included in their evaluation. None of the papers reviewed indicated that there is a reliable or valid tool for measuring patient experience or satisfaction in relation to moving and handling interventions. Hobbs et al. (2007) report of satisfaction being moved by the lift team and equipment supports studies in the scoping review that there is a general acceptance of mechanical aids (McGuire et al. 1996; Ruszala and Musa 2005; Pellino et al. 2006; Alamgir et al. 2009).

While patient experience of moving and handling in hospitals may not have been the phenomenon investigated or the focus of these studies, there are some shared findings. A few studies also indicated aspects of moving and handling studied elsewhere but not in hospital settings, that indicate gaps in the evidence. The next section considers where there may be gaps in the literature on moving and handling in hospitals.

2.5. Gaps in the literature.

An overview of themes that form the patient experience and some frameworks for assessing the experience was provided in Section 2.1. of this literature review (Jenkinson et al. 2002; NHS National Quality Board 2012; National Quality Board 2015). The summarised definition of patient experience was “what the person experiences” and “how that made them feel” (National Quality Board 2015). However, the brief definition does not provide insight into factors that may inform experience. In this study The NHS Patient Experience Framework (NHS National Quality Board 2012) will be used as a guide to factors that may impact on the experience of patients in relation to moving and handling. The framework is looser than the original 15 questions of Jenkinson et al. (2002) and general enough to frame the study without forcing pre-identified topics to the fore.

The papers from the literature review were examined with reference to those themes of particular relevance to moving and handling and helped detect unanswered questions. The three themes not addressed in the studies were:

1. *Respect of patient-centred values, preferences, and expressed needs.*

McGuire et al. 1996 supported the need for patient consent. Their summary of implications for nursing practice recommended a patient consent form. They suggested that a form could show patient agreement for the use of mechanical aids in hospital. Coulter Smith et al. (2016) recommended considering the patient's history and not only immediate care needs. There were no studies found indicating patient involvement in decision-making and how they make their preferences known. Patient satisfaction with moving and handling practice in hospitals has not been adequately reported. Hobbs et al. (2007) included a sentence in their report that indicated these data had been collected, for example, satisfaction surveys and conversations, but did not report details other than to say the indications were positive for the use of lift teams. Dissatisfaction with caregivers handling skills seemed to grow over time in the community (Knibbe et al. 2012). It is unknown if patient satisfaction and preferences in how they are assisted to move, changes over time in hospital. Taylor et al.'s (2014) study in care homes indicated that residents accepted assistance in the absence of choice. There has been no similar study in the hospital setting and it has not been determined if patient mobility and autonomy is similarly affected.

2. *Information, communication and education.* McGuire et al. 1996 noted that patients generally received an explanation of why mechanical equipment was being used. The need for education when mentioned in the studies it was generally explored in relation to caregivers (McGuire et al. 1996; Kjellberg et al. 2004; Almagir et al. 2009; Coulter Smith et al. 2016). Information needs of patients related to other aspects of care such as exercise (Coulter Smith et al. 2016). Taylor et al. (2014) indicate that care home residents are not informed of choice in mobility assistance

from staff. There is little detail on how much information patients are given on the different options available to assist their movement transfers; or the type of information patients feel that they need.

3. *Welcoming the involvement of family and friends.* The involvement of family and friends in moving and handling practice was not considered by any of the papers in the literature reviewed. Hobbs et al. (2007) reported conversations with family and satisfaction with the use of lift teams but did not include any data or additional comment. It remains unknown whether patients would welcome the involvement of their family and friends in such an intimate practice and at what stage of their hospital journey this would be most appropriate. The studies in the scoping review considered patient experience but not involvement or satisfaction of family and friends ((McGuire et al. 1996; Kjellberg et al. 2004; Ruzsala and Musa 2005; Pellino et al. 2006; Alamgir et al. 2009; Luz and Echternacht 2012; Coulter Smith et al. 2016). If little is known on this subject it is difficult to achieve true person-centredness and recognise when the involvement of their loved ones may be most rewarding. Recovery and rehabilitation continue following a person's discharge from hospital with family often becoming the primary carers. Section 1.1 of this thesis indicated that most litigation and dissatisfaction with moving and handling care occurred when people were at home. Family involvement in care and forward planning may be useful in reducing their dissatisfaction or feelings of helplessness.

The papers studied give little indication of what it actually feels like to be the recipient of manual handling in care and the experience of care delivery. None of the studies reviewed indicate whether patients agreed with decisions made about how their care is delivered.

The low number of papers, low sample sizes and lack of reliable or valid tools to measure patient satisfaction/experience in the literature review makes generalisation difficult. The search was regularly updated, and additional sources investigated throughout the clinical doctorate. Most of the research on manual

handling in healthcare focusses on manual handling injuries to care staff, mainly epidemiology and interventions for prevention such as the effectiveness of training (Kay et al. 2014).

The Code of practice followed by Registered Nurses identifies physical handling as one of the basic essentials of nursing care and as fundamental to patients as ensuring that they are properly hydrated and nourished (Nursing and Midwifery Council 2018). Section 1.2 of The Code specifies that this care must be delivered effectively. Section 6 of The Code also describes the need for practice to be rooted in the evidence base. The paucity of research into patient experience in this field makes effective practice difficult and leaves unanswered questions.

The focus of this study is to investigate the patient experience of moving and handling in hospitals. The next chapter describes how the research aim and questions were formulated before selecting an appropriate methodology.

Chapter 3. Methodology

This chapter describes how the research aim and questions were developed. Once the aim and questions became defined it led to the selection of an appropriate methodology and the rationale for this selection is discussed. The chapter concludes by outlining the methodology and specific aspects that need to be present in the conduct of the research.

The unanswered questions about patient experience of moving and handling were used to formulate the questions for this research study.

3.1. Formulating the Research Aim

As explained in section 2.2., following Creswell's (2014) recommendation on the approach used to inform the literature search was also used to identify the research aim. The aim of the study is to;

Develop a theory of factors that influence the patient experience of being moved and handled in hospitals.

The descriptor 'moving and handling' includes all manual handling assistance from healthcare staff (for example, manually assisting patients from sitting to standing) and use of lifting equipment. Topic outlines from The NHS Patient Experience Framework (NHS National Quality Board 2012) are used to prompt consideration of aspects of care and identify patient opinion. This framework was chosen as described in Chapter 2 because it encapsulates elements of the previous literature while remaining general enough to allow further exploration of the patient experience.

The research questions need to be patient-focussed to capture patients' experience of moving and handling. Previous studies have contextualised the patient experience within the perspective of the caregivers' work. The research questions were formed from the gaps in the literature identified in section 2.5. with relevance to the Patient Experience Framework:

1. Respect of patient-centred values, preferences, and expressed needs.

2. Information, communication and education.
3. Welcoming the involvement of family and friends.

The research questions are:

What is the patient perspective on moving and handling in hospitals?

What involvement do patients have in decision making?

How does moving and handling care received match patients' expectations?

What information do patients receive?

What involvement have friends and family had in the way that patients have been moved and handled?

3.2. Rationale for Selecting Methodology

The aim formulated for this study relates to exploration of the patient experience. The aim is useful in driving the identification of a research framework (Creswell 2014). An interpretative framework based in the Constructivism worldview was felt to be most appropriate. A Constructivist approach does not begin with a hypothesis but relies strongly upon the participants' experience of the world around them and how they interpret that experience (Guba and Lincoln 1994; Shwandt 2000). It accepts that the researcher's experience may affect the interpretation of the data (Charmaz 2014; MacKenzie and Knippe 2006). A social constructivist approach finds meaning in situations and experiences (Creswell 2014). This study's research aim and questions all relate to patient experience. The need to discover meaning from experience led to a qualitative method of enquiry.

A reason for rejecting quantitative research methods in favour of qualitative, is due to the approach's focus on numeric or ranked data. There is difficulty in fully exploring a lived phenomenon by numbers. In choosing what is to be counted, the researcher may be assuming that aspects, such as comfort, security and time have relevance to patients. The studies by McGuire et al. (1996), Kjellberg et al. (2004), Alamgir et al. (2009) and Pellino et al. (2006), all selected a predetermined factor that was ranked upon a scale, for example, comfort. Is comfort one of the most important factors to a patient? The patient's voice may be lost in the focus of the researcher that selects the area for study. The

literature review indicates that there is little understanding of the patient experience of being assisted to move while in hospital and therefore an inductive research approach would be most suitable.

Silverman (2014) suggests that considering exactly what the researcher wishes to do may assist to identify the best approach to employ. Is it to compare and contrast, or to examine in detail? He suggests that a quantitative approach may be best suited to the former; while a qualitative approach is more amenable to examining the phenomenon of interest in detail.

Silverman also links some qualitative methods of enquiry with Constructivism. These methods include Grounded Theory, Narrative Analysis and Discourse Analysis. Other approaches are recommended by Creswell (2007) who adds Phenomenology, Ethnography and Case Study to the list of methods that may be used in this type of investigation.

All of the aforementioned qualitative methods were considered, and some were more easily dismissed than others. Those dismissed on initial review were:

Ethnography, this originated in anthropology but is now widely used by social researchers to generate theory (Ethnography 2015). This methodology requires the researcher to submerge oneself in the culture of the group under study and could not be readily achieved in the timeframe for this study. The researcher would need to spend excessive periods of time in hospital and observation of patients during intimate care would be unnecessarily intrusive in this instance. It would fail to collect data on the range of their experience, giving only a snapshot.

Case Study. Yin (2009) describes how various sources can be used in a case study: observations, literature, personal experience, health records etc. A case study can facilitate an in-depth study of a phenomenon. The difficulty in this instance presents in selecting the 'case' to study that will reflect patient experience. In

experiencing Moving and Handling in hospitals there are stages of dependency and perhaps gender or age-related aspects of personal care that need a slightly wider sample. In a case study the focus of the case or cases may be too narrow to describe the phenomenon. Baxter and Jack (2008) refer to the use of multiple case study design in this type of instance but acknowledge that this design is “extremely expensive and time consuming to conduct” (p.549). The expense and cost in time would be prohibitive for a student project.

Narrative Analysis is the study of the story from the participants’ recollection. It looks at how people construct their story or narrative. This form of inquiry helps to understand how participants interpret and develop meaning from events (Silverman 2014). The researcher’s experience and relationship with the participant is an essential part of narrative analysis as they structure and report the story (Clandinin and Caine 2008). Researcher experience cannot be ignored – but in this study patient experience must be at the centre to develop wider understanding of the phenomenon. Similar to case study, in narrative analysis the focus may be too narrow and the experience very particular to the patient.

Discourse analysis places the emphasis on language and the social context in which it is used (Zajacova 2002). The focus solely upon language and communication may overlook factors of relevance to the patient experience.

The main qualitative approaches remaining are Phenomenology and Grounded Theory. Both approaches would provide insight into the patient experience of moving and handling in hospitals, thus meeting the aim of the study. There are features shared by these approaches, for example, one main method of data collection is the interview with subsequent analysis by the researcher (Wimpenny and Gass 2000).

Phenomenology would add much to the understanding of the patient experience of moving and handling in hospitals. This approach would assist to put into context the patients' understanding of what is happening, and how it feels to be involved in the process. There are challenges using this approach; Norlyk and Harder (2010) studied the use of phenomenology in peer reviewed nursing research. The studies they reviewed in their analysis included many with a lack of clarity around the methodology. They cite widely published authors on phenomenology in support of their assertion that phenomenology is principally a philosophy and not a research method (Giorgi 1997; Giorgi 2006; Dahlberg et al. 2008). Phenomenology is used to understand experience, to capture the essential essence of it (Silverman 2014). The aim of this study is to develop a theory that describes the patient experience of moving and handling in a wider context. Rather than capture the essence of the experience, this study seeks to investigate the variety of factors that patients feel contribute to the experience.

The exploratory nature of Grounded Theory better meets the specific aim outlined, developing a theory of the factors affecting the patient experience. The primary purpose of Grounded Theory methodology is that it seeks to generate theory (Glaser and Strauss, 1967). It is for this reason that Grounded Theory is the methodology employed in the design of this study.

3.3. Grounded Theory

Grounded Theory is a methodology that seeks to ensure that theory is derived entirely from the data available. It was developed by researchers to assist in generating a new theory based upon the participants lived experience, rather than test a theory previously devised by theorists (Glaser and Strauss, 1967). The data needed for this study had to be mainly generated through patients' own descriptions of being assisted to move by caregivers or machines in hospital.

Sections of interview transcripts, paragraphs of literature text, researcher's notes and observed behaviour are studied for meaning and 'coded'. Coding is the central process of Grounded Theory (Holton 2007). A code is a "researcher generated-construct" that "translates" data (Vogt et al. 2013 p13). Saldana (2016) describes a code as "a summative, salient, essence-capturing and/or

evocative attribute for a portion of language based or visual data” (p4). Coding is the process of applying codes to the data and a code is the meaning of the data as interpreted by the researcher

New data and codes are compared or contrasted with the previous in constant comparative analysis (Glaser 1965; Glaser and Strauss 1967). This analysis of data generates codes and categories informing further data collection; and further analysis prompts more areas to be explored (Holton 2007; Connelly and Peltzer 2016). Categories are formed when common aspects can be seen in the codes by the researcher. Categorising can conceptualise and investigate these aspects further (Charmaz 2014). Themes may develop that occur throughout the data. Morse (2008) describes a ‘theme’ as an “essence” that runs through the data (p.727) and how it is usual that themes in grounded theory emerge later in the process.

The use of this design (relying solely upon the data) assists to ensure that previous theories are not adopted (Charmaz 1996). No theory was found related to moving and handling experience in the literature; insights from the articles reviewed have largely been generated from the perspective of caregivers. An example is that the most studied area of the literature informs us that patients find mechanical aids acceptable, safe and comfortable (McGuire et al. 1996; Ruszala and Musa 2005; Pellino et al. 2006; Alamgir et al. 2009). We cannot be sure this is of great import to the patient if it is the only question asked of them.

3.4. Constructivist Grounded Theory

Bryant and Charmaz (2007) describe Grounded Theory as being like a family of methods. Each method is related to the others but has distinct characteristics. There have been developments in Grounded Theory in the years since its inception. The worldview and methodology of Grounded Theory have evolved, with even the original inventors, Glaser and Strauss, taking divergent stances (Glaser 1992; Charmaz 2008a; Markey et al. 2014; Birks and Mills 2015). Barney Glaser has remained closest to the original methodology, now known as Classic or Glaserian Grounded Theory (Evans 2013; Alammari et al. 2018). Anselm Strauss further developed the approach to data analysis in Grounded

Theory. Strauss collaborated with Juliet Corbin and developed a set of systematic tools for analysing and sorting data (Strauss and Corbin 1990). Kathy Charmaz was a student of Glaser and Strauss who championed the constructivist approach (Mills et al. 2006).

A constructivist approach to Grounded Theory is the route chosen to interpret the data in this study. This approach follows Charmaz's (2000, 2014) version of Grounded Theory. This methodology acknowledges the researcher's interpretation of the data is unique and part of the research process (Mills et al. 2006; Charmaz 2014). A researcher's situation in life, experiences and knowledge bring them to their study of a particular field. The time commitment for research and access to participants usually means that it is part of a chosen profession or course of study. It is very difficult to ignore who you are and what you know. The theory that emerges is a construct of the researcher's interpretation. I felt that it would be impossible to ignore my knowledge and experiences from over 20 years in this nursing specialty and that this had potential to filter my interpretation of the data.

The validity of this approach has been challenged by other researchers (Markey et al. 2014) including an inventor of Grounded Theory, Barney Glaser (Glaser and Holton 2004). Glaser felt that the approach was becoming so diluted that the Constructivist Grounded Theory methodology should no longer be considered Grounded Theory. One question Glaser asked of the Constructivist approach was if this method was a convenient way of avoiding rigorous review and monitoring for researcher bias (Glaser 2002). This viewpoint can be interpreted as a caution that rigorous self-monitoring should be used in Grounded Theory studies. Monitoring methods are described later in this chapter in sections 3.8 – 3.9.

The methods used for Straussian data analysis in Grounded Theory are not used in this study to remain true to the Constructivist approach. The Straussian methodology to coding Grounded Theory demands a "highly systematic and rigorous coding structure" (Kenny and Fourie, 2015, p1274); Charmaz (2008a)

counters that this can stifle the creativity of the researcher and that there should be a more intuitive approach. Charmaz's less structured method allows tentative links to be drawn between pieces of data, before a bigger picture and theory emerges.

Use of existing literature is an example of another area where opinion has diverged in development of Grounded Theory. Classic Grounded Theory would have the researcher consult the literature at the end so that the theory does not become contaminated (Glaser and Holton 2004). Straussian Grounded Theory suggests consulting the literature when appropriate as directed by the data (Strauss and Corbin 1990). Charmaz agrees with this approach but also recommends a literature review (McGhee et al. 2007, Kenny and Fourie 2015). Charmaz recommends that the literature review be carried out at the end of the study to "avoid importing preconceived ideas" (Charmaz 2014, p306). However, she also acknowledges that most courses of academic study and grant applications expect some review of the literature (as was the case in this study). The scarcity of existing literature could be seen as advantageous, where there was little to shape opinion.

The methodology adopted for this study is Constructivist Grounded Theory. The method of collecting data must be directed by the selected approach. The following three sections describe how data is to be collected, how this may be achieved more effectively through sampling and how to decide when enough data has been collected.

3.5. Data Collection

Interviews are the tool of data collection most prevalent in Grounded Theory studies (Thompson 2011; Charmaz and Belgrave 2012; Foley and Timonen 2015; Singh and Estefan 2018). Interviewing participants seems the most direct way of answering the research questions in this study. The research questions seek to discover more on the patient experience and what participants themselves would expect from the experience.

Interviews in qualitative research are generally unstructured or semi-structured, and there are points in favour of both approaches (Holloway and Jefferson 1997). If questions are too structured, a participant may feel something is unimportant as the question was not asked by the interviewer; the interview is interviewer led rather than participant led (Corbin and Strauss 2015). Charmaz (2008a) suggests that there are advantages to using an interview guide. A guide is formed by questions that give direction to the interview but remains flexible to explore the responses. The interview guide can change to capture further data on emergent codes and categories. Charmaz describes that “A well constructed guide fosters asking open ended questions.... avoids loaded and leading questions and gives you direction” (p.81). It is this form of interview guide that is applied in the study. The guide (appendix 7) ensured that the research questions formed with reference to aspects of The NHS Patient Experience Framework (NHS National Quality Board 2012) were covered when the data was collected. The patient participants were provided with an opportunity to feedback on their relevance to moving and handling. For example, participants were asked to comment on how much information they were given about how they could be moved and how much involvement they had in planning this form of care.

3.6. Sampling

Sampling involves identifying the sources of data to be analysed. In a quantitative approach, large random samples are used to generalise study findings. Small sample sizes may not be indicative of the statistical significance desired by a quantitative approach but provide the opportunity to delve deeper and investigate beyond the surface data. This issue of transferability affected two of the studies described in the literature (section 2.2) where small numbers of participants shared their experiences of moving and handling on a rated scale. Marshall (1996) contends that random sampling is not appropriate for qualitative studies. Two of the differences described by Marshall are that qualitative researchers use smaller numbers and recognise that some individuals are a more valuable source of information pertinent to the study than others.

A judgement or purposeful sample identifies participants most likely to have experience of the phenomenon under study (Marshall 1996; Palinkas et al. 2015;

Chun Tie et al. 2019). It is more efficient for those interviewed to have experience of the phenomenon and to be representative of the population being investigated (Morse and Niehaus 2009; Palinkas et al. 2015). The aim of the research should inform the sample population. In this study participants must be hospital in-patients with experience of being physically assisted to move by staff during their stay. There is a need to identify the initial sample group, but thereafter participants are needed that can assist with or check theory construction, not upon population representation (Charmaz 2008b). This recruitment based upon exploring emerging theory is referred to as theoretical sampling.

Theoretical sampling helps to examine more closely concepts emerging from interviews and is part of Grounded Theory methodology (Glaser and Strauss 1967; Morse 2007; Corbin and Strauss 2015). The researcher may infer a reason for findings in the data. The inference needs to be checked with future participants that can assist in checking and clarification (Corbin & Strauss 2015) i.e. constant comparative analysis.

Theoretical sampling is not restricted to the participants recruited. In addition to participants' interview data, previous data, for example, literature review findings and researcher's reflections, need to be revisited and examined to support inferences made by the researcher (Charmaz 2014). Corbin and Strauss (2015) describe that "the basis for sampling is concepts, not persons" (p147). The researcher used the experience described of moving and handling care in previous data to inform questions of new participants. Corbin and Strauss (2015) suggest that even when writing up findings new insights can occur to the researcher. It may be necessary to collect further data but often the answers to questions are in previously gathered data, and the researcher found that was often the case in this study as all participants had wide experience of moving and handling in hospital.

The interrogation of the data may suggest that a participant with certain characteristics (e.g. previous experience, age, gender) should be interviewed.

An example pertinent to this study is that the majority of patients requiring moving and handling are over 65 years old, and an older female felt it was perhaps her age that accounted for her preferences in caregivers and this required investigation. The reasons for preferences was investigated with those of a similar age, but her statement suggested it was important to interview someone younger for comparison of aspects, for example, being handled by male nurses; male nurses feel that older women are more accepting of their care (Chan et al. 2014). If this participant was found to be an exception, exceptions should not be ignored but incorporated into the analysis as further probing can provide clarity and definition to emerging ideas (Morse 2007). In this instance questioning provided insight into the relationships formed with caregivers.

Theoretical sampling provides opportunity to investigate emerging categories. The analysis and reflection upon data forms questions on the qualities of the categories and discovers variation within them (Charmaz 2014). For example, feedback on progress seemed important to participants in this study. A question arising was 'why is feedback is important?' The answer to this provoked further enquiry as to how feedback is provided, the nature of feedback and the effects of feedback. Data had been gathered in relation to feedback, but I felt it necessary to investigate further and find someone who would have experienced varying feedback when being assisted to move. It was specified that the next participant should demonstrate a rehabilitative progression and reduction in physical assistance from others. This type of participant could provide insight to any variation in the nature and importance of feedback as dependency on others to assist movement decreased.

The number of participants interviewed and continued collection of data in Grounded Theory is dependent upon when saturation of data is reached.

3.7. Saturation

Charmaz (2014) describes saturation as the point where all new data emerging on your categories has been exhausted and there are no new insights or properties. If interviewees seem to be repeatedly visiting the same aspects, and no new facet or contra-opinion in the data has emerged, then the data can be

described as saturated (Fusch and Ness 2015). These authors suggest that selecting an appropriate sample leads to quicker saturation; however, the paper that they cite refers to quantitative sampling rather than qualitative (Burmeister and Aitken; 2012). The contention that data saturation will be quicker with an appropriate sample is repeated elsewhere in relation to qualitative methods (Marshall 1996; Malterund et al. 2015). Guest et al. (2006) report that 'metathemes' are likely to become saturated quickly in a study. They cite other authors in support of as few as six cases and their study showed 80 percent saturation of codes at this stage. Hagaman and Wutich (2017) explored this further and found that fewer than 16 interviews were needed across sites if the participants were a homogenous group.

Saunders et al. (2018) describe different approaches in deciding when saturation is reached. The common ground in when to stop sampling seems to be that there is nothing new, for example, data saturation of a category, no new codes occurring in the data or no new emergent themes.

3.8. Quality in Qualitative Studies

How to ensure quality in qualitative research has been the subject of review, with some contending that the rigours of quantitative research cannot be applied at all (Mays and Pope 2000). Creswell and Miller (2010) outline various authors attempts to define critique structure, for example, "Maxwell's 5 types, 1992; Lathers 4 frames, 1993 and Schwands 4 positions 1997" (p.124). The authors comment that while the profusion of advice may be confusing, there is consensus that qualitative research should be trustworthy and sincere (Lincoln and Guba 1985; Tracy 2010). To establish trustworthiness, Lincoln and Guba (1985) recommend establishing credibility, transferability, dependability and confirmability. A definition of each of these terms is provided in Table 1, together with an example of a technique used in this study to meet their criteria.

Table 1. Trustworthiness

Term	Definition	Technique Used
Credibility	Confidence in the 'truth' of the findings.	Check of interpretation with peers.
Transferability	Showing that the findings have application in other contexts	Thick description – contextualising behaviour
Dependability	Showing that the findings are consistent and could be repeated	Audit and review by supervisors
Confirmability	Showing the findings are shaped by participants and not the researcher.	Reflexivity

Guidelines and qualitative checklists have been developed to assist those writing or reviewing qualitative papers. These seek to establish that the research presented is credible, has been methodological, is transparent and can be generalised. The checklist CASP (Appendix 5) was applied to the papers of the literature review in this study. CASP helped identify whether there were any validity issues in the conduct and presentation of studies (Chapter 2). Morse et al. (2002) contend that it is not adequate to leave quality issues until the end of a study and that researchers should take ownership for the reliability of their research. Tong et al.'s (2007) 32-point checklist (Coreq) for preparing reports of qualitative studies involving interviews, was referred to in the conduct and writing of this study (Appendix 8). The use of checklists in this study ensured that quality could more readily be achieved.

Reviewers feel that a method to ensure quality in relation to Grounded Theory is to remain true to the approach selected (Weed 2009; Corbin and Strauss 2015; Berthelsen 2017). The methodology should not be mixed by picking and choosing aspects from Classic, Straussian and Constructive Grounded Theory to suit the researcher's purpose.

Published papers using a constructivist grounded theory approach seek to provide evidence of rigour to establish their validity. Recent examples include

Baranova et al. (2019) who describe their adherence to the methodology and their use of constant comparative analysis validated by group discussion. This adherence and peer review are also described by Williams et al. (2018) who additionally sought to demonstrate the trustworthiness of their research by demonstrating how they met the criteria outlined by Lincoln and Guba (1985) for example "Transferability was enforced through set inclusion criteria and detailed demographic information" (p.329). A study design used by Haracz et al. (2018) involved interviewing the same people several times, this provided an opportunity to check ongoing analysis with participants for validity. All these studies used memos as an ongoing audit trail and reflected on the validity in a section on limitations. This approach has been followed in this study. In Chapter 7, Section 7.5. the limitations and quality of this study are discussed.

The use of field notes, memos and ongoing reflexivity assists the researcher to monitor for bias. Reflexivity allows the researcher to self-examine and demonstrate their theory development and the sincerity of their work to others (Mays and Pope 2000; Mruck and Mey 2007).

3.9. Reflexivity

"The theory depends on the researchers view; it does not and cannot stand outside of it". Charmaz 2014, p.239.

Reflexivity is a process that involves analysis of how the researcher interacts with the data and participants and how this affects the analysis. Strategies are required to curb its potentially negative effects (Berger 2015). Negative effects can include researcher bias and interpreting the data through a filter of experience, rather than surface value. This self-questioning can evidence ongoing monitoring and demonstrate rigour (Jootun et al. 2009).

The researcher needs to question their own bias and assumptions, recording these reflections (memos) in a journal to make the research process more transparent. The main types of memos are field notes and theoretical memos.

3.9.1. Field Notes and Theoretical Memos

Field notes capture the researcher's observations and thoughts in the field; while theoretical memos capture thoughts on codes, interconnection and theory development (Montgomery and Bailey 2007). Charmaz (2014) devotes an entire chapter to the writing of memos and describes them as a "crucial method in grounded theory". She states that memos provide a place to engage in critical reflexivity (p163). Researchers need to constantly review how they engage with participants, the data they collect and what may be shaping their analysis. The rigorous application of reflexivity helps to address the question Glaser asked of the Constructivist approach when he suggested this method may be avoiding monitoring for researcher bias (Glaser 2002). Berger (2015) summarises other authors in stating that reflexivity increases the trustworthiness of a study as the researcher reviews and accounts for their own role within it. Further examples of reflexivity in practice are presented in the relevant sections of this report where they assisted in analysis and questioned developments.

3.10. Plan for Data Analysis

The data on participants experience of moving and handling in hospitals, collected through interviews was analysed by a constant comparative method (Glaser and Strauss 1967; Charmaz 2014). Coding begins when the data from the first interview is collected.

The first interview is new insight of patient experience of moving and handling. Descriptive coding helps identify topics in the data, Saldana (2016) states this form of coding can be "particularly appropriate" for "beginning qualitative researchers learning how to code data" (p.292). Topics are not a part of grounded theory analysis, Charmaz (2014) suggests that this type of coding is superficial but does recommend coding descriptively and then using gerunds to appreciate the difference. A gerund is a verb ending in 'ing' for example 'coding' that defines an action; Charmaz (2014) describes gerunds usefulness in that "this type of coding helps to define implicit meanings and actions" (p121). Initial use of descriptive coding in the primary two interviews identified aspects of moving and handling described by participants. Descriptive coding confers a topic to the data (Saldana 2016) but recoding with gerunds is necessary to

discover insights into further meaning within the data and the actions that participants describe. Analysis of the primary interview forms concepts for further investigation and theoretical sampling can begin as previously described (section 3.6).

Data collected and analysed is compared and contrasted with existing data and codes. Codes that appear more dominant can be sorted and coding itself become more focussed around these codes; previous codes may be recoded. Charmaz (2014) describes this as 'focussed coding', others as 'intermediate coding' (Chun Tie et al. 2019). Ongoing sorting and comparison become more focussed around an emerging core category or categories as a framework to build theory and coding centred upon the emergent theory ('theoretical coding' Charmaz 2014). An example of some early codes and the more focussed code is provided in Appendix 9. Theoretical sampling and constant comparative analysis continue until a theory is generated that accounts for the findings and saturation of data is reached.

The plan for analysis of data in this study is summarised in the following steps;

1. Identify purposeful sample.
2. Conduct initial interview
3. Descriptive coding of initial interview
4. Recode initial interview using gerunds to increase awareness
5. Repeat with interview 2, thereafter use only gerunds.
6. Comparative analysis and theoretical sampling to investigate data
7. Identification of categories, check emerging data, revisit existing data through constant comparative analysis and focussed coding.
8. Identify core category or categories to form framework for theory, theoretical coding, checks through theoretical sampling and comparative analysis.
9. Emergent theory, checks through theoretical sampling and comparative analysis.
10. Observe for data saturation of emergent theory

These steps can be mapped to Tweed and Charmaz (2012) visual representation of a grounded theory and are shown below as Figure 1.

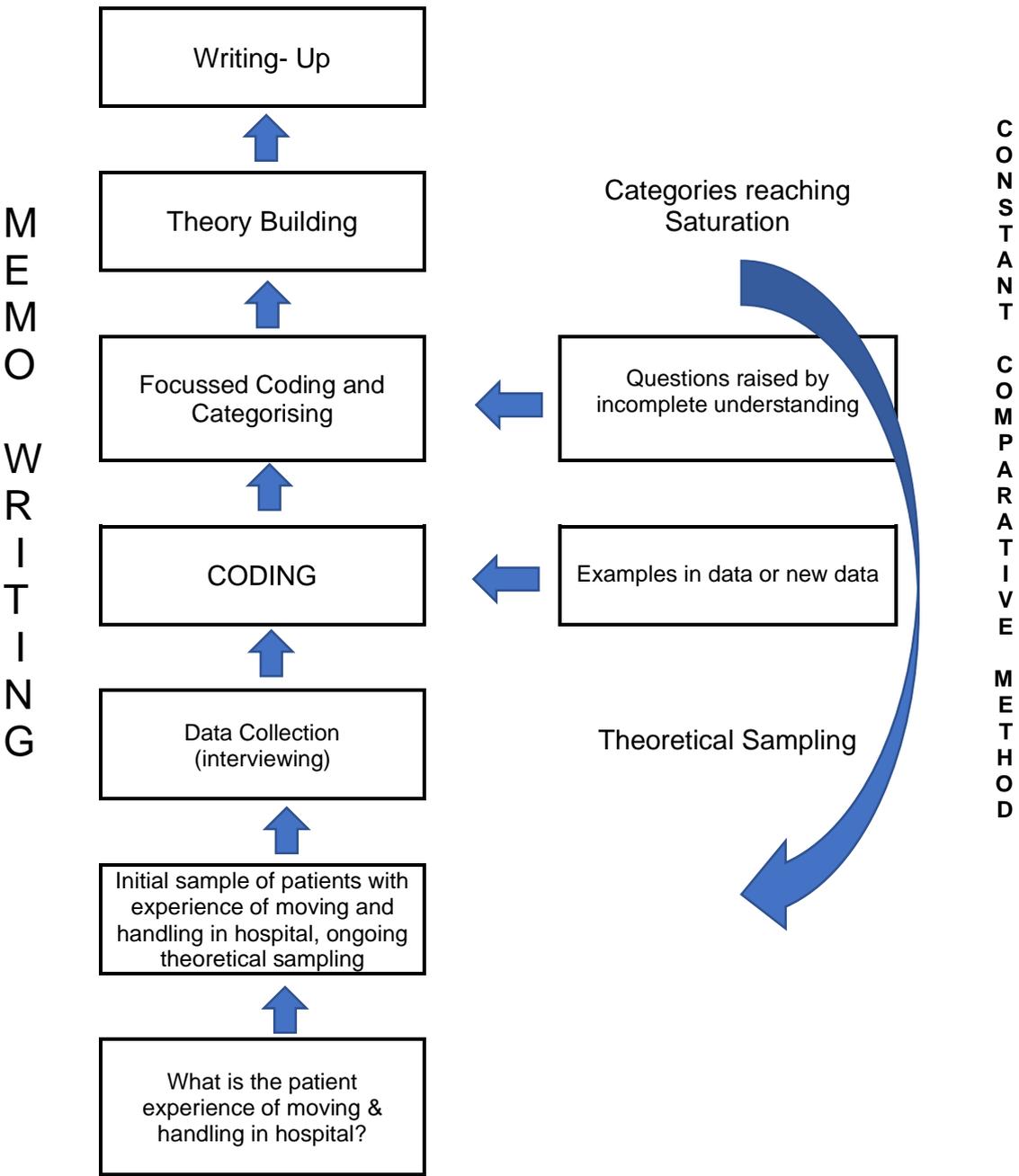


Figure 1. Plan for Analysis (adapted from Tweed and Charmaz 2012)

3.11. Summary of Methodology

The identification of the research aim and questions led to choosing a qualitative approach in order to explore more thoroughly patient experience of moving and handling in hospitals. Constructivist Grounded Theory was the methodology selected. The background and development of this approach to Grounded Theory has been described together with the main features of the methodology. Section 3.10 outlines the plan for implementing the methodology to analyse the data. The need for quality and credibility has also been explored.

Credibility can be achieved by the methods outlined in this chapter. Reflexivity, recording analytical memos, use of guides or checklists and remaining true to the selected approach can all demonstrate trustworthiness. Examples of the use of field notes and memos are provided within the findings chapter, demonstrating reflexivity of the researcher.

The researcher not only has a duty to ensure credibility of research, but also to ensure ethical conduct. The following chapter considers the ethical aspects of conducting this study, from recruiting participants to control and storage of the data generated.

Chapter 4. Ethics.

Research ethics protect participants from adverse effects of participating. In the National Health Service protection is particularly important where participants may be suffering ill-health and increased vulnerability (Council for International Organizations of Medical Sciences 2002). An Integrated Research Application System (IRAS) form needs to be completed before access to patients is granted (IRAS 2019). While laborious, the form does force the researcher to consider the conduct of their research and potential implications for participants. The form also requires the specific area from where patients will be recruited and how this will be achieved. Precise details are required on how patients will be approached, what will happen if they decide to withdraw and how data will be managed. Copies of interview guides, information sheets and consent forms must also be provided for review.

The sections of this chapter outline the recruitment of participants, how consent was obtained from participants, granting of ethical approval from organisations including IRAS and how data was protected.

4.1. Recruitment

It is necessary that the participants have experience of the phenomenon being studied (Marshall 1996; Palinkas et al. 2015). Recruitment would be more readily facilitated in areas where moving and handling occurs frequently.

The initial approach would be to the types of wards identified by Bell (1984) and Pheasant (1997) in Chapter 1 (section 1.3). Both identified 'Geriatrics' as a patient group and this directed the initial purposeful sample toward older people. The Clinical Nurse Managers for the Care of the Elderly Service were first approached for permission to visit wards in their jurisdiction. Agreement from the managers to be site contacts for IRAS and ethical consent was also obtained. The remit of these two managers included acute elderly care wards and all rehabilitation facilities in the geographical NHS Board. Wards were identified and permission granted to recruit from these areas.

The direct healthcare team was approached in the wards and their role was crucial in assisting to recruit patients. In the first instance Charge Nurses were consulted, but the task was often delegated by them to another member of the team. The team have knowledge of the patients' case history and decision-making ability (for informed consent). The assistance of the team means that patients who did not have experience of moving and handling or lacked capacity were not involved in any part of the recruitment. The lack of researcher involvement in this stage ensures that participants were not coerced by the researcher to take part in the study.

Experience in being moved and handled in hospital was essential for participants but additional considerations were necessary for ethical conduct. The criteria given to the care team was that patient participants must have no serious cognitive impairment or learning difficulty and have capacity to consent (Adults with Incapacity (Scotland) Act 2000). A patient losing capacity to consent before or during the interview phase would be removed from the study. If the patient lost ability to consent after the interview, their consent obtained when capable would have applied (including deceased participants). Participants needed to be able to discuss their experience and may need to be excluded for other reasons. An example reason for exclusion would be speech difficulties and poor ability to use communication devices, this would limit the ability for discourse and may cause patient distress. If nursing staff identified patients who could not speak English, a translating service could be used with any translator signing a confidentiality agreement.

The inclusion criteria in the first ward was that the patient must require assistance of staff to transfer and have recent experience of the acute hospital setting. Criteria later became more specific, to assist theory development, for example, specifying age, gender, equipment use or mobility status. A Participant Information Sheet (Appendix 10) was supplied to the nurses to distribute to all patients that they felt met the inclusion criteria. Diug and Lowthian (2013) found that recruitment in the elderly population was more likely to be successful if the approach was made by a third party familiar to them. A detachable form with an

addressed envelope was provided so that patients could indicate their willingness to participate. It was made clear that written consent would be obtained by the researcher from any patient that agreed to be interviewed, they could change their mind and withdraw from the study at any subsequent time.

4.2. Consent and Consultation

Informed consent protects participants from harm. Consent must be fully informed and freely given (Economic and Social Research Council, 2014). Provision of adequate information that informs the patient's choice to participate, and the right to withdraw at any time are essential parts of The Nuremburg Code and earlier guidelines designed to protect individuals from medical abuse (Goohi 2011).

The Participant Information Sheet (Appendix 10) sets out that participation is voluntary and can be withdrawn. This information sheet is based upon the Health Research Authority's information form template (Health Research Authority, 2016).

The Participant Information Sheet was consulted upon for clarity and to identify any concerns before its use with patients. The assistance of volunteers from the selected NHS Organisation's Patient Participation Forum was sought to ensure that it was readily understood. The Volunteers Coordinator acted as a mediator, e-mailing the researchers request for review to Forum members. Two responses were received, the main feedback was dislike of the term "handled by caregivers" this was changed to "being moved by".

A consent form based upon the details in the information form, and the Health Research Authority's consent form template, is set out in Appendix 11. Written consent was obtained by the researcher before any interview began. In instances where the patient was unable to write, a caregiver was asked to sign as a witness to consent (one instance).

The interviewees were not offered a copy of their transcribed interview. Hagens et al. (2009) found that there were some advantages to sharing the transcript.

The advantages included providing an opportunity for the participants to edit, clarify or expand their contributions, however, they found that this added little to the accuracy of the transcript. Disadvantages that they described include discomfort to the interviewee if reliving an original distressing experience again. Participants also felt discomfort from reading their own diction and grammar within the verbatim transcript. Sections of transcript may be withdrawn by the participants which the authors suggest would have major impact on a small-scale study. Mero-Jaffe (2011) studied interviewee review of transcripts and their subsequent actions. The study concluded that interviewee review can cause ethical and methodological problems and affect research credibility.

4.3. Ethical Approval Process

The research proposal, when agreed with Supervisors, was submitted and approved by the University of Stirling Faculty of Health Sciences and Sport's Research Ethics Committee. Favourable consent was given by the NHS, Invasive or Clinical Research (NICR) Committee on 6 April 2017.

Research involving participants recruited via the NHS is also subject to governance arrangements and the approval of ethics committees. An Integrated Research Application System (IRAS) form was completed and submitted. Research aims were also explained and discussed with the West NHS Scotland Research Ethics Committee. This is necessary as the host NHS organisation must ensure responsibilities are clear in the research process and risks mitigated (UK policy framework for health and social care research 2017). Some amendments were requested by the IRAS committee. The main recommendation was that there should be an 'opt in' process whereby patients would indicate their willingness to be approached by the researcher. This recommendation is what prompted the provision of a tear-off page. The page was added to the Participant Information Sheet so that it could be returned to the investigator. An addressed envelope marked 'confidential' was supplied to post in the hospital's internal mail system. Final approval from IRAS was received on 12 June 2017 (Appendix 12).

The ongoing development and implementation of the research was overseen by Academic Supervisors from the University of Stirling, Faculty of Health Science and Sport. Annual reports were submitted to the NHS Scotland Research Ethics Committee via NHS Ayrshire and Arran Research and Development Department.

4.4. Information Governance

All data were stored in encrypted electronic format. Details of individuals interviewed was treated as person specific confidential information and stored separately from other information. For example, patients were identified by a participant number on interview transcripts. All information was treated in compliance with the Data Protection Act, 2018, The Stirling Code of Research Practice (University of Stirling, 2015) and NHS Ayrshire and Arran Information Governance and IT Security Guidance for Researchers (2012). Information governance was monitored by Academic Supervisors.

The interviews were recorded on a digital recorder and uploaded to the Winscribe computer programme. The recording was then only accessible by a code number allocated to the researcher. The transcriptions from the interviews were anonymous with only a participant number. The anonymous transcriptions were later uploaded to a secure Stirling University server with participant consent. Participant consent included that these transcriptions could be used by bone-fide researchers in future research.

The application of the University and NHS research ethic approval processes, written guidance and information governance assisted to protect patients involved in this study. The following chapter, Chapter 5, describes the conduct of the research in the clinical setting.

Chapter 5. Conduct of the Research

This chapter describes how the methodology was applied in the conduct of the research. Sections describe recruitment in practice, the interview process and how data was recorded and analysed.

Chapter 3 provided an overview of why a qualitative approach was deemed appropriate and that Constructivist Grounded Theory (Charmaz 2014) was identified as the methodology for this study. In Classic Grounded Theory the researcher is a detached observer free from personal bias, this would be difficult to achieve having worked in and studied moving and handling for decades. There have also been suggestions from scholars that it is naïve to believe that freedom from researcher bias is possible (Reiger 2018). The Constructivist approach embraces the presence of bias and uses reflexivity as a tool to question the researcher's interpretation of data (Charmaz 2014). Another aspect of the Classic approach is the assumption that there is a 'real' world that can be observed and interpreted (Charmaz 2000, Corbin and Strauss 2015).

Charmaz (2014) disagrees with the assumption of one reality and describes that the resulting theory is only one interpretation of the data seen through the filter of the researcher. The worldview of Classic Grounded Theory has been described as positivist with its emphasis on the researcher as a detached observer (Age 2011), while Glaser (1998) himself described the approach as pragmatic in that the resultant theory works to explain what is happening in the social process, and what will happen in the future. Timonen et al. (2018) describe the biggest point of departure between the Constructivist approach and other approaches to Grounded Theory is the Constructivist belief that knowledge generated can only be an interpretation constructed by the researcher. A reason for rejecting the Classic approach is that I shared the belief of reality as a construct and could not be completely detached in a field where I was knowledgeable.

Charmaz (2008) felt that Strauss also saw the researcher as objective, but Corbin and Strauss later agreed with the constructivist viewpoint (2015 p.26) that

theories are constructed by the researchers. A reason for rejection of the Straussian approach was their analytical method of axial coding (Strauss and Corbin 1990). Axial coding defines how the researcher must analyse the data through a series of processes seeking factors such as conditions and consequences. I felt this coding process would constrain my interaction with the data, I wanted to be more intuitive in my analysis. Charmaz (2014) does allow for the use of tools developed by other researchers if appropriate to the analysis, so there was no need to reject these entirely.

Examples of how the Constructivist Approach to Grounded Theory was applied in the conduct of the research are provided throughout this chapter.

5.1. Population and Sampling

Interview participants were recruited from two rehabilitation hospitals. Experience of care in the acute hospital setting was in the recent past, affording an opportunity for patient reflection on both environments. The patients participating have been moved and handled by healthcare workers during their hospital stay.

The selection process involved initial purposeful sampling, requesting that the nursing staff on the ward approach a small number of patients that met the inclusion criteria with the information sheet. More purposeful guidance was given when the data suggested that it was important to question a particular subset of patient to find the information required and develop further theory (theoretical sampling). This theoretical sampling assists to more closely examine emergent categories and theory (Glaser and Strauss 1967; Morse 2007; Charmaz 2014; Corbin and Strauss 2015). The use of theoretical sampling in this study has been described in section 3.6. The initial purposeful sample was taken from a pre-selected area as the site needed to be specified in the ethical approval process.

The patient groups reflect those identified by Bell (1984) as most likely to be involved in handling activities, mainly older adults. Four specialties were selected in these hospitals:

- The Elderly Care ward was the specialty identified with reference to the identification of 'geriatrics' as the group most using mechanical lifting devices by Bell (1984). 'Geriatrics' also has higher than average levels of acute back pain in nurses related to manual handling (Pheasant 1997), indicating a higher instance of manual handling interventions.
- The Stroke Rehabilitation ward provided patients with experience of moving and handling in acute care and ongoing rehabilitation, this represented the 'General Medical' specialty identified by Bell (1984) as having a high hoist use and Pheasant (1997) as having a high rate of manual handling. Stroke was not a discreet medical speciality at the time of Bell's study, or the papers reviewed by Pheasant.
- The Orthopaedic and Vascular Consultant-led rehabilitation ward was selected as 'orthopaedics' was an area indicated by both Bell (1984) and Pheasant (1997) of higher than average manual handling activity and hoist use. This ward also provided a group with acute onset illness, some with the need to be assisted following life-changing surgery, for example, amputations.
- Neuro-rehabilitation, Bell's study indicates that although the overall hospital population of this specialty is small, the percentage hoisted is high (52 percent).

The IRAS form submitted for ethical approval indicated that 15 patients might be approached. If it was necessary to find more participants, a further ethical request would have been submitted. It was thought that saturation was reached on the ninth interview, with a tenth interview to confirm saturation. A further interview was held when a plus size person was admitted to a ward in the study, on the realisation this specific type of data had not been collected. The decision was made to approach this patient as there may be unique experiences for a larger person (circa 200 kilograms) being assisted to move for care delivery. A main difference, for example, is the type of equipment used to assist care (Muir and Rush 2013). Would this affect the experience in a significant way? The decision was made to interview the patient and discover if this was the case. In the event, no new information or code emerged from the interview.

5.2. Sample Characteristics

Eleven hospital in-patients participated in the study. Table 2 describes the characteristics of the participants in terms of age and the length of their stay in hospital. The longest stay was a full year since admission with the majority having spent more than a month in hospital. One participant had been admitted to the rehabilitation hospital directly from home, all other participants were initially admitted to either one of two large acute hospitals. Reasons for hospital admission included stroke, sepsis, fractures, neurological disorders and physical complications related to morbid obesity.

Table 2 Age Range and Length of Stay

	Range	Mean	Median
Age	44 - 95	67	62
Hospital Stay (weeks)	3 - 52	17.9	16

Table 3 identifies the age range of the participants by gender. The term 'gender' is used rather than 'sex' because the subject was explored in terms of a culture rather than physiology. The study of this situational experience seems to fit more appropriately with the World Health Organisation (2015) definition of 'gender' rather than 'sex'.

Table 3 Age Range and Gender of Participants

Age Range	Female	Male
<55	1	2
56 - 65	1	2
66 - 75	1	1
75 +	2	1
Total	5	6

The inclusion of a similar number of younger and middle-aged participants in a population thought to be mainly elderly (Bell 1984; Pheasant 1997) reflects the use of theoretical sampling.

Information on each participant's journey through the hospital setting and changing mobility with moving and handling requirements is provided in Table 4. Diagnosis/reasons for admission were not included, this data was not collected as moving and handling requirements are not fully determined by diagnosis. For example, someone diagnosed with motor neurone disease could be anywhere on a broad mobility spectrum. Questions about movement range, fatigue and what movements or positions provoke pain are more productive and keep patient confidentiality on a 'need-to-know' basis. Some participants did share details of their condition, but this information is not included in table 4 to reduce the possibility of identifying individuals.

Table 4 Participants' Hospital Journey

Participant Number.	Hospital Journey	Moving and Handling Assistance
1.	A&E, ICU, surgical ward, rehabilitation ward. Hospital Stay at interview, 9 weeks	Independently mobile prior to admission when bedfast, then required passive hoist use. Now uses wheelchair and transfer board with assistance of 1-2 caregivers. Hopes to be independent as possible on discharge.
2.	A&E, surgical ward, rehabilitation ward. Hospital Stay at interview, 52 weeks	Long-term electric wheelchair and hoist use post childhood injury. Passive hoist with 2-4 caregivers. Discharge location uncertain e.g. supported accommodation.
3.	A&E, surgical ward, rehabilitation ward. Hospital Stay at interview, 6 weeks	Mobile with walking stick prior to admission. Now wheelchair user with passive hoist for transfers, using active hoist for rehabilitation sessions. 2 caregivers operate equipment. Expects local authority carers on discharge.
4.	Home – rehabilitation ward. Hospital Stay at interview, 16 weeks	Progressive decline in mobility using wheelchair and active hoist at present, being introduced to Stedy transfer aid. Employed carer at home.

Participant Number.	Hospital Journey	Moving and Handling Assistance
5.	A&E, ICU, surgical ward, rehabilitation ward, acute medical ward, return to rehabilitation ward. Hospital Stay at interview, 16 weeks	Mobile at home with walking frame. Post admission bedfast, passive hoist, then active lifter. Deterioration in condition, bedfast then passive hoist and currently using active hoist. Expects local authority carers on discharge.
6.	A&E, HDU/high care medical ward, medical ward, rehabilitation ward Hospital Stay at interview, 19 weeks	Minimal details (became unwell). Wheelchair and passive hoist user.
7.	A&E, HDU/high care medical ward, medical ward, rehabilitation ward Hospital Stay at interview, 10 weeks	Independently mobile prior to admission when bed bound, then required passive hoist use. Now uses wheelchair and Stedy transfer aid with assistance of 1-2 caregivers. Hopes to be independent as possible but will initially have carers and family support on discharge.
8.	A&E, elderly care ward, rehabilitation ward. Hospital Stay at interview, 20 weeks	Supported at home by local authority carers prior to admission using wheelchair, transfer board and 1-2 carers. Currently passive hoist with 2 caregivers. Expects to return home with care package resumed.
9.	A&E, elderly care ward, rehabilitation ward. Hospital Stay at interview, 3 weeks,	Supported at home by family transferred manually. Use of passive hoist and 2 caregivers initially, now uses wheelchair, walking frame and assistance of 1 caregiver. Expects to return home to family.
10.	A&E, surgical ward, rehabilitation ward. Hospital Stay at interview, 32 weeks	Mobile with stick prior to admission (but supported by carers). Initially required passive hoist but currently mobile with stick. Expects to return home with care package resumed.
11.	A&E, medical ward, rehabilitation ward hospital 1, rehabilitation ward hospital 2. Hospital Stay at interview, 13 weeks	Passive hoist and care package at home. Currently using double-cassette gantry hoist and 2 caregivers. Expects resumption of care package on discharge.

5.3. Interviews

Various methods were used during the conduct of this study to help ensure that the researcher informed but did not force the direction of the study; and considered the interaction with participants. This section firstly describes preparation for interviews and entering the field and subsequently the conduct of the interviews themselves.

5.3.1. Preparing for Interviews

Preparing for the field by self-questioning is an example of prospective reflexivity (Attia and Edge 2017). Planning for interviews included reflexivity on possible scenarios that could occur in their conduct. “*Once a clinician, always a clinician*” warn Hay-Smith et al. (2016) in their systematic review examining dual-role clinical researchers. They describe that the role of clinician and researcher can often be blurred and propose a set of 11 questions that should be considered prior to entering the field. An example question is “when is it appropriate to give physical assistance?” They suggest that prior to entering the field possible scenarios should be considered. Question one and the consideration are detailed below. The full question set has been deliberated in Appendix 13.

1. When is it appropriate to address a clinical question from a patient?

In the case of simple requests for clarity e.g. definition of medical terms, I will briefly explain and offer to give more detail at the end of the interview. If it is a question on quality or judgement, this is not appropriate for me to answer. I will refer back to the caregivers.

Referral back to the Direct Care Team may be appropriate for most concerns, but I will also need to be aware of safeguarding issues and if this is the prelude to another question. Reflecting back e.g. “I’m wondering why you asked that question?” may help solidify the patients concerns.

In general the best approach may be to defer all questions to the end of the interview then give my contact details. I can be contacted by any service-user in my day-job, so this is not preferential treatment.

Other deliberations made before entering the field included how conducting the research within the employing organisation could affect the process. This is evidence of ongoing reflexivity, necessary to consider the researcher position in the Constructive approach (Charmaz 2014). The interaction with participants and possible researcher influence upon them was reflected upon prior to entering the field, in the conduct of interviews and the interpretation of data.

A journal was kept from an early stage of the study, starting at the time of developing the proposal. This journal was used to capture thoughts, feelings, intuitions and reflections (memos and field notes) throughout the study. The example below is thoughts upon a communication from the Patient Participation Forum on the use of the word 'handled' in the draft Participant Information Sheet.

Example of a reflective memo.

I will need to try and bear in mind that patients don't like being referred to as 'being handled'. I will need to reflect upon this, as other words may be more unsuitable, for example, 'touched by'.

The participants' expectations of a researcher were also considered as recommended by Lisiak (2015). The group were likely to be older adults with longer life experience. Dressing too business-like may cause participants to perceive a sense of formality that could reduce conversational flow, but too casual may imply sloppiness that might reduce trust. Smart-casual dress and being neatly groomed seemed necessary when visiting participants.

A topic guide was drafted as part of the study method (Appendix 7). This draft guide illustrated the types of questions likely to be asked and is based upon the interview construction guide in Charmaz, 2014. Charmaz's stance on use of an interview guide was also a factor in selecting Constructivist Grounded Theory. Glaser felt an interview guide "forces and feeds participants responses" (Glaser 2007 p.95) and supported non-structured interviewing. Corbin and Strauss (2015) acknowledge that a guide is necessary for ethical approval but warn against the use of a guide to construct interviews. Charmaz (2015) supports use

of a guide, especially for novice researchers who may face challenges in the craft of interviewing and provides guidance on guide construction. The guide assisted ethical review by giving an indication of the type of questioning participants would face but was not a fixed script. Halse and Honey (2005) found that this approach was appropriate and that ethics committees accepted the need for departure from a script due to the emergence of new issues.

Five Moving and Handling practitioners reviewed the interview guide from the perspective of field experts. Few amendments were suggested. Amendments proposed by two of the practitioners were that additional questions be asked. The questions that they suggested were directive and sought answers of professional interest. Examples of questions that practitioners would like answered were if the person had ever been physically lifted from the floor or dragged by the underarm; both of these manoeuvres are condemned lifting practices (Smith 2011). The practitioners' suggestions were politely rejected with further explanation by the researcher of the rationale behind the methodology selected.

The semi-structured guide permits flexibility in response to the data from interviewees (Charmaz 2014; Rubin and Rubin 2005). If patients seem to focus on a particular aspect, for example, characteristics of caregivers, there was a need to explore this aspect further. The sifting of the data for meaning is the essence of Grounded Theory. The constant comparative analysis and exploration between interviews and other sources of data ensures that the emerging concepts remain grounded in the data collected, not a predetermined agenda of the interviewer (Glaser and Strauss 1967; Hennick et al. 2011). Relying upon the patients' words, the meaning of the experience will emerge, and factors they consider important in the experience.

5.3.2. Conduct of Interviews

Interviews were to be held in a private area, for example, the patient's side-room at a prearranged mutually convenient time. This did not always work in practice. In the first ward visited, agreement was that interviews would be held in the patient's side-room or Charge Nurse's Office if the patient shared a dormitory.

On the second visit nursing staff expected the interview to be held at the patient bed-side in a shared dormitory as the office was being used by other staff. A compromise was reached where the patient was brought to an empty dayroom that was seldom used.

In the instance of a plus-size participant who was using two bed spaces, the interview had to take place in the dormitory as his larger wheelchair had yet to arrive. It would have been unnecessary manual handling risk exposure for nurses if they moved a heavy patient, on a heavy bed, up a corridor to the other side of the ward. It would also have lacked dignity for the patient. The double bed space did afford slightly more privacy. There was a wall to the one side and a full bed space between the next patient's bed. The interview was interrupted several times by nursing staff and ward volunteers entering behind the partially drawn bed screens (not fully closed at participants request). In these instances, the voice recorder was shown by the researcher to let staff know that anything said was being recorded. The purpose of the interruption, for example, giving the patient a cup of tea was quickly accomplished. Field notes were recorded during an interview only if something would not be apparent from listening to the interview recording, for example gestures made by participants.

Eleven interviews were recorded. The duration (excluding introductions and obtaining consent) ranged from five minutes and 38 seconds to 64 minutes. The briefest time was when onset of fatigue and spasms in the participant led to the interview being terminated. Data was retained from this brief interview as consent had been obtained prior to recording. The average time (mean) was 31 minutes. One participant asked if his visitor could be present at the interview and his presence was agreed.

The interviews were an opportunity not just for data collection, but also for analysis (Charmaz 2014). The pronouncements of participants could be explored and examined, asking them to expand on meaning, or identify sources of perceptions, thus giving greater depth to the data. An example is when a participant mentioned feedback: I was able to ask who gave feedback and more

about the form it took. One technique I was mindful of in interviews was to be alert for the use of 'red flag' words such as 'always' and 'never' and to question further if these words appeared, a technique used in Straussian Grounded Theory (Corbin and Strauss 2015; Reiger 2018). These words are absolute and should be investigated to seek the boundaries that they imply.

The eleven interviews took place over a period of almost a year, from 7 July 2017 to 29 June 2018. This provided time between interviews for transcription and analysis. The time was valuable for comparing and contrasting the data, analysing the data into codes, categories and themes, and exploring properties of emergent theory, such as relationship with caregivers.

The exceptions, without a minimum time of two weeks between interviews, were interview eight and nine which were conducted in one day (morning and afternoon). The Senior Charge Nurse had been over-helpful and scheduled the interviews with participants. There were various reasons that these could not be rescheduled, for example, impending discharge. An initial concern was that the patients had been unduly influenced by the Charge Nurse to become participants. This concern was discussed and allayed when obtaining consent as described in chapter 4 (section 4.3). This tight scheduling meant that the first recording had to be replayed in the break between interviews and only a cursory analysis made in fieldnotes. No time was afforded for transcription and coding. Transcription of the interviews is described in the next section.

5.4. Transcription

All interviews were audio-recorded with prior consent. The investigator listened to recordings and made further field notes on the day of interview. A grant was obtained from the local NHS Charity Fund to assist in the transcription of interviews. A scribe was found in the administration team of Occupational Health and Safety. Transcription took place out-with the scribe's working hours in her NHS office. The clerical worker had signed information governance agreements as an NHS employee, it was explained that these applied to all patient participants. The scribe did not have access to participant details and the

recordings could not be accessed remotely, only on NHS computers linked to the secure drive.

The scribe's initial transcriptions were then read in conjunction with the recordings and amended with fieldnotes. The process of amending the transcript could be lengthy as the scribe had no knowledge of lifting equipment or medical terminology. Participants may have made gestures, or there may have been interruptions to the interview. There could also be loud background noise on the recording (for example, a noisy baby seagull on the roof of a conservatory). In one instance it took five hours over a three-day period to amend just seven pages of a 17-page interview transcript; the participant had made gestures, discussed prescribed medication (that necessitated an internet search for the correct drug name) and specific aspects of lifting equipment. The lengthy process of reviewing the transcripts provided more time for immersion and reflection upon the data. The one exception that did not allow time for transcript between interviews, was interview eight as described in the previous section.

Once transcribed, the content of the transcriptions was analysed. Data analysis is described in the following three sections.

5.5. Data Analysis.

The transcribed recordings were analysed using a Constructivist approach to Grounded Theory. Charmaz (2014) chose the term 'Constructivist' to take into account that the theory developed was not an accurate representation of the world studied, but a construction of it by the investigator's interaction with the data. Selection of this approach acknowledges that the Investigator has 34 years' experience as a registered nurse and more than 20 years of this was spent working as a specialist moving and handling adviser. It would prove extremely difficult to ignore knowledge and experience gained over the course of a lifetime. The main strategy to counter encroaching bias is reflexivity as previously described (section 3.9). Reflections upon the participants responses, data, analyses and potential researcher bias were recorded in a journal. An example of a field note (post interview three) and the subsequent action taken is described overleaf.

Example field note after interview with Participant 3

“..... I also feel I need to remove the first question. It sets me off on the wrong foot. The participants seem to feel I’m testing their understanding of the words ‘moving and handling’, rather than just wanting to know their perception of the concept”.

In this example, how the interaction with participants could be improved was considered. Removal of the first question “What do the words ‘moving and handling’ mean for you?” meant that the participant need not worry about giving a wrong answer. The new first question became more neutral and provided an entry to their remembrances, asking “When did you first experience being physically moved by workers in the hospital?”

This field note provides an example regarding the need for flexibility in the interview guide. The journal was also used to describe stages in the analysis and how codes developed from the data.

5.6. Coding the transcripts

The interview transcripts were reviewed, and the participants discourse coded by the investigator. Coding is central to Grounded Theory, it forces the researcher to ask questions of the data and focus upon what the participants are saying about their experience (Charmaz 2014). Coding of the first interviews used ‘open codes’ and descriptive analysis of what the participant said such as ‘restrained by ability’ but were subsequently recoded with gerunds. The rationale for this approach was described in section 3.10. An example of how codes changed from the first experimental coding with descriptive terms, then subsequently with gerunds is given in Appendix 14.

Charmaz (2014) describes how descriptive coding identifies topics, but the use of gerunds in grounded theory explains the actions of participants and leads to a deeper understanding of what is happening. In Chapter 3 it was described that gerunds are verbs that function as nouns, by adding the suffix ‘ing’, for example, choosing, fearing and consulting. Use of gerunds means that the researcher

names the actions that they feel the participant is describing. In using gerunds to describe actions it is less likely that the researcher's bias will enter the analysis. For example, by using the exact word used by the participant (rather than my own choice of word) I can reduce researcher bias during the data analysis process (Charmaz 2014).

Gerunds very closely reflected participants statements, for example, 'needing support', 'losing choice'. As a result, I felt close to and engaged with the data and participants' stories. The gerunds helped to encapsulate in a few words what the participant described. As coding progressed, I became more confident and larger chunks of data of several sentences were coded. An example is the code 'Bargaining for care' where a participant offered a trade in future behaviour if a request was met. The codes relating to these larger chunks of data or events were more aligned with the actions of participants and provided more insight to the behaviours described by them.

Saldana (2016) recommends novice researchers or those on small scale studies avoid using computer applications, they may find a lot of their time is spent learning to use the software rather than analysing the data. This recommendation was followed, and data coded by manual input to Microsoft Word. A two-column table was used with the transcription in the left column and coding on the right. Initially line by line coding was used to interpret meaning of the interviews. The first four interview transcripts and coding were reviewed by research supervisors at the University of Stirling. This peer review of coding can assist to uphold the quality of the study as previously described in section 3.8. Codes were then compared with other codes to see if they fit with data and for relationships or novelty.

5.7. Comparative Analysis

Interview content was compared with other descriptions in the same text, for example, descriptions of relationships with staff. Each transcript was coded then compared with previous transcripts. This comparison assists to confirm categories and analyse emerging theory (Glaser and Strauss 1967; Bryant and Charmaz 2007; Charmaz 2014).

Four transcripts had been coded when some consistent categories were seen. Initial codes were refined as analysis of subsequent data enriched the description. These codes were attributed to aspects that participants revisited throughout the transcripts revealed by early codes such as 'needing connection' or 'needing to feel safe'. Morse (2008) suggests one way of checking for themes is to use a word processing feature to collect notes into the one document for examination. Codes and notes were copied and pasted into the one document and checked for frequently occurring aspects. The theme of 'needs' and 'needing' was heavily present in the early codes and suggested that these codes may have been more descriptive than intended. 'Needing' is a gerund but describes the participants' narrative rather than their actions. The transcripts were revisited and recoded and a number of categories were named by the essence of what is understood by those categories. Appendix 9 provides an example of codes, categories and the theme of 'needs'.

Sometimes participants generated an 'in-vivo code', their own words being a more apt description than the code previously constructed. After interview five, the decision was made to develop a concise code-list, this more focussed coding helps to categorise the data (Saldana, 2016). Earlier codes were revisited and recoded then compared with emergent categories, an example of this is provided in appendix 9. Charmaz (2014) suggests that coding the codes is a helpful device to stop coding descriptors becoming mundane. The codes on the code-list were described in memos for example,

Codes and why I chose them. 19 June 2018.

"Becoming the expert" evolved when participant 2 spoke about how he was the expert on his condition and that his knowledge should be deferred to. Why did they ask healthcare professionals about his needs or treatment when he was the expert? Participant 4 was the coordinator of a patient support group and read all the latest research. This is an example of how participants build self-esteem.

The code 'Becoming the expert' emerged in interview 2, but when compared with interview 1 it was also applied in retrospect to text such as,

An' then they came an' asked me if they could write a journal, about what had happened to me. I [just] said [yes], if it helps somebody else. So [one of] they Professors come down ..." [P1]

Recoding earlier interviews also confirmed if the newer codes are grounded in the interview data or are being unduly influenced by the literature and researcher. It allowed the investigator to see if there were aspects of the data that the codes or categories did not account for and is a key component of constant comparative analysis.

Abductive reasoning is where a researcher forms possible reasons for their findings and by checking the various reasons or hypotheses decides upon the most likely explanation. Strauss believed these checks provided verification of a researcher's ideas, however, Charmaz feels they do not verify but only check the hypothesis (Charmaz 2014). Participants in this study blurred descriptive boundaries in their descriptions of moving and handling care, for example, describing nurses attending to personal hygiene. Such descriptions seemed to infer that they did not view moving and handling as a discreet element of care. The inference arising from the data was checked with the next and subsequent participants in line with the selected approach.

The development of a more concise code-list assisted to identify when the data was becoming saturated. Interview 8 added only one new code to the data, and that was an aspect of an existing code. A fully coded transcript is provided as Appendix 15.

The codes were sorted into categories manually by writing them onto post-it notes. This allowed the codes to be moved and grouped as connections developed. The connections and inter-relationships defined the categories.

Appendix 16 shows emergence of a core category and the initial subcategories within that category. Appendix 17 illustrates the code-list of the core category when further transcripts had been coded.

Emergent categories, themes and theory were later examined with relevance to the existing literature. The information from the literature was compared, contrasted and helped to refine the emergent theory, but did not generate its development. Corbin and Strauss (2015) describe theoretical sampling as a way to “maximise opportunities” to develop concept and theories (p134). Care had to be taken that the literature informed the emerging theory and did not drown the data from the participant’s experience, this is a concern shared by all branches of Grounded Theory (McGhee et al. 2007, Kenny and Fourie 2015). The examination of related literature on the emergent theory was left until the final stages of analysis in line with a Charmazian constructivist approach (Charmaz 2014).

5.8. Summary of Conduct of the Research

This chapter explained how conduct of the research followed Constructivist Grounded Theory methodology. Theoretical sampling was applied when selecting candidates for interview that could assist in theory development. Reflexivity was recorded in the form of field notes and memos. Data were coded and constant comparative analysis applied in the sifting of data for meaning.

The research findings in the next chapter detail the theory that emerged from the data. The synthesis of the findings illustrates the linkage between the categories, the core category and the theory that developed.

Chapter 6. Research Findings

The findings of this study were unexpected. There was some confirmation of the literature, for example patient acceptance of mechanical aids, but participants described aspects previously unreported. The first research question is “What is the patient perspective on moving and handling in hospitals?” The participants in this study did not appear to distinguish Moving and Handling as a discreet category of care, but as an integral part of care delivery, with participants focussing on whether care matched their expectations. How this finding came about is described in the following section, alongside factors that participants identified as having relevance to moving and handling. The aim of this study was to ‘develop a theory of factors that influence the patient experience of being moved and handled in hospitals’.

Subsequent sections of this chapter describe how analysis led to the development of a theory that centred on the patient experience of moving and handling, developed through interaction with the factors described. Throughout the text, direct quotes will be attributed to the participants as P1-P11 and the researcher as R.

6.1. Moving and Handling Care.

Participants’ expectations of moving and handling care delivery gained prominence throughout the interviews. An expectation is a strong personal belief that things will happen in a certain way. Participants spoke more about the caregivers and their level of performance, than the mechanics of physical transfers. Generally, there did not seem to be a clear distinction for the participants between moving and handling and other factors of care delivered, for example, meeting hygiene needs. This section describes participants’ data on moving and handling care.

The participants’ lack of distinction of moving and handling from other activities could be frustrating from the perspective of the researcher. This frustration was captured in a field note regarding interview 4.

Field note after P4 interview

“To tell the truth I was a little frustrated at times because she wasn’t speaking to the topic that I wanted to cover. What she said doesn’t fit the specific theme of my study, but it does add to it”

Participants’ comments suggest an overlap of aspects of care in their perceptions. The way that participants are held and assisted to move forms an integral part of their overall experience of caring. Within the first minutes of the first interview, Participant 1 [P1] linked handling to other aspects of care.

R: “When you first experienced being moved and handled what kind of discussion took place?”

P1: “Well they did discuss it with me. They put me onto a hoist then onto a chair ‘n’ back again, ‘n’ then ah’d tae [I had to] get washed in the bed. Ah mean they were great. Told me everything they wur [were] doing, them turning me and washing me, (chuckles slightly at the memory) feeding me”

The participants appeared to meld physical handling into the care experience and other fundamentals of care. The following examples illustrate comments:

R: “.. what do the words moving and handling mean to you?”

P1 “...hoisting up and down, moving me across the bed, putting ma [my] clothes on and off, washing me.”

R: “.. what do the words moving and handling mean for you?”

P3: “It means care and attention .. to the patient without ehmm, causing any distress in anyway and also, ehmm, I think making sure the patients comfortable with what’s happening to them that’s what I feel.”

The examples given relate to the first three interviews provoking a sense-check with P3 near the end of the interview,

R: *“I am finding when I am speaking to people a bit now. They’re finding it difficult to separate the moving and handling from just the general treatment in the wards, how do you feel?”*

The participant’s answer seems to confirm this,

“Eh.. with moving and handling from A to B from when it happens from when you go into hospital. I find that wonderful, it’s very, very good. The day I was brought in I couldn’t ask for better treatment I was full of praise for them... because I have got to say the nursing care on a whole is very, very good and ...”. [P3].

6.1.1. Matching care to Expectations

Much of the data appeared to be rating the care given or ranking care delivery, for example ‘good’, ‘great’ or ‘bad’ in relation to moving and handling transfers. The environment and equipment were rated for quality and performance, but not as frequently as the interaction with caregivers.

The caregivers’ interaction with the participant was the most memorable feature of handling encounters. P1 had described her first experience of moving and handling:

P1 *“..Ah mean they were great..”*

R. *“What made them great?”*

P1. *“Well there was just a great attitude among them..” [P1].*

R. *“What types of things were they doing with you then?”*

P1. *“Well lifting me. Spoke to me quite a lot ‘n washed me, turned me, sat me up, (laugh) put me back down, everything”.*

Initial codes included ‘Rating the quality of care’, ‘Ranking performance based on attitude’ and ‘Rating the skill of caregivers’. It became clearer as the interviews progressed that the participants were not ranking or scoring in an arbitrary fashion. Participants were matching care against their own expectations of care and caregiving and described what should or shouldn’t happen;

“..very good at what he did. He covered up all the areas that he should’ve done” [P3]

Codes on rating and ranking moving and handling care were consolidated into an early category ‘Matching care to expectations’.

It was found through early analysis of transcripts that the expectation of moving and handling care was that this care should be delivered with compassion. Some aspects were repeatedly visited by the participants during interview in their retold experience of moving and handling care:

1. Care - not being rushed by caregivers, them being gentle and kind in moving and handling interventions;
“there has been a couple on instances where I have been quite roughly handled because they’re rushing” P3.
2. Competence - caregivers familiarity with lifting equipment and being competent in its use;
“that (hoist) belt needs redesigning. It’s complicated and people here are very experienced” P4.
3. Communication - knowing what is happening and why, being asked about preferences in the ‘when’, ‘how’ and ‘who’ of moving and handling interventions.
“if I say I prefer another way, well they say- oh no we can’t dae that, y’know?” P2.

Moving and handling was often interchangeable with attending to personal hygiene, movement therapy and other aspects of care. The aspects given most description by participants are described in the subsections below: Care, Competence, Communication and Celebration.

6.1.2. Care – being gentle and kind

At times moving and handling care delivery was judged with participants saying that caregivers’ behaviour or attitude should never happen. This stronger perception of care delivery was described in a code ‘passing judgement on

caring’, that code was reviewed and shortened to ‘judging caring’. Extracts from interviews are given in table 5 to provide examples of matching care to expectations or judging caring from the interviews.

Table 5 Care Delivery

Code	Comment
Matching care to expectations	<p><i>“It [was] a great team that worked with me down there.” [P1]</i></p> <p><i>“..they’ve improved tremendously over the last few days even.” [P2]</i></p> <p><i>“I mean as far as the nurses were concerned my nursing was exemplary” [P5]</i></p>
Judging caring	<p><i>“..and the nurses that talk like that should automatically go to prison” [P2]</i></p> <p><i>“.. unforgivable there is no need to say that” [P3]</i></p> <p><i>“She’s fit for the [town] jail to be a warder.” [P8]</i></p>

Comments in table 5 relate to moving and handling interventions such as being hoisted to bed and the interaction with the caregivers. The stronger aspect of judgement was generally applied to individual nurses rather than groups. Most of the descriptors are positive – but those recounted to the interviewer with most emotion were negative experiences. Participants in this study described how the inability to move themselves could mean that interventions were delivered without empathy and in an uncaring manner. The following transcription extracts illustrate how some participants described manners that could be perceived as uncaring:

“they’re a bit short tempered with you at times, and it’s awful. But, at times. And you think, well I can’t do it myself you know, I need help.” [P3]

“You know they [just] go in and get somebody on a hoist. I always think that poor person wisnae [wasn’t] even awake” [P1]

*“Because I wasn’t approached from a “shall we do this” it was just like, no conversation, “You will do this”. My immediate reaction is “No I’m not”. Y’know, f**k off and come back in half an hour and don’t treat me like a child. But that is very rare.” [P4].*

The last event recollected above was described as “very rare”, but the participant revisited it several times in the interview.

P3 reflected that *“80 percent of them are really nice”*. This contrasts with negative experiences described by P3 and others in more detail than the positive encounters. Some of the patient perspective on lifting equipment also appeared to be formed by negativity dominance, such as a participant that recalled her days on the farm and hoisting dead animals.

Time to care was mentioned by participants. P3 described being handled more roughly when staff were rushing and described learning not to ask for anything approaching shift changeovers. P1 spoke of being told by busy staff that they were *“short-staffed”* quite often. On one occasion this led to her still being in bed at 11.30am from 6.30pm the night before (18 hours), awaiting a hoist transfer into a chair. P1 did empathise with the staff as,

“they were run off their feet half the time.” [P1].

Participants passed judgement on individual nurses, but overall recall being helped to move by the care team positively. Codes devised such as ‘Appreciating Care’ and ‘Trusting Carers’ reflect the positive aspects of the caring relationship mentioned by participants. Another aspect of compassionate care expected by participants was competent carers.

6.1.3. Competent Carers

The participants expected that caregivers would be competent and acknowledged where competence was demonstrated.

“You just know the people that you can rely on. Some were better than others. Not saying they were all wonderful, but some are really gifted.” [P10].

“I mean they know what they’re doing. And the ones that haven’t used it before, there’s always someone that does know how to use it and they’re learning at the same time.” [P5]

The expectation of competence described above related to the use of lifting equipment. Other participants spoke about advising staff on the correct use of equipment. This especially applied when the equipment was more specialised, for example, the bariatric equipment used for plus size patients.

“I trust them, [you know]? I trust them and plus they listen to what I am telling them because I [know] more about this (twin cassette gantry hoist) than what they [do]. [You know]? So, they listen to me so... ehmm, so I am actually teaching them as well [you know]? So they...., so I’m learning, they’re learning and I trust them, aye it’s alright.” [P11].

Fear or dislike of hoists related to life experience. Two participants had a fear of hoists, one patient [P6] had previously fallen from a hoist during a transfer (the sole example of incompetent hoist use expressed in the interviews). The participant who had fallen from the hoist became unwell during the interview and little elaboration was given. The other participant with “*the fear*” had memories of winching animals on the farm and related being hoisted to this experience:

“Because it takes me back farming. When we had a dead horse or a cow that couldnae [couldn’t] stand, whatever was wrong with it. And if it calved, it could take milk fever. Right? Have you cottoned on? And it was lying there prone to everything. So the two uncles and me, we had to go and make a make do hoist. I mean it’s strong enough and we could get them up. And that’s what it reminds me of, then. ... See I’ve always been feart of [had a fear of] hoists, even when you had hoists working in

your hay shed or whatever. The hoist grabs everything up. No, I never liked that, no I never.” [P8].

A code used in relation to being lifted by a hoist was ‘objectifying as load’, this code described when participants alluded to total passivity in being lifted or moved by staff or machine. Another participant had a fear of heights and did not like this aspect of being hoisted, but acceded,

“It is necessary, I couldn’t walk there.” [P3].

The overall impression of mechanical assistance is that participants viewed equipment as a tool of caregiving, rather than separate from the care experience. Most participants expressed no strength of like or dislike, with three participants indicating dislike or fear. A few (n=3) felt the necessity of equipment to protect caregivers’ health and safety, and competence in use is expected (n=5).

Another aspect of compassionate care discussed by participants was communication. An overview of participants’ experience of communication during moving and handling encounters is provided below.

6.1.4. Communication

A question on the interview guide asked what type of information patients received before being assisted to move. Responses did not detail specifics but did indicate general discussions:

“They always talked about what they’re [doing], always.” [P6].

“It was explained to me, they did that on the ward.” [P7].

“They used to tell me how they were going to move me and that sort of thing. So that I was prepared for any movements that they wanted me to do.” [P10].

Communication continued during transfers, for example, questions about the patients' comfort [P5] or "a wee bit of banter" [P11].

A type of communication given weight by participants was feedback. Feedback helps motivate patients. P10 elaborated on an instance,

"I think it (feedback) makes a big difference. Especially somebody that this has happened to and they haven't been through anything like it before. And a bit of encouragement goes a long way." [P10].

In this quote the participant is explaining that it is important that she received encouragement to increase mobility and reduce dependence on assistance. P11 supported this saying,

"Gies [gives] me a wee bit more incentive, wee bit more motivation. Ehm, when these lassies are praising you and that, then you ken [know] you're doing well." [P11].

The participant described that he was now able to assist the staff by rolling in bed.

P9 describes the affect following praise,

"I said to maself [myself] "I'm gonna stick tae dae [to do] it", tae [to] walk." [P9].

P9 demonstrates here that patients are using the feedback themselves to motivate.

A code applied in instances of this type of description was 'celebrating success for esteem'. Celebrating success seemed of relevance to the patient journey.

6.1.5. Celebration

It seemed important to participants to regain self by being less dependent on equipment and others to move. The code developed describing this type of comment was 'taking steps to self'. The code emerged when a participant [P7]

described the effect of changing from a passive hoist to an active hoist, for example, a standing aid. A passive hoist suspends a patient in a sling whereas the standing aid supports a patient from sitting into a standing position (Smith 2011). A patient using the standing aid must be able to hold onto the machine and take some weight through their legs. When compared to the analysis of previous interviews, 'taking steps to self' largely replaced the code 'progressing to independence and normalising'. The participants may never walk again, but the new normal had to include the maximal amount of active participation. One participant seemed proud that she could roll onto her side in bed so caregivers could apply the sling attachment for the passive hoist,

"Roll, I have been doing it for seven years lass and I can dae [do] it... and they were saying "you'll soon no' need us." [P8].

All participants were asked to describe a transfer in as much detail as possible. P7 described the first time that a standing aid had been used rather than a passive hoist,

P7: "so it was a test to see if it went ok. And it felt great to stand up because I was doing something myself, myself. And it was."

R: "What made that occasion spring to mind?"

P7: "ehmm, felt really good doing it. Felt as if I was doing it myself, although they are helping but it was down to me doing something that. The thing... was going to work if I chipped in, if I done my bit. I felt as if I could see something."

One participant felt reducing to one handler increased 'normality'.

"It's nicer having one person. You don't feel quite so special or vulnerable. It's just anxiety and how you feel about yourself really. You've got six people hovering around you because everybody is terrified. It doesn't fill you with confidence." [P4].

Another participant felt that,

“Although there is two of them that does it [gantry hoist transfer] but you could actually do it with one.” [P11].

The feeling that assistance from less handlers is better was not shared by all participants,

“Sometimes there is two of them and sometimes four. If anything I prefer four Everything feels better with four. It all goes smoother and more coordinated ... and y’feel the ones that know what they are doing outnumber the other ones.” [P2].

Unlike other participants, P2 had been using hoists since childhood and for him hoist use was ‘normal’.

The participants felt good about achievements and progress in mobility, and reductions in the level of mechanical or physical assistance required. Feedback and communication celebrating even small achievements appeared encouraging for them.

6.1.6. Summary

Section 6.1. has explored patient experience of moving and handling as described by participants in the context of care. Negativity dominance was seen in the participant’s recollection of specific interactions as demonstrated by quotes in table 5. However, most generalised recollections are of positive encounters. Caregivers attitude and behaviours seemed most influential to the moving and handling care experience. The participants’ expectations of care reveal the factors of importance to them in moving and handling care delivery: care, competence, communication and celebration. The aim of this study was to ‘develop a theory of factors that influence the patient experience of being moved and handled in hospitals’. Factors were disclosed in the participants’ expectations of moving and handling care, but further analysis was required before theory development.

The codes generated formed an early category of matching care to expectations, however further analysis and gerund codes revealed that the participants displayed actions. The actions taken by participants were behaviours to influence care when care does not match expectations.

6.2. Influencing Care

Matching care to expectations was an early category emerging from the analysis. This section focusses on behaviours described by participants or observed during interviews on how participants may influence care to meet their expectations. Gerunds explained the actions of participants and the sorting of codes into categories revealed connections between the categories. Constant comparative analysis revealed connections between categories resulting in the development of a core category.

The title of the core category evolved through the ongoing analysis. The first tentative title was 'coping with care' this described the sense that the participants exhibited behaviours in response to a mismatch between their expectations of good care and care received. Memos were noted as previously described in Chapter 3, section 3.9.1 on codes and category development. A memo from March 2019 on categories shows further reflections.

Memo dated 11/3/19

I went off the idea of using the term 'coping' a couple of days ago. This was when I read a paper by a professor saying she was tired of students using basic terms such as 'coping'. At the moment I've changed it to 'adapting to care' but that still doesn't capture it.

Several more category titles were reviewed, but none seemed to capture the sense of the data. The behaviours described and observed were responses to the mismatch with expectations of care. Participants tried (consciously or not) to influence the way that their care was delivered. The core category was renamed 'influencing care'.

The Cambridge English Dictionary (2019) offers six definitions of 'influence'. In this instance the gerund 'influencing' does not imply control over another's behaviour. 'Influencing' in this context refers to an ability to change the way that a person thinks or behaves. The thoughts or behaviour of the caregiver may be modified in response to the behaviour of participants. The behaviour of participants was also seen to be influenced by the initial approach of the caregiver. Therefore, 'Influencing Care' emerged as the core category as it provided the strongest explanatory power of all the other categories.

The four categories that emerged within the core category were:

- Yielding
- Analysing
- Sharing
- Asserting

The codes in appendix 17 were recoded into a more concise list and the focussed codes that form the four categories are summarised in Table 6.

Table 6 Codes

Influencing Care			
Yielding	Analysing	Sharing	Asserting
<ul style="list-style-type: none"> • Surrendering autonomy for aim • Suffering to achieve aim • Detaching from activity • Losing self • Feeling vulnerable to circumstance 	<ul style="list-style-type: none"> • Matching care to expectations • Jumping the gun • Individualising care quality • Labelling the carer • Trusting in carers • Fearing the unknown • Feeling own schemes are subservient 	<ul style="list-style-type: none"> • Sharing Scars • Using others as proxy • Redesigning relationships • Making little of much • Participating as a partner in care • Celebrating success • Wanting dignity 	<ul style="list-style-type: none"> • Taking steps to self • Challenging Care • Becoming the expert • Needing control • Feeling over-ruled by carers

The qualities of each of the categories that developed from the codes is described in the following sections, section 6.2.1. – 6.2.4.

6.2.1. Yielding

Codes that form the yielding category are when participants indicated that they could not or would not influence their care delivery. A working title for this category was Surrendering/Suffering.

“I don’t pity myself, I just take what comes along” P10 said elaborating upon what makes a negative hoisting experience. From the participant’s perspective being already in a low mood made for a negative experience. The phrase seemed to indicate a bowing down to circumstance.

Working of the codes during analysis is reflected in a memo,

Codes. 9 January 2019

I sometimes thought that I need new codes, then realise that they aren’t actually new- they were discarded earlier in reworking of code-lists. The ‘being a passive participant in care’ code was discarded because the gerund ‘being’ is one I don’t like. It’s a bit of a cop-out as it can be tied to any adjective. Rather than resurrect the previous phrase, I’ve tried to look at what was really meant. It’s when the person detaches and practically becomes an observer rather than participant. The code is brought back as a rephrased ‘detaching from activity’.

Participants’ description of ‘detaching from activity’ was found in other transcriptions, grounding this code in the earlier data.

P4. *“They had to move me into bed and move me to the loo and everything like that”.*

The category including the code ‘detaching from activity’ for example seemed to be about choosing not to participate or to challenge care, this category was initially named ‘surrendering self’.

In the immediate aftermath of trauma or acute illness some participants had no recall of how they came to be in hospital. Friends or family were able to provide them with their recollections but they themselves could not remember immediate care delivered. Those participants that could remember, described the care and carers in positive terms. Paramedics, Emergency Care and Intensive Care workers were “great”, “outstanding” and “very very good”. In answering the research question on whether how they were moved matched their ability, those that recalled being moved felt assistance was necessary as they could not move themselves. A code used in some instances was ‘surrendering to circumstance’.

P1. “Well I jst think it was the hoist... I gradually accepted it. That’s the way it would be for a wee while”.

The care needs of patients in high dependency or intensive care can be life or death situations. Those participants with little recollection of immediate care were unconscious or heavily sedated. They had little or no expectations of care delivery or how they were moved and handled. The physical needs of the patient and the urgency of decision making does not often permit patient involvement. The acuity of needs appears to leave little option but to surrender or yield.

Memo dated 22/04/18

Sifting the myriad of codes generated ... I’ve been absolutely stunned about how much it related to needs- especially those basic ones. It’s inversely linked to the amount of control a person has. I can’t help thinking of Maslow’s pyramid.

The fact that name of this author sprang immediately to mind while scribbling a memo illustrates that this insight was generated by researcher experience. While this insight was generated by researcher experience, the data had provided the direction of thought. Codes like ‘restrained by needs’, ‘losing control’ and ‘surrendering autonomy for aim’ prompted researcher knowledge.

An additional part of the insight in the memo was that of an inverse relationship. The memo shows that initial thoughts were that this relationship was with

patients' control of their circumstance. As analyses progressed it became clearer that the relationship was with the participants' expectations of care. Those in acute trauma with great physical and physiological needs have little or no expectation of being involved with decisions or being asked about preferences. Patients yield, surrender and suffer. Initial codes had been largely about needs but the descriptive nature of these codes was recognised. Coding with gerunds realised the actions described by participants (see appendix 9) but a background theme of 'needs' could be sensed that ran through the data. Initially physiological needs and how these needs could only be met by others related to the inability to move oneself.

Yielding was not confined to the intensive care situation. The code 'suffering for aim' was created when participant 3 discussed being physically assisted into bed,

"But last night, I was trying to work out who the night staff were -and that's the problem. Ehmm... and the girl that was looking after me yesterday I really like, she is a nice little girl. She's a nice little nurse. She's a nice person, a caring nurse. And I just said to her at half past seven, ok then, you can put me to bed. Eh, but I couldn't get comfortable cause I was in bed for so long. And that's why I was awake all night with pain." [P3]

There is an inference that while the day nurse was nice, some of the night staff may not be. The participant had previously described the pain suffered if lying in bed too long. It seemed that there was a conscious decision to suffer pain in exchange for a pleasant or 'nice' interaction with nursing staff. In this way the participant influenced the care delivered that evening.

'Conceding to carers' was an early code applied when a male nurse offered to manually assist P3 from a commode. She explained a preference to wait for the female nurse who assisted her onto the commode initially,

“Oh [female nurses name] was going to come and see to me”. He said “I’ve been here 10 years, she’s only been here a week.” Well you couldn’t argue against it, could you?” [P3].

This is an example of surrendering preferences to meet immediate needs. The dependence on mechanical or physical assistance meant participants relied on others to meet their physical needs or wishes. Other participants also described yielding their plans to nurses who were pressured for time or constrained by availability of staff,

“They always say “Och we’re short staffed the day”, when [I was] wanting to get up [one] day, n’ it’s nearly quarter to eleven.” [P1].

Loss was a condition that appeared linked to yielding behaviour. Codes relating to this included ‘losing function’, ‘losing control’, ‘losing heart’ and ‘losing respect’. This was consolidated into the code ‘losing self’. A sudden loss of mobility leads to immediate dependence on others to meet basic needs such as nutrition and hydration. A feeling of hopelessness (losing heart) can cause a person to surrender and yield to circumstance. Participants described being detached from care and described themselves like loads that were lifted and laid during moving and handling transfers.

“And they attached me to it. Like a crane. Lifting me up, put me ... in a chair.” [P7].

‘Objectifying as load’ and ‘detaching from activity’ were codes applied in these types of circumstances.

As recovery progresses, participants described experience that was coded in terms of making sense of what is happening. When the physiological needs and the acuity of the patients’ conditions decreased, they described becoming more curious and analysed care delivery.

6.2.2. Analysing

When the acuity of physiological needs has lessened there is still uncertainty for participants about their new circumstances and the order of their new world. This sub-category was originally titled 'Questioning/Analysing'. The behaviour is not necessarily an outward display but could be an internal thought process.

"I say to myself, that's nae [no] way of learning to walk." [P9].

This was stated by the participant reflecting upon being hoisted before any rehabilitation therapy began. P9 provided an in-vivo code for this type of internal dialogue *"but see you're jumping, you jump the gun."* 'Jumping the gun' was appropriate to those situations when participants are impatient for recovery and question the moving and handling care delivered and its efficacy. It is only in retrospect that they appreciated the stepwise progression of rehabilitation. P9 questioned the necessity of seemingly pointless exercises involving small movements. The code could be applied to previous interviews when other participants had described similar thoughts. It was also applied when the participants felt that they should be progressing to a handling aid that required active participation, but it was obvious as an observer that they did not have the muscle tone or strength required. This code illustrates that while patients may still be yielding, they have begun to question their care and surroundings.

Some participants spoke of a developing trust in carers, while they may not necessarily agree with the care delivered and 'jump the gun'. There seemed a need of participants to progress and become more independent, but the reassurance of staff assisted them to accept the necessity of assistance at that time.

"The toilet. I think something like a wee, I should be able to do myself. I felt like I was putting staff who could be doing something else out. But that wasn't the way they made me feel." [P7].

A code 'fearing the unknown' described when participants thought in terms of the future and what the next steps in their journey might entail with the new dependency upon others for moving.

"They think they're worrying me, they're worrying me when they don't tell me." [P8].

This code also absorbed an earlier code 'fearing the unknown possibility' in relation to hoist use, when patients described initial anxiety but were unable to define what made them anxious.

"People can say things like that to you and it doesn't make any difference. You're still terrified and hanging onto that strap. Eventually you get used to it." [P10].

The participants analysis of their circumstances sought to order what they were experiencing with their previous knowledge. Participants began to make comparisons and match care to their expectations when their physical needs were less acute. Matching care to expectations also ran through the analysis and has been previously described in section 6.1. The participants recall life experience and try to make sense of their current situation, to bring order to their circumstance. Examples of rating and judging care delivery from the participants transcripts are provided in table 5 (Section 6.1.1). Participants rated care received with descriptors such as bad, good, very good or expert,

"And some nurses are quite expert at it ..." [P2]. (hoist use)

A linked code to 'judging care' was 'enforcing rules' when patients felt nurses should not behave in particular ways such as commenting on their weight or rudeness when delivering moving and handling care.

Descriptions of carers behaviour were often associated with a positive experience of care by participants. In addition to the code 'trusting in carers'

other codes such as 'appreciating care given' developed. 'Appreciating the extra' was used when carers went beyond expectations. P11 described a charge nurse pushing for a piece of specialist lifting equipment,

"It was her that kinda pushed for that 'cause she recognised it was more beneficial." [P11].

More often appreciation was expressed in general terms. Participants reflected upon demands placed on caregivers,

"It's a job, a hard job that staff handles people's thoughts and conditions." [P7].

'Feeling own schemes are subservient' was expressed in the interview transcripts and coded. Sometimes the participants questioned the role of the ward routine determining when their handling needs could be met.

*"They come into the room in the morning, an one nurse will say we'll get (P2) up first and the other nurse will say we will leave him tae later... Once the breakfasts come in, then that's the absolute priority. "Oh, got to give you breakfast before it gets cold". An' I mean, you consider, I only ever have cornflakes and milk and a roll and marmalade and butter. Nothing I actually get does get cold anyway, so it just sounds like absolute sh*tte to me, so it does."* [P2].

R."What's the single biggest improvement if any that we could make to moving and handling for people in hospitals?"

P3. *"I think just generally more care when it comes to dealing with an individual. They tend to rush sometimes. Like in the morning with washing and that because the breakfast trolley is there. Or they are half-way through doing something and someone will say "oh it's time for your breakfast" and the nurse will go off and somebody else will..., and I just*

think two or three minutes you know, they would have finished what they were doing and you have to start all over again with somebody else.”

Timings such as arrival of the meal trolley and the route of the drug trolley influenced when participants could get out of bed or receive medication. At times this code related to the needs of other patients who were mobile and perceived to have greater control over meeting their own needs.

“I tend to go to bed between half six and quarter to seven. Eh, and that’s me for the night, whereas other ones can wait up late because they don’t need the hoist.” [P2].

Participants made comparisons between their former circumstances and their current condition, coded ‘making comparisons’. If participants formerly had been recipients of care, then the quality of care and environment was compared to that elsewhere. P4 brought an international perspective having been cared for in a South American hospital and a rehabilitative setting on mainland Europe. A main difference in the South American hospital and with P4’s carer elsewhere was the level of physical assistance offered; staff would physically lift for transfers. The use of aids was generally accepted with some participants rationalising that you had to protect nursing staff from harm.

“I don’t want nurses getting broken backs an’ hunch backs and wee cripples an’ everything” [P2].

“I had to use the hoist at first and as a backup in case they were straining something” [P7].

One participant did feel that the need for caregivers’ safety was at the expense of her preferences, however she had made a decision to accept the hoist as the result of an internal analysis,

“I think I am, surprisingly, a people pleaser. OK you want me to use the hoist cause you want to feel safe. I will make you feel safe, whereas I am resentful as hell every single time.” [P4].

While hoist use was not the preference of P4, the choice was to make others feel safe.

Lifting equipment was critically appraised with recommendations for improvement in some instances. Two participants felt the comfort of a standing aid could be improved by redesigning the harness. Participants that had used aids or equipment at home preferred equipment similar to equipment that they were used to at home, coded in transcripts as ‘matching with mine’.

“I would say it was about right, because I had a standing aid at home very similar to ...” [P4].

This acceptance also was applied to furniture with one participant finding the bed uncomfortable and missing the comfort of his own. When making comparisons, the more familiar the surroundings or equipment seemed to be, the more acceptable it was. In relation to performing transfers between bed and chair, for example, participants who had been assisted at home expressed a preference for being moved in a similar way. This preference sometimes did not take account for changes in the participants physical ability as a result of their current health crisis.

The use of their preferred standing aid or transfer board needed to be part of their rehabilitation goals rather than a continuation of care. Familiarity also allowed for ‘taking shortcuts’ a code that was applied to several transcripts. The more familiar a participant became with routine or transfers; the less information or explanation is required. Caregivers could move more directly to the task at hand, taking a shortcut. There is no need to repeatedly explain what is happening when the patient is familiar with and has learned the process.

“They used to tell me they were going to move me.” [P10].

This statement puts the need for explanation into the past tense. In relation to the research question on what information do patients receive, it appears that most information is required in the introduction of elements of care and less as familiarity grows.

Participants observed staff and attached adjectives to carers related to their demeanour and behaviour. ‘Labelling the carer’ was the code used to describe this, for example, one participant’s thought that a nurse was ‘hormonal’ when uncharacteristically abrupt [P5]. Characteristics were attached to groups such as younger or older nurses described as being more caring during moving and handling interventions than the other. This label was checked to see if it was applied consistently, was one group perceived more positively by patients? In this small sample of participants, it did not appear to be the case that younger or older nurses were perceived as more caring. Different participants described different aspects they valued in the care delivery, for example, time spent with them or length of experience and therefore perceived competence of nurses. A linked code was ‘individualising care quality’ when participants reflected that the quality of care was linked to the individual nurse that delivers it.

‘Labelling the carer’ shows that the participants were categorising care staff. Labels include “nice”, “thorough”, “good”, “clever”, “tomboy”, “trouble-maker”, “rude”, “wee lassies” and “auld yins”. This helped participants influence their care by deciding who to interact with. The earlier description of P3 choosing to be assisted to bed by the “nice nurse” is one such example. In contrast, care from those disliked can be rejected,

“She disnae [doesn’t] like me but she tolerates me, she kens noo [knows now]. She’ll come in and say, “You needing anything or wanting anything?”. “No, it’s alright. I’ve got everything I need.” [P8].

This was recounted by P8 who also described using Scots words knowing the “young yins” had difficulty in understanding the meaning. P8 had stated a preference for experiencing care from “auld yins”. This participant felt that younger nurses had less time for her,

“The young yins come in and everything is just put over your heid [head] or pulled doon [down]. I ken [know] the difference” [P8].

Research questions included ‘What is the patient perspective on moving and handling in hospitals?’ and ‘How does moving and handling care received match patients’ expectations?’. From the perspective of this group of participants, it is dependent upon who delivers that care. Participants attempts to influence who delivered care were not always successful, nurses would continue with a task explaining their own competence or availability.

Participants analyse their surroundings and care delivery. They make comparisons or judgements to reflect upon circumstance and other people. They may use this analysis to try to influence who delivers care.

The next section describes how participants began to form relationships and share information with those around them. This information can relate to their previous experiences, analysis of their current situation, their perceptions of care and caregivers, or their personal concerns.

6.2.3. Sharing

Codes in the category ‘sharing’ relate to establishing bonds and using those around to influence care.

Peer support is evident with five participants telling of interactions with those around them in hospital wards. ‘Sharing scars’ was code used to describe conversations with others relating to previous ordeals. ‘Others’ were fellow patients in shared dormitories, but the code was also used when participants related past traumatic events during the interview. ‘Sharing scars’ originated as an in vivo code when a participant did exactly that by lifting clothing during the interview to show evidence of operations. The code was applied to transcripts

when the participants described sharing their experiences with others. It shows their experience is not unique,

“There’s one that needs the hoist and the rest don’t. So the one that needs the hoist is in the same position as me... and then he has to wait until there was two members of staff to get lifted. An’ I thought I’ve been there; I know how that feels.” [P2].

‘Using others as proxy’ described when others could help if a lack of mobility stopped participants doing everyday things like changing TV channel or dormitory lighting. It also described sharing experiences in the hope that they would be relayed back to influence care.

P3 shared several instances that she perceived as misconduct by staff. I had inadvertently let slip that I knew the ward Charge Nurse. P3 described an instance of the Charge Nurse’s doggedness in sorting social care for a dependent left a home. I laughed at this characteristic behaviour (having been on the receiving end in the past) and said that I knew her to explain my laughter.

Field note dated 11/11/2017

Could have kicked myself for mentioning that I knew the ward Sister.

Wondering if a lot of what followed thereafter was an attempt by P3 to bring things to her attention via me.

I felt certain that this was the case and promised myself that there would be no repeat. At the end of the interview P3 summarised some complaints and concluded *“I think Sister might have something to say about that”*. The sentence was initially coded ‘hoping researcher will feedback’. This is an example of how P3 tried to indirectly influence care by sharing during the interview.

There were other aspects of researcher interference I felt that could not be changed. P2 described his sense that I had been an indirect influence on care

received, the quality of moving and handling transfers seemed to improve prior to my visit.

“They’ve improved tremendously over the last few days even. As if they suspected you were coming (chuckle)” [P2].

Recruitment of participants had been through the direct care team, as was the scheduling of interview appointments. I felt that P2 was sharing he felt that care was not always of a high standard.

A feeling of appreciation and trust for the nurses and the amount of time spent in each other’s company, seems to develop some close nurse-patient relationships. The relationship with nurses appeared to be viewed at a personal level. Participants referred to nurses as “my pal”, “like my daughter” and other similar terms. Clarification had to be asked of participants whether nursing or physiotherapy staff were assisting in transfers because of terms like “the girls”.

“But the girls havin’ tae lift me up and things like that” [P1]

“if I ask them, the girls, can you take me down..”[P3]

“I don’t want to give the girls more work than they need.” [P5].

This type of categorisation by the patient was originally coded in terms of ‘seeing carers out-with roles’ and ‘fostering a carer’. The group code assigned was ‘redesigning relationships’. These relationships may have evolved because of the length of time spent in hospital and each other’s company. Participants gave indication of evolving communication and familiarity with their moods or fluctuations in ability:

“Then gradually we all came to a decision.” [P1].

(On equipment use)

“I just became a bit more assertive and then the girls get to know me an’ ... ‘she’s crap in the mornings but y’know she will be ok later’ , so they were quite sensitive to it.” [P4]. (On timing of bed to wheelchair transfer)

“They’ve just been doing it for so long most of them that ..., they’re patient, they don’t mind if you’re not a [hundred] percent.” [P5]. (On equipment use)

The average length of participant stay was 17 weeks and participants would have spent many hours with nurses on the wards. Some had spent weeks in the Intensive Care or High Dependency Units before moving to other medical/surgical wards and then the rehabilitation hospital. P3 asked nurses how they “do it?”,

“Well it’s a career and we love it” and they do. They do love it..... they’ll give you a hug if you need it, that kind of thing.” [P3].

While some of the patients may view nurses as friends, the nurses are required to maintain professional boundaries. One participant [P3] viewed the behaviour of a nurse as negative and domineering when she was in charge of a shift. The participant reported that the nurse reprimanded others for their conduct and apologised to the participant saying, the other nurses (perhaps the participant’s ‘friends’) had been observed moving her without the specified equipment. The participant did not need this information and was left unable to understand the behaviour of the nurse in charge,

“..and I thought “why?”, because she is such a nice person. Eh, but I think it was just kinda flexing her muscles a bit.” [P3].

The code ‘redesigning relationships’ does not just apply to the ward ‘family’. Participants relationships with their family and friends also changes. Those with dependants are unable to care for them when in hospital and have become the recipients of care themselves. A research question was,

What involvement have friends and family had in the way that patients have been moved and handled?

Almost all of those spoken to have an expectation that employed carers rather than family would be involved in their care, including assisting movement after discharge. Some lived alone and had far-flung family, others lived with partners who were elderly and had health conditions themselves so that there was no potential for family involvement in moving and handling. In some instances, the need for carers had been discussed in discharge planning, in others it would be a resumption of existing care packages. The exception was P1, who despite multiple amputations envisaged being as independent as circumstances would allow and was learning to self-transfer with the aid of a transfer board. P7 expected the involvement of carers but was the only participant who expressed a wish for family involvement in physical transfers in hospital. His brother had become his “*primary visitor*” and observed physiotherapy with an intention to help with transfers into the car in the future. P7 also described how his young children visited often and had also stayed for physiotherapy sessions,

“They even sat in, watched me walking. I got a boost out of that, they actually helped. They asked one of the physios, asked to help. She was helping doing some things with my fingers and that. So, it’s been a nice eh, experience.” [P7].

Both P1 and P7 were at the younger end of the participants age spectrum and had experienced dramatic sudden health events. Others with long term conditions experiencing a health crisis, or those of advanced aged and frailty may be more used to accepting the assistance of others.

‘Using others as proxy’ described when participants used family and friends to attend to their everyday lives. Checking unattended homes, collecting mail, shopping and paying bills were examples of tasks that were undertaken on behalf of participants. An example previously described (in the hospital environment) is when P1 was impatient to get to bed and nurse attention was

delayed for a time following her request. P1 co-opted her daughter to deliver the necessary assistance. She described the nurses' confusion when they later found her changed into fresh nightwear and in bed,

"I said ma [my] daughter helped me. They wurnae [weren't] long in helping me after that." [P1].

'Using others as proxy' largely replaced an earlier code 'using others as advocates' in relation to influencing care. The term 'advocates' seemed to imply a championing of the participant, when assistance could be more mundane such as moving the participant in the wheelchair. 'Using others as proxy' seemed to cover all those instances when a patient was unable to do something for themselves and another person could be recruited to assist.

An example of others becoming the voice of the patient is when P7 asked for his brother to be present throughout our interview. It became apparent that his brother was used to answering questions on his behalf when he volunteered to fill in gaps in P7's memory *"I don't know whether you want me to chip in or not..?"* I politely declined the offer with an explanation that I wanted to examine patient experience. The brother did occasionally provide words when he felt that the participant was struggling with his vocabulary. Families also shared experiences with participants from the time when they had been unable to make wishes or feelings known themselves. Using others to complete gaps in the memory gives insight to the time that participants lacked awareness.

The category 'Sharing' is when aspects described previously in sections 6.1.4 Communication and 6.1.5. Celebration are seen in the coding of transcripts.

"I think it (feedback) makes a big difference ... a bit of encouragement goes a long way." [P10].

“Gies [gives] me a wee bit more incentive, wee bit more motivation. Ehm, when these lassies are praising you and that, then you ken [know] you’re doing well.” [P11].

Information, feedback and encouragement on the progress of rehabilitation become important to the participants. Several participants mentioned setting shared goals with the physiotherapists giving them something to work towards. Participants spoke of celebrating success and feedback in relation to physiotherapists more than nursing staff. This is a missed opportunity for nursing staff who spend more time in the company of patients. Feedback was appreciated by participants and travelled both ways. The code ‘mirroring the attributes of carers’ (absorbed in the group code ‘participating as a partner in care’) was used when participants responded in the manner of those that approached them. If an abrupt approach was made, then the response would be similar. If humour was used, then the transaction would be light. Most participants appreciated good humour or banter in interactions. Sharing supports participants social needs and sense of belonging.

‘Making little of much’ was a code used in relation to participants sharing their experience with humour during interviews. Participants likened hoist transfers to fairground rides or joked about lack of mobility, dependency and hoisting.

“I say to them don’t [drop] me, they say ‘you shut up or we will drop you’. It’s just a bit of banter.” [P11].

Sharing with humour seems to promote connecting on a level that does not involve pity.

Participants made conversations seem more like peer interactions and conversed with more fluidity when the tone (if not the content) was lighter during interviews. Humour made it easier to share information. This may explain why participants value humour and banter in moving and handling interactions with carers.

“I think nurses if they are worth their salt, make things funny. Y’know? If they can, if there is a way around it, don’t make you frightened.” [P10 on being hoisted].

Information on participants’ preferences and experiences can be shared without seeming to seek pity or cause offence. Sharing humour can level the playing field and facilitate more active participation in choice.

When ‘sharing’ the passivity demonstrated during ‘yielding’ is no longer evident and active participation in care begins. The active participation can be physical as patients regain movement and control of the body. ‘Participating as a partner in care’ is a code describing when patients became more equal in social interactions and involved in sharing tasks relating to movement and fundamentals of care. P5 describes washing his *“private parts”* in the shower leaving the nurses to assist with his back and legs. P8 was proud of her ability to roll in bed to assist and to sit forward in a chair to help nurses pull clothing down her back. P11 also felt progress when he was able to roll in bed and assist caregivers, appreciating the feedback from them.

“So now I can roll about myself ken? So.... And the Physios seem to be quite impressed wae what I’m doing too.” [P11].

Further questioning revealed that the Physios had praised his progress

“and the way I look at it I done well”.

Others describe similar ways they could contribute and share in the activity, even if only following instructions, such as folding arms to keep them in the sling when being hoisted [P9].

This was not an easy time for participants as recovery progressed. In addition to meeting their social needs, they began to consider social status.

“I felt it was degrading, lifting me up to put me in a chair ... ‘cause I couldn’t move ... that really got to me.” [P1].

The participant became throaty when recounting her feelings, in contrast to joking earlier about being supported on the bedpan by nurses when she was too ill to move from the bed. The sentiment was repeated by other participants, especially in relation to toilet use and the requirement for physical assistance. A clunky code 'regaining autonomy regains inhibitions' was used to capture the change from accepting care in physical crisis, to analysing the social implications during recovery. This and other codes like 'regaining respect' became a focussed code 'wanting dignity'.

'Sharing' describes how participants become a partner in moving and handling activities and have rapport with those assisting. Increased knowledge of each other informs moving and handling interactions and feedback is valued. The participants' perspective is that their wishes should be known and that they should have involvement in moving and handling and other decisions. Participants became more confident in sharing their thoughts and progressed to assert their wishes.

6.2.4. Asserting

Participants described physical recovery and adjusting to circumstance, they began to challenge the delivery of care. The codes that relate to this became categorised as 'Asserting'.

As previously described participants felt that depending upon others for basic needs could be undignified. They seemed to adjust to the change in status and grow into their new self, accepting the ongoing assistance of others. Codes like 'progressing to independence and normalising', 'taking steps to self' and 'adjusting to a new normal' describe the transition from total dependency and a growing sense of self. These codes were consolidated into the code 'taking steps to self'.

In relation to manual handling the need to be as independent as circumstance permits was described in terms of reducing dependency on others and mechanical aids. The use of a transfer aid manufactured by Arjo Huntleigh, the

Stedy, was described as a milestone. This device has no lifting actuator and relies on the patient being manually assisted by caregivers to a standing position before a seat in the form of two solid 'flaps' is lowered from each side beneath their bottom. The patient sits, is transferred, assisted to stand so that the flaps can be removed, then they can sit upon the new surface beneath, for example, bed or toilet. The patient progresses to pulling themselves into a standing position, then caregivers assistance is confined to adjusting the seating flaps and wheeling the device from point A to point B. P4 recounted proudly,

"I am now a Stedy person."

Some physical assistance from caregivers may still have been required as she elaborated,

"Nearly, nearly, not quite qualified, but almost."

The need for assistance of only one handler also made a difference,

"It's nicer having one person. You don't feel quite so special or vulnerable." [P4].

In the instance of P7 this equipment had become a goal to strive for,

"I seen it [the Stedy] come about and thought this was my goal, to start using that; 'cause it looked like I was doing something. The person was doing, doing the lot himself." [P7].

Even when the potential for rehabilitation had been exhausted, participants adjusted,

"It was quite pleasant once you got used to it. Getting wheeled around in the air." [P10 on continuing hoist use].

P11 had similar reflections,

“The first time I went up on it [the hoist], eh, I was a wee bit apprehensive. But you actually went up ‘n’ that. Eh, this is good, y’ken [you know]?”
[P11].

The fear of the unknown previously described was no longer evident in the transcripts as a sense of self grows.

The earlier stage of questioning and analysing is no longer an internal dialogue. With a growing sense of self, participants described making their wishes known. This growth was a progression of ‘participating as a partner in care’, such as P7 asking for his brother to be present at physiotherapy sessions. Some participants described using the logic from their internal analysis to challenge caregivers. P3 asked for assistance to sit up in bed,

“No” she said, “I’ve got a sore arm” she said, and the next time it was a sore back. And I said to her “then why are you at work?” [P3].

P2 felt always “left ‘til last” to get up in the morning. He stated that this was because he required the assistance of two nurses and described his attempts to assert his wishes,

“But my point is, the only time they’re both free at the same time, is if they make me first, and I just canny [can’t] seem to get that across to them. Y’know?” [P2].

Codes related to this type of description like ‘challenging authority’ were organised into a new code ‘challenging care’.

It was easier for participants to challenge from a position of authority. ‘Becoming the expert’ is a code that described the gaining of knowledge and expertise by the participants on their journeys through healthcare. P4 had a long-term condition with much experience of care at home and in hospitals and was a

coordinator in the UK Society for her neurological disorder. P5 had an encyclopaedic knowledge of drugs prescribed, all the contra-indications and side-effects. The relation of facts like these indicated their growing knowledge of aspects of their care including moving and handling. P11 used a specialised piece of lifting equipment for plus sized patients and would explain the use to nurses unfamiliar with the overhead gantry twin-cassette hoist. P2 wondered why the opinions of nurses seemed to have more weight,

“I think that with ma’ [my] experience of being hoisted, it should be done ma’ way. But they say – oh we’ve been a nurse of x number of years, so they’ll be right. Y’know? And the minute I hear that I switch off, because I know it’s pointless.” [P2].

P2 described similar instances relating to multi-disciplinary meetings where he felt out-numbered. This led to a code ‘feeling over-ruled by staff’ when participants’ attempts to assert themselves led nowhere, because of caregivers expressing the opposite viewpoint. Another aspect of this code was ‘out-numbered and over-ruled’ when the number of healthcare staff in inter-disciplinary meetings was described as over-whelming the participants’ preference. The individual is feeling over-ruled because of the number expressing an opposing view to their own solitary opinion. In the case of P8 the reason for caregivers refusing her step down to a transfer board from a hoist was apparent to an observer. P8 outlined staff reasoning,

“That’s another thing that I heard. That I hadn’t enough body strength to get out of my Banana Board, to get off my bed and onto my chair. And I need the hoist.” [P8].

I observed that she could move her thorax from the chair backrest but had little core strength. Abdominal strength is required to sit upright on the small board. If unable to remain sitting upright with minimal support, the person transferring would lose balance and fall from the board.

Asserting seemed linked to a wish for control over circumstance. A group of codes was consolidated into 'needing control'. The most extreme example was P2 who's transcript was coded as 'craving power' in several sections. He felt that multi-disciplinary meetings should be chaired by him with a "talking stick". He would use this stick to point to the person allowed to speak. A further proposal by P2 was that:

"..the way to do it is to give patients control of the therapy budget. I would go one further and give them control of how the nurses are paid. Like A, B, C or D gets a wee bonus. But only the patients can contribute to that. That would get them working better." [P2].

Other examples of needing control were less in relation to power over staff, but for control of circumstances. Simple things like when to go to bed and when to get up were issues. Four participants described how they could do more in a wheelchair than lying in bed. P5 felt that there were detrimental effects of an enforced bedrest in an acute ward, following a further episode of ill-health during rehabilitation. The bedrest meant that he was more dependent on physical assistance of caregivers on discharge from the acute ward than before admission to it.

The need for control nearing the end of the hospital stay may be related to preparation for leaving. Participants spoke about planning their new life and had been involved in discussions. P8's wish for a transfer board was one of the instances coded 'matching with mine' described earlier in section 6.3.2. of this chapter. She'd previously used a board at home and did not want the hoist that would be there on discharge. In most participant cases, the person leaving hospital is much changed from the person that they were before traumatic events. There is a new dependency on others because of the loss of physical ability.

Asserting describes how participants begin to assert themselves in preparation to take control in their new lives. The participants revealed how they have the

ability to assert their wishes, but the outcome may not necessarily be what the person wanted. Other factors such as the safety of caregivers also require consideration in selecting transfer techniques. Knowledge of healthcare grew and participants could assert their wishes with informed reason.

The relationships between the four categories 'yielding', 'analysing', 'sharing' and 'asserting' as aspects of a core category of 'Influencing Care' is illustrated in figure 2. The relationships between the core category and levels of physiological need, led to the development of a theory outlined in the next section, 6.3.

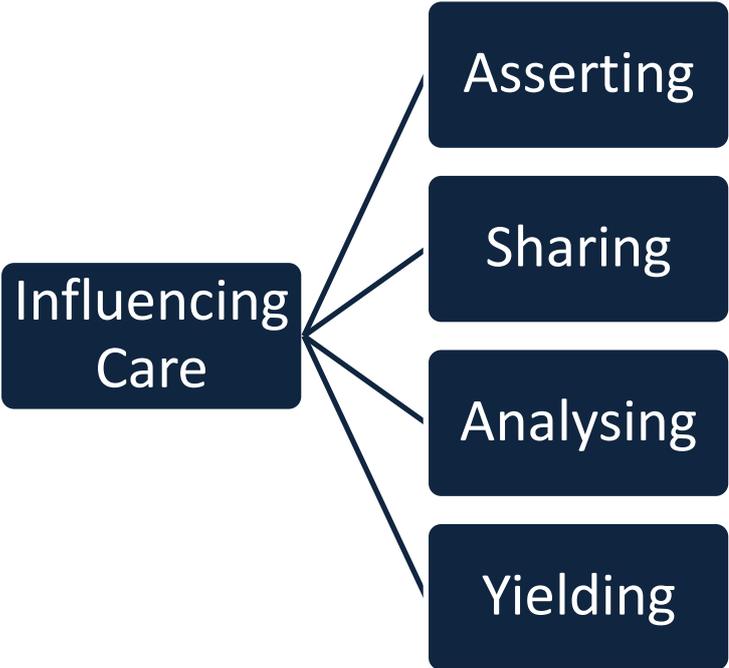


Figure 2. Core Category

6.3. Needs, Expectations and Capacity to Influence Care

This section will describe how the analysis of data met the aim of the study and formed a theory based upon the factors that influence the participants' perception of moving and handling care. The factors described components participants deemed important in moving and handling interactions; care, competence, communication and celebration. The data moved beyond

describing these factors when participants related how they could influence these factors and their moving and handling care.

The theme of 'needs' that ran through the data is previously described (section 6.2.1.) and is illustrated in appendix 9. This theme did not explain participants' actions, but on a descriptive level contextualised the data and provided background for events related by participants. The need for moving and handling encounters could be a physiological, for example, elimination or pressure relief, but moving and handling assistance was also necessary to meet other needs, for example, to move to a comfortable position or sit in a chair for social interaction.

In Section 6.1. participants identified the factors that influenced moving and handling encounters: care, competence, communication and celebration. These factors were the foundations of their expectations of what good moving and handling care should be. Participants held little expectations of care delivery when their physiological needs were most acute and felt less capable of influencing care. The less acute their physiological needs and the higher the sense of self-actualisation, the greater was the expectations of care delivery and their capacity to influence care. Participants described transitioning from yielding when their physiological needs were greatest to asserting their wishes when their capacity to influence care increased. The finding that patients exhibit behaviours to influence care and match their expectations of what good care should be is novel. Behaviours described are:

- Yielding; expectations are of effective medical interventions. There is little wish for involvement in decisions about moving and handling because of the urgency of care needs. due to the demand for physiological care and support. As physiological needs diminished so did the participants' tendency to yield to the caregivers making decisions on their behalf.
- Analysing; participants internally questioned the moving and handling care delivered and matched it to their expectations. Caregivers are labelled in terms of their manner and behaviour. Participants tried to

influence who delivered their care but did not question caregivers directly.

- Sharing; Participants would share their thoughts and opinions with others. The others could be used by proxy to influence care. Questions are shared with caregivers and more active participation in all moving and handling care and decisions is expected. Feedback and celebration are important for psychological wellbeing. Bonds form with the care team and humour is used to help belong to that team.
- Asserting; Participants adjust to their new circumstance and challenge moving and handling care when it does not meet expectations or preferences. They seek control over their care and want to be involved in decisions relating to them. They readily make the wish for involvement and their frustration if over-ruled known to carers.

The lower the level of self-actualisation and the greater the basic needs of the patient, the smaller their expectations of care and capacity to influence care delivery. The greatest need in acute care would be to remain alive. The inverse relationship is depicted in Figure 3, a diagrammatical depiction of the theory I developed.

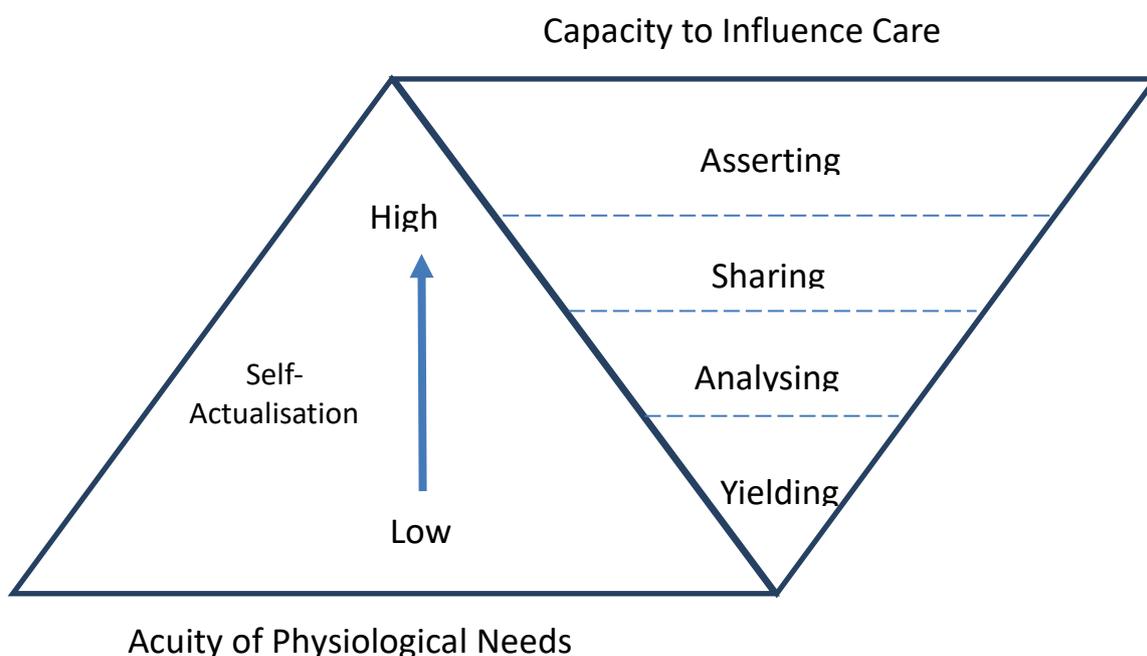


Figure 3. Needs and Capacity to Influence Care

The two triangles in figure 3 reflect the inverse relationship of 'physiological needs' and 'capacity to influence care'. Expectations of moving and handling care was very low when patients were acutely unwell (and where physiological health was at its lowest, for example, within intensive care) and when needs (particularly physiological) became less acute expectations and influence over care grew. Expectations of moving and handling care included the need to be involved and participate in moving and handling interactions.

The core category described was 'Influencing Care'. The analysis of data had shown actions that the participants took when moving and handling care did not meet their expectations. The capacity to influence care delivery grew with the individual's increased self-actualisation. The categories within the diagram indicate behaviours that influence the delivery of care. The less acute the participant's physical needs and the higher their sense of self, the more influence they can apply. The dotted line between each of the categories indicates that a patient may move between adjacent behaviours or display two concurrently, for example analysing or questioning care while sharing an experience. Asserting and yielding are opposite ends of the spectrum that are not displayed together. Yielding is not a behaviour purposely exhibited to influence care, but is a behaviour described, for example, by those suffering from extreme trauma or feelings of powerlessness.

This theory draws together the actions taken by participants, contextualised by their described needs and expectations of care. The stated aim of this study in section 3.1. was to 'develop a theory of factors that influence the patient experience of being moved and handled in hospitals'. The factors were outlined by participants in their expectations of care, but the participants went further and revealed their reactions if the experience did not meet expectations and how this was influenced by their physiological state.

6.4. Findings on the Research Questions

The findings of this study are two-fold. The research questions are answered, but the data speaks more about expectations of moving and handling care and how participants behave to influence care delivery. A new theory is developed of

growing expectations of this care linked to self-actualisation and increased ability to influence care. The answers to this study's research questions, evident in interview transcripts and analyses, are described in the following section.

6.4.1. The Research Questions

What is the patient perspective on moving and handling in hospitals?

The participants in this study did not reflect upon or distinguish moving and handling from other aspects of care. Their primary concern is the way that the care is delivered and the interactions with caregivers. It is important to feel part of the team during physical transfers and participate as much as ability permits.

What involvement do patients have in decision making?

Participants with the greatest physical need cannot participate in discussions around how to be moved and handled due to the urgency of the situation. During rehabilitation shared goals are set with therapy staff. Participants try to be more involved in decision making as their physical needs become less through a process of analysis and developing rapport and confidence. They do not always feel that their choices are approved.

How does moving and handling care received match patients' expectations?

Participants reflections on care received is seldom related to the mechanics or handling of physical transfers. More data relates to the way the care is delivered (for example, rushed) or the manners of caregivers delivering that care. Participants wish to actively participate and to use equipment with the lowest level of dependency to match their abilities. Fear is a factor that participants describe when disliking mechanical aids. The origins described for this fear of equipment are mostly unrelated to the experience of care, for example, fear of heights.

What information do patients receive?

Participants are given information on aids and why they are being used when they can understand the information given. The information is most useful when the equipment or technique is introduced, and increased familiarity reduces the need for information.

What involvement have friends and family had in the way that patients have been moved and handled?

Most of the participants in this study did not expect family and friends to be involved in their future care. The few that want family involvement (n=2) describe instances when family had already assisted in care. There is an expectation that formal carers would deliver care at home for the majority.

6.5. Expectations of Care and Influencing Care Delivery

Analysis of data revealed participants made little distinction between moving and handling and other care fundamentals. Participants' expectations of care are related inversely to their level of physiological needs. The greater the basic needs, the lower the participants' expectations.

Participants described stages in their growing sense of self and adjusting to dependency in moving. The participants' growing capacity, for example increasing awareness and ability to communicate, facilitated increased capacity to influence the delivery of care.

The more acute the participants' physiological needs, the lower was their expectations of care. The ways that participants sought to influence care when it did not meet expectations seems related to self-actualisation. The most dependant yield, while those with a greater sense of self can assert their wishes.

Chapter 7. Discussion

The following discussion summarises the findings of this study before comparing and contrasting with the existing literature. Later sections of the chapter review the limitations of the study, the implications of the findings, and consider recommendations for future research and moving and handling practice.

7.1. Summary of the Findings

This study sought to discover the patient perspective on Moving and Handling in Hospitals. The essence of the findings is that participants did not distinguish Moving and Handling as a discreet element of care, but rather perceived it as an integral part of care delivery. The participants exhibited groups of behaviours when delivery of care did not meet their expectations. Participants tried to influence care to match what their expectation of good moving and handling care should be. Expectations increased with growing levels of self-actualisation resonating with Maslow's theory (1943). Increased self-actualisation, increased the participants capacity to influence care. Participants at or near the peak of self-actualisation had the capacity to assert themselves, make their wishes known and challenge decisions. This does not mean that their wishes were always complied with.

The findings of this study were contrary to the findings of the limited evidence from existing literature where there was a focus on the technical aspects of care. Rather, within this study, participants' experience was mainly concerned with the interactions with carers. However, when technical aspects were discussed, participant perception largely supports the previous literature on moving and handling equipment and transfers. The following sections discuss the relationship of the findings to the current knowledge base and gaps in the literature, before exploring additional considerations generated by the findings.

7.2. Themes in the literature

The themes identified in existing literature and listed in Appendix 6 are Safety, Acceptance of Mechanical Aids, Skills and Knowledge of Caregivers and Person-centred Care.

7.2.1. Safety

Safety was the predominant theme in the literature comfort (McGuire et al. 1996; Alamgir et al. 2004; Kjellberg et al. 2004; Pellino et al. 2006; Luz and Echternacht 2012; Coulter Smith et al. 2016), yet when discussed by participants in this study related more to the protection of nurses than the personal safety of participants. Participants indicated concern for caregivers' safety and musculoskeletal health, although one did wonder why a nurse with aches was at work if not physically able to assist their movement.

A gap identified in the literature was what does 'safety' mean to patients?

Participants described a relationship between feeling safe and fear/anxiety.

Participants spoke of fear and anxiety in hoists and told of personal factors such as a previous bad experience or fear of heights. Knibbe et al. (2012) found in care homes that safety was linked to fears such as the hoist would not support the person's weight or might topple over. 'What actions can be taken to improve safety?' was a further gap identified in the literature. By virtue of the relationship between safety and fear/anxiety, patient perceptions of safety could be increased if fear/anxiety is reduced. The reduced acuity of physiological needs and increasing ability to influence care may lead to a perception that participants have more control over safety.

7.2.2. Acceptance of Mechanical Aids

Previous studies investigated patients' acceptance of mechanical aids and the findings from participants supported most investigations on this topic. The acceptance of aids was the main theme explored in Chapter 2, review of the literature (McGuire et al. 1996; Alamgir et al. 2004; Kjellberg et al. 2004; Ruzsala and Musa 2005; Pellino et al. 2006; Luz and Echternacht 2012). Knibbe et al. (2012) found that acceptance of mechanical assistance grew with time for patients at home and in care-homes. A gap identified in the literature was that little was known about how patients' perceptions changed over time in hospitals. Participants in this study described how they became less fearful and more accepting of mechanical aids as time progressed and they became more familiar with the experience of being hoisted. The lessened acuity of physiological needs allowed participants to analyse and then share in the activity of hoist transfers. All participants in this study used aids on admission to hospital; at interview the

participants average stay had been 17.9 weeks (mean). This provided ample time for participants to become used to mechanical transfers. Some had used mechanical devices at home before admission. The perception described in section 6.1.2, of mechanical aids as a tool of care delivery may influence participants' views. There is a general dislike of some tools of healthcare, for example needles, with some patients having a genuine fear. Recommendations for healthcare staff regarding dislike of needles are less about obtaining informed consent as in the case of hoists (McGuire et al. 1996) and more on developing interventions to increase acceptance for injections (McLenon and Rogers 2019). The three participants in this study that had a distinct dislike of hoists had a personal reason for the dislike. Acceptance can be increased by understanding the cause of intolerance and allowing the patient to influence care.

Participants discussed pieces of equipment that were more acceptable than others. Previous studies relate acceptability to safety or comfort (McGuire et al. 1996; Alamgir et al. 2004; Kjellberg et al. 2004; Pellino et al. 2006; Luz and Echternacht 2012; Coulter Smith et al. 2016) but the main criteria for participants in this study seemed to be that transfers permitted a degree of active participation. This helped participants feel like part of the transfer and less depersonalised, like an object being lifted and laid. The participants described detaching from the activity when they were 'yielding'. Even a small role in the transfer, such as positioning their limbs to assist in the manoeuvre, allowed participants to feel part of the team and share in the activity. The sharing in the activity meets higher social needs, whereas being passively moved for fundamental care meets only basic needs.

7.2.3. Skills and Knowledge of Caregivers

The need for competency, training and education was discussed in papers included in the review of the literature by McGuire et al. (1996), Alamgir et al. (2004), Kjellberg et al. (2004) and Coulter Smith et al. (2016). Skills, knowledge and competence of caregivers was also explored by participants in this study, for example, in relation to specialist equipment such as the twin cassette gantry hoist and implied by the patient fall from hoist. The increased familiarity with hoists is supported by findings that participants grew more used to the

equipment. Knibbe et al. (2012) found that the perceptions on caregivers skills using the hoist became more negative when the patients became more used to transfers in the community setting. Knibbe et al.'s finding of reduced confidence in carers ability, contrasts with this study's finding that trust in caregivers in hospitals seemed to grow over time. This reduction in satisfaction with caregivers' skills in community settings may be linked to the finding of Sixma et al. (1998), that those with chronic conditions tend to have lower satisfaction levels. An alternative explanation is that there are different factors at play in relationships formed with caregivers out-with the hospital setting.

Areas of specific training needs identified include those related to specific conditions such as osteoporosis (Coulter Smith et al. 2016), and specialist equipment such as overhead gantry identified by a participant in this study and Almagir et al. (2009). The hospitals participating in this study are part of The Scottish Manual Handling Passport Scheme (2014), all caregivers would have received initial training and regular updates or competency assessments. The training provided may be adequate for routine hoist use, but further input may be required for more unique scenarios. De Ruiter and Liaschenko (2011) also suggest that nurse training on equipment use should involve problem solving and complex patient conditions. The time and expense of delivering this training to all nurses would be prohibitive. The recommendation in the Scottish Manual Handling Passport is that training be targeted to the speciality that nurses work in. Targeted training means that courses of shorter duration can be provided for nurses in some specialties, for example, Operating Theatre Nurses. There is no need to train these nurses to assist patient transfers into chairs from bed, and from sitting to standing and mobilising etc. Shorter duration of input to lower risk groups frees resources to focus on situations needing detailed specific training. An additional training package in development for the Scottish Manual Handling Passport involves the handling of small children and babies (Fife Council 2018). There may be other scenarios yet to be identified where additional training is recommended. The only instances of training needs referred to by participants related to specific pieces of equipment that were less routinely used by staff.

Staff will have been trained at induction how to use this equipment but need refreshed if it has been sometime since induction training.

An identified gap in the literature was ‘what forms patient perceptions of skilled and knowledgeable care in relation to moving and handling?’ The small clarification offered by participants is that different people value different factors in their rating of moving and handling care delivery such as the caregivers’ length of experience or time spent caring for them during manual handling transfers.

Another theme in the literature linked to patient experience of moving and handling transfers was the experience of comfort or discomfort.

7.2.4. Comfort

The study of comfort in previous research (McGuire et al. 1996; Kjellberg et al. 2004; Pellino et al. 2006) was supported by three participants that mentioned discomfort in transfers (two participants identified the same sling design as uncomfortable). Rather than a distinct aspect of moving and handling assistance, comfort when discussed by participants was linked to acceptance of mechanical aids. McGuire et al. (1996) linked comfort to attitudes towards mechanical aids and Pellino et al. (2004) used comfort as a measure to indicate acceptance of one transfer aid over another. Kjellberg et al (2004) used comfort as a factor in assessing the technique of the caregiver. Findings of my study support comfort as a measurement factor of acceptance of mechanical aids or transfer technique.

The theme least explored in the literature was person-centred care in relation to moving and handling.

7.2.5. Person Centred Care

McGuire et al. (1996) and Coulter Smith et al. (2016) are the only studies in the literature review that considered person-centred aspects. These aspects were provision of information, consent and knowing more about the individual’s medical history. By contrast the participants in my study spoke more of their

experience of caring than the mechanical aspects and implied a need for moving and handling care to be more person-centred. The following section explores experience of care

7.3. Experience of Care

The findings of this study were unexpected and contrast with most previous studies on patient experience of moving and handling in hospitals. The previous literature is largely concerned with the mechanics, skills and techniques of manual handling transfers (McGuire et al. 1996; Alamgir et al. 2004; Kjellberg et al. 2004; Ruszala and Musa 2005; Pellino et al. 2006; Luz and Echternacht 2012; Coulter Smith et al. 2016). The aspects of moving and handling that the previous research focussed upon was chosen by the researchers rather than the participants. In my study the participants were asked to describe the topic in less directive terms. Participants themselves focussed on the manner, rather than the mechanics of care delivery, and how it matched their expectations.

Section 6.1. of the findings of this study indicated where care did or did not match participants' expectations. Participants expectations of what good care should be, is similar to what has been described in the literature as 'compassionate care'. The aspects touched upon by participants in this study are outlined in the '6C's of Compassion' (NHS Commissioning Board 2012) and Dewar (2011). These were described in section 6.1 as Care, Competence, Communication and Celebration. Durkin et al. (2018) in their systematic review of compassion in nursing, contend that the concept of compassion in care is still poorly defined. They developed a model of qualities of a compassionate nurse developed from their review of the literature. Qualities include the aspects of Communication and Competence. Care is implied in other aspects of the model by qualities such as Empathy, Connecting and Involving Patients.

A lack of compassionate care has been associated with poor patient experience and health outcomes. A notable occasion is when concerns on care standards and patient morbidity in Mid Staffordshire NHS Trust prompted an independent inquiry and report (Francis, 2010). Francis notes that aspects of patients' treatment had impact on their dignity. Specific to moving and handling care is

“the following are notable causes for concern, ... On occasion, patients were handled and moved in ways that caused pain and distress without any evidence of a sympathetic approach” (p. 109). Participants also reported nurses being ‘rough’. This finding of the Francis (2010) report implies that similar data may have been found from participants elsewhere in the United Kingdom. The recommendations published subsequent to the Public Inquiry (Francis 2013) called for a ‘culture of caring’ with a focus on compassionate care (Recommendation 185). There remains a lack of evidence on effective interventions to support compassionate care (Crunden et al. 2017).

The finding that the manner of care delivery is more important than the mechanics of care is novel in relation to studies on patient experience of moving and handling. There is previous evidence of this finding in the nursing literature on care. Attree (2001) concluded in a study on ‘good’ and ‘not so good’ care that her findings were in opposition to the prevalent view at that time, the view that patients most valued technical aspects of care. The patients and relatives in Attree’s study placed more value on individualised care delivered by caring staff. In contrast, a systematic review of the literature comparing patient and nurse values of care found that patients placed more emphasis on competence and technical aspects (Papastravou et al. 2011), however, 17 of the 23 papers that the authors reviewed (65 percent) predated Attree’s 2001 study. Attree’s conclusion has since been supported by other reports and studies (Goodrich and Cornwell 2008; Suhonen et al. 2012). The experience of moving and handling care as described by the participants supported Attree (2001) in that the participants placed greater emphasis on individualised care delivered rather than competence in equipment use and skills in moving and handling transfers, whereas the literature reviewed placed more emphasis on training and skills (McGuire et al. 1996; Kjellberg et al. 2004; Pellino et al. 2006; Alamgir et al. 2009; Coulter Smith et al. 2016). McGuire et al. (1996) and Coulter Smith et al. (2016) were the only papers to consider aspects of person-centred care.

McCormack and McCance (2006) describe the attributes of the nurse as an essential pre-requisite of person-centred care, my study participants support this

view. The relevance of staff interaction and individualised care is now generally accepted and included in recommendations to improve patient experience and measures of patient satisfaction (NHS National Quality Board 2012, Picker Institute 2016, 2019). However, nurses themselves can be at odds to demonstrate a preference for either clinical competence or caring, with 'caring' linked to an outdated view of nurses as angels (Rhodes et al. 2011).

Participants in this study repeatedly linked moving and handling to other facets of care. Measures of patient satisfaction collect data on aspects that they discussed, for example, involvement in decisions, confidence in staff and having someone with whom to share concerns. A recent survey (Picker Institute 2019b) described 18 percent of in-patients having had nurses talk over them as if they were not present, a behaviour disliked by the participants in this study. This shared commonality illustrates that the experiences of participants are not unique to the sites visited.

The majority of moving and handling care received by participants was described in positive terms such as 'great', 'good' and 'exceptional'. These reflections were shared with relevance to the general overall experience of being moved and handled by caregivers. Specific encounters that were described in most detail focussed on negative experiences.

7.3.1. Negativity Dominance in Recollections

When asked to describe one moving and handling transfer in detail, the recollection was of a negative experience. Participants described occasions when care was lacking with more emotion and in more detail. This supports the phenomenon described by Baumeister et al. (2001) that "Bad is stronger than good" in its effect on our experience of everyday events, relationships or interactions. Baumeister et al.'s paper argues that it makes evolutionary sense to remember and subsequently avoid 'bad' things. Negative emotions also enhance memory retention (Kensinger 2007) making it easier to recall such experiences. This phenomenon is labelled in Kahneman's overview of the subject as 'negativity dominance' (Kahneman 2011). The Royal College of Nursing (2013) studied patient and relative comment on the Patient Opinion public website in

relation to the attitudes and behaviour of nurses. While most posts were positive, those recounted in more depth and at greater length were negative experiences. A finding reflected in the participants' transcripts.

Change in delivery of care is often brought about by examining 'bad' cases (Francis 2010; McLean 2014). However, a Kings Fund report (Appleby et al. 2011) suggests that knowledge does not always lead to action. Variation is not always negative; some hospitals and organisations perform well above average. The report recommends that variation needs to be monitored and interventions made to help the 'bad' to become more 'good'. The negative experiences recounted by the study participants can provide opportunities for reflection. Their perspective is that moving and handling is an integral part of the care process and is a fundamental of care.

7.3.2. A Fundamental of Care

In Chapter 2 it is described that The NMC (2018) define physical handling as a fundamental of care, like nutrition or bladder and bowel care. It seems that the participants in this study also share this perspective Feo et al. (2018) reviewed the literature and felt that there was a lack of consensus on the definition of fundamentals of care. This lack of consensus is similar to that previously described in this chapter in relation to the term 'compassionate care' (Durkin et al. 2018). Feo et al. (2018) indicated that there was an overlap with the use of the terms 'fundamentals of care' and 'compassionate care' in the literature. Their paper did identify an area of difference, the authors felt that only 'fundamentals of care' were linked to the physical needs of patients in the literature. Maslow (1943) described the physiological needs of a person as the most basic and urgent requiring sating. Moving and handling by others is necessary for those who are unable to meet their own basic needs.

Assisting the patients' movement is a pre-cursor of meeting all the physical needs of a person who is unable to move themselves. Occasions when there is a requirement for repositioning include for pressure relief, personal hygiene, to use the toilet and to eat and drink. Participants in the study did not confuse moving and handling with other aspects of care, but rather recognised its

essential nature in meeting all their basic care needs. The finding that the manner of care delivery is more important than the mechanics relates to the delivery of compassionate care in nursing. Participants spoke of times that they felt compassion was lacking in their moving and handling care.

7.3.3 Compassionate Care.

There is difficulty in defining the term “compassionate care” in nursing (National Institute for Health Research 2017), this is despite compassion being a key element of the nursing Code (NMC 2018). Section 1.1. of the Code directs nurses to prioritise people and treat them with kindness, respect and compassion. Discourse on compassionate care was a theme in participants’ transcripts. ‘Four C’s’ found through the transcripts: care, competence, communication and celebration, all recognised elements in compassionate care delivery (Dewar 2011; NHS Commissioning Board 2012). ‘Compassionate care’ can be summarised as “treating others how we ourselves would wish to be treated” (Armstrong 2009). Models and frameworks exist to support the delivery of compassionate care (Dewar 2011, Edinburgh Napier University and NHS Lothian 2012; Dewar and Nolan 2013; Sinclair et al. 2016). However, the essential premise of treating others in the way that we would wish to be treated can serve as guiding principle.

The first standard of the Code for nurses requires that they uphold patient dignity and treat patients with respect and compassion (NMC 2018). This requirement puts the accountability for compassionate care upon each individual practitioner. However, the literature implies that implementation of compassionate care should not be left to individual nurses and that an organisational culture of caring is essential (Dewar et al. 2014; Tierney et al. 2019). Participants in my study felt that nurses were so busy that they did not have time to care, for example rushing moving and handling transfers. The availability of busy staff for moving and handling assistance also impacted on participants’ choice. When to go to or get out of bed was commonly discussed with one participant giving the example of 17 hours in bed when her choice would have been to get out of bed and sit in a chair.

Power (2016) notes a widening theory-practice gap in relation to compassionate care delivery. In Scotland this has led to initiatives that aspire to imbed compassion in the nursing culture. The Leadership in Compassionate Care Programme (LCCP) is one such initiative and the development, implementation and findings of this project has been widely reported (Smith et al. 2010; Dewar and Nolan 2013; Dewar and Cook 2014; Dewar and Kennedy 2016; Smith et al. 2017). The LCCP final report (Edinburgh Napier University and NHS Lothian 2012) made recommendations on assessing compassion in the nurse selection process, strategies for nurse education, support for new staff nurses and development for leadership. The 2030 vision for nursing (Scottish Government 2017) has personalising care as a key theme. The document emphasises that care and compassion “mean different things to different people – what may seem caring and compassionate to one person might seem patronising or even intrusive to another” (p.17). To deliver compassionate care nurses must learn about their patients. Participants described how nurses came to know them and when they were having a bad day, or the best time to approach them. The LCCP included this aspect of individualisation in the theme ‘knowing me, knowing you’ of the framework for compassionate care that the project developed. Durkin et al. (2018) also include ‘connecting and knowing the patient’ in their qualities of a compassionate nurse model.

These strategies for compassion imply that nurses taking time to converse with their patients, sharing and discovering more, can help embed compassion in care. My findings, especially in relation to celebrating success and providing feedback, support the implication that brief sharing has a positive outcome and is reflected in the approach ‘Making Every Contact Count’ (Health Education England 2020). There are challenges in taking this time at ward level that may account for the theory-practice gap observed by Power (2016). Some of the barriers to delivering care with compassion are discussed in the following section.

7.3.4. Barriers to Caring with Compassion

Nurses related barriers to meeting participants’ wishes as due to ward routine, workload and staffing levels, participants also spoke of these barriers. This

reflects the findings of previous studies, that staffing and workload keep nurses from spending time at the patient's bedside (Houghton et al. 2016). A recent survey showed nurses in England working an average of three hours unpaid overtime weekly to cover for staff shortages (Campbell 2019). The Royal College of Nursing also recognised that missed breaks were becoming the norm for UK nurses and launched a campaign to encourage nurses to take them for their wellbeing (RCN 2018).

Nurses recognise that such pressures impact on compassionate care. A 2017 survey of 696 nurses found that their ability to deliver care in keeping with their values is negatively impacted by lack of staff, time and other resources (Kristjánsson et al. 2017). The conflict with their personal values, and ability to deliver care that matches these values because of pressure of work, can lead to stress in the nursing staff.

An ongoing effect of stress and high work demands is burnout, a reduction in physical and emotional capacity (Khamisa et al. 2015). Burnout and compassion fatigue (Coetzee and Klopper 2010) can account for some of the nursing behaviours described by participants that may be interpreted as uncaring. Uncaring and unsympathetic behaviour was also noted in relation to moving and handling in the Francis Report on poor care standards (Francis 2010). Dempsey et al. (2014) describe how managers must recognise and address the issue that hospital culture can lead to nurse burnout and compassion fatigue. They identified that resultant nurse behaviours lead to unnecessary suffering for patients. A recent French court case has demonstrated that employees can feel so pressurised by an uncaring culture at work that they become depressed and take their own lives (British Broadcasting Corporation 2019). Hospital culture needs to be kinder to staff and staff need to engage in 'self-compassion' to allow a culture of compassion to flourish (Dewar et al. 2014).

Care delivered did not always match the expectation of participants in this study. Participants drew links between their expectations of care and care received that led to the development of a theory. The theory developed (section 6.3) linked

capacity to influence care to needs and the level of self-actualisation as defined by Maslow (1943). Section 7.4 discusses Maslow's theory and its relevance in this study.

7.4. Needs and self-actualisation

Maslow (1943) proposed a theory of self-actualisation that is still widely taught across many disciplines involving the study of human motivation (Pritchard 2015). The theory is illustrated as a pyramidal hierarchy progressing from the most basic and urgent physiological needs, such as the need for the body to be hydrated, at the base and is illustrated in Figure 4. Maslow theorised that when one level is satisfied a person could progress to the next, for example, a person may risk their safety to sate a severe physiological need like hunger or thirst.



Figure 4 Maslow (1943) A Theory of Self-Motivation

Maslow's theory of motivation recognises that want is a natural state, but that there is a priority of needs to be met. In my study 'want' related to the desire to influence care. Maslow's model is applied to the workplace and the motivation of workforce but has also been applied to nursing and healthcare (Jackson et al. 2014; Shih et al. 2019).

Maslow considered self-actualised people to have met their basic needs, thus allowing them to grow and fulfil their potential (Maslow 1970). Properties Maslow described of self-actualisers included being sensitive to dishonesty and the

ability to judge people and situations correctly. In relation to my findings, this growth in awareness appears related to a growth in participants expectations.

Other theories explore motivation and the need for personal growth. Carl Jung first described the state he referred to as 'individuation' (Jung 1962). This was the result of a growth process whereby individuals become increasingly aware and assimilate their internal psyche with experience of the world. Hertzberg's motivational hygiene theory (Hertzberg 1966) also describes growth in aspects such as knowledge, creativity, self-awareness and being able to maintain individuality. These theories like Maslow (1943) relate to self-growth and awareness in relation to motivation. Contrasting theories suggest that motivation is related to expectancy, that is, the amount of effort expended, and the level of satisfaction achieved at the outcome (Vroom 1964; Porter and Lawler 1968). Analyses of the data in this study was instrumental in the linkage to Maslow's theory of motivation (1943) rather than another theory. However, the participants' growth in expectations does uphold aspects these theories. Participants became increasingly self-aware as acuity of physiological needs lessened (Jung 1962; Hertzberg 1966) and as expectations of moving and handling care increased, they expended more effort to make that care satisfactory (Vroom 1964; Porter and Lawler 1968).

Participants spoke of assistance required to meet the 'lower needs' described by Maslow and growth in social aspects such as communication throughout their physical recovery. The description by participants of their journey from full dependency and mental isolation, to a critical and social individual in need of respect seemed to mirror Maslow's hierarchy.

There has been much criticism of Maslow's theory (Kaur 2013). Tay and Diener (2011) studied needs across 123 countries and found that fulfilment of needs is not dependent on meeting the needs at preceding levels on the hierarchy. An example is that some self-actualised people do not need to feel a sense of belonging. Maslow clarified in later editions of his theory, that a need did not have to be fully satisfied before progressing to the next and that this belief was a

misinterpretation of his work (Maslow 1987). Other cases can be found that illustrate divergence from the model, Harvarth (2008) feels that this relates particularly to older adults who may choose autonomy over safety. Examples she gives include preferring living alone to living in a care home despite previous falls and eating textured food despite dysphagia. This type of choice seemed to be reflected by a participant in my study who chose a pleasant social interaction over physiological pain. Permitting some person-centred risk taking has been identified as a theme in the delivery of compassionate care (Edinburgh Napier University and NHS Lothian 2012) and the need to allow patients to take informed risks is now enshrined in standard 2.2.4 of the Health and Social Care Standards (Scottish Government 2018c).

Rollin (2011) felt that Maslow's hierarchy made care become task focussed on the physical needs of the patient and prohibited getting to know them, however, her interpretation may have been made with regard to only 'lower needs'. Maslow (1943) describes physiological needs at the base of the pyramid as 'lower needs' and self-actualisation as 'higher needs.' In the context of this study the hierarchy of needs corresponds to the individual capacity to meet those needs. The participants in this study described behaviours that analyses linked to Maslow's hierarchy. Those at the base of the pyramid are unable even to cry out for help, while those at a higher level now possess factors such as communication, relationships and self-esteem. If they cannot physically meet a physiological need, for example moving in bed to reduce pressure, they can meet their needs through others. The ability to influence others to meet care needs, as described by participants, grows with self-actualisation.

7.4.1. Meeting Needs

Jackson et. al (2014) describe the lower levels of needs in Maslow's hierarchy as "survivorship" in relation to patients of the Intensive Care Unit (p. 439). They suggest that first physical needs must be met before addressing more cognitive needs. The participants in my study who described experience of intensive care or high dependency units (n=4), had little recollection of when their physical needs were most acute and indicated little expectations of care. Their inability to act or interact with others because of their physical incapacity may also have

been enhanced by the effects of sedation and delirium. There was an acceptance that moving and handling interventions were necessary to meet their physiological needs. Participants that did not describe experience of high care units also told of yielding and surrendering to circumstance. Admission to an Acute Hospital itself indicates a physical health crisis, with attendant physiological needs that could not be met at home. The concept of 'survivorship' supports the theory that patients focus on staying alive and yield to circumstance.

Chapter 6, section 6.2.2 describes that when the acuity of physical needs lessened, participants in the study analysed their new circumstances and questioned how their needs were being met. Information given by nursing staff helps to adjust and is a patient expectation (Kalyani 2014). While questioning and analysing, participants did not necessarily verbalise perceived shortcomings in care delivery. In a systematic review of papers detailing patient complaints (Reader et al. 2014) found treatment issues to be the most common cause (22.1 percent). However, those issues relating to compassionate care were reported under separate headings such as dignity and respect, staff attitude, and skills and conduct. When combined these categories account for 42.5 percent of reports. These were the type of issues described by participants, often questioned but not reported. New et al. (2019) found, similar to participants, that the patients with kidney disease in their study did not act upon concerns, although some did verbally question. Fear of reprisal was the leading reason given for not taking further action. The Parliamentary and Health Service Ombudsman (2015) also found fear of reprisal to be the case for older adults, they did not want to make a fuss and worried about what would happen if they did. This corresponds with Maslow's need for safety and freedom from fear.

New et al. (2019) suggest that patients felt 'taken care of' when physical needs are met, and 'cared for' when emotional needs are met. The participants appeared to become more used to their surroundings, the staff and hospital culture through repeated exposure. This reflects the phenomenon of the 'mere-exposure effect' also known as the familiarity principle (Zajonc 1968; Zajonc

2001). Bornstien's (1989) meta-analysis of the literature supports Zajonk's findings that familiarity can lead to 'liking'. This liking can apply to the environment or other repeated audio or visual stimuli such as nurses' voices or faces. The longer length of time spent in the company of nurses also assists in forming inter-personal bonds (Forchuck 1995). An older patient group may be predisposed to seeking bonds with others. Musich et al. (2015) found that up to 60 percent of older, sicker adults also suffer from loneliness. Physical closeness and touching are also important factors in bonding (Chillot 2013), both of which are essential in the handling of patients. Hill et al. (2014) found familiarity is not an essential pre-requisite of psychosocial support, but the bonds formed seemed to help participants in this study to share and to meet social needs.

Bonding occurred, but nurses must maintain professional boundaries because of the imbalance of power in the relationship (Griffith 2013; Gardner et al. 2015; NMC 2015). Most of the literature supports maintaining boundaries, although some argue it reduces trust (Smyth et al. 2018). This was seen in the transcript of one participant, questioning the actions of the nurse in charge who reprimanded colleagues for a breach of moving and handling protocol. The code 'trusting in carers' was used more frequently than this isolated incident. Trust helps maintain the bonds and supports the nurse-patient relationship. Support from staff was important to participants throughout their recovery.

An aspect of staff sharing, and support given relevance by participants was feedback, especially in relation to becoming less dependent upon caregivers or equipment to move. Findings on feedback are supported in the literature. Feedback is an essential element for delivery of compassionate care (Smith et al. 2017) and can increase motivation which improves performance (Lauber and Keller 2014). Participants described how feedback gave encouragement and made them feel good about themselves. The participants wanted to be as independent as possible and this saw some setting their own goals. Some may have been too ambitious and seemed to be 'jumping the gun'.

Scobbie et al. (2009) cite patients' unrealistic expectations as an impediment to setting shared goals with healthcare staff. Additional barriers they include in their literature review are patients' low motivation and poor acceptance of their altered physical condition. Patients need realistic and timely feedback to allow setting shared goals. Feedback need not be formal, but can be presented gently and conversationally, even with humour. Schopf et al. (2017) found that humour helps protect relationships by softening criticisms or facilitating the expression of negative emotions.

Socially, the use of humour in interactions seemed important to participants. Patenaude and Brabant's (2006) review of humour in the nurse patient relationship found that patients feel supported by humour; and that it also reduces tension, stress, anxiety and fear. Their review found that the social dimension of humour helped pass the time and set aside established social roles. For both patients and nurses in the literature, dialogues were more sincere if the ambience was lighter. This reflects the findings described in Section 6.2.3. of Chapter 6. Nurses share the opinion that humour is a principal factor in knowing their patients and contributing to a positive perception of care (Costello 2017). Schopf et al. (2017) found that humour was most often initiated by patients and used to protect relationships as previously described. The softening of negative emotions such as frustration helps patients to express themselves without jeopardising the relationship with caregivers. Schopf et al.'s findings also support the observation in this study that participants used humour to 'level the playing field'. Functions of humour that the authors describe are to decrease 'the power asymmetry' and 'create an in-group feeling'. Humour assists to meet social needs by providing a sense of belonging.

The needs described as higher level by Maslow such as respect, esteem and status, appeared to grow when participants had addressed social needs. Gallagher (2004) linked respect and esteem with the concept of dignity in care. Gallagher cites Pullman (1999) in the contention that there is a difference between 'basic dignity' that should be afforded to everyone and 'personal dignity'. The difference described is that 'personal dignity' is a social construct

and linked to self-esteem and autonomy. Participants in my study began to feel undignified as their physical recovery progressed and they considered the social aspect of nursing interactions. Moser et al. (2007) reviewed patient autonomy in nursing care and described how it can be dynamic, dependent upon the situation the patient finds themselves in and responsive to interactions with others. In the clinical setting, autonomy has been linked to being informed and involved in decisions about clinical care (Scott et al. 2003; Entwistle et al. 2010).

'Becoming the expert' was described in the findings (section 6.2.4). The 'expert patient' was promoted as a way of empowering patients to take charge of chronic conditions (Department of Health 2001). There is a sense in the literature that 'expert patients' become focussed on their condition. Fox et al. (2005) found that being the expert patient can be empowering, but it can also constrain beliefs about self to a medical model rather than a more holistic view. Patients can find themselves in conflict with healthcare professionals as information gleaned is not always from the evidence base (Boulet 2016). There was a sense that 'becoming the expert' did occasionally see participants in disagreement with those caring for them. Not all participants seemed to need to become experts. Tattersal (2002) suggests that being the expert patient may be dependent on personality, some may prefer to be looked after. Florin et al. (2006) found that patient expectations of participating in decisions can be at variance with nurses' perceptions. Nurses felt that patients needed more control, whereas patients preferred more collaboration in decision making. Similarly, autonomy for most participants in this study seems to be less autocratic and more dependent upon social interactions and status. The increased self-actualisation of participants enabled them to share and assert needs.

Maslow's higher-level needs and a person's sense of worth are dependent upon the person's social construct of themselves (Pullman 1999). Basic dignity can be linked to human rights, especially the right to dignity and family life (Article 8 HRA). While participants may have felt undignified when others attend to hygiene needs, there was no obvious breach of this right. The Patient Rights (Scotland) Act (2011) aims to allow the patient to participate as fully as possible

in decisions relating to their health and wellbeing. Florin et al. (2006) indicated that patients would like collaboration more than freedom in decision making. Where the participants felt thwarted and constrained related more to choices on everyday self-determination. An example of everyday decisions that was an issue for several participants in my study is when they went to bed and rose in the morning. Participants asserting choices that could not be gratified was described as 'feeling over-ruled by carers'. Participants provided reason and logic for their choice. Nurses also employed reason, advising participants moving and handling needs could not be gratified at the time of their choosing.

When participants basic needs for physiological stability and safety were met, social interactions become more important. Participants addressed their emotional and social needs through others. This sharing allowed them to express concerns. The example was given in Chapter 6, section 6.3.3. where a participant shared information hoping it would be relayed to the Ward Charge Nurse for action. Mruck and Mey (2007) also noted this type of behaviour and suggest that "subjects suffering from chronic illness sometimes use interviewers as a "megaphone" to communicate" (p.522). Families and friends were also used to help participants communicate and address everyday needs. Ball (2015) recalls his hospital experience and describes his parents as 'guardian angels' who knew him best and must be involved with care.

7.4.2. Meeting Future Needs

Most participants using mechanical aids at interview expected the need to continue post-discharge. There was also an expectation that formal carers would visit to operate the equipment and assist with care needs. Social support from family seemed to be important in the hospital setting, but few of the participants expected them to become the main caregivers on discharge. Participants spoke of family members having their own lives or living at a distance. Increasing the mastery of tasks can improve the confidence and competence of informal caregivers such as family (Reinhard et al. 2008). In hospitals caregivers are involved in learning to pass nasogastric tubes and other routine aspects of care. There is a lack of knowledge on family involvement or education in the moving and handling of patients during their hospital stay, especially relating to the use

of mechanical lifting equipment. Two of my study participants expected ongoing family involvement in moving and handling at home. In one instance the family had been shown manual assistance techniques by physiotherapists. Personal experience and that of colleagues is of perceived barriers to family involvement on the wards, such as nursing staff believing they are not competent or qualified to 'teach' these skills.

In a systematic review of caregiving Kang et al. (2011) found the role of the continuing informal carer to be demanding and involved feelings of isolation, anxiety and a lack of support. The role can be burdensome and the expectation of most participants was that formal carers would be in attendance on discharge. The meeting of care needs through employed carers impacts on health and social care policy and planning (Cornwell 2012). There is international recognition that systems need to change to cope with the growing number of older people with multi-morbidities needing care at home (Goodwin et al. 2014). Most of the participants in my study expected carer support to meet physical, and some social needs, at home. In the hospital setting, family met some of the participants social needs, but interactions with staff were those most frequently described in transcripts.

The finding that most participants (n=8, 72 percent) expected to be moved and handled at home by formal carers will require resources from health and social care partnerships in Scotland. The need for additional resources reflects concerns on planning and redesigning services for the aging population discussed in section 7.3.1. (Cornwell 2012; Goodwin et al. 2014).

There are challenges to providing the workforce that participants expect to be there for continuing care. In common with the rest of the population, the health and social care workforce is aging (Scottish Government 2018b). A great deal of planning has gone into how to retain the aging, mainly female, nursing workforce, for example, in primary care services, 60 percent of District Nurses were over the age of 50 in 2017 (Scottish Government 2017). Many of this workforce will have caring responsibilities at home as well as work, with people

in their 50's and 60's being the age group most likely to provide informal care (Office of National Statistics 2019). Moving and handling people is physically demanding and becomes increasingly so with age (Ryan et al. 2017). Storey et al. (2009) in their literature review of retaining nurses at work after the age of 50, identified physical workload as a factor influencing retention in the community workforce. They cite Foschen et al. (2005) in that those older nurses with musculoskeletal disorders and less access to lifting equipment, were more likely to leave. In a survey of UK nurses, they themselves put the physical demands of nursing as a leading concern of working for longer (Keogh 2013). The evidence points to reducing the physical burden upon the aging community workforce, but policy seems to be going in the opposite direction. There is a current initiative in community care to reduce the number of caregivers attending to people at home.

'Single handed care' is where one, rather than two carers, assist with the moving and handling and care needs of a patient or client. Two participants indicated a preference for fewer handlers, that they felt 'less special' being assisted by one handler rather than two. The concept of single handed care was largely driven by equipment manufacturers, illustrating cost benefits by increasing use of new technology, and thereby reducing human resources. The main paper on the theme from the University of Salford (Phillips et al. 2014), was sponsored by an equipment manufacturer.

Anecdotal evidence (from colleagues who are service providers) is of Local Authorities implementing single handed care without investing in the necessary equipment, saving more money for hard pressed services. The Column, Journal of the National Back Exchange (an association for those interested or active in Moving and Handling) reported a survey of key stakeholders (Harrison 2018): the survey participants (n=4585) felt the main drivers for change were money saving (61 percent) and staff shortages (49 percent). Councils that had begun to implement single handed care reviews reported projected or actual annual savings of £150,000 to £1 million. One Council district reported a saving of £395,000 with no additional equipment spend. Both participants in this study that

indicated only one caregiver would be necessary, related this to a specific piece of mechanical assistance.

Harrison's (2018) survey participants mainly felt that an inexperienced carer should not be allocated a single handed care package (61 percent). The example of single handed care included in Phillips et. al.'s 2014 paper includes a caveat from a Moving and Handling Adviser; "*I cannot stress enough the importance of considering the individual capabilities of the carers, and a generic approach is not sufficient here*" (p.41). In Chapter 1 (Introduction) I explained the judgement from the East Sussex Case that the provision of manual handling care should always begin with a risk assessment. 'Blanket' policies cannot hope to address all the variables involved.

New technology and equipment, more advanced than a mobile hoist, such as overhead ceiling hoists, will reduce the time required for transfers and reduce costs (Hoenig et al. 2003). Nurses are more likely to use a ceiling hoist rather than a mobile hoist (Lee and Rempel 2019). Service users have also expressed a preference for the care by one rather than two people (Phillips et al. 2014) as did participants in this study. Provision of equipment reduces the physical demands of the task for the workers, reducing ill-health and injury claims; although the quality of the evidence supporting reductions is poor (Hegewald et al. 2018). Investment in new technology is recommended as a method for changing services to meet the needs of the older population (Goodwin et al. 2014). The technology requirements identified focuses on telemetry and communications rather than mechanical aids. Greater investment in equipment to reduce the physical burden on caregivers and improve the experience for patients is required. Participants using more specialist equipment in this study suggested that this was an area where more training is required.

The previous sections of this chapter describe the relationship of the findings to the existing knowledge base. Section 7.5 discusses limitations there may be in the study and steps taken to ensure quality.

7.5. Limitations and Quality of this Study

Transferability of the findings of this study is limited related to the small number of participants (eleven). The findings are however important in their own right, as they provide a novel insight to the experience of Moving and Handling in Hospitals. It has previously been described in Chapter 3 (section 3.6.) that a large numbers of cases are not always necessary to reach saturation of data (Guest et al. 2006; Hagaman and Wutich 2017), especially if the group is representative of the population being studied (Marshall 1996; Malterund et al. 2015). Representativeness was not an objective of the recruitment strategy, but a range of patient care-pathways was included in the final population sample. My study has added explorative qualitative information on patient experience of moving and handling in hospital. The sample size of eleven participants is not small for a study of this type.

Care was taken in theoretical sampling to ensure recruitment of participants that could enrich the data relating to the experience of moving and handling in hospitals. The main findings unexpectedly related to expectations and the experience of care delivery, rather than the mechanics of manual handling. The findings may be unique to the group of patients who require moving and handling assistance. Bell (1984) found that patients being 'lifted' accounted for 28 percent of the 13,107 in-patients studied. The absence of any recent study in the United Kingdom means that there is no current estimate of how many in-patients require moving and handling in modern healthcare. The numbers are likely to have risen, given that the population are living for longer in the 35 years since Bell's report and are contending with multiple physical ailments (Goodwin et al. 2014). While my findings may not be transferrable to the whole adult inpatient population, they may provide valuable insight into the aspects of moving and handling and its associated care that are important to patients.

A means of ensuring quality described in Chapter 3, section 3.10., is remaining true to the selected methodology and not mixing aspects from the different Grounded Theory approaches (Weed 2009; Corbin and Strauss 2015;

Berthelsen 2017). I feel that I adhered to the methodology outlined by Charmaz 2014 and remained true to this approach.

A concern of grounded theory studies is to ensure that any theory generated is grounded in the data (Glaser and Strauss 1967). Constructivist Grounded Theory acknowledges that any theory generated is interpreted through the filter of the researcher's own experience (Charmaz 2014). An unstated question that I have pondered upon was why there has been so much contention of moving and handling policy reported in the general community (described in Chapter 1, section 1.2 'Loads with rights'), but none reported in the hospital setting? The evolved theory on increasing self-actualisation leading to increased capacity to influence care answered this question. I do not feel that I purposely set out to answer an alternative question but must acknowledge that this occurred. I feel the answer to my own question is that people in their own homes are more self-actualised and assertive. They are less tolerant of others assuming control than those who may be adjusting to new circumstances or conforming to an institution's social norms.

The ready application of Maslow's 1943 hierarchy of needs and theory of self-actualisation could be interpreted as researcher driven. This concern was repeatedly reflected upon in memos during the analysis of the data. I feel that the data drove me towards this finding, and I did not impose my knowledge to shape the data to fit a theory. Would others have seen what I saw in the data? How representative was the patient experience described? I decided to seek validation with colleagues in the moving and handling community.

Initial findings were presented to the Scottish Manual Handling Forum on 30 May 2019. The annual study day at St Margaret University, Edinburgh, was attended by 120 delegates, speakers and core group members. Delegates mainly work in the caring professions and have some involvement in the delivery of moving and handling training. Video extracts were shown of colleagues reading from four sections of transcript. The audience were asked for their interpretation of what the participants were relating. I discussed aspects of my own interpretation for

validation, if these aspects had not been raised by delegates. There was consensus that participants had linked handling to basic care needs. I asked for written comments from the group on how representative of the population they felt these encounters to be. Only eight comments were received on the post-it notes made available for this purpose. Four comments related to the writer's own reflections on the presentation, the others were:

"Expect this to be the same in care homes and community. Sad it's 2019",

"More realistic of patient experiences",

"Felt the anecdotal evidence from hospitals is mirrored across community care" and

"Appalled by this, but not surprised."

The last comment relates to negativity dominance of the participants' experiences (Khaneman 2011). The video clips shown were of unpleasant encounters described in detail by participants, despite the general experience being described as 'good'. Three delegates later approached me to recount similar stories told to them by patients. I felt reassured of the representativeness of the study participants experiences.

The participants experience, and findings of this study have implications for nursing practice that are outlined in the next section.

7.6. Implications for Practice

The implications of the findings for nursing practice are considered under three subheadings, Nurse Education, Patient Care and Policy.

7.6.1. Nurse Education

Participants in this study placed greater emphasis on inter-personal relations during moving and handling transfers than the competence of caregivers. This is an aspect that requires more emphasis in nurse education on moving and

handling. Richardson et al. (2015) reviewed the literature and found that compassion and empathy can be taught, and metrics used to measure interventions. They suggested Muetzel's (1988) model of therapeutic relationships for use as a framework whereby student nurses can assess their developing skills. The main concepts of this model are Partnership, Intimacy and Reciprocity. Assessing the therapeutic aspects of moving and handling interventions can assist student nurses to improve the patient experience of being assisted to move.

Reassurance for the patient being hoisted is currently a feature of moving and handling education. Explanation of reasons why the patient may need reassurance, such as the patient having a fear of heights, and what interventions could be made to reduce anxiety would be useful. My study supports a link between anxiety on hoist use and patient perceptions of hoist safety as found in Knibbe et al's study (2012). By learning to allow patients more influence over how they are assisted to move, nurses may lessen anxiety and increase feelings of safety. Participants saw moving and handling as an integral part of their care and an essential adjunct to meeting physical needs. Findings of this study corroborate the need for ongoing training and support in developing compassion as recommended by the LLCP final report (Edinburgh Napier University and NHS Lothian 2012). The element of compassionate care needs more emphasis in moving and handling education.

7.6.2. Moving and Handling Care

Understanding that physical recovery increases expectations of care and that patients move through stages in their capacity to influence the delivery of care provides opportunity for nurse support. Nurses describing the reason for moving and handling interventions as they deliver them, can help patients to transition from 'survivorship' and 'being taken care of' to feeling 'cared for'. Routine information is most important when the patient is analysing and adjusting to their new situation. Information on the lifting equipment used and its safety is most important on introduction of the equipment and less so when the patient has become used to it. If a patient unexpectedly expresses a dislike for something that has been an aspect of their routine since admission, the knowledge of why it

is only now that they feel comfortable to share the dislike, may increase acceptance of their viewpoint.

Participants found feedback and celebrating success was shared more often by physiotherapists than nursing staff. There is more time spent with nursing staff and more opportunities to make patients feel a sense of celebration and achievement. Participants need to be a partner in moving and handling care and participate as much as possible. Nurses need to vocalise observed improvements in the patient's ability or physical condition to them. Most nursing interactions, including moving and handling transfers, provide time to converse and share any noted improvement, however small. Example opportunities for positive feedback include patients increasing ability to participate in moving and handling transfers and progress on other care goals.

Findings around participant experience with equipment can be incorporated into patient care. Discovering if patients with long-term conditions have used equipment at home, and the type of equipment used, may increase acceptance in hospital if similar equipment is available. There also must be recognition that patients need support and time to adapt, if their physical condition has deteriorated making a more passive form of mechanical assistance necessary.

All participants with a dislike or fear of hoists had a specific reason for this. If the reason can be identified, then care can be modified to meet the patient needs. If a patient is afraid of heights, then alternative equipment to a lifting hoist could be considered, such as a lateral transfer board or standing aid with a fully supportive transfer sling. If the patient's condition prohibits use of this alternative equipment, then measures such as keeping the lift height to the lowest level possible and transfer over the shortest distance can be applied. There needs to be a method for recording and communicating reasons for patient concern or anxiety. This will assist in communication with the patient and partnership working to reduce this concern.

7.6.3. Policy

There is a lack of current knowledge on how much moving and handling takes place in United Kingdom hospital wards and departments. When something is unknown, it cannot be monitored, and the resources required cannot be forecast and appropriately allocated. Bell's (1984) study cannot be compared to Kayser et al's (2020) study in the United States because of legislative differences, newer data from a current investigation is required.

The findings of this study support previous knowledge on the escalating care needs of the population in terms of long-term care and support on discharge. The challenges of retaining the aging health and social care workforce has also been considered, and the challenges that aging nurses face working for longer. There is a need to 'join the dots' and not view these as separate issues. Older, less physically able nurses need lifting equipment to reduce the increasingly physical workload. The recent widespread introduction of single handed care packages reduce the expense in human resources but may increase the physical workload on those resources.

The next section, outlines recommendations generated from the findings of this study.

7.7. Recommendations

Recommendations are for moving and handling education, moving and handling practice and future research.

7.7.1. Moving and Handling Education

Participants in this study focussed more upon caring inter-personal relations than safety or competence in moving and handling transfers. There is a need for this core finding to be incorporated in moving and handling education. The Scottish Manual Handling Passport (2014) specifies core learning outcomes for training modules. Person-centredness is considered in learning outcome C6 describing the need for involvement in manual handling decisions (p.12). The passport specifies that trainees must be given adequate time for practice of manoeuvres. An enhancement of person-centredness would be to include the instruction that

trainees should also reflect upon caring demonstrated during the manoeuvres practiced. Patients need to participate as much as possible in moving and handling transfers to become a partner in care.

7.7.2. Moving and Handling Practice

The knowledge that participants had specific reasons for disliking or fearing mechanical equipment can inform practice. Identifying the reason for patients' anxiety is the first step in formulating methods to reduce it. A question could be incorporated in moving and handling care-plans to ensure that this is addressed.

In-patient information leaflets should contain a section explaining that if patients are unable to move for themselves, equipment may be used to assist. It could also ask that patients inform staff if they currently use lifting equipment at home and the type of equipment used. This information would assist with the 'matching with mine' (described in Chapter 6) and may save nursing time in assessment.

Two participants described discomfort in a specific lifting sling. A recommendation for review has been sent directly to the equipment manufacturer.

7.7.3. Future Research

The caring aspects of moving and handling patient interactions have not been the subject of previous study. Most of the pre-existing literature in moving and handling is from the perspective of safety, particularly safety of nursing staff. Participants in this study demonstrated that the manner of moving and handling care delivery is more important to this group of patients than safety or competence of caregivers. More qualitative research is required to investigate this aspect further and identify focus for future interventions that could improve the quality of moving and handling education and care.

The theory developed from this study could be explored further. An example of how this could be undertaken is to follow patients from admission to intensive care then through their hospital journey. Observation would assist to support the relationship between growing self-actualisation and the ability to influence

change. Richer information on facets of moving and handling such as the role of family and friends could be gleaned from this observation.

Only one patient required bariatric lifting equipment and moving and handling care delivery in this study. While the participant described experiences like the other participants, research into the moving and handling experience of plus size patients may warrant further study due to the specialised nature of equipment and increased risk in handling activities.

This is a small study and transferability of the emergent theory was questioned in section 7.5. of this chapter (limitations). Further study is required to support or negate this theory. Maslow's theory of self-actualisation was developed for motivation of the workforce. Are the findings transferrable to the world of work? Could 'capacity to influence care' be 'capacity to influence change'? Those growing to self-actualisation at work may exhibit behaviours similar to participants. That is, they attempt to influence workplace change through yielding, analysing and sharing before they reach a level of self-actualisation where they can assert their wishes or concerns.

A difficulty encountered at the outset of this study was identifying the patients who require assistance to move (Chapter 1, section 1.3). There is no current knowledge on how many patients or the types of patient in hospitals that require physical or mechanical assistance to move. A 'snapshot' survey method similar to Bell's 1984 study would address this. A comparison might be made against the 1984 data to indicate growth or otherwise. The knowledge generated would help inform resource needs and future planning.

The findings support the evidence of the aging population needing increasing resources for moving and handling assistance to meet their needs at home. Most study participants expected formal carers to be involved in their continuing care and the cost implications in terms of human resources were previously discussed (section 7.4.2). A financial risk assessment tool needs to be

developed to focus allocation of technology. A long-term study can determine the value of this approach in terms of mechanical versus human resource costs.

7.8. Conclusion

Moving and handling during patient transfers needs to be safe for all participants involved in the task. However, participants in this study focussed more on the manner of care delivery than safety or competence of caregivers. There needs to be a move towards incorporating more of the caring aspect of moving and handling interventions in nurse education and practice. Patient choice should be incorporated in moving and handling care-planning wherever possible and patients need to be as involved as possible in moving and handling transfers to be a partner in care. Assistance to move for those unable to do this themselves is a necessary pre-requisite for other aspects of care. Participants did not distinguish moving and handling from these aspects of caring, and the manner of care delivery is important.

This study supports previous literature on person-centredness in nursing care. An original finding of the study is how the growth in the patients' level of self-actualisation corresponded with a growth in the need for involvement and consultation in moving and handling.

The description of how patients may try to influence the delivery of moving and handling care to meet their expectations of good care is also novel. Knowing that patients' capacity to influence care is part of recovery and increasing self-actualisation, provides understanding of the motives behind behaviour and opportunity for support.

Wordcount 57035

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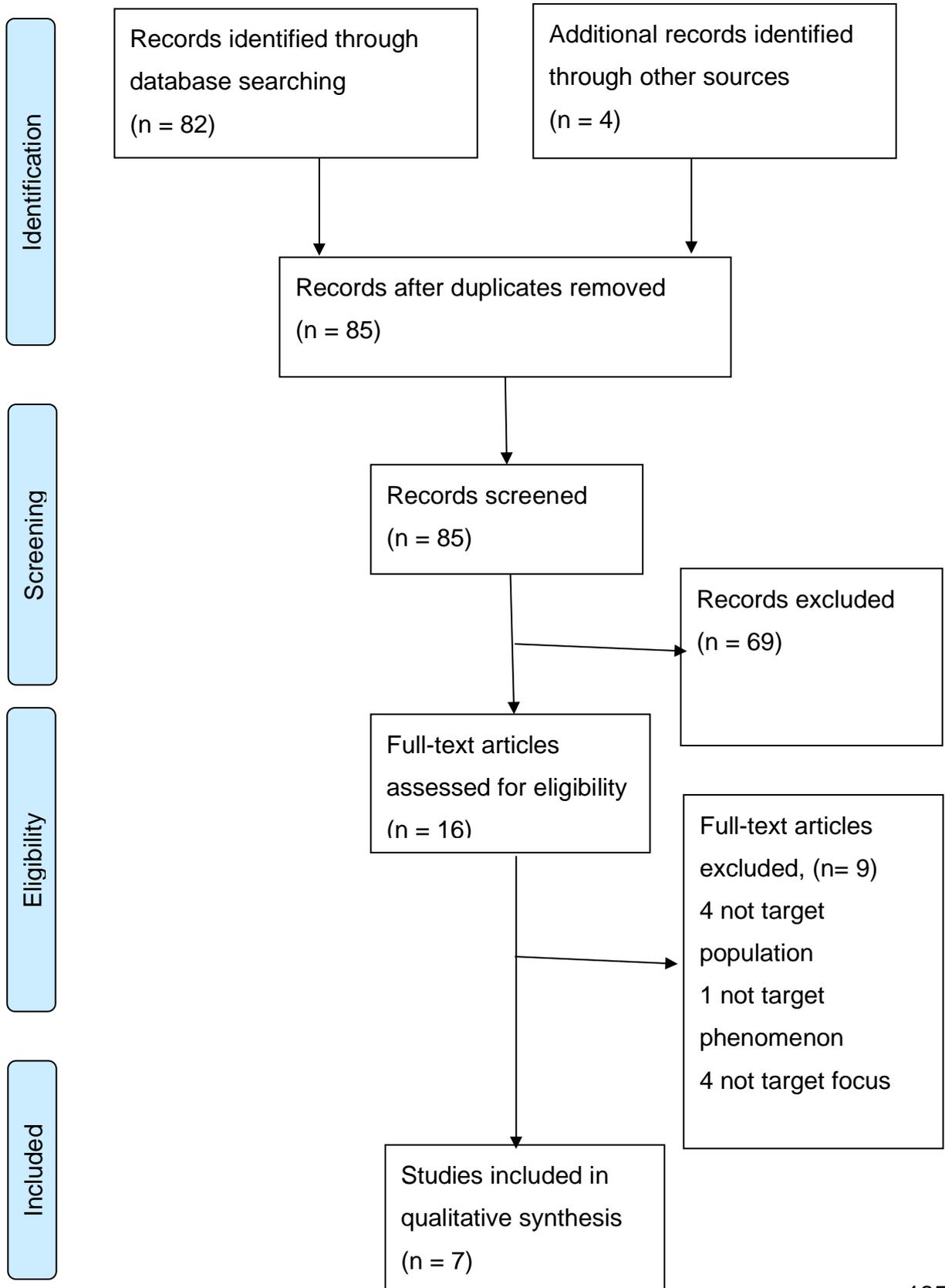
Appendices

Appendix 1. Mind mapping and database search

Area of search focus	Terms searched	Additional information
Moving and handling	1. lifting 2. "manual* handl*" 3. "moving and handling" 4. hoist* 5. 1 or 2 or 3 or 4	2. truncated to include phrases such as "manually handled" 3. limited to specific phrase to avoid topics such as complaints handling etc. 4. truncated to include hoists, hoisting etc. 5. searches combined with "or" to include all results
Qualitative research	6. qualitative 7. "action research" 8. "grounded theory" 9. phenomenol* 10. narrative 11. "case study" 12. ethnograph*. 13. interview*. 14. "focus group*" 15. 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14	7, 8 and 11 limited to the specific phrase 9, 12, 13 truncated to capture words with the same root 14. limited to phrase and truncated 15. searches combined with "or" to include all results
Patient	16. patient* 17. in-patient* 18. 16 or 17	16 and 17 Truncated to capture words from the same root 18. searches combined with "or" to include all results

Area of search focus	Terms searched	Additional information
All search terms	19. 5 and 15 and 18 20. 19 Limited to the English language	19. Searches combined with “and” to include only those results involving qualitative research relating to moving and handling patients 20. Search limited to results that could be screened in the readers first language

Appendix 2. PRISMA Flow Diagram (Moher et al. 2009)



Appendix 3. Reasons for exclusion from the literature review

Inclusion Criteria	Reasons for exclusion
<p>Qualitative literature that appraises Manual Handling defined as - necessity for healthcare workers to assist in movement e.g. transfers or rehabilitative handling.</p> <p>Patient experience relates to being a hospital in-patient.</p> <p>Patient experience explored: all genders all adults over 18 years.</p>	<p>Self-administered rehabilitation, movement or exercise e.g. lifting weights.</p> <p>Patient experience of “lifting” relates to cosmetic surgery e.g. facelift.</p> <p>Study participants without involvement of secondary care nursing or healthcare workers e.g. care or nursing home residents, persons with long-term conditions supported at home by carers.</p> <p>Study relates only to healthcare workers experience of manual handling and not patient experience.</p>

Appendix 4. Papers included in review

Papers included in review (in chronological order of publication)

Lead author and year of publication	Population characteristic and sample size	Method of understanding phenomenon	Purpose of investigating focus	Outcome	CASP Quality Assessment
McGuire et al. (1996)	In-patients from 2 wards, orthopaedic and elderly care. n=20 All patients that met selection criteria interviewed. UK-Scotland	Semi-structured interviews Observational	To investigate if nurses' perceptions of patients dislike of mechanical aids was justified.	Lack of patient compliance is less of an obstacle to mechanical aid use, than the attitude of nurses.	Value is the contribution of patients' perception directly reported and not obtained via caregivers. Appropriate methodology. Ethics not considered. Small sample size and limits reported by researchers – make strong recommendations despite this.
Kjellberg et al. (2004)	2x Physiotherapist and 1xnurse role-playing patients Sweden- Goteborg	Ratings of safety and comfort Video observations	To explore any relationship between nurses work technique and patients perceptions of safety and comfort.	Positive correlation, but low correlation coefficients.	Value is in comparison of caregivers' skill and safety/comfort ratings. No patients included, so unable to achieve stated aim related to patients' perception. Limitations acknowledged. Methodology, data collection and analysis appear rigorous.

Lead author and year of publication	Population characteristic and sample size	Method of understanding phenomenon	Purpose of investigating focus	Outcome	CASP Quality Assessment
Ruszala and Musa (2005)	In-patients who needed assistance to stand in 2 rehabilitation hospitals. n=7 (3 later excluded from original sample of 10) UK- England	Patients views documented by Physiotherapists	To evaluate the use of equipment in rehabilitative sit-to-stand.	Equipment can compliment manual assistance.	Value is in examining the benefit equipment can bring to interventions by physiotherapists. Poor reporting of patient views (27 words). Views not directly obtained but reported via physiotherapists. However, not primary aim of study.
Pellino et al. (2006)	Convenience sample orthopaedic patients during lateral transfers n= 132 (patient may have been transferred several times) USA- Wisconsin	Likert scales rating comfort and security of patients and perceived exertion of nurses. Observation / timing.	Comparison of nurses perceived exertion and patient comfort during manual or mechanical lateral transfers.	Patients and nurses rated mechanical transfers higher than manual for comfort and security.	Value is in collecting and relating a large number of patient ratings of comfort and safety, but data is more quantitative than qualitative. Consent not obtained from participating patients.

Lead author and year of publication	Population characteristic and sample size	Method of understanding phenomenon	Purpose of investigating focus	Outcome	CASP Quality Assessment
Alamgir et al. (2009)	Patients in a "complex care facility" N=12, all patients able to participate. Canada-Vancouver	Semi-structured interviews (and satisfaction rating) Analysis of adverse outcomes e.g. falls in comparison to ceiling hoist provision.	To explore relationship between ceiling hoist provision and patient care quality indicators; and patient perceptions of care received using overhead hoists.	Ceiling lifts are not detrimental to the quality of care, and patients prefer being transferred by lifts.	Value in discovering patient preferences on lifting hoists. Strong data presentation and analysis. More quantitative than qualitative. Recognises limitation in transferability to Acute care areas.
Luz and Echernacht (2012)	Convenience sample "Elderly patients" N=3 Brazil – Minas Gerais	Patient interviewed Ergonomic work analysis	To generate equipment design that considers the needs of patients and caregivers	Recommendations on design of mechanical hoists.	Value is that the authors considered patients' opinion of mechanical aids. Study design is more an evaluation of equipment and does not demonstrate the rigours of research. Transferability is very limited related to geographic and economic issues.
Coulter Smith et al. (2016)	self-selecting patients in one health board with osteoporosis age 64+ n=16 UK-Scotland	Semi structured interviews of healthcare staff and patients. Thematic analysis Systematic literature review	Research education project; moving and handling needs of older people with osteoporosis	Need for improved knowledge and understanding of osteoporosis to enhance delivery of person-centred care Training package developed.	Value is in discovering patient experience in context of acute setting. Transferability may be limited to patients diagnosed with osteoporosis.



10 questions to help you make sense of qualitative research

How to use this appraisal tool

Three broad issues need to be considered when appraising the report of a qualitative research:

- Are the results of the review valid?
- What are the results?
- Will the results help locally?

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions.

There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

These checklists were designed to be used as educational tools as part of a workshop setting

There will not be time in the small groups to answer them all in detail!

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Screening Questions

1. Was there a clear statement of the aims of the research?

Yes Can't tell No

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

2. Is a qualitative methodology appropriate?

Yes Can't tell No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?



Detailed questions

3. Was the research design appropriate to address the aims of the research?

Yes Can't tell No

HINT: Consider

- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research?

Yes Can't tell No

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue?

Yes

Can't tell

No

HINT: Consider

- If the setting for data collection was justified
 - If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
 - If the researcher has justified the methods chosen
 - If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
 - If methods were modified during the study. If so, has the researcher explained how and why?
 - If the form of data is clear (e.g. tape recordings, video material, notes etc)
 - If the researcher has discussed saturation of data
-

6. Has the relationship between researcher and participants been adequately considered?

Yes

Can't tell

No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
 - (a) Formulation of the research questions
 - (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration? Yes Can't tell No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous? Yes Can't tell No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings?

Yes Can't tell No

HINT: Consider

- If the findings are explicit
 - If there is adequate discussion of the evidence both for and against the researchers arguments
 - If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
 - If the findings are discussed in relation to the original research question
-

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Table 1. Themes identified in the literature relating to patient experience

	McGuire et al. (1996)	Alamgir et al. (2004)	Kjellberg et al. (2004)	Ruszala and Musa (2005)	Pellino et al. (2006)	Luz and Echernacht (2012)	Coulter Smith et al. (2016)
Safety	X	X	X	X	X	X	X
Acceptance of mechanical aids	X	X	X	X	X	X	
Skills and knowledge of caregivers	X	X	X				X
Comfort	X		X		X		
Person-centred care	X						X

Appendix 7. Interview Topic Guide

Recap information sheet, particularly the necessity to disclose safeguarding issues and that the authorities may need access to audio-tapes.

Obtain written consent.

Initial Open-Ended Questions

1. What do the words “moving and handling” mean for you?
2. When did you first experience being physically moved by workers in the hospital?
3. What discussion took place before you were moved by caregivers?
4. Tell me about how the way you were moved matched your abilities and preferences?

Intermediate Questions

(check interviewee is happy to continue)

1. Tell me about your journey through the hospitals, and the different ways you've been assisted to move in bed or been helped from bed to a chair or toilet.
2. How did you feel about being reliant on other people to move you?
3. Would you please describe an occasion you were moved in as much detail as possible?
 - What made that occasion spring to mind?
4. What sorts of information were you given about the different ways that you could be helped to move?
 - (- What information do you feel would have been helpful?)
5. How do you feel about the way that you're assisted to move at the present time?
6. How much involvement have you had in planning the way that you would be moved day to day?
7. What involvement have your friends and family had in the way that you have been moved and handled?
 - Who would you like to have been involved? (and how much involvement would you like them to have?)

8. How much involvement have you had in planning for how you will move around on discharge?

9. Will someone be helping you to move at home? When do you feel that they should begin to get involved?

Closing questions

1. What is the single biggest improvement (if any) that we could make to moving and handling people in hospital?

- Are there any others that spring to mind?

2. If you had to write a newspaper article about your experience of moving and handling in hospitals, what would the headline be?

3. Can you think of anything else that you remembered or would like to tell me about your experiences?

4. Is there anything that you would like to ask me about?

(Thanks, what happens next and estimated timescale – transcript, analysis, write-up, sharing of findings, re-establish consent).

Appendix 8. Coreq Checklist

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
<i>Personal Characteristics</i>		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	Section 1.4
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	Section 1.4
3. Occupation	What was their occupation at the time of the study?	Section 1.4
4. Gender	Was the researcher male or female?	N/A
5. Experience and training	What experience or training did the researcher have?	Section 1.4.
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	Section 4.1.
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Appendix 10
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Section 1.4.
Domain 2: study design		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Section 3.4.
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Section 4.1.
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Section 4.1.
12. Sample size	How many participants were in the study?	Section 5.2.
13. Non-participation	How many people refused to participate or dropped out? Reasons?	N/A
<i>Setting</i>		

14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Section 5.3.2.
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	Section 5.3.2. Section 6.3.3.
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	Section 5.2.
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Section 5.3.1. Appendix 7
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	Section 5.4.
20. Field notes	Were field notes made during and/or after the interview or focus group?	Section 5.3.2.
21. Duration	What was the duration of the interviews or focus group?	Section 5.3.2.
22. Data saturation	Was data saturation discussed?	Section 5.1.
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Section 4.2.
Domain 3: analysis and findings		
<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	Section 5.6.
25. Description of the coding tree	Did authors provide a description of the coding tree?	Section 6.1. Section 6.3.
26. Derivation of themes	Were themes identified in advance or derived from the data?	Section 6.1.
27. Software	What software, if applicable, was used to manage the data?	N/A
28. Participant checking	Did participants provide feedback on the findings?	N/A
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Chapter 6
30. Data and findings consistent	Was there consistency between the data presented and the findings?	Section 7.5.
31. Clarity of major themes	Were major themes clearly presented in the findings?	Chapter 6
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Chapter 6

Category; **Needs** (sample codes)

Identifying that needs influence choice

Dismissing need for communication

Struggling to meet basic needs

Qualifying the need for assistance

Accepting help at times of most need

Focussed Coding

Surrendering autonomy for aim

Yielding

Influencing Care

Category

Core Category



Title of Project: Influences upon Patient Experience of Moving and Handling in Hospitals

Researcher: Ms Marlene Murty, Occupational Health and Safety
Department, NHS Ayrshire and Arran

Information Sheet

Background

“Moving and Handling” are words used in NHS Ayrshire and Arran to describe when nurses or other people help patients to move. Some patients need help, for example, to turn over in bed or move from a bed to a chair. In some instances, equipment may be used to assist. There have been many studies that look at health workers involvement, but very little has been written about patients’ experience. I am keen to find out what you think and feel about this aspect of care and how you have been involved.

As part of the study I hope to visit your hospital and interview a small number of patients. I am going to give you information and invite you to be part of this research. You do not need to decide today and you can ask questions to help you decide. This study is part of my work towards a Doctor of Nursing degree at the University of Stirling and my progress will be overseen by Academic Supervisors.

Why have I been approached?

You have been chosen by healthcare professionals on your ward that feel you are able to participate in this study. You have experience of being moved by caregivers in hospital, but your decision to take part is entirely voluntary.

Do I have to take part?

No, it is entirely up to you if you decide to participate. Participation is entirely voluntary and you do not have to take part in this project. You do not have to give a reason why you do not want to participate. This will not affect your care in any way.

What happens if I agree to take part and then change my mind?

You can let any member of your care team know that you have changed your mind and no longer wish to take part. Before beginning the interview, I will recap this information, ask if you are happy to take part and ask you to sign a consent form. You are under no obligation to participate and can withdraw your consent at anytime, for example, during the interview. This decision to withdraw will have no effect on the treatment you receive.

What would I need to do?

You would be invited to discuss your experience of moving and handling since your admission to hospital and answer a few questions on this theme. Interviews will be held in private at a time that suits you. This interview should take about an hour of your time and will happen in private on the ward or a nearby area. This includes the time to assist you to move to another room if necessary. The interview will be audio-recorded.

Confidentiality

The information you give will not be directly shared with your caregivers but will be reported anonymously with other participants' views at the end of the study.

The interview will be audio-recorded, then transcribed and your name will not appear on the recording or transcripts. Digital audio recordings will be securely stored in an NHS encrypted file and then deleted at the end of the study. The anonymous written transcripts will be retained (with your permission). These transcripts will be securely stored at the University of Stirling and be made available to future researchers who wish to study similar themes.

Safeguarding

If you disclose abuse or other inappropriate behaviour, the researcher has a duty to safeguard you. The allegations will be discussed with the Adult Support and

Protection Officer and if necessary reported to social services or police. In this instance the researcher may be required to share any audio recording with the investigators.

What are the benefits from taking part in the study?

There are no immediate benefits to you, giving up some of your time may even be an inconvenience. It is hoped that sharing your experience will inform the way that we care for patients in the future.

What will happen with the results of the study?

The findings will be presented preserving confidentiality. The outcome of the work will be shared, for example, with patient forums in NHS Ayrshire and Arran and be presented in professional journals or seminars.

It is hoped that insight into the patient experience of moving and handling will inform care planning and improve the quality of the experience.

Who to contact.

If you have any questions please contact me:

Marlene Murty

Clinical Simulations Unit

Ailsa Hospital

KA6 6AB

Tel: 01292 885974

Email: marlene.murty@aaaht.scot.nhs.uk

If you would like to talk to someone about this research who is not directly involved with the research study, you can contact;

Professor Jayne Donaldson

Dean of Faculty

Faculty of Health Sciences and Sport

University of Stirling

FK9 4LA

Tel: 01786 466345

Email: jayne.donaldson@stir.ac.uk

Yes - I would like to take part in your study. What do I need to do now?

Please complete your details below; detach this page from the others and then send it to me in the addressed envelope provided.

I will contact you after receiving your details. We can then discuss participation in the study and your consent to be interviewed.

My name is

(Please print):

I am interested in taking part in your study and understand that I can change my mind at any time.

Please contact me at:

Ward

Signature:

Date:

Appendix 11. Participant Consent Form



UNIVERSITY OF STIRLING

Title of Project: Influences upon Patient Experience of Moving and Handling in Hospitals

Researcher: Ms Marlene Murty, Occupational Health and Safety
Department, NHS Ayrshire and Arran

Please
Initial Box

I confirm that I have read the information sheet dated 27/05/17, version 3 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

I give permission for my interview to be audio recorded.

I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers

I understand that relevant sections of data collected during the study may be looked at by individuals from the University of Stirling, from regulatory authorities or from NHS Ayrshire and Arran relevant to my taking part in this research. I give permission for these individuals to have access to my records.

I agree to take part in the above study.

Print name of person giving consent:	Signature of person giving consent:	Date:
Print name of person taking consent:	Signature of person taking consent:	Date:



Health Research Authority

Yorkshire & The Humber - South Yorkshire Research Ethics Committee

Room 001
Jarrow Business Centre
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0207 1048091

12 June 2017

Miss Marlene Murty
Moving & Handling Service Manager
NHS Ayrshire & Arran
Clinical Simulation Unit
Ailsa Hospital
Ayr
KA6 6AB

Dear Miss Murty

Study title:	Influences upon Patient Experience of Moving and Handling in Hospital
REC reference:	17/YH/0158
Protocol number:	NICR 16/17 42
IRAS project ID:	206456

Thank you for your letter of 9 May 2017, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the

A Research Ethics Committee established by the Health Research Authority

Appendix 13. Planning Research with Patient Participants
(Hay-Smith et al., 2016)

Using Clinical Skills:

1. When is appropriate to address a clinical question from a patient?

In the case of simple requests for clarity e.g. definition of medical terms, I will briefly explain and offer to give more detail at the end of the interview. If it is a question on quality or judgement, this is not appropriate for me to answer. I will refer back to the caregivers.

Referral back to the Direct Care Team may be appropriate for most concerns, but I will also need to be aware of safeguarding issues and if this is the prelude to another question. Reflecting back e.g. "I'm wondering why you asked that question?" may help solidify the patients concerns.

In general the best approach may be to defer all questions to the end of the interview then give my contact details. I can be contacted by any service-user in my day-job, so this is not preferential treatment.

2. What will you do if you think the patient-participant or another person (such as their carer) is asking you to use your clinical influence or expertise?

I will reflect the question back to the care team e.g. "It sounds like you feel a need for more detailed assessment. Let your nurse know that you would like your care plan reviewed and that she can contact the Moving and Handling Team for support if necessary". I will need to be careful to say "it sounds like you feel...", rather than "it sounds like" which the patient may see as validation of their feelings.

3. When you feel the urge to give physical assistance, what makes it appropriate or not?

The selection criteria mean all patients will have recent mobility difficulties and need help to transfer. I consider it appropriate to push the person in the wheelchair to the place of privacy, but not to assist in the physical transfers. The reason for this is that pushing the wheelchair is similar to walking along the corridor with someone that has the ability to walk. Assisting in the physical transfer is slipping into the role of caregiver and given my background I would most likely assume the role of the person in charge of the lifting operation. The patient-participant's perception of me would

become influenced by this level of intervention. It would be inappropriate to deal with needs such as toilet hygiene and I would address these to the care team.

Dynamic assessment will be required during the course of the interview. I will always need to ask the patient if they would like assistance and not automatically attend to their positioning e.g. “you seem to have been slipping down in the chair. Would you like assistance to move into a more comfortable position?”. If the patient-participant struggles for some time to lift a beaker to their mouth for a drink, it is not a use of clinical skills to assist. In this instance consent can be briefly asked e.g. “May I help you there ? ”, it may be that the person is determined to do it without assistance.

4. If you incidentally identify a clinical issue or a patient-participant need, how will you manage this?

If this comes to light during the course of the interview, make a note to address at the end. I will explain to the patient-participant that I feel this warrants more investigation and if it has not already been discussed with the care team, seek permission to share. If permission is withheld, then dependant on the severity of the need and legal requirements e.g. safeguarding; explain to the patient-participant the next steps that I intend to take, even without consent.

5. When is it acceptable for the patient to receive beneficial (therapeutic) benefit from taking part in the research?

It is common in research for participants to receive benefits for participating. In this instance there are none identified – possibly a brief escape from the monotony of ward routine and a cup of tea.

Creating a relationship with the patient-participant

6. What assumptions can you make about understanding based on shared clinical ground?

We’ll both have a shared general understanding of hospital roles, hierarchy, routines, basic equipment etc. My first question will seek more information on the participants understanding of the topic under discussion. I am using the patient as an expert opinion on how it feels to be the recipient of care and must show the appropriate level of respect. I have no understanding of this apart from role-playing.

7. What risk is there of using a trust relationship for your own ends?

The risk exists. If I suspect an unsafe practice is routinely used in the area, e.g. drag lift; I may be tempted to use the verification to change practice. However, if I have this suspicion – it's up to me to challenge it by other means e.g. when the team implement the annual competency assessment schedule.

8. What signs are there that a patient-participant may feel coerced or obliged.

Signs that I need to observe for and directly question include:

Reluctance to pinpoint a time for the interview;

Postponing accompanying me to a place of privacy;

Hostile questioning or defensive body language e.g. folded arms

Reticence when asked questions;

Vagueness and ambiguity in answers;

I will need to be aware of the potential for reluctance and question the patient-participant on their certainty that they wish to be part of the process.

9. What will you do if a patient-participant reveals intimate information of concern?

Safeguarding has been considered as part of the ethics process. The Participant Information Sheet and Consent Form detail the need to take action and what this will be.

10. How will you know if you are “too close to see”?

If data doesn't seem to make sense, then I need to acknowledge that I may be too close. It made sense to the patient-participant. Other indications may be when I feel tempted to clarify the patient participants words to suit the definitions that I know; instead of listening to the words that they use, in the context that they say them.

It is anticipated supervisors will challenge me to reflect upon my assumptions in the progress of the study. This reflexivity will assist me to understand my interpretation of data.

After the Research

11. What happens if you and the patient-participant meet again, this time as a clinician and patient?

It would be rude not to acknowledge that we have already met. This does not need to involve disclosure. Non-verbal language e.g. a smile and nod of recognition will let the participant know that disclosure is in their gift, not mine. Care will be needed not to reveal previous discussions e.g. by very targeted questions.

If the patient-participant wants to follow on discussions that took place in the interview, I will need to ask the patient to recap for the benefit of others present.

There is a distinction between what took place as part of research and a professional consultation for care-planning. The differences need to be clarified, the main one being that care cannot be planned in privacy. Members of the direct care team need to know the justification for implementing the plan e.g. a customised sling for long-term care because the generic type causes discomfort in a personal area.

Interview One: Initial Coding	
Transcript	Coding
<p>It was the bed tae a commode cause ah didnae like using a bed pan, cause so they were really great with me,so ah just went straight to the toilet. And the girls, the nurses took me, waited with me, ‘n then thingwied me on ‘n off; first wi’ a board but then ah thought ah could dae this masel’ ; so ah did. (triumphant smile and nod for emphasis)</p>	<p>Basic needs that had to be met Choice in the way needs are met Positively ranking performance Seeing caregivers out-with roles Support accepted when necessary Progressing to independence and “normalising” Achieving independence is the goal.</p>
Interview One: Recoded using code-list	
Transcript	Coding
<p>It was the bed tae a commode cause ah didnae like using a bed pan, cause so they were really great with me, so ah just went straight to the toilet. And the girls, the nurses took me, waited with me, ‘n then thingwied me on ‘n off; first wi’ a board but then ah thought ah could dae this masel’ ; so ah did. (triumphant smile and nod for emphasis)</p>	<p>Identifying resources needed. Matching care to expectations Participating as a partner in care Taking steps to self Celebrating success for esteem.</p>

Participant 9.

Theoretical sampling; someone who was hoisted and has progressed to mobility.

Fieldnote to question the nature of feedback if mentioned by participant.

<p>R: That's it switched on now. So when did you first experience being moved by the workers in hospital?</p>	
<p>P: Och, its I came in eh on the 27th just before eh Christmas . And I'm just a bit doon, because there's an old fella lying a'side me and he was gey ill, and there was a fella up the ward. And he was a'ways shouting "come on, come on". So when his wife was faced with the doctor; I says "how are you getting on?" and she ...(pause). And when the doctor came to me and he said "How you going Mr ###"? "Well" I said "I was going on a bit better and I could got up and I fell that yin". I mean I hate anybody like that. You'd think he was the only yin that was in the ward.</p>	<p>(no relevance to MandH)</p>
<p>(Pause)</p>	
<p>R: Uhmm And when you were admitted how did they help you to move in and out of bed or..?</p>	
<p>P: Oh well. But. When I came doon here they had me in this kind of hoist that they've to use oot your bed and into the chair. Then you've got your breakfast and that whisks you out of the chair and then put you back into your bed. But it's.... I say to masel that's nae way of learning to walk. But see, you're jumping, you jump the gun. So you are. That day I was sitting here and this woman was shouting ma name. It was one of those, what</p>	<p>Objectifying self as load</p> <p>Detaching from activity</p> <p>Analysing and questioning care</p> <p>Jumping the gun</p>

<p>you cry them? Physios. And eh, “So come on Mr ##. We’re going up to the.., the.., the room”. Ken? The.., where you learn. So I went up there. Here, she sat me on this bike. You pedal it. And then you’re pedalling it so long.., you reverse it. And then she turned me, pirried it round and tell you to dae it with your hands. I says “That’s nae use”, but see I was jumping the gun. So here; she says, “Eh, come on and try the bar”. So I went up and tried the bars and then.., eh, a while after that this is what I was daen’ . The bike and the bars; the bike and the bars and I can walk noo. I’ll tell you they’re, they’re guid Physios. I tell you.</p> <p>R: (Coughing) Ehmm. When, when you were being hoisted how did you feel that matched your abilities to move?</p> <p>P: Well they dae what they dae. So put your arms in like that (folds arms into body) so your arms would’nae get knocked. No they were.., eh, they were alright that way.</p> <p>R: And how did you feel being...., relying on other people to move you?</p> <p>P: Och, it didn’t bother me about folk having to move me. I just went where I was to go. Because, I think what happened there... when I telt that doctor that I would have kilt that yin. He got me shifted doon to the...., doon here. So he did. I have met him mair doon here than I have up there. Because you hardly ever seen yon o’ those Physios . ‘Cause it’s a big...., a big hospital. (pause)</p> <p>R: And what about being moved by the nurses and the hoist?</p>	<p>Detaching from activity</p> <p>Analysing and questioning care Jumping the gun</p> <p>Taking steps to self Rating the caregiver</p> <p>Participating in care</p> <p>Surrendering autonomy for aim</p> <p>Feeling vulnerable to circumstance</p>
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<p>P: Oh they were guid. So.. I tell you what they did. They telt ye to have your arms like that (folds arms) so your arms are no' sticking oot and hit something. Oh they watch you. I'll tell you, it's the physios, they, they watch you too and they tell you "you're daen that wrang" and you've got to do it richt. Oh I was guid, see me working my legs, so I was.</p>	<p>Rating the caregiver Participating in care</p>
<p>R: Aye (nod) Can you describe one occasion when you were helped to move in as much detail as possible? So when somebody was actually helping you to.. to walk or hoist or?</p>	<p>Using feedback Celebrating success</p>
<p>P: Ah well..., aye. They took me up in the chair to the place and then they put you on this bike, ken? You're doing all this pedalling and they time you. And then they took me.., the hands (makes circular motion with hands), they time you there and checked how many miles you did. So they did. Then I asked them about this, I showed her that (indicates large lipoma type lump on arm). This was the path that you had to walk. Oh they look after you well, they telt you.</p>	<p>Detaching from activity</p> <p>Using feedback</p> <p>Appreciating care</p>
<p>R: And you mentioned earlier how things weren't coming quick enough like you were being hoisted and thinking this is no way to learn to walk?</p>	
<p>P: Aye you don't know these things yersel. You're no' a doctor or a nurse. You've got to go with what they say.</p>	<p>Trusting in carers</p>
<p>R: What type of information were you given about that?</p>	
<p>P: Oh, oh they just.. how to.., how to get in tae the bed to get ... til the doctor says "Eh, you'll need to see the Physios to learn to walk". I said "right enough", I</p>	<p>Setting shared goals</p>

<p>says "ok". But eh, I was glad to see me on my legs for I couldnae walk when I came in. (pause)</p>	<p>Taking steps to self Regaining something that was lost</p>
<p>R: That's good.</p>	
<p>P: Aye, but you've got to, you've got to put your mind tae it. There's no use saying "To hell with that", oh no.</p>	<p>Taking steps to self</p>
<p>R: And what types of feedback did you get when you were progressing along the way? (Pause)</p>	
<p>Eh did anyone speak to you about how you were getting better or?</p>	
<p>P: Och aye, the, the the Physios telt me "You're daen well". Och aye, they're, they're guid.</p>	<p>Rating the caregiver</p>
<p>R: And what kind of affect did that feedback have on you?</p>	
<p>P: Well I.. I said to maself "I'm gonna stick, tae dae it". To walk. Because I would rather walk than sit (cough). Lie in your bed for the rest of your life (groan).</p>	<p>Taking steps to self Fearing the future</p>
<p>R: Was the encouragement to move only in the Physio department or when you came back to the ward did it carry on?</p>	
<p>P: Oh och, when you came back from the Physios I done that much hard, I just said to the nurse "Put me back, put me onto my bed till I rest". Oh I didnae sit, oh I'm no' daen this, I got stuck into it. So I did.</p>	<p>Detaching from activity Taking steps to self</p>
<p>R: Eh Had you had involvement in planning how you would move and how you would progress? What involvement did you have?</p>	
<p>P: Eh I did not. I eh, got yin of these (walking frame) and then I started to walk. (pause)</p>	<p>Taking steps to self</p>
<p>R: And have your friends and family been involved helping you?</p>	
<p>P: Oh aye. My son helped me and eh, the nurses helped me and my daughter in law helped me.</p>	

<p>R: What kind of difference has that made having your family?</p> <p>P: Oh eh, the more I had to sleep doon the stair, the more I was sleeping. When I needed the toilet, I gave them a shout. And they got me out of bed and lifted me up and took the thingways doon and put me on tap of the eh toilet. Oh aye, but he's wanting me back, he's missing me, oh aye.</p> <p>R: Have you been planning for discharge?</p> <p>P: I don't ken when I am going to get it.</p> <p>R: Have you been involved in planning for it?</p> <p>P: No, they've just said... yin of them said it. They says "It won't be long till your oot". Well I say "I hope it's this week sometime". Getting oot the end of the week.</p> <p>R: And.., eh. So you mentioned your son will be helping you at home?</p> <p>P: Oh aye. The son and the nurses.</p> <p>R: Hmm, what involvement have they had while you are in here.., helping?</p> <p>P: What's that?</p> <p>R: Your, your son.</p> <p>P: Oh my son and that .., the daughter in law comes up to see me. And the grandweans.</p> <p>R: So before you could walk with the frame were they involved in helping you move at all?</p> <p>P: The what?</p> <p>R: (Points at frame). Before you could walk were they involved in helping you move your, your son?</p> <p>P: Well. She phoned the ambulance. Phoned the doctor then phoned, then phoned the ambulance. And then they took me oot. In a wheelchair. Oh no. (Pause)</p>	<p>Identifying need</p> <p>Detaching from activity</p> <p>Identifying need</p> <p>Jumping the gun</p> <p>Detaching from activity</p>
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R:	And when you were being hoisted, how did that feel?	
P:	Och well. You get what you, what you've got to to dae. They telt they'll pick you up while you was (mimics sling around self), the chair.	Surrendering autonomy for aim Detaching from activity
R:	And were ... were there any things that made a difference to that experience when you were being hoisted?	
P:	Ah well. I just said to masel. I says "That's nae use"; I mean you're no' learning to walk. When you want to walk. Cause I said that the.., the doctor said that I need to see the Physios. The Physios saw me, and they've been at me every day this week.	Analysing and questioning care Jumping the gun
R:	Its sounds as though you didn't like being hoisted?	
P:	Oh well, it's not, it's no' the getting hoisted. You want to walk, that's the thing. The hoisting was awe richt but you want to walk.	Losing function Jumping the gun
R:	And what types of things made a difference to that hoisting experience. Were there good times and bad times....?	
P:	Oh, they were all good times.	
R:	All good times?	
P:	Aye. Oh they watched you. They telt you what tae dae. You had to dae it.	Participating as a partner
R:	So what....? It's ok... So what's the biggest improvement we could make if any to the way you're moved in hospital?	
P:	Well the thing is. See when I got, you get doon and when I feel tired I cannae get the legs up ontae the the bed. Because they are not strong enough, the legs. And eh, eh the Physios said that. "You're bending your legs, you've got to keep your legs straight". I said "That's alricht for you to say". I says "I tried but my leg's	Losing function Using feedback Challenging the carer

<p>P: Och, its nae bother getting moved about. It's just if you don't get the richt, ken, Physio. You lose hert and by God they.., they gie me it. I tell you that I am that tired after they have done with me, I've got to lie doon on ma bed.</p>	<p>Individualising care quality</p> <p>Losing heart</p>
<p>R: What type of feedback did they give you on how you were doing? (pause) What type of feedback did you get on how well you were doing? Did they...?</p>	
<p>P: Oh they telt you were doing alright.</p>	
<p>R: And what difference did that make?</p>	
<p>P: Oh it made a lot of difference. The day she says "You got a hunner oot of hunner". Aye. Oh I was getting battered into it. That was the only thing. Where you're at these things you don't think they are daen ony guid. But they are. (Pause, 7 secs)</p>	<p>Appreciating feedback</p> <p>Using feedback</p> <p>Jumping the gun</p>
<p>R: Oh well. I don't think I have any questions. I'll just switch the tape off.</p>	



Figure 1. Core Category



Figure 2. Sorting the Codes of the Core Category

The pictures illustrate the central category that emerged (figure 1) tentatively named “coping behaviours”. The codes in this category were grouped with related codes (figure 2) before the groups were named as subcategories of the core category.

Appendix 17. Core Category

Analysing	Asserting	Sharing	Surrendering/Suffering
<p>Analysing and questioning care Taking short-cuts Making comparisons Individualising care quality Regaining autonomy regains inhibitions Jumping the gun Labelling the carer Matching or to expectations Ranking care Trusting in carers Enforcing rules Feeling own schemes are subservient Passing judgement on caring Fearing the unknown Identifying needs</p>	<p>Asserting self to gain need Becoming “the expert” Progressing to independence and “normalising” Taking steps to self Adjusting to a new normal Planning a new life Feeling overruled by staff Challenging care Needing control</p>	<p>Using others as proxy Sharing with peers for support (sharing scars) Sharing success Participating as a partner in care Fostering a carer Appreciating feedback Using feedback Expecting consistency from care Celebrating success for esteem Redesigning relationships Seeing care-givers out of roles Mirroring attributes of carers Setting shared goals Making little of much</p>	<p>Appreciating care given Having needs wants thwarted Having schemes thwarted Depending on the attitude of carers Surrendering autonomy for aim Suffering to achieve aim Losing control, care or respect Objectifying as load Depending on the attitude of carers Relying on competence of others Relying on integrity of equipment Conceding to carers Feeling vulnerable to circumstance Losing self -Restrained by needs and ability Detaching from activity Losing heart Losing function</p>

Patient experience of moving and handling: matching care to expectations and the capacity to influence care

Abstract

Aim: The aim of the study is to develop a theory of factors that influence the patient experience of being moved and handled in hospitals.

Background: The implementation of manual handling policy has been publicly criticised in community settings, but there is little knowledge of the in-patient experience. This study sought to discover the in-patient perspective on this aspect of care in hospitals.

Methodology: A constructivist grounded theory approach was employed. Theoretical sampling technique continued until data saturation was reached. Constant comparative analysis was used to produce a theory from categories and themes.

Conduct: Eleven patients from two rehabilitation hospitals participated in semi-structured interviews. Most participants had recent experience of the acute hospital setting.

Findings: Participants did not distinguish moving and handling as a discreet element of care, but rather perceived it as an integral part of care delivery. Participants described how the manner of care delivery was more important than the mechanics. The analysis of data indicated that expectations of care grew through the recovery process and capacity to influence the delivery of care also increased. The emergent theory linked Maslow's 1943 theory of self-actualisation, patients' expectations of care and their capacity to influence care. Capacity to influence care moves through stages; from yielding when physical needs are greatest, to asserting when there is a need for autonomy.

Conclusion: The study theorised that as patients move through stages of recovery, their expectations of care and their capacity to influence care increases. This can provide understanding of patient motivation and opportunity for nurse support.

Keywords: Moving and Lifting Patients, Nursing, Grounded Theory, Patient-Centred Care, Maslow.

Introduction

Most of the research on manual handling in healthcare focusses on manual handling injuries to care staff, mainly epidemiology and interventions for prevention (Kay et al. 2014). This study wished to explore the experience of those being assisted to move in hospitals. There is evidence that patient experience is positively associated with clinical safety and clinical effectiveness (Doyle et al. 2013). In examining the patient experience in this area, we can therefore reflect upon outcome measures in the safety and quality of moving and handling patients.

Literature

A scoping review of the literature was undertaken following the PRISMA-Scr checklist (Tricco et al. 2018). Five databases were searched (CINAHL, Medline, Embase, Cochrane Library and HMIC) using the terms derived by mind-mapping the subject headings: Hospital Patients, Experience, Moving and Handling and Qualitative studies. An initial 85 studies were screened, all papers relating to hospital in-patients' experience of manual handling was included in the final selection. Only seven articles met this criterion. The themes explored were Safety, Comfort, Acceptance of Mechanical Aids, Skills and Knowledge of Caregivers and Person-Centred Care. Recommendations of studies relate to the need for training and skills (McGuire et al. 1996; Kjellberg et al. 2004; Pellino et al. 2006; Alamgir et al. 2009; Coulter Smith et al. 2016), better equipment design (Luz and Echternacht. 2012) and changes in professional practice (McGuire et al. 1996; Ruszala and Musa. 2005).

There are gaps in the literature relating to the patient experience and patients' perceptions regarding moving and handling in hospitals.

The Study

1. Research Question

The main research question was, What is the patient perspective on moving and handling in hospitals? The descriptor 'moving and handling' includes all manual assistance from healthcare staff and use of lifting equipment.

2. Methodology

A constructivist Grounded Theory approach was the route chosen to collect and analyse the data. The approach followed Charmaz's (2014) version of Grounded Theory (Glaser and Strauss 1967). Theoretical sampling technique continued until data saturation was reached. Constant comparative analysis was used to produce a theory from categories and themes.

3. Ethics

The research proposal received ethical approval from the University and the Health Research Authority's Integrated Research Application System (Ref:17/YH/0158). The Participant Information Sheet, developed in conjunction with a patient participation forum, was distributed by the direct care team. A tear-off slip was posted by potential participants to indicate interest and provide a 'cooling off' period before consent was sought at interview. Interviewees were not offered a copy of their transcribed interview. This would have meant collecting unnecessary information such as home address.

4. Conduct of the Research

Inclusion criteria for participants were that they had experience of being moved and handled by staff in hospital and had capacity to consent to interview. Additional characteristics were added when emerging categories or theory required investigation (theoretical sampling, for example, a person who required bariatric equipment). Semi-structured interviews used a topic guide developed in consultation with five moving and handling practitioners as field experts. The interviews were transcribed and manually coded. Data were sorted through constant comparative analysis as categories, relationships and theory emerged. Coding and analysis by the lead researcher was reviewed by research supervisors.

5. Quality

Tong et al.'s (2007) 32-point checklist (Coreq) for preparing reports of qualitative studies involving interviews, was referred to in the conduct and writing of this study. The use of field notes, memos and ongoing reflexivity monitored for researcher bias. Reflexivity allows the researcher to self-examine and demonstrate their theory

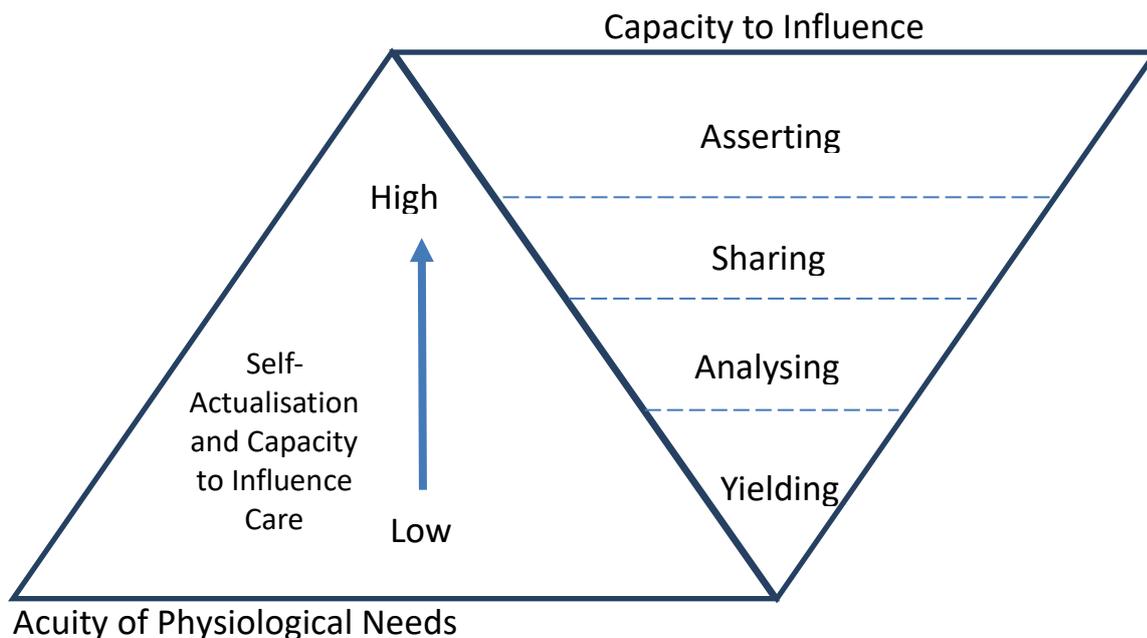
development and the sincerity of their work to others (Mays and Pope 2000; Mruck and Mey 2007).

6. Participants

Interview participants were recruited from two rehabilitation hospitals. The initial patient group reflected those identified by Bell (1984) as most likely to be involved in handling activities, mainly older adults. Eleven hospital in-patients participated in the study (five females, six males). Participants were aged 44-95 and had spent an average (mean) 17.9 weeks in hospital. All bar one of the participants were admitted via one of two large acute hospitals. Reasons for hospital admission included stroke, sepsis, fractures, neurological disorders and physical complications related to morbid obesity.

7. Findings

The participants in this study did not appear to distinguish Moving and Handling as a discreet category of care, but as an integral part of care delivery. The core category that emerged was 'influencing care', participants explained instances when care did not meet their expectations and described behaviours that could influence the delivery of care. The findings were synthesised into an emergent theory of how patients behave to influence care when it does not meet their expectations. It was found that the patients' expectation of care and responses when these are not met, are linked to levels of self-actualisation (Maslow 1943). Maslow considered self-actualised people to have met their basic needs, thus allowing them to grow and fulfil their potential. Figure 1 represents the findings in a diagrammatical format.



(Figure 1. Capacity to Influence Care)

The diagram reflects the interview data analyses indicating that the lower the level of self-actualisation and the greater the basic needs of the patient, the smaller their expectations of care delivery. The greatest need in acute care would be to remain alive. The categories within the diagram indicate patient behaviours that may influence the delivery of care. The less acute the patient's physical needs and the higher their sense of self, the more influence they can apply. Maslow considered self-actualised people to have met their basic needs, thus allowing them to grow and fulfil their potential (Maslow 1970). Properties Maslow described of self-actualisers included being sensitive to dishonesty and the ability to judge people and situations correctly. This growth in awareness seems related to a growth in expectations.

The dotted line between each of the categories indicates that a patient may move between adjacent behaviours or display two concurrently, for example analysing care while sharing an experience with others. Asserting and yielding are opposite ends of the spectrum that are not displayed together. Yielding is not a behaviour purposely exhibited to influence care, but is a behaviour described, for example, by those suffering from extreme trauma or feelings of powerlessness.

The study focussed on moving and handling, but it was participants' expectations of care delivery that gained prominence throughout the interviews. Participants spoke more about the caregivers and their level of performance, than the mechanics of physical transfers. Generally, there did not seem to be a clear distinction for the participants between moving and handling and other factors of care delivered, for example, meeting hygiene needs. The way that they are held and assisted to move forms an integral part of their overall experience of caring, according to the participants' transcripts (P1-P11). Within the first minutes of the first interview, Participant 1 [P1] linked handling to other aspects of care when asked what kind of discussion took place,

“Well they did discuss it with me. They put me onto a hoist then onto a chair ‘n’ back again, ‘n’ then [I had to] get washed in the bed. Ah mean they were great. Told me everything they [were] doing, them turning me and washing me, (chuckles slightly at the memory) feeding me.”

The participants appeared to meld physical handling into the care experience and other fundamentals of care. The following example illustrates P3's response to the question *“What do the words moving and handling mean to you?”*

“It means care and attention to the pa .. to the patient without ehmm, causing any distress in anyway and also, ehmm, I think making sure the patients comfortable with what's happening to them that's what I feel.” [P3]

Near the end of this interview the participant was asked, *“When I am speaking to people... they're finding it difficult to separate moving and handling from just the general treatment in the wards, how do you feel?”*

The participant's answer seems to confirm this,

“Eh, with moving and handling from A to B, from when it happens from when you go into hospital. I find that wonderful, it's very, very good. The day I was brought in I couldn't ask for better treatment I was full of praise for them...”

because I have got to say the nursing care on a whole is very, very good and ...” [P3].

Much of the data appeared to be rating the care given or ranking care delivery, for example ‘good’, ‘great’ or ‘bad’. The environment and equipment were rated for quality and performance, but not as frequently as the interaction with caregivers. The caregivers’ interaction with the participant was the most memorable feature of handling encounters. Initial codes included ‘rating the quality of care’ and ‘rating the skill of caregivers’. It became clearer as the interviews progressed that the participants were not rating in an arbitrary fashion, they were matching care against their own expectations of care. The codes were consolidated into an early category ‘matching care to expectations’. A stronger perception was described and coded as ‘judging caring’. Extracts from interviews are given in Table 1 to provide examples.

Table 1. Care Delivery

Code	Comment
Matching care to expectations	<p><i>“It [was] a great team that worked with me down there.” [P1]</i></p> <p><i>“they’ve improved tremendously over the last few days even.” [P2]</i></p> <p><i>“I mean as far as the nurses were concerned my nursing was exemplary.” [P5]</i></p>
Judging caring	<p><i>“and the nurses that talk like that should automatically go to prison.” [P2]</i></p> <p><i>“unforgivable there is no need to say that.” [P3]</i></p> <p><i>“She’s fit for the ... jail to be a warder.” [P8]</i></p>

The stronger aspect of judgement was generally applied to individual nurses rather than groups. Most of the descriptors are positive – but those recounted to the interviewer with most emotion were negative experiences.

“Because I wasn’t approached from a “shall we do this” it was just like, no conversation, “You will do this”. My immediate reaction is “No I’m not” come back in half an hour and don’t treat me like a child. But that is very rare.” [P4].

This last event was described as “very rare”, but the participant revisited it several times in the interview. P3 reflected that *“80 percent of them are really nice”*. This contrasts with negative experiences described by that participant and others in more detail than the positive encounters.

The core category that emerged was ‘influencing care’. In this instance the gerund ‘influencing’ does not imply control over another’s behaviour. ‘Influencing’ in this context refers to an ability to change the way that a person thinks or behaves. The four subcategories that emerged were: Yielding, Analysing, Sharing and Asserting.

Yielding.

Codes that form the category yielding are when participants indicated that they could not or would not influence their care delivery. In the immediate aftermath of trauma or acute illness, some participants had poor recall of how they came to be in hospital. In answering a question on how they were moved matched their ability, they felt that assistance was necessary because they could not move themselves. A code used in some instances was ‘surrendering to circumstance’. The acuity of needs appears to leave little option but to surrender or yield.

Researcher’s Memo dated 22/04/18

Sifting the myriad of codes generated, I’ve been absolutely stunned about how much it related to needs- especially those basic ones. It’s inversely linked to the amount of control a person has. I can’t help thinking of Maslow’s pyramid.

While this insight was generated by researcher experience, the data had provided the direction of thought. Codes like ‘restrained by needs’, ‘losing control’ and ‘surrendering autonomy for aim’ prompted researcher recollection of Maslow’s theory of self-actualisation (Maslow 1943). This theory is most often represented in the form

of a pyramid that progresses through stages from basic physiological needs at the base, progressing through safety needs, social needs and esteem needs to self-actualisation at the pinnacle. The theory has since been expanded, but it was the basic hierarchical structure that came to mind from researcher experience of nursing theory.

An additional part of the insight in the memo was that of an inverse relationship. As analysis progressed it became clearer that the relationship was with the participants' expectations of care. Those in acute trauma with great physical and physiological needs have little expectations of care, for example, being involved with decisions. Loss was a condition that appeared linked to yielding behaviour. Codes relating to this included 'losing function' and 'losing control'. A sudden loss of mobility leads to immediate dependence on others to meet basic needs such as nutrition and hydration. A feeling of hopelessness ('losing heart') can cause a person to surrender and yield to circumstance.

Analysing.

Participants described experience that was coded in terms of making sense of what is happening as they recovered. They described becoming more curious and questioning care delivery. The behaviour is not necessarily an outward display but could be an internal thought process.

"I say to myself, that's [no] way of learning to walk." [P9 on being hoisted].

P9 provided an in-vivo code for this type of internal dialogue *"but see you're jumping; you jump the gun."* 'Jumping the gun' was appropriate to those situations when participants are impatient for recovery and question care delivered. The code could be applied to previous interviews when other participants had described similar thoughts. While patients may yet yield, they have begun to question their care and surroundings. A code 'fearing the unknown' described when participants thought in terms of the future and what that might entail.

Participants made comparisons between their former circumstances and their current condition. They preferred surroundings or equipment like that they were used to,

coded in transcripts as 'matching with mine'. In the analysis of their circumstances they sought to bring order to their new situation. 'Feeling own schemes are subservient' was also expressed in the interview transcripts. Sometimes the participants questioned the role of the ward routine determining when their needs could be met. Timings such as arrival of the meal trolley and the route of the drug trolley influenced when they could get out of bed or receive medication.

Participants observed staff and attached adjectives to carers related to their demeanour and behaviour. 'Labelling the carer' was the code used to describe this, for example, P5 thought that a nurse was 'hormonal' when uncharacteristically abrupt. Characteristics were attached to groups such as younger or older nurses described as being more caring than the other. The label was checked to see if it was applied consistently, was one group perceived more positively by patients? It was not, different participants described different aspects they valued in the care delivery, for example, time spent with them or more experienced nurses. A linked code was 'individualising care quality' when participants reflected that the quality of care related to the individual nurse that delivers it. Labels include "nice", "thorough", "good", "clever", "tomboy", "trouble-maker" and "rude". This helped participants influence their care by deciding who to interact with. P3 choose to be assisted to bed by a "nice nurse" in the early evening, despite knowing she would suffer pain lying too long in bed. In contrast, care from those disliked can be rejected,

"She disnae [doesn't] like me but she tolerates me, she kens noo [knows now]. She'll come in and say "You needing anything or wanting anything?". "No, it's alright. I've got everything I need." [P8].

This was recounted by P8 who also described using Scots words knowing the "young yins" had difficulty in understanding the meaning, she preferred older nurses.

Sharing.

Codes in the sub-category 'Sharing' relate to establishing bonds and using those around to influence care. 'Sharing scars' originated as an in vivo code when a participant did exactly that by lifting clothing during the interview to show evidence of

operations [P1]. The code was applied to transcripts when the participants described sharing their experiences with others. It shows their experience is not unique,

“An’ I thought I’ve been there; I know how that feels.” [P2].

The relationship with nurses appeared to be viewed at a personal level. Participants referred to nurses as “the girls”, “my pal”, “like my daughter” and other similar terms.

“And that’s what this unit is like, a family of cousins coming in and out. And that’s the way the staff seem to give that sort of rapport.” [P5].

The group code assigned was ‘redesigning relationships’, the code does not just apply to the ward ‘family’. Participants’ relationship with their family and friends also changes. Those with dependants are unable to care for them when in hospital and have become the recipients of care themselves. P7 expected the involvement of carers, one of only two participants who expressed a wish for family involvement in physical transfers. His brother had observed physiotherapy with an intention to help with transfers into the car in the future. P7 also described how his young children visited often and had also stayed for physiotherapy sessions,

“They even sat in, watched me walking. I got a boost out of that, they actually helped. They asked one of the physios, asked to help. She was helping doing some things with my fingers and that. So, it’s been a nice eh, experience.”

[P7]

‘Using others as proxy’ described when participants used family and friends to attend to their everyday lives. An example in the hospital environment is when P1 was impatient to get to bed and nurse attention was delayed. P1 co-opted her daughter to deliver assistance. She described the nurses’ confusion when they later found her changed into fresh nightwear and in bed.

When sharing, aspects such as ‘celebrating success’ are seen in the coding of transcripts. Feedback and encouragement on progress become important to the participants, this was discussed more in relation to physiotherapists than nursing staff. ‘Making little of much’ was a code used in relation to participants sharing their experience with humour during interviews. Participants joked about lack of mobility or

likening hoist transfers to fairground rides. They conversed with more fluidity when the tone (if not the content) was lighter during interviews. Participants valued humour and 'banter' in interactions with carers. Sharing humour seemed to level the playing field and facilitate more active participation in choice. 'Participating as a partner in care' was a code describing when patients became more involved in sharing tasks relating to movement and fundamentals of care. Even if only following instructions, such as folding arms to keep them in the sling [P9] or rolling over in bed [P8], it seemed important to do whatever they could to share in the activity.

As recovery progressed participants began to consider social status.

"I felt it was degrading, lifting me up to put me in a chair 'cause I couldn't move ... that really got to me." [P1].

The participant became throaty when recounting her feelings, in contrast to joking earlier about being supported on the bedpan by nurses when she was too ill to move from the bed. The sentiment was repeated by other participants, especially in relation to toilet use. Maslow's esteem needs include achievement, independence, status, self-respect and respect from others. As participants described becoming less acutely unwell and adjusting to circumstance, they began to challenge the delivery of care. The codes that relate to this became categorised as 'Asserting'.

Asserting.

Codes like 'Progressing to independence and normalising', 'taking steps to self' and 'adjusting to a new normal' described the transition from total dependency and a growing sense of self. In relation to manual handling the need to be as independent as circumstance permits was described in terms of reducing dependency on others and mechanical aids. Even when the potential for rehabilitation had been exhausted, participants adjusted.

"It was quite pleasant once you got used to it. Getting wheeled around in the air" [P10 on continuing hoist use].

The fear of the unknown previously described was no longer evident in the transcripts as a sense of self grows. With a growing sense of self, participants described making their wishes known. Some participants described using the logic from their internal analysis to challenge caregivers. P3 asked for assistance to sit up in bed,

“No” she said, “I’ve got a sore arm” she said, and the next time it was a sore back. And I said to her “then why are you at work”? [P3].

This type of description was organised into a group code ‘challenging care’. It was easier for participants to challenge from a position of authority. ‘Becoming the expert’ described the gaining of knowledge and expertise by the participants on their journeys through healthcare. P4 had a chronic condition with much experience of care at home and in hospitals and was a coordinator in the UK Society for her condition. P5 had an encyclopaedic knowledge of drugs prescribed. P11 used a specialised piece of lifting equipment for plus-size patients and would explain the use to nurses unfamiliar with the overhead gantry twin-cassette hoist.

Asserting seemed linked to a wish for control over circumstance. A group of codes was consolidated into ‘needing control’. The most extreme example was P2 whose transcript was coded as ‘craving power’ in sections. He felt that multi-disciplinary meetings should be chaired by him with a “talking stick”. He would use this stick to point to the person allowed to speak. A further proposal by P2 was that, *“..the way to do it is to give patients control of the therapy budget. I would go one further and give them control of how the nurses are paid. Like A, B, C or D gets a wee bonus. But only the patients can contribute to that. That would get them working better”*.

Participants spoke about planning their new life. In most cases, the person leaving hospital is much changed from the person that they were before traumatic events. There is a new dependency on others because of the loss of physical ability. Participants begin to assert themselves in preparation to take control in their new lives.

8. Discussion

The findings of this study were unexpected and contrast with most previous studies on patient experience of moving and handling in hospitals. The literature is largely concerned with the mechanics, skills and techniques of manual handling transfers (McGuire et al. 1996; Alamgir et al. 2004; Kjellberg et al. 2004; Ruzala and Musa 2005; Pellino et al. 2006; Luz and Echternacht 2012; Coulter Smith et al. 2016). Participants themselves focussed on the manner, rather than the mechanics of care delivery and how it matched their expectations. This finding is novel only in relation to moving and handling. There are similar results in the literature on care. Attree (2001) concluded that patients and relatives placed more value on individualised care delivered by caring staff. Attree's finding was in opposition to the prevalent contemporary view (that patients most valued technical aspects) but has since been supported by other reports and studies (Goodrich and Cornwell 2008; Suhonen et al. 2012).

Participants expectations of what good care should be, was similar to what has been described as 'compassionate care'. Durkin et al. (2018) contend that the concept of compassion in care is still poorly defined. The aspects touched upon by participants in this study are outlined in the '6C's of Compassion' (NHS Commissioning Board 2012). The three aspects are Care, Competence and Communication, another 'C' given relevance by participants was 'Celebration' recognised in Dewar's 2011 model of compassionate relationship centred care. A lack of compassionate care has been associated with poor patient experience and health outcomes. Francis (2010) in an inquiry on poor care standards notes, "On occasion, patients were handled and moved in ways that caused pain and distress without any evidence of a sympathetic approach" (p.109). This indicates that similar patient experiences could be found elsewhere. Negativity dominance (Khaneman 2011) was seen in participants' recollections. Baumeister et al. (2001) contend that "bad is stronger than good" in its effect on our experience of events or interactions. They argue that it makes evolutionary sense to remember and subsequently avoid 'bad' things. Negative emotions also enhance memory retention making it easier to recall such experiences (Kensinger 2007).

The Code for UK nurse conduct (Nursing and Midwifery Council 2018) defines physical handling as a fundamental of care. Feo et al.'s (2018) review found an overlap in the use of the terms 'compassionate care' and 'fundamentals of care' in the literature, but only 'fundamentals of care' were linked to the physical needs of patients. Assisting the patients' movement is a pre-cursor of meeting all the physical needs of a person who is unable to move themselves, for example, personal hygiene. Participants in the study did not confuse moving and handling with other aspects of care, but rather recognised its essential nature in meeting all their basic care needs.

The theory developed links to Maslow's theory of self-actualisation (1943). Maslow is widely used in relation to workforce motivation but has also been applied in nursing and healthcare (Jackson et al. 2014; Shih et al. 2019). Jackson et. al (2014) describe the lower levels of needs in Maslow's hierarchy as "survivorship" in relation to patients of the Intensive Care Unit. The concept of survivorship supports that patients focus on staying alive and yield to circumstance. There has been criticism of Maslow's theory (Kaur 2013). Cases can be found that illustrate divergence from Maslow, such as starving families sharing love. Harvarth (2008) feels in nursing that this relates particularly to older adults who may choose autonomy over safety. Examples she gives include living alone despite a history of falls and eating textured food despite dysphagia.

When participants' basic needs for physiological stability and safety were met, participants addressed their emotional and social needs through others. New et al. (2019) suggest that patients felt 'taken care of' when physical needs are met, and 'cared for' when emotional needs are met. The longer length of time spent in the company of nurses may assist in forming inter-personal bonds (Forchuck 1995). An older patient group also may be predisposed to seeking bonds with others. Musich et al. (2015) describe that up to 60 percent of older, sicker adults also suffer from loneliness. Hill et al. (2013) found familiarity is not an essential pre-requisite of psychological support, but the bonds formed seemed to help participants in this study to share and to meet social needs. Participants used humour in interactions, Schopf et al. (2017) describe this as most often initiated by patients and used to protect

relationships. Nurses share the opinion that humour contributes to a positive perception of care (Costello 2017).

The needs described as higher level by Maslow such as respect, esteem and status, appeared to grow when participants had addressed social needs. Pullman (1999) describes a difference between 'basic dignity' that should be afforded to everyone and 'personal dignity', the latter is a social construct and linked to self-esteem and autonomy. Basic dignity can be linked to human rights, while participants may have felt undignified when others attend to hygiene needs, there was no obvious breach of this right. In the clinical setting, autonomy has been linked to being informed and involved in decisions about clinical care (Scott et al. 2003; Entwistle et al. 2010). This involvement was often not possible for those participants with the greatest physiological needs, those addressing esteem needs expected it.

9. Limitations and further research

Transferability of the findings may be limited due to the one geographical area used and the small sample size of the study. However, large numbers of cases are not always necessary to reach saturation of data in studies of this type (Guest et al. 2006; Hagaman and Wutich 2017).

The use of a group of patients who require moving and handling assistance may provide a unique insight into aspect of care and how it is perceived by this patient group. Only one patient required bariatric lifting equipment, research into the experience of plus size patients may warrant further study.

Bell (1984) found that patients being 'lifted' accounted for 28 percent of the in-patients studied. The percentage is likely to have risen, given that the population are living for longer with multiple comorbidities since Bell's report. Therefore, it could be suggested that the expectations and needs of this patient group may form a larger proportion of in-hospital population than ever before. Further research is required to understand the expectations and needs of patients who require to be moved and handled in hospitals.

10. Implications for Nursing Practice.

Participants saw moving and handling as an integral part of their care and an essential adjunct to meeting physical needs. Understanding that recovery increases expectations of care and that patients move through stages in their capacity to influence the delivery of care provides opportunity for nurse support. Nurses describing the reason for interventions as they deliver them, can help patients to understand and transition from 'yielding' through 'analysing' to 'sharing'. Routine information is most important when the patient is analysing and adjusting to their new situation. If a patient unexpectedly expresses a dislike for something that has been an aspect of their routine since admission, the knowledge that it is only now that they feel comfortable to share the dislike, may increase acceptance of their viewpoint.