HOSPITAL TO HOME: PERCEIVED NEED FOR CARE AND SUPPORT

By

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Abstract

Falls are a major health problem for older women. In British Columbia, women aged 75 years and older comprise 85% of the total number of individuals admitted to hospital with a fall. Falls result in physical and psychological consequences.

A review of the literature indicates that most studies on falls are epidemiological in nature. There are no studies that deal with the consequences of the fall and their effect on the older woman's perceptions of her need for care and support after hospitalization for a fall.

The purpose of this study is to describe the need for care and support as perceived by women aged 75 years and older returning home to live alone after a hospitalization for a fall. Phenomenology is the chosen research method. This method describes human experience as it is lived.

Subjects were recruited through the liaison nurses and home care coordinators from the Health Department. Eight women participated in the repeated interviews guided by trigger questions. Certain themes emerged from data analysis and were coded accordingly. These themes were verified, validated, and/or discounted in subsequent interviews.

The findings indicated that the elderly women perceived the fall as both a significant and unpredictable event in their life. It resulted in a change of routine as they
returned home to live alone. In response to this change, the women described threats to their self-esteem, particularly to their feelings of independence, activity, and autonomy. A variety of behaviours were used to cope with the threats to their self-esteem. Use of social support was one behaviour used by all the women. In describing this behaviour, reciprocity was important in the friendships of elderly women. This study also concluded that there were numerous difficulties in using social supports from a formal program. The implications for nursing research, practice, and education were discussed in light of these findings.
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CHAPTER ONE: INTRODUCTION

Introduction

Falls are a major health problem for older women. In 1984-85 in British Columbia, women aged 75 years and older comprised 85% of the total number of individuals admitted to hospital with a fall (Statistics Canada, 1989). Falling and the resultant injuries are the sixth leading cause of death among elderly individuals (Tinetti, Speechley, & Ginter, 1988). Those older women who survive falls may experience physical and psychological consequences (Hindmarsh & Estes, 1989).

Kleinman's (1978) Health Care Systems Model contains three structural arenas in which "sickness is experienced and reacted to" (p. 86). Explanatory models (EMs) can be elicited from practitioners, patients, and family members for sickness episodes in the three arenas.

An explanatory model for an elderly woman's fall will interpret the resultant physical and/or psychological consequences. As well, it will explain her perceived need for care and support when she returns home from the hospital to live alone. Therefore, in order to ensure continuity of care from hospital to home, nurses must become familiar with the elderly woman's explanatory model for a fall. An understanding of this model will help to ensure that these
women's needs for care and support are met within the community setting.

Background to the Problem

Women who are 65 years of age and older are the fastest-growing segment of the elderly population (Fletcher & Stone, 1982; Robinson, 1986). Some 1.2 million Canadian women were aged 65 years and older in 1978 (Fletcher & Stone, 1982). The latest projections from Statistics Canada suggest that by 2001, more than two million women will be aged 65 years and older. Some projections envisage that 7 to 8% of the population will be women who are aged 75 years and older by 2021.

A significant problem for persons of either sex, aged 65 years and older living in the community, is the occurrence of a fall. It is reported that the annual incidence of falls among the elderly living in the community increases from 25% at 70 years of age to 35% after 75 years of age (Tinetti & Speechley, 1989). In particular, women fall more often than men until the age of 75 years, after which the frequency is similar in both sexes (Nelson & Amin, 1990).

According to the International Classification of Diseases (1989), an accidental fall includes falls on or from stairs, on or from ladders, from a building or other structure, into holes or other openings in a surface, and from one level to another. As well, falls from slipping,
tripping, or stumbling, from collision, pushing, or shoving by or with another person, and from unspecified fractures are included in the classification. In Canada, between 1984 and 1985, 40,311 individuals were admitted to hospital with a diagnosis of an accidental fall (Statistics Canada, 1989). Included in this national statistic were 4,383 individuals living in British Columbia.

Statistics substantiated that falls were a significant problem for older women (Statistics Canada, 1989). It was noted that 24,235 individuals from the national figure or 60% were women aged 75 years or older. Women in this age bracket were more prominent in the British Columbia statistics. Here, they comprised nearly 85% or 3,716 individuals.

Falls in the elderly are due to physiological changes associated with aging, underlying physical illnesses, medications, and environmental hazards (Nelson & Amin, 1990; Schulman & Acquaviva, 1987). With many falls, these factors may be interacting with each other.

The elderly are not only at an increased risk of death from a fall, but are likely to suffer more severe nonfatal injuries from a fall than younger persons (DeVito, et al., 1988). Falls have physical and psychological consequences for the elderly. It is reported that 50% of elderly patients hospitalized for a fall injury will not survive another year (Nelson & Amin, 1990). Falls also produce a lack of
confidence and a fear of further injury which may limit mobility and independence (Hindmarsh & Estes, 1989). This diminished activity may result in further social isolation and physical decline (Nelson & Amin, 1990).

As well, these women may be returning home to live alone. It is reported that in Canada, between 1961 and 1976, there was a three-fold increase in women aged 65 years and older who live alone (Fletcher & Stone, 1982). There are several factors that have contributed to the recent rapid increase in the number and proportion of older women living alone. Significant factors are the longer life expectancy for women compared to men, the increase in the number of older widowed women, the absence of children available for family living arrangements, and the desire for independence (Fletcher & Stone, 1982; Robinson, 1986; Schank & Lough, 1990). Living alone has also become more socially acceptable during the last two decades (Fletcher & Stone, 1982).

Women who are 75 years of age and older may also experience deficits in their informal support networks (Auslander & Litwin, 1990). Informal support networks may include nuclear family members, other relatives, friends, and neighbours (Auslander & Litwin, 1990). The deficits may be due to death of the members, reduced mobility among the members, and reduced reciprocity on the part of the aged women.
In conclusion, falls are a significant problem for women aged 75 years and older. Trends indicate that many of these women live alone and have insufficient informal support networks. The physical and psychological consequences of falls have been well-documented in the literature. Yet, little is known about the effect of these consequences on elderly women and their perceived need for care and support as they return home after a hospitalization for a fall.

Theoretical Framework

The theoretical framework is useful for the study purpose and provides direction for the study design (Woods & Catanzaro, 1988). The theoretical framework chosen for this proposed study is Kleinman's (1978) Health Care System Model. This Model is an attempt to understand health, illness, and healing in society as a cultural system.

According to Kleinman (1978), health care systems contain three structural arenas in which "sickness is experienced and reacted to" (p. 86). The popular arena is composed of the family context of sickness and care, as well as the social network and community activities. The professional arena is composed of nursing, medicine, and other health professionals. The folk arena consists of non-professional healing specialists. The two most important arenas for this study will be the professional and popular arenas.
According to Kleinman (1978), EMs can be elicited from practitioners, patients, and family members for particular sickness episodes. EMs contain "explanation of any or all of five issues: etiology; onset of symptoms, pathophysiology; course of sickness (severity and type of sick role); and treatment" (Kleinman, 1978, p. 88). Individuals use EMs to interpret illness.

The EMs of professionals are most likely to denote the disease aspects of sickness. In this model, "disease denotes a malfunctioning in or maladaptation of biological and/or psychological processes" (Kleinman, 1978, p. 88). For falls, this includes the causes, risk factors, resulting physical and psychological consequences, and prevention.

In contrast, the EMs of the popular arena are more likely to include the experience of the illness event. Here, the EMs are "most frequently articulated in a highly personal, non-technical, concrete idiom concerned with the life problems that result from sickness" (Kleinman, 1978, p. 88). Elderly women will interpret the physical and/or psychological consequences of a fall as part of their explanatory model. As well, the consequences of a fall will affect these women's perceptions of the need for care and support as they return home from the hospital to live alone. These perceptions will also be included as part of the elderly women's explanatory models for falls.
Statement of the Problem

Falls are a significant problem that may result in a hospitalization or treatment in an Emergency Department for women aged 75 years and older. These women constitute the fastest growing segment of the elderly Canadian population. Once discharged from the hospital, these women may return home to live alone. As well, they may have insufficient informal support networks in the community. Falls have physical and psychological consequences for elderly women. Yet, little is known about the effects of these consequences on the elderly women's perceived need for care and support as they return home to live alone after a hospitalization for a fall.

Purpose

The purpose of this study is to describe the need for care and support as perceived by women aged 75 years and older returning home to live alone after a hospitalization for a fall.

Research Question

The purpose of this study is to answer the overall question: What is the need for care and support as perceived by elderly women returning home to live alone after a hospitalization for a fall?
Significance for the Profession

This study has practical significance for nurses working with elderly women who suffer a fall, which results in a hospitalization. This study also has value in that it is an attempt to describe the perceived need for care and support from the elderly woman's perspective as she returns home from a hospitalization for a fall. This information may be used in the planning of community services. After all, the expectations of those who use community services should be considered. As a result, the gap will be reduced between service needs and service availability.

Definition of Terms

Fall. An untoward event in which the individual comes to rest unintentionally on the ground (Morris & Isaacs, 1980).

Hospitalization. An admission to a hospital facility as an inpatient, or medical assessment and treatment in an Emergency or Outpatient Department.

Introduction to the Methodology

Phenomenology is the proposed research design for this study. Giorgi (1986) states that phenomenology devotes itself to the study of how things appear or are given in experience. Oiler (1982) states that it is a research method in which the aim is to describe experience as it is lived. Our access to experience is perception. Perception is being
Phenomenology is an inductive, descriptive, research method and is particularly appropriate for nursing research where the goal is to understand human experience. Therefore, the approach is appropriate for this study, since the purpose is to understand the perceived need for care and support from the elderly woman's perspective after she returns home from a hospitalization for a fall.

In phenomenology, the researcher enters into the world of those people whose experience is under study (Oiler, 1982). As a result, the researcher becomes immersed in the subjects' experiences before attempting to interpret them. In order to control bias in the reflection of lived experience, the researcher brackets or holds back one's previous knowledge or experience. The result is the generation of hypotheses rather than hypothesis testing (Knaack, 1984). The researcher's interview technique must evoke description from the subjects without telling them what to say (Knaack, 1984). Therefore, the use of open-ended questions provides the opportunity of exploring the depths of the subject's experience (Woods & Catanzaro, 1988).

**Assumptions**

1. The elderly women participating in this study will be articulate in expressing their perceived need for care and
support.

2. A fall may result in physical and/or psychological consequences which affect the individual's perceptions of the need for care and support, once discharged from the hospital.

3. Elderly women use explanatory models to interpret illness events. The elderly woman's explanatory model for a fall event will contain an interpretation of the physical and/or psychological consequences and the perceived need for care and support.

Limitations

1. The perceived need for care and support may be influenced by the extent of the elderly woman's awareness of available resources.

Summary

In conclusion, falls remain a major health problem for older women. In Chapter One, a background to this problem is provided and, therefore, explains the need for the proposed study. As already discussed, there is a paucity of information that deals with the elderly woman's need for care and support as she returns home alone after hospitalization for a fall. The problem statement, purpose, and research question for this study are stated in this first chapter. As well, an explanation of the theoretical framework that guides the study is outlined. A definition of terms and a statement of both the assumptions and limitations are also included in
this chapter. A brief introduction to the methodology is also included in this first chapter. Subsequent chapters focus on the critical review of the literature and a more detailed explanation of the methodology for the study. In Chapter Four, the findings and interpretation of the data are presented. A discussion of the findings is presented in Chapter Five. Finally, Chapter Six includes a summary, conclusion, and implications for nursing.
CHAPTER TWO: CRITICAL REVIEW OF THE LITERATURE

Introduction

The following review of the literature includes both research and theoretical readings. The first section deals with studies that focus on falls. This review identifies what is known about falls. It includes topics such as causes of falls in the elderly, associated risk factors, physical and psychological consequences, and fall prevention. This explains the health professionals' explanatory models related to falls.

The second section deals with studies that focus on social support networks. This review provides information that discusses the social reality of living alone. Deficits in informal support networks and living alone are important variables that may influence the elderly woman's perceptions of the need for care and support as part of her explanatory model for a fall event.

The third section deals with research on discharge planning and perceived needs for care and support. This reviews the current research on perceived needs for care and support.

Falls

The causes of falls in the elderly can be classified as extrinsic and intrinsic. Extrinsic factors are medications
and environmental hazards that produce the opportunity for a fall to occur. Medications such as phenothiazines, benzodiazepines, and tricyclic antidepressants are associated with falling independently of other risk factors (Nelson & Amin, 1990; Tideiksaar, 1986). Environmental hazards include loose rugs, slippery surfaces, objects on floors, poor lighting, low-lying objects such as toys or pets, low beds and toilet seats, poorly-maintained walking aids, lack of handrails on stairs, badly repaired steps, ill-fitting footwear, unlaced shoes, high heels, and slippers without soles (Nelson & Amin, 1990; Tinetti & Speechley, 1989). It is interesting to note that the environment-related factors account for 30 to 50% of reported falls (Nelson & Amin, 1990). However, it is thought that many falls attributed to accidents really stem from an interaction between identifiable environmental hazards, medications, and increased individual susceptibility to hazards from the accumulated effects of age and disease.

Intrinsic factors are age- and disease-related changes within the individual that increase the likelihood of falls. Intrinsic causes include visual and hearing impairments, neurologic and musculoskeletal disabilities, dementia, age-related changes in gait and musculature, and postural hypotension (Nelson & Amin, 1990).

Factors associated with a risk of falling are increased
age, female sex, the presence of more than one disease, polypharmacy, changes in gait and/or visual perception, sway, decreased mobility, confinement to the home, dementia, depression, acute illness, and a history of falling (Hindmarsh & Estes, 1989).

The most common physical consequence of a fall is a fractured hip (Reinhard, 1988). This type of fracture is referred to as the "widow's disease" since 75% of the clients with hip fracture are female, often widowed and living alone prior to the fall event. Statistics from the United States suggest that the annual incidence of hip fractures will increase from the present figure of 200,000 fractures to 330,000 over the next 15 years.

The most common psychological consequence following a fall is an individual's fear over falling again (Tideiksaar, 1986). It is reported that an elderly person who falls may become fearful of going outdoors, of becoming helpless, and of incurring serious injury and subsequent hospitalization. Serious injury may lead to the development of immobility with the eventual loss of functional independence. Immobility may lead to loss of muscle strength, contractures, inability to perform the activities of daily living, pressure sores and depression.

Factors involved in prevention are assessment of the individuals' intrinsic risk factors, balance and gait,
environmental safety, and the history of previous falls (Tinetti & Speechley, 1989). After the assessment, preventative measures should be implemented for individuals with a high risk of falling.

In reviewing the literature, two prospective studies on falls were found that dealt with community-based elderly (Campbell, Borrie, & Spears, 1989; Tinetti, Speechley, & Ginter, 1989). The first study (Campbell et al., 1989) reviewed risk factors that contributed to falls. This study indicated that this information is necessary to improve individual patient management and for the development of a public health prevention program. According to the theoretical framework, this study provided further information for the explanatory model in the professional arena on falls for both men and women.

In the study, the sample consisted of 761 subjects who were 70 years of age and older. The results indicated that 39.6% of women and 28.4% of men experienced at least one fall. In women, 84% of the falls were due strictly to intrinsic factors. For men, the value was similar in that 83% of the falls were due to intrinsic factors.

As well, the risk factors for women and men were different in relation to falls. In women, the risk factors were the total number of drugs, psychotropic drugs, and drugs liable to cause postural hypotension (standing systolic blood
pressure of less than 110 mmHg), and the evidence of muscle weakness. In men, decreased levels of physical activity, stroke, arthritis of the knees, impairment of gait, and increased body sway were associated with an increased risk of falls.

In analyzing this study, the sampling strategy was not discussed. The sample consisted of individuals living in the community and residential homes. The data from the individuals in the residential homes may have biased the data. These individuals may have had more age- and disease-related changes, resulting in institutionalization. These changes may have also predisposed them to an increased incidence of falls, compared to the community sample. As well, the falls in the facility may have been accurately recorded compared to the community sample where self-reporting was used. For example, Campbell et al. (1989) reported that men, in particular, were reluctant to admit having fallen and knowledge of a fall was gained from the man's wife or other observer. Self-reporting was then another limitation of the study.

The second study (Tinetti et al., 1988) used a sample of 336 individuals who were 75 years of age or over, living in the community. This study also reviewed risk-factors and stressed that a simple, clinical assessment could identify the elderly persons who are at the greatest risk of falling.
Similar to this first study (Campbell et al., 1989), it was concluded that research on risk factors resulted in preventive strategies.

This second study reported that 32% of their sample fell at least once. During the study, it was shown that 26 subjects (24%) who fell had a serious injury from a fall. The category of serious injury was not clearly defined in the study.

This study briefly addressed fear of falling, a psychological consequence of a fall. Fifty-two of the 108 subjects (48%) who fell reported that they were afraid of falling. Twenty-eight individuals (26%) reported that they had curtailed activities such as shopping or housecleaning, due to fear. Here, fear of falling had an effect on the individual's perceived need for care and support in the community. This is the type of information that pertains to the EMs or interpretation of the illness event.

The results of the study indicated that the risk of falling increased with the number of disabilities. It was noted that medical, surgical, rehabilitative, and environmental interventions may be effective in reducing the prevalence of several risk factors. Once again, the limitation of this study was that it relied on the subjects to remember the fall event. As well, this study was done at the factor isolating level. Even though the study described
the intrinsic, activity, and environmental factors present at the time of the falls, no causal relationships were found.

Cummings, Nevitt, and Kidd (1988) studied the accuracy of histories of falls provided by elderly men and women for specific intervals of time over one year. It was important to review this study since the accuracy of the histories of falls was noted as a limitation for the studies already discussed.

As part of another research project to study risk factors, Cummings et al. (1988) used an intensive system of follow-up on falls. In this study, the participants reported on a weekly basis by mailing in a post card. Each week, the subjects were to report whether a fall had occurred. If a fall was reported, a follow-up visit was made by a public health nurse.

At the end of the study, all participants were interviewed by phone. In this interview, they were asked whether they had fallen during the past 12 months.

During this study, 179 of 325 participants confirmed falls. However, at the end of the study, 23 (13%) did not recall having a fall. One hundred and forty-three participants reported injuries due to a fall. During the study, 18 (13%) participants did not recall having a fall, and 40 (28%) did not recall having any injury as a result of a fall.
As a result, the researchers concluded that elderly subjects do not often recall falls that occurred during specific periods of time. Recent recall (3 months) of falls appeared to be less complete than recall of falls over the previous 12 months. This may be due to the fact that the subjects remembered their enrollment in the study and could remember whether a fall occurred during the initial examination. The 3- and 6-month periods of recall were not marked by such distinct events and, therefore, it may have been difficult for the subjects to recall a fall during these periods. As a result, they concluded that researchers and clinicians should use methods besides long-term recall for ascertaining and counting falls over specific periods of time.

One nursing study (Craven & Bruno, 1986) identified factors indicative of a high risk for falling in a group of ambulatory elderly. This study was also preliminary to developing and testing a teaching protocol designed to prevent falls in the elderly. The factors identified were age, living alone, visual deficits, balance problems, and neurologic problems. The researchers indicated that this set of predictors may be used to identify persons with a need for learning about preventive measures. Craven and Bruno (1986) also discussed the nursing implications of their findings. These implications were not part of the study.
One limitation to this study was that the data collected was based on self-reporting of physical deficits and general health status by participants. The sample technique (convenience) may have influenced self-perception and self-reporting of these deficits. As a result, the findings may have limited generalizability to other elderly populations.

The study's conclusions provide information about risk factors for falls. As mentioned earlier, this is the type of information that belongs to the EMs of professionals. However, this study does consider the EMs of individuals in fall prevention. For example, this study reported that 53 of the 99 participants took no action to prevent falls. The researchers concluded that involving elderly persons in the process of learning to prevent falls through mutual problem-solving was important.

It has already been mentioned that fear of falling was an important psychological consequence resulting from a fall. Tinetti, Richman, and Powell (1990) developed an instrument entitled the Fall Efficacy Scale (FES) to measure fear of falling. The overall purpose of developing this instrument was to determine the extent to which fear of falling exerts an independent effect on functional decline among the elderly.

This instrument was designed to assess the degree of
perceived efficacy (i.e., self-confidence) at avoiding a fall during each of 10 relatively non-hazardous activities of daily living. According to the theoretical framework, the instrument would be measuring fear of falling as part of the individual's EM. In the development of the instrument, health professionals such as physical therapists, occupational therapists, rehabilitation nurses, and physicians were asked to name the 10 most important activities essential to independent living, that while requiring some position change or walking, would be safe and non-hazardous to most elderly persons. A second group of professionals were asked whether they agreed with the choice of activities. The final list of activities was converted into the Fall Efficacy Scale.

Tinetti et al. (1990) stated that the consensus among the therapists, nurses, and physicians concerning the activities in the scale supported the validity of the items. This was the type of information contained in health professionals' EMs on falls.

After the development of the instrument, it underwent two pre-tests. The purpose of the first pre-test was to determine the test-retest reliability of the FES and to examine the spread in responses to individual items. The purpose of the second pre-test was to compare FES scores with self-reported fear of falling and to examine the relationship
between selected subject characteristics and FES scores.

In the first pre-test, the test-retest reliability of the instrument resulted in a Pearson's product-moment correlation of .71. This correlation indicated that the measurements (i.e., scores or responses) changed very little between the test and retest (Woods & Catanzaro, 1988). In addition, a high stability coefficient revealed that the instrument was measuring fear of falling on each occasion. In the second pre-test, it was determined that sex, age, living situation, perceived health status, and depression were not associated with the FES scores in bivariate analysis. The score was also not affected by recent history of a fall. The FES was associated with difficulty getting up after a fall, anxiety trait, general fear score, and several measures of balance and gait. As well, depression was significantly associated with FES scores in multiple regression analysis.

One limitation to this study was that the sample sizes were small. For the first pre-test, the convenience sample consisted of 18 cognitively intact, ambulatory persons over age 65. As a result, there may have been inadequate power to detect associations with FES scores. Six of the individuals in the sample lived in the community, while the remainder lived in intermediary care facilities. As a result, this convenience sample was probably less likely to suffer from
self-imposed activity restrictions than the spectrum of community-living elderly.

Even though further testing of this instrument will be required in the future, it is an attempt to look at this psychological consequence. "If fear of falling proves to be an independent factor in functional decline, and if individuals at risk of developing fear of falling can be identified, then fear of falls efficacy should be a specific target of clinical intervention" (Tinetti et al., 1990, p. 242). This study addressed fear of falling, but Tinetti and colleagues indicate that we still lack information about how this fear may influence the individual's need for care and support in the community.

In summary, the studies on falls were mostly epidemiological in nature. There was a great emphasis on the causes of falls, associated risk factors, and prevention. This is the information that constitutes the EMs health professionals have regarding falls. In fact, the only way the experience of the fall was addressed was through the EMs of health professionals. As well, there were no studies that addressed the physical and/or psychological consequences of falls in terms of their effect on the perceived need for care and support of elderly women returning home alone.

Social Support

Living alone and having insufficient informal support
may be important variables as the elderly women describe their perceptions of the need for care and support as they return home from a hospitalization for a fall. Therefore, it is important to review the literature on social support to increase one's understanding of the social reality of living alone for elderly women.

The term social support not only includes the contacts in a social network, but also "encompasses the emotional support, advice, guidance, and appraisal, as well as the material aid and services that people obtain from their social relationships" (Ell, 1984, p. 134). The two types of social support are informal and formal. Informal support includes nuclear family, friends, neighbours, and other relatives. Formal support is a group that is deliberately organized to deliver a particular type of support (i.e., Meals on Wheels) (Fletcher & Stone, 1982).

In reviewing the literature, it appears that elderly persons draw initially on aid from informal supports followed by additional aid from formal agencies and organizations (O'Brien & Wagner, 1980). Chappell (1985) found that users of home care were more likely to live alone than non-users, confirming the notion that the more isolated receive formal supports. However, Chappell's study was done in a province where there is an explicit policy of home care that considers the informal support from a family prior to providing formal
support. As a result, this finding may have limited generalizability to other samples and their use of formal support in other locations.

Cafferta (1987) studied the relationship between marital status, living arrangements, and the use of health services by elderly persons. Her findings indicate that individuals who live alone are more likely to use services than people who do not live alone. This finding may reflect the presence of gatekeeping behaviour on behalf of family members and friends for those individuals living with others. Gatekeeping refers to the family member's perceptions that seeking formal support for the elderly person is not required at the time. Here, the social network is important in controlling the elderly individual's use of formal supports. Individuals who live alone may not encounter this difficulty in seeking formal supports. The studies (Cafferta, 1987; Chappell, 1985; O'Brien & Wagner, 1980) confirm that living alone is a significant variable and will probably affect the EMs of elderly women in this proposed study.

Auslander and Litwin (1990) attempted to clarify the degree to which formal help seeking may be related to diminished network resources. According to the theoretical framework, this would represent a change in the popular arena. Their findings revealed that individuals applying for formal assistance had smaller networks and felt less loved
and admired by the network members upon whom they could rely.

According to Auslander and Litwin (1990), one limitation to this study was the instrument used to gather data on the social networks. Even though the Norbeck Social Support Questionnaire (NSSQ) has construct and content validity, it has been used primarily with younger populations. In using the instrument with the elderly population, it was questioned as to whether the elderly individuals could differentiate between affective, affirmational, and instrumental aid, the three types of support measured.

In summary, the studies indicated that elderly persons draw initially on aid from informal supports. Individuals who live alone are more likely to be recipients of formal supports. As well, increased age and functional capacity play a role in the use of formal supports (Auslander & Litwin, 1990). These findings are relevant as this writer attempts to describe elderly women's perceptions of the need for care and support as they return home alone after a hospitalization for a fall.

Perceived Need for Care and Support

Besides identifying needs and providing services to meet the needs from the health professionals' perspective or arena, it is imperative that the elderly participate in the assessment of needs, setting of priorities, and evaluation of outcomes (Canadian Medical Association, 1987; Hauser, 1987;
National Advisory Council on Aging, 1981). As well, attempts must be made to address individual client's explanatory models which contain interpretations of the perceived need for care and support in the community. This section of the literature review will deal with perceived needs for care and support as they relate to service utilization and discharge planning.

The area of service utilization will be addressed first. According to Coulton and Frost (1982), need factors are a criterion for service utilization. These factors comprise both subjective perceptions (self-assessed) and objective judgements (professionally evaluated). According to the theoretical framework, need factors would involve both professional and popular EMSs.

In many situations, health professionals structure services on the basis of a hypothetical target population rather than on the basis of self-reported need by elderly service recipients (Connidis, 1985; Wilson & Netting, 1987). "It is often the case that program or agency funding is reliant upon demonstrated need based upon case load" (Connidis, 1985, p. 4). As a result, agencies have a vested interest in documenting a high demand for their services. Using Kleinman's theoretical framework, services are then based on the EMSs of professionals rather than the EMSs of individuals within the popular arena.
In one study (Wilson & Netting, 1987), there was a high degree of incongruence between the perception of needs of the elderly and those of the professionals. One specific finding indicated that the elderly underestimated their physical disabilities in contrast to health professionals who overestimated them. Overall, Wilson and Netting concluded that health professionals were not good predictors of the health status or needs of the elderly.

Starrett (1986), in his study, also concluded that a gap existed between the demand for services by the elderly and the evaluation of needs by the "expert" professional. As well, this study concluded that future program development in the area of home care should consider programs that deal with sociopsychological variables (i.e., counselling, caregiver support.) At the present time, the providers of home care consider the traditional health and rehabilitation factors only, in both Canada and the United States. The studies (Connidis, 1985; Starrett, 1986; Wilson & Netting, 1987) lend strong support to the thought that the elderly's perceptions of their health care needs may not always be congruent with the professionals completing the assessment.

Several studies (Harding & Modell, 1989; Naylor, 1990; Schaefer, Anderson, & Simms, 1990; Victor & Vetter, 1988) deal with the process of discharge planning in the hospital for elderly individuals. This is important because
discharge planning in the hospital is often the first professional contact to assess the person's need for care and support after discharge from the hospital. Here, again, the EMs of the professionals may not be congruent with the EMs of individuals.

The first study (Harding & Modell, 1989) described the elderly individual's experience of discharge from hospital. A questionnaire was developed and pilot tested prior to beginning the study. One hundred and fifteen people were interviewed within four weeks of their discharge from hospital. The individuals had been hospitalized for a variety of medical reasons. The results indicated that 38 individuals (33%) were not visited by family, friends, or neighbours. Sixteen of the 38 individuals (42%) felt that they had required more help at home than was provided. Of the remaining 77 individuals who were visited by family, friends, neighbours, and/or professionals, 14 individuals (18%) felt that they had required more help at home than was provided. Although this study did not address any specific needs for care and support, it stressed the importance of elderly individuals receiving help appropriate to their perceived needs at the time of discharge from hospital.

Victor and Vetter's (1988) descriptive study involved a random sample of 2,711 participants who were 65 years of age and older. Three months after discharge from hospital, a
questionnaire was mailed to all participants. The questionnaire was tested for test/retest reliability. No specific testing for validity was mentioned. The study concluded that 50% of the sample was discharged home without any discussion of their care needs at home. This is an interesting point and has relevance as one does research with elderly females returning home from hospital.

Schaefer et al. (1990) studied the perceptions of readiness for discharge and the need for family and community resources at home among persons aged 65 years and older. A questionnaire served as the data collection instrument. The reliability and validity of the questionnaire were not discussed. The results indicated that post discharge needs for assistance included bathing, medications, housekeeping, shopping, meal preparation, transportation, and wound care. The study's results have limited generalizability to other elderly populations, due to sample size and the fact that the majority of the sample were married.

As well, the literature indicates that it may be difficult to address perceptions with a questionnaire format (Connidis, 1985). A questionnaire is considered an appropriate data collection method for quantitative studies. Since perception is being there to see, to hear, to experience, and to know, it is best addressed through a qualitative research design such as phenomenology (Munhall &
Oiler, 1986). As a result, the questionnaire addressed self-assessed needs rather than perceived needs. Despite this limitation, Schaefer's (1990) study was an attempt to look at areas where people require assistance after discharge from the hospital.

In conclusion, a recurrent theme throughout the literature is that health professionals must start to document the perceived need for care and support of elderly individuals returning home from hospital. The literature review indicates that the individuals' perceived need for care and support is not only misunderstood, but, in many situations, their perceptions are not even addressed. As a result, the proposed research remains relevant and necessary since it will describe the perceived need for care and support of elderly women returning home alone after hospitalization for a fall.

Summary

Chapter Two has provided a literature review on falls, social support, and the perceived need for care and support. The review presented the current theoretical and research findings in all three areas. As already mentioned, there were no studies that addressed how the psychological and/or physical consequences of a fall may affect an older woman's perceptions of the need for care and support after hospitalization for a fall. As well, the importance of
living alone was stressed as these women draw on aid from both informal and formal support networks as they attempt to meet their need for care and support in the home setting. In addition, the review indicated that an individual's need for care and support is not only misunderstood but, in many situations, the need is not even addressed as they leave the hospital setting to return home. The next chapter will present a discussion of the methodology for the proposed research.
CHAPTER THREE: METHODOLOGY

Introduction

In this third chapter, the methodology of the study is discussed. Phenomenology has already been briefly described in Chapter One. Due to its difference from the quantitative research method, the first section of this chapter addresses the methodological issues. The ethical considerations of the proposed study are then addressed. This is followed by the discussion on the selection of participants. This discussion includes the selection criteria, recruitment procedures, and the characteristics of the participants. Lastly, the data collection and data analysis processes are discussed.

Methodological Issues

Phenomenology is a qualitative research method. As well, it is considered to be both a philosophy and an approach. The goal of phenomenological research is to understand human experience from the individual's perspective.

The criteria for evaluating qualitative research will be reviewed. These criteria consist of the following: (a) truth value, (b) applicability, (c) consistency, and (d) neutrality.
Truth Value

"The truth value of a qualitative investigation generally resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects, rather than in the verification of a priori conceptions of these experiences" (Sandelowski, 1986, p. 30). This is different from quantitative research where the truth value, typically called internal validity, depends on the degree of similarity between the study data and the phenomena to which they relate (Guba & Lincoln, 1981).

Therefore, Guba and Lincoln (1981) suggest that credibility rather than internal validity be the criterion by which the truth value of qualitative research is evaluated. As a result, the qualitative researcher is most concerned with testing the credibility of findings and interpretations with the various sources from which the data are drawn.

Applicability

The second criterion is applicability which refers to fittingness in the qualitative study and external validity in the quantitative study (Guba & Lincoln, 1981). Fittingness is when the findings of the study, "whether in the form of description, explanation, or theory, 'fit' the data from which they are derived" (Sandelowski, 1986, p. 32). In quantitative studies, external validity refers to the
generalizability of findings and the representativeness of subjects, tests and conditions for testing (Sandelowski, 1986).

At issue for this criterion are the techniques used for sampling to ensure representativeness and generalizability (Sandelowski, 1986). In qualitative studies, the sample sizes are smaller due to the length of the data-gathering interviews and the detail of the complete description (Omery, 1983; Sandelowski, 1986). As well, subjects are chosen for the study because they have lived the experience the investigator is researching. Sample sizes are not predetermined because there may be further selection of participants, depending on the findings that emerge throughout the study. The sample size is considered to be representative if subjects in the sample belong to the group who have lived the experience. As well, representativeness refers to the data rather than the subjects or settings.

In contrast, the sampling techniques in quantitative studies include random selection and assignment of participants to experimental and control groups. As well, sample sizes are predetermined prior to beginning data collection.

Consistency

The third criterion is consistency which pertains to auditability in qualitative studies and reliability in
quantitative studies (Guba & Lincoln, 1981). Qualitative research emphasizes the "uniqueness of human situations and the importance of experiences that are not necessarily accessible to validation through the senses" (Sandelowski, 1986, p. 33). Therefore, auditability is the criterion that should be used with qualitative research. A study and its findings are auditable when another researcher is able to follow the progression of events in the study and understand their logic. Another term for this is the decision trail or audit trail (Guba & Lincoln, 1981).

Reliability in quantitative research rests on the assumption that the same data will be collected each time in repeated observations of the same phenomena and that there is an observable regularity about human experience that is a function of the experience not as a result of the testing procedure (Babbie, 1986; Sandelowski, 1986).

Neutrality

The last factor is neutrality which refers to confirmability in qualitative studies and objectivity in quantitative research. Confirmability in qualitative studies is established when auditability, truth value, and applicability are present in the study. In contrast, objectivity in quantitative studies is achieved when reliability and validity are established (Sandelowski, 1986). It should be noted that Sandelowski (1986) notes two
biases in qualitative research. They are the "elite bias" and "holistic fallacy." The elite bias must be recognized in qualitative studies in that the subjects who participate in the study are "frequently the most articulate, accessible, high-status members of their group" (Sandelowski, 1986, p. 32). The holistic fallacy refers to the tendency to make the data look more patterned or congruent than they are. As a result, the study's conclusions are presented as representing all the data.

Procedure for Protection of Human Rights

The approval of the UBC Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects was obtained prior to data collection. The standards, as approved by the committee, were followed throughout the study.

All participants were asked to sign a consent form (see Appendix A) to ensure protection of their human rights. In securing consent, each participant received a verbal and written explanation of the purpose of the study, the nature of their requested involvement, the amount of time required, and the means of ensuring confidentiality (see Appendix B). The participants were also advised that they were free to withdraw from the study at any time without compromising their rights for any type of service.

The taped interviews were coded so that the
confidentiality of the subjects was ensured. The data was not shared with anyone else besides the thesis committee members. As well, there was no mention of any names in discussing the data with the thesis committee members. In writing the thesis, there was no information reported that could identify the subjects. All tapes were erased once the thesis was completed.

Selection of Participants

Selection Criteria

The subjects were chosen for the study because they lived the experience the investigator was researching. The criteria for selection described each individual in the following manner:

1. Female, 75 years of age or older, and have experienced a fall which results in a hospitalization or treatment in an Emergency and/or Outpatient Department.

2. Living alone in a house or apartment which is not part of a care facility.

3. Able to converse fluently in English.

4. Living in the City of Vancouver.

5. Alert and orientated to time, person, and place with no significant cognitive impairment prior to admission or following discharge from hospital.

Recruitment Procedure

A specific procedure to acquire participants was planned
and followed. Approval for the research was obtained from The University of British Columbia (UBC) Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects. At the same time, the Executive Officer for Nursing with the Vancouver Health Department was contacted to obtain permission for the study. As well, the Director of Nursing for the Short Term Assessment and Treatment (STAT) Unit at Mount Saint Joseph (MSJ) was contacted to obtain this agency's permission to recruit subjects for the study.

Participants were recruited from the community health liaison nurses (CHLN) who function as discharge planners at Vancouver hospitals. Participants were also recruited through the home care coordinators at the health units operated by the City of Vancouver Health Department. As well, participants were recruited from the head nurse of the STAT unit at MSJ.

The CHLN, home care coordinators, and head nurse were provided with a written description of the purpose of the study and the sample selection criteria. These professionals identified potential subjects for the study. As well, they gave a verbal explanation of the study and provided the individuals with an information letter from this researcher (see Appendix B). These professionals also obtained permission from the individuals for this researcher to contact them.
Characteristics of the Participants

There were eight women who participated in the study. They ranged in age from 75 to 102 years of age. Of the eight individuals who wished to participate in this study, five were referred to this researcher at the time of their discharge from hospital. Three of the five women had sustained hip fractures and were referred from a geriatric rehabilitation unit within an acute care facility. One woman who sustained injuries to her lower back was referred to this researcher after treatment at a hospital Emergency Department. The last woman was referred upon her discharge from a surgical ward in an acute care facility. In her fall, she sustained extensive lacerations to both lower legs that required skin grafting.

The remaining three women were referred from the community. Two of the three women were referred by the home care staff visiting them. One woman fractured her wrist. The other woman sustained lacerations to her face. The last woman was referred by the nurse assessor at the STAT unit. She was being screened for attendance at the Day Hospital. Even though she did not have any specific injuries, her falls reoccurred on a frequent basis.

As stated in the criteria for the study, all the women lived alone at home. Seven of the eight women lived in apartment or condominium complexes. The 102-year-old woman
was still living in her own home.

Three of the eight women had experienced previous falls. Two of the three women reported that this was their second fall. The third woman reported that this was her twelfth fall.

Four of the eight women were unable to explain the reason for their fall. One of these women was presently undergoing extensive medical investigations. The other four women identified the reason for their fall. Three of the four women identified an environmental hazard as part of the extrinsic cause for their fall. For example, one woman reported tripping on her bedspread. Another woman tripped on a sweater that was tangled in a chair.

One woman identified an intrinsic cause for her falls. The woman who had fallen twelve times stated that her falls were due to episodes of weakness that were due to a neuromuscular disorder.

Four of the eight women reported that they had children living in the Lower Mainland Area. Three of these four women had phone contact or saw their children on a frequent basis. Two of the eight women reported that their family support consisted of nieces and nephews. The other two women reported no family within the area. Their supports consisted of friends.
Data Collection

Since phenomenology was the chosen research design, the interview was the appropriate process for data collection. This writer actively engaged in the interactive process and thereby entered into the world of those people whose experiences were under study (Oiler, 1982). This allowed this writer to get as close as possible to the subject's experiences before attempting to interpret them.

Effective listening skills were used in the interview technique (Knaack, 1984). "The use of 'bracketing' was part of the effective listening skills. This skill allowed this writer to put aside any preconceived thoughts about the phenomenon being studied" (Oiler, 1982). It allowed information from the experience to be understood precisely as it was presented (Giorgi, 1986). The use of bracketing established the credibility or truth value of the study and, therefore, ensured that the study's findings were representative of the true phenomenon as described by the subjects.

All interviews were conducted by this writer. The interviews ranged from 30 to 60 minutes in length, and were tape-recorded. As well, this writer made some written or field notes. A set of open-ended or trigger questions were used to guide the interview (see Appendix C). These questions helped the writer to avoid putting personal
interpretations on the subjects' statements. However, as the data analysis proceeded, new trigger questions were developed based on the previous data analysis from earlier interviews. Four of eight women participated in second interviews. The purpose of the second interview was to verify with the participants that the meaning of the experience was understood correctly by the researcher (Knaack, 1984). Once again, the interview technique evoked description from the participants without telling them what to say. The verification of the data helped to establish credibility of the study.

**Data Analysis**

The process of data collection occurred simultaneously with data analysis. All taped interviews were transcribed by a typist or this writer. All transcriptions were subsequently checked by the writer by listening to the tapes and reading the text simultaneously. All misconstrued words were then corrected to ensure verbatim accounts of the taped interviews.

Data analysis was done following the steps outlined by Georgi (1985). The first step was to read the entire description to get a sense of the whole. The second step was to read the descriptions more slowly and identify the meaning units or themes. This step also consisted of eliminating redundancies in the units, clarifying or
elaborating the meanings of the remaining units by relating them to each other and to the whole. The meaning units that were constituted by this procedure were viewed as constituents. According to Giorgi (1985), a constituent was determined in such a way that it was context-laden.

The third step was the transformation of the subject's everyday expressions into concepts of science. Here, the transformations took place basically through a process of reflection and imaginative variation. The last step was to integrate and synthesize the insights into an exhaustive description of the phenomena of the perceived need for care and support.

The data analysis in Chapter Four will be articulated by the use of a clear decision trail. This will help to establish auditability of the study.

Summary

This chapter examined the phenomenological research design used for this study. The criteria for evaluating qualitative studies was discussed. The procedure for the protection of Human Rights was presented in this chapter. Following this discussion, the criteria for selection of participants and the recruitment procedure were outlined. This chapter also contained a description of the study's participants. Lastly, the process for the collection and analysis of data was discussed. The next chapter contains the results of the data analysis.
CHAPTER FOUR: DATA ANALYSIS

Introduction

The results of the data analysis are presented in this chapter and discussed in the next chapter, using the relevant theoretical literature and research findings that are currently available.

This chapter provides an indepth exploration of the phenomenon that surfaced during the collection and analysis of the data. It begins with a description of the fall as a significant event, and progresses to a description of the treatment received within the Health Care System. Following this, the changes in routine upon their discharge home are described by the elderly women. This is followed by a description of the threat to their self-esteem as they responded to the changes in their routine. A discussion of how the women coped with the fall and the subsequent threats to their self-esteem concludes this chapter.

Two predominant concepts emerged as the elderly women were asked to describe their experience in relation to their perceived need for care and support as they returned home after hospitalization for a fall.

The first concept was self-esteem. From the analysis and verification of the data, it appeared that the fall and treatment within the Health Care System resulted in physical
and psychological consequences for the women as they returned home. These consequences resulted in a change of routine at home for them. As a result, they viewed themselves differently than they did prior to the fall. The themes of independence, activity, and autonomy were interwoven into the self-esteem concept.

The adaptation process was the second concept that emerged from the analysis of the data from the elderly women. The women talked about behaviours used to cope with the changes in routine once they returned home. This included behaviours used to cope with the perceived threats to their self-esteem. Each woman coped with the situation in her own unique way. However, there were common categories of behaviours used. As well, the two major themes of problem-focused and emotion-focused coping behaviours were identified.

Fall as a Significant Event

The fall was a significant event for all the women in the study. Even though this study did not focus on the experience of a fall, during the course of the interview several women asked if they could describe their fall for this writer. The descriptions of the fall event were rich in detail. For example, some of the details included the time of the event, activities preceding the fall, a description of the fall itself, and sequence of events after the fall. The
following descriptions from four women in the study illustrate these points:

I'd hung up, I was going over to my daughter's for dinner and the dress I was going to wear was a 2-piece dress and the skirt needed pressing and I did that and I wasn't reaching up high just from the handle of that door when I went down.

The second description gives details as to how the incident happened:

I opened the fridge door and got something out and I think it was supposed to be a spring on the door, they close automatically, but this didn't close because there was this square vegetable container sticking out of the bottom shelf so when it went back the next time it wasn't closed. Well, I expected a little resistance so I grabbed to pull, because you've got to sort of yank it, and I just swung back and went down, hit the back of the kitchen cupboards and the counter; I don't know if I hit the counter, I hit the back of the kitchen--then I got to the phone and phoned my friend and she came over.

The next subject described the sequence of events after the fall:

This time this was a terrifying experience, it really was. I never felt so helpless, and I lay there. It happened in the bathroom, you see I had three stitches
in here (points to head). My head must of hit one of the taps, fell, I lay there on the floor, blood and water. How I ever, to this day, how I ever got up, grabbed the rag, wiped my face, picked me up and walked out of the bedroom. I don't know. But I did.

Another woman described the events after the fall:

Well, because I went out the back of the bus one day, and I landed up on the sidewalk. You see, when I get down, I can't get up. So, I'm there on my hands and knees on the sidewalk, and some woman came along and said, "What are you doing down there?" I said, "Well, I fell off the bus, and I can't get up." She said, "You can't get up?" And I said, "No." I would have to crawl right across the sidewalk to get to something to pull myself up, you know? At my age, it's a bit embarrassing, really."

Health Care System

All the women talked about their experience within the Health Care System. Treatment within this system included the care within the institution, as well as the care within the community setting. Similar to the description of the fall event, their stories were also detailed. Most of the women were dissatisfied with the care they received from the Health Care System.

One woman described the events prior to her discharge.
She had requested to be discharged on Friday, but the staff advised her that she had to wait until Monday. On Monday, her doctor would be available to discharge her:

They didn't even want to let me out of there. They said I couldn't go out at a certain time. I felt that I was ready to go but they didn't want to let me go home.

When asked how that situation made her feel, she replied that it made her feel angry because she felt that the staff were not listening to her. Here, the woman expressed dissatisfaction with the staff regarding their inability to listen and involve her in the decision-making process. This incident was her first exposure to the fact that her wishes were not respected. Further discussion on this point will occur as the theme of autonomy is discussed.

Another woman described the events surrounding her discharge from the acute care facility:

The only thing that surprised me . . . is that the other operations I have ever had at the hospital they always wheeled you out to the thing, you know, whatever . . . the car you were going home in. But, listen, I called a taxi by myself and had to take my own bag down (laughs). She stated that she managed to do it. However, this process represented an inconsistency in her care:

But, for all my other, "Don't do--you can't do it." You just sit there like a silly in a wheelchair right down
and you didn't really need it. You could have walked down.

Another woman described her trip to an Emergency Department for back x-rays, three weeks after her original fall:

And, I went into Emergency and they kept me all afternoon. They did some tests. They put me on intravenous. And, at 7:00 o'clock, they said, "We're getting you dressed. You can sit in the wheelchair and the ambulance will come." I was out there; it was cold and I wasn't dressed properly. I went up in the ambulance, rolled up in a blanket. So, I was there for 3 1/2 hours, in PAIN... I finally went over and laid down on some chairs and a woman told me that the bed I had vacated was made up and never occupied. Finally, one of her friends picked her up and took her home since there were no ambulances available.

Another woman talked about the bedside care she received:

I like it a lot in the hospital. But, there could be some improvements made there, especially with what do you call these, Filipino nurses (lowers voice). My goodness, they are rough. They need more training in bedside care. Oh yes, dear, oh yes. I know, especially when the patient is helpless and sore all over. They
can't push the people around like that. That is where
the help is needed.
When asked how that type of treatment made her feel, she
replied, "Oh, dependent on others, which I don't like." Even
though stated briefly, it was the beginning of the threat to
her self-esteem. More specifically, this was related to the
theme of independence. This theme will be discussed later in
the chapter. As well, it was probably the beginning of her
adaptation to her change in routine. Here, she was
developing new coping behaviours, such as using social
support to deal with her situation. This theme will also be
discussed later in the chapter.
Two women talked about their experience with the
Community Home Care Program. The first woman described her
experience with the homemakers who were sent to her home:
Oh, yes, they're helpful. The girls are very nice.
They've given me a [sic] sponge baths. They are all
Filipinos, they are very hard to make out and another
thing I resent is first you'll get a different one every
[time] and you have to tell them, holler from here in
the kitchen, where things are. Well now, the little one
that came this morning, she knows, she's been here
about five or six times. She knows where things are,
but they don't give you one person and they don't know;
you have to tell them every time a new girl comes; you
have to go into a big discussion and they can't find things.

When asked how this made her feel, she replied, "Frustrated."

Once again, this description stated some of the problems in terms of accepting help from others. In using social supports, the importance of continuity of care and communication were addressed. As well, the work performance of the individuals was important. This discussion will occur later in the chapter.

Another subject talked about her inability to obtain home help once she returned home:

Not only a little but I am really peeved about it. I tried several times and then they came over here, what should I say, from the office, and they spoke to me nicey-nice. To me, it wasn't nicey-nice, it was just words to get me to make me feel better towards them. Because I was wronged.

She stated that she was initially accepted and then told that her income was too high and she did not qualify for home help assistance. She indicated:

I have had no help at all. None, even a bath, which I beg [sic] them to do before when I fell because I was scared the first time. I begged them to, just to give me a bath but they didn't even do that. I did it on my own, too.
When asked how she felt about the way she was treated, she responded:

Oh, I am really disappointed. I guess I thought the system was better than that. And I heard from other people that they give you help, but I never got any help at all which I thought was really bad. Because, like people like me need any help. They can't do it on their own. But we are expected to.

For this woman, this experience reflected a lack of regard for her autonomy. It also reflected a decision-making process that did not regard her requests for help.

Another subject's description of the contact with a neurologist was detailed in the following account. This woman was undergoing medical investigations to determine the reasons for her falls:

They just say the muscles are dying; this clown over at the hospital told me, my neurologist told me my muscles and nerves were dying, and when I said, "What?" he said, "Nothing." Very cheerfully, he says, "We don't know what causes it, so we don't know what cures it, so come back and see me in a year." You know, that's nice, isn't it?

When asked how she felt about that, her anger was reflected in the following statement: "It made me feel like kicking him." She commented further as to how she coped with this
situation:

I went back once more and then my doctor said this time it was time to go back. I said, "I'm not going back to him. I want to see someone else." I felt that I just had to have a say in telling my doctor that I was not satisfied with [that] type of treatment.

This description reflected the woman's ability to exert her autonomy in trying to obtain more medical information about her condition. Here, the woman used the behaviour of trying to exert some control to cope with the situation.

All of the women talked about their change in routine since coming home from the hospital after their fall. One woman described succinctly the change in her routine: "Well, you know very well you can't do the things after you've had that, that you could do before." Several women commented on their situation in terms of meal preparation at home. These descriptions were detailed in the following accounts:

Now she'd made a sandwich for I [sic] eat for lunch and that and I think she's got my soup made for tonight, because I'll be alone but I will have to crawl, well with my walker right around there you know, it's pretty hard.

Not that great. I have to make my own meals which is hard. I have to stand in one spot because my leg is sore. Then it gets sore and it gets really like cramps.
When the last woman was asked to explain more about why she felt it was hard, she replied:

Well, just to get a meal, you have to wander over here and over there and it's not that easy. We have to wander back and forth. You bring things from there, you miss something you have to go back, things like that which isn't abnormal in the kitchen.

For these women, the term "hard" seems to reflect a degree of struggle for them in managing at home. Both women reported that they were independent in these tasks prior to the fall.

One subject explained the change in meeting her personal care needs after the fall. She described this difficulty due to fear resulting in a loss of confidence. "They bathed me, showered me, because I was frightened to get in the shower myself at first with this funny cast--this Hoffman thing with all the metal in it."

Another woman talked about her loss of confidence resulting in a change of routine. "You lose your confidence, certainly after having had a fall. I stayed home a little bit more. I didn't feel like going out on my own."

Several women reported a change in their strength or feelings of fatigue after the fall. The following two accounts are described:

Once you are hurt, especially when you are hit, it takes a lot out of you. You feel weak. It is slow. Really
slow. I was strong at one time. But, now I am not.

I can't stay up long enough. I hurt the upper part of my back. The upper part and I get tired and I don't stay up long enough.

One woman developed osteomyelitis in her wrist after being sent home. She was re-admitted to hospital for treatment. Upon her discharge from hospital, the second time, she stated: "Oh, I was very, very ill. Very weak for awhile."

Upon further analysis and verification of the data, it appeared the change in routine resulted in threats to the elderly women's self-esteem. As indicated earlier, the three themes were independence, productivity or activity, and autonomy.

Self-Esteem

Independence

All of the women in the study perceived themselves to be independent prior to the fall. Independence was seen as the ability to provide for one's own physical and emotional needs. As disclosed earlier, the change in routine at home reflected a change in their level of independence. This theme is illustrated in the stories of several women in the study.

Upon returning home, the 102-year-old woman remarked that everything in her life had changed. Her perception of
her situation, prior to the fall compared to after the fall, was contained in the following passage: "Very different. Because I hadn't been well, nurse, previously but I had carried on in a minimal way and that gives you a sense of independence the other takes from you." When asked to explain further about her situation after the fall, she stated: "Well, for one thing, I was helpless, absolutely helpless." When asked how that felt, she replied: "Awful! Awful, to an independent old me. Not only was I less independent, but I felt awful."

For this woman, independence was an important part of her self-esteem. When asked if independence was an important part of how she viewed herself, she stated: "Yes, very much so." The fall threatened the elderly woman's self-esteem. When asked how that felt, she responded: "Hard, awfully hard. I had no sense of direction, and you wonder, it is a more a sense of anxiety wondering about the future."

Another woman talked about the fall in terms of its effect on her level of independence:

Well, I have never been not able to do for myself. I am very independent. And when I fell this last time by opening the fridge door and swinging on it, well, I have been helpless more or less ever since. And it's terrible. I can't stand it.

When asked to explain further, about her feelings, she
stated: "It makes me feel angry. It makes me feel angry that I am not able to do for myself and have to have help in." Similar to the other woman, independence was an important part of her self-esteem. From both women's accounts, loss of independence was perceived as a threat to their self-esteem. This threat resulted in feelings of anger, helplessness, anxiety, and worry.

A third woman also confirmed that independence was an important part of her feelings about herself. She stated: "Oh, very much. I have a nice friend that would just smother me to death. But, I am very independent." When asked what she liked about being independent, she responded:

But, I like my own way of doing things. And I just love and I think that way you get more freedom back from the people. They don't feel as if they're very put upon, looking after you if you're independent. I think that you have a better relationship with people.

When asked if she felt it was important to project this image to family and friends, she responded: "Oh, yes. Very much so. Oh, yes. I am not frightened of going anywhere myself. You know, I do things on my own."

This woman was asked about her feelings related to her loss of independence. She stated:

I never felt helpless, even if I had to crawl. I was just grateful for the wonderful care I received. I knew
I was sick but I also knew I would get better.

This woman experienced dependency differently from the other two women.

A fourth subject also described the fall's effect on her level of independence:

I feel that it affected my whole entire system; what I can do, what I can't do; you can't move around that much; you have to keep yourself limited, in what you can do!

Her feelings in relation to the loss of independence were:

Well, it wasn't that great. I wanted more help, but I didn't get any help. So, that really I was peeved with that because I thought there was more help coming to Seniors.

This particular woman felt that receiving some support at home would have helped to make her more independent, thereby lessening the threat to her self-esteem. She was not provided with homemaking or nursing assistance once she returned home. Her anger, regarding her loss of independence, was directed at the system for not providing adequate supports to her. She agreed that independence was important in terms of her self-esteem or feelings about herself. When asked what she liked about independence, she stated: "Well, just to be more aggressive and you know, feel free, do as you please, which you can't do now."
to clarify what she meant by aggressive, she said:

Well, say for instance, now I can't go out and weed in the garden because I can't bend down and stuff like that. I am used to hard work. I love working around being like, I say, independent. I can't do it now. Even though this woman was experiencing threats to her ability to be independent, she was hopeful that she would return to her previous level of functioning.

Another woman talked about living alone since her husband died 15 years ago. She stated that she:

Managed my own things and I always managed my own banking, my own everything. I wasn't dependent on anybody and I don't want to be dependent on my daughter because she's a very busy little girl.

After discharge from the hospital, she was receiving homemaker services to assist with her activities of daily living in the community. She stated: "If I didn't have this little girl, it would be quite hard 'cause I know my daughter couldn't come any more than a couple of times a week or three times." She went on to say that her greatest fear over the loss of her independence was the dependence on her daughter. Here, again, feelings of fear were stated to loss of independence.

The last description was from a woman who talked about her recovery over a 6-week period. Initially, she stated
that she was quite dependent but now was feeling as independent as she was prior to the fall. She stated that she was frustrated due to the fact that her friends still viewed her as dependent:

I don't want to be treated like a baby. Good heavens! Some of my friends have been over solicitous. They nearly died when I told them I went downtown yesterday. They said, "Why didn't you tell us and we would have driven you." But, as I say, I don't want to be treated like a baby. If I can go out and do things for myself, I want to be able to do that.

She stated that she recognized her own limitations after this experience but it was still important for her to strive for independence. She became frustrated when her friends became over-protective or treated her as if she was dependent.

**Activity**

Productivity or activity was another theme within the self-esteem concept that was identified throughout the interviews. All of the women stated that their activity in their life changed after the fall. One woman described her life prior to the fall. "Oh, going out and having fun and doing everything, yes, no trouble at all." Later in the interview, she spoke again about her activity prior to the fall. She stated: "Going down to the golf club or going wherever I want. There was nothing wrong with me; I was just
as natural as you are." When asked to describe her life after the fall, she commented on the length of the days. She replied, "Well, I guess they could be shorter, just you know, it is not very nice, sometimes always alone." She stated that she had been home for about three weeks and had not been out of her apartment once. She was looking forward to Friday when her daughter's friend was taking her to a hair appointment. When asked how she felt about the change in her activity level, she responded: "Well, you know very well you can't do the things after you've had that, that you could do before."

Another subject described her activity prior to the fall: "I was active before I had the fall. I was out every day, more or less. I went shopping, go downtown." This same woman was admitted to hospital and required skin grafting to the abrasions on her lower legs. After her discharge from hospital, she described her level of activity:

I stayed home a little bit more. I didn't feel like going out on my own, but my friends would take me if I wanted to go anywhere special in the car. I was quite content; I was tired. It takes a lot out of you.

Activity was an important part of these elderly women's perceptions of self. As documented, all the women talked about their various activities prior to the fall. In analyzing the data, there were several different types of
activities. Some of the women talked about social activities. Other women talked about activities that were goal-directed, such as providing support to friends or assisting with the care of other family members. Other women talked about activities such as craft work that kept them busy at home.

Several of the women talked about their social activities prior to the fall. One woman described the following: "I used to love dancing, but I can't do it now. (Laughs). I love music and dancing. I still do. Just before I fell, I had been out dancing." This woman experienced a fracture of her hip and, at the time of this interview, she was still walking with a walker.

Another subject described some of her social activities within the Senior's complex where she resided:

We usually, we go down for the mail, and usually, you know, there are two or three down there and we sit and yap. But, and then we have a nice room upstairs where we go once a week for afternoon tea.

Another subject who fractured her wrist described her social activities prior to the fall. She stated: "You know, I have fun and I have a lot of parties and go to a lot of dinners at the club, you know." She went on to say that she had to cancel a trip to Whistler, B.C. because she was unable to drive her car, due to the fracture. She was planning to
go on a 35-day cruise to the South Sea Islands in September. Besides social activities, this woman also described her activity in terms of providing support to others. Here, there was some feeling of productivity in her life. She had been a teacher and her husband had been a psychologist. They had no children of their own but stated that they had provided support to many children through the years: "And that was my husband's and my life; [we] have been helping, helping children adjust to difficulties. Right now, I am supporting a niece down in California." Apparently, while in the hospital, she provided some support to the woman in the next bed:

If I can help somebody else. She was so nervous, that little woman, absolutely panicky; if I could give her some support. Although it was hard on myself. I do that and I want to do it.

When asked how it felt to give support to someone else when she wasn't feeling well herself, she stated: "No, it just came out."

Similar to this woman's goal-directed activity, another woman talked about her role as a caregiver to an older sister:

I was always a busy person and on top of that, I have an older sister that didn't have, well, she had a very fine husband, but he passed away and she never had any
children, so about 10 years ago she moved up here to be near me and my children. This 79-year-old woman was driving her own car prior to the fall. She stated that she visited her sister on a daily basis in the private care facility. Besides visiting her, she also shopped for any clothes or toiletry items that her sister required.

Another subject talked about her activity level in terms of the craft work she did at home. She talked about completing all the cross-stitch and petit-point pictures in her apartment:

But that way I keep myself occupied. I can sit for hours and embroider and enjoy it and watch the television and all the silly stuff on there, but still—you learn more.

It was interesting to note that three of the women incorporated their past activities into their present self-concept. One woman, in response to a question about the activity in her life, responded: "I used to work every day." Upon further questioning, she indicated that she had worked up until a couple of years ago. When asked about the type of work, she stated: "Hard work. I worked in the fish market. I used to carry fish and all that stuff, ice—I really worked hard all my life." Even though she had not worked recently, this past work had important meaning to her.
The second woman talked about her past activities. These activities remained an important part of her present self-concept and resultant self-esteem: "Well, that's if you see, playing golf, well not just before, but all my life I played, and bowled 10-pins." She went on to say that she just loved it. At one point, she had been a member of the Executive of a private golf course in Vancouver. She showed this writer a picture that had been taken of all past members of the Executive:

These are all the past-presidents and I'm there. I think it's a lovely picture. We have the banquet once a year and he's going to continue taking pictures of us every year, so that's all right.

Another women talked about her years as a nurse. At 83, she had not practiced for many years. Yet, her description implied that this part of her life remained an important part of her self-concept: "I graduated in 1930, so I am getting to be old-hand at the job. I graduated from the Regina General [Regina, Saskatchewan]." She was looking forward to a reunion of her nursing school in September:

It is just a wonderful evening. Hopefully, everything will be okay and I will be going. I stayed on staff after I graduated for 13 years so I know a lot of the nurses. And they know me. They remember me.
All of the women confirmed that being active or productive was an important aspect of their self-concept and resultant self-esteem. It did not appear that any one activity was judged to be more important than the others. The woman who provided support to her family stated that this was an important part of her self-esteem.

Another woman described the events of the morning in response to the question about the importance of activity for her self-esteem:

Well, this morning, I got up and made coffee. I had some corn flakes and then I put some chicken on too, bones on to stew because I had some leftover chicken, can of leftover chicken soup. I took the meat off of that and the broth and put that away. Well, I made dishes.

When asked about this level of activity, she responded: "But, I am more active than I was and that makes me feel better about myself." This woman had spent three weeks in bed at home after returning from the Emergency Department. The first interview had been done with her lying in bed. The above conversation took place on the second interview, approximately five weeks later. During the second interview, she was dressed, and able to sit on the couch for the entire length of time. The fall and the resultant change in routine had posed a threat to her self-esteem in terms of activity.
It was evident that even though her activity level had changed since the fall, she still placed value on the activity component of her self-esteem.

**Autonomy**

A theme of autonomy emerged from the data analysis as this writer tried to determine the elderly women's perceptions of their need for care and support at home. Matteson and McConnell (1988) stated that autonomy or self-determination meant that individuals were respected as decision-makers about their own care. Within the theme of autonomy, the elderly women described three different decision-making processes. These processes were well-represented along a continuum. At one end, the women described decisions made solely by themselves in relation to their medical care. In the middle were decisions made by the women in consultation with family, friends, and/or health professionals. The other end of the continuum was represented by decisions made for the elderly women by health professionals and others involved in their care.

The first process of decision-making was represented by those decisions solely made by the women regarding their care. One woman talked about the decision-making process involved in deciding whether to have surgery on her fractured wrist. The surgery option arose after the initial treatment of putting her wrist in a cast was not successful: "I'm in
charge of my life. I certainly decided that I wanted the operation and I decided that I wanted to go home as fast as I could." She decided to have the surgery and returned home. She was home for approximately three weeks and then was re-admitted to hospital with osteomyelitis. She described her discharge after this hospitalization:

Yes, in fact I probably shouldn't have been home alone, but I wanted to be home alone so much. I wanted to be in my own home that I put up with being alone.

Here, again, this woman's ability to make her own decisions regarding her care was evident.

Another woman talked about her role in the decision-making regarding some type of abdominal surgery. This 102-year-old woman had experienced a fall related to dizziness due to anemia. She was experiencing a loss of blood through her bowel. She described the experience of seeing the surgeon:

He examined me down here (points to lower abdomen). And I didn't ask him any questions because I had my mind made up. I was not having surgery. No, not me. No! And I had no desire when the call comes for me, nurse, I am ready. That's all important. I don't want to do anything that would hasten it. I couldn't see where this would help me; I haven't got what it would take.

When asked if she felt her wishes were respected, she stated:
"I don't think Dr. G. liked it but don't say anything." She stated that her wishes were respected. "They [wishes] have to be. I would never have gone on then. No, I have had all that, and it remains with the Lord what the future holds for me."

In the middle of the continuum were decisions made by the elderly women in consultation with health professionals and/or family members. One woman talked about the occupational therapist's visit to her apartment prior to her discharge. She was returning home after being hospitalized for a fractured hip:

They did all that from the General Hospital; the girl came and said this had to be raised because it's too low to get out, you know, and so they did, they got this and, oh, they did a lot of things; I think that we did a good job.

Upon further questioning, she indicated that the therapist had discussed her recommendations with her and that she was in agreement with the equipment being ordered.

This same woman also talked about her involvement in the decision-making process regarding personal care home placement. She described her initial ambivalence towards this idea: "But I thought, no, I can't go, I can't go and leave my friends, and I have a lot of friends in Vancouver, you know, the golf club." Upon further reflection and
discussion with her daughter:

When I started to think about it how many friends do come and visit you if you can never go out, you know, so I thought, well, gee, I'd rather be where my daughter is. So, we've talked it all out and we've decided and I think we've made a good decision.

During the course of the study, this woman moved to a personal care home in Langley, B.C. which was closer to her daughter.

Another subject talked about involving family members in decisions regarding personal matters such as finances. She made it explicit that she discussed the matter with them but, ultimately, it was her decision:

I have a wonderful financial advisor, my cousin, that's made money for me and looks after me that way. And if I, like with this trip, I said, "Do you think I should go?" he said, "By all means, because your time is running out. Go and have fun now." And we discuss things with my aunt and things like that. I discuss it but it is my decision, very much in my life.

Finally, at the other end of the continuum were decisions made by health professionals for these women. Here, the health professionals appeared in control of the decision-making process.

One woman talked about wanting to change her physician
to a physician with admitting privileges to the local hospital. She described her discussion with her physician over this matter: But I brought it up to him and he wasn't very happy about it." She explained further the rationale for her decision:

The thing was, is that he does not practice at any hospital. And at the back of my mind, I thought, "If I do fall and break my hip or anything and get landed in the hospital, he can't come. I have to just take whoever they dish out to me. Which I don't think is very satisfactory.

She described her doctor's reaction to her suggestion and her resulting frustration:

So, I said this to him, and he said, "Well, I would come and see you," and I nearly said, "Well, I'd love to see you sitting beside my bed, but if you can't do anything for me."

She stated that she planned to stay with him until autumn and then she would try to get him to accept the idea and refer her to someone else.

A second subject described her experience of not being involved in the decision-making process regarding her own care. She talked about not receiving any home care help after her hospitalization for a fractured hip:
They could have given me more help, you know, to get me up and going, but they didn't; like I said, they didn't want to even give me help for a bath. They could have come a couple of times and then I would have said, "You don't have to come any more." I would have but they didn't even say that--it was just, no--that was it.

When asked why she did not get any help, she responded:
"It's just more or less because they told me you have to make so much money and if you make that much you have to pay it."

The only support this woman received was the physiotherapist to assess her walking. She described this experience: "They send that woman out here to walk with me. I can walk by myself! That doesn't make sense, does it?" She stated that she tried to go walking for short distances each day. She advised the therapists that their visits were not necessary. She described the following experience: "I'm coming down to take you out for a walk. I don't need that. Who needs that? I don't. So I tell them." She described their response to her: "Well, they said we have to come. I can't see that 'we have to come.' Is that what I should say? Regulation or whatever like that."

At the time of the second interview, approximately four weeks later, she stated that she had finally been successful in stopping their visits: "I just told her that I am not going. That was it, because I didn't see the sense it made."
In order for individuals to be autonomous, they must be provided with adequate medical information about their health status. This was another important theme in the data. Several women described their attempts to increase their understanding about what was happening to them.

The woman who remained in bed for three weeks after her discharge from hospital talked about trying to organize medical follow-up to obtain medical information. This discussion took place on the second interview:

So, then today I phoned. I am not well. I phoned Dr. C., he's at the Arthritic Centre. He's one of the, if not the top doctors in Canada on arthritis. He's sending someone in tomorrow to do some blood work. That's related to the dermatomyositis. My muscles are very poor. Of course, this awful rash on my head is inflammation. It drags you down. So anyway, we've got some wheels going.

Another subject talked about her trip back to an Emergency department to have her cast checked. This cast had been applied two days earlier:

That was a joke. I went over there when I cracked it, and one doctor bound me up in a cast, some new kind of cast, and said, "Now that's got to stay on for one week and you see the doctor then." And in two days it had worked loose. So I thought, well--so I went back over.
The nurse was rather perturbed at my coming back. I said, "Well, I really didn't know what to do. It's no good this way."

The woman who saw the neurologist felt that she had been treated too indifferently. She stated:

I do find it rather aggravating. I mean, if you because you don't know--I suppose you can't find anything to get a medical book and read it. But you don't want to end up in a wheelchair or what you're going to do.

As noted, autonomy was also perceived as an important part of their self-esteem. It appeared that as the decision-making shifted from their own responsibility to the responsibility of the health professionals, the women experienced a threat to their self-esteem. As well, lack of medical information played an important role in their ability to make autonomous decisions.

Adaptability

In the interviews, the women talked about behaviours that they used to cope with their change in routine and threats to their self-esteem. As discussed earlier, the threats to self-esteem changes were primarily related to independence, activity, and autonomy.

Each woman coped with the situation in her own unique way. However, there were still common categories of behaviours that were identified. As well, the two major
themes of problem-focused and emotion-focused behaviours were identified. Both behaviours were used by the women in coping with the fall event and resultant treatment within the health care system.

The coping behaviours or resources that were identified were the following: use of positive beliefs, maintaining control, compliance, prevention, use of social supports, and planning for the future. Some of these behaviours were identified as being used in other stressful life events. Some of the other behaviours developed in response to the fall event.

**Use of Faith/Positive Beliefs**

Most of the women in the study spoke of the use of faith and/or positive thinking as a coping behaviour that they used to cope with life difficulties. In particular, they had used this behaviour to cope with the consequences of the fall. This was considered to be an example of an emotion-focused coping behaviour.

The 102-year-old woman continued to experience difficulties at home after her fall. Her bowel condition resulted in periods of dizziness and weakness. She stated that the fall had affected her level of independence. She spoke of having a sustaining Christian Faith. When asked if she felt the faith helped her to cope, she responded:

*It is everything to me, everything. I know in whom I*
have believed. I am persuaded that He is able to do everything for me and when the time comes, if I didn't have that, dear, I would be even more helpless, hopeless. I am not hopeless, nurse.

Another subject talked about her ability to look on the positive side of life. She had fractured her wrist and had stated that she was quite dependent on her return home from hospital. When asked how she felt she coped with the dependency, she stated:

I'm looking at the positive. Just being as patient as I can. I am sort of a positive thinker. Very much so with mental health and my husband's background and my own feelings towards life that you have courage, march on.

Throughout the two interviews, she stated several times that this positive outlook provided support to her.

A third woman also referred to her positive outlook. She stated that she was angry about being dependent after her fall. When asked how she coped with this feeling, she stated: "I was angry but I don't let things get me down. I was mad at myself for falling. However, I try to be optimistic and have a positive outlook."

Another woman talked about not being able to drive her car after her return home. She described the experience of allowing her daughter to drive the car while she sat in the
back seat: "I sit in the back and we have fun pretending she's my chauffeur." When asked about using humour, she stated that she always tried to look on the positive side of life:

Oh, sure, that's what life is, you know, if you're sour grapes. I guess it's really dreadful if you're ill; maybe you couldn't help it. No, you've got to laugh at things. I think the more you think you're fine you do get better whereas if you focus on all the bad things, you will feel worse.

The last illustration of this positive approach was from the woman who was denied home care supports upon her return from hospital. She talked about her positive approach in recovering from her fractured hip: "I didn't do it purposefully, but nevertheless, you have to live with it; you have to come over the hump and get better."

Compliance

Another behaviour pattern that was used in coping with the physical and psychological consequences of the fall was compliance. This behaviour was considered to be an example of problem-focused coping. Most of the women experienced some restrictions in their activity level related to their medical condition. For example, the women who fractured their hips were restricted in their weight-bearing and flexion of the affected leg. Other women were given
exercises or other regimes such as diets to follow at home. All of the elderly women described their adherence or compliance to these restrictions or regimes. Most of the women talked in an accepting manner about these restrictions. One woman's comment illustrated this point: "But I'm intelligent enough to know that when you have to do something, you have to do it and have to do everything that I had to do to get better, which I've done."

As mentioned earlier, some of the instructions were related to weight-bearing on the affected leg. One woman described this:

I still am not supposed to put my whole weight on this when I walk. I put my weight on this and my hand. I touch my foot down kind of on my toes and put not the full weight on it. I have to wait until they tell me when I can put my full weight on it.

Several of the women who had experienced fractured hips talked about not being able to have a bath. They described the experience of sitting on a bathboard and using a handheld shower: "Still, just sitting on that silly board." When asked how that felt, she stated: "Awful! They haven't told me yet that I can get into the tub." Another woman described this experience: "Quite what should I say, not like a bath—not like a good bath; water splashed on you, more or less."
The woman with the fractured wrist talked about exercising her fingers of the affected hand: "He [physician] told me to wiggle it as much as I can. So, I could see my muscles down there moving. I think it is almost better than a cast for moving."

As one woman progressed from a walker to a cane, she began to think about driving her car again. Here, again, her compliance to the health professional's advice was evident:

I feel that I could drive because you see all me, like the gas and the brake is with the right foot, there's nothing to the left. I've been warned by friends, "Don't start until your doctor or your physio tells, says you can, because if you had an accident, they say that's the first thing they do, is check back on your history, so I wouldn't dare."

She refrained from driving until the doctor gave her permission. It was interesting to note that these elderly women did not experience any difficulties adhering to the restrictions.

**Maintaining Control**

Several of the women described situations where they felt the need to maintain some control over their environment. This behaviour appeared to be related to those situations where the women experienced threats to their autonomy. This behaviour was also an example of problem-focused coping. As already mentioned, one woman felt the
need to tell her physician that she wanted to see another neurologist: "I went back once more and then my doctor said this time it was time to go back. I said, 'I'm not going back to him.' I said, 'There's no way I'm going back to him.' So then, that's when I went up to U.B.C."

A second subject described her experience in relation to giving directions to the home helpers:

Well, I guess they get sort of annoyed with me. But, I go out in the kitchen and say, "Oh, heat this leftover chicken up in this package of bouillon, chicken bouillon." I try to tell them how to do things which I guess they don't appreciate.

Control will also be discussed further in the coping behaviour of using social supports.

Another woman described stopping a medication that she felt was making her sick. She made the decision after consulting a medical dictionary:

I took some medicine and I guess they gave it to me all the time I was in hospital, I don't know, but I know, then I read about this medicine and they said it makes you lose your appetite; 'be sure to tell your doctor if this is happening.' I told my doctor too and if you lose your appetite and you're thirst is getting a little stronger, and you do this and I think I had everything that they said would happen with this pill.
Prior to stopping the pill, she consulted her doctor about her loss of appetite. She was told that this happened with many medications. Ultimately, she stopped the medication.

Prevention

Previous falls had been experienced by 3 of the 8 women. The other five women coped with the physical and psychological consequences of their first fall. The data was rich in detail in relation to the women trying to determine why the fall occurred. Subsequently, the women talked about being more careful or taking preventative steps to protect themselves from another fall. Prevention was viewed as another problem-focused coping behaviour.

There was considerable worry over the possibility of experiencing another fall. Some of the women talked about general safety measures such as putting the rubber mat down in the tub during a bath or shower. This example was from the woman who tripped on the sweater wrapped around the chair.

Several of the women talked about being more careful in relation to all their activities. The woman who had fractured her hip after tripping on her bedspread described her worry over her first few outings outside the home: "There is no guarantee that it can't happen. It could happen any time. Even when I go out on the street it could happen." When asked how she coped with this worry, she stated:
Well, you have to be more careful, watch out for everything that comes your way. For instance, you are walking on the street in case a bike comes along you worry because you are going to get hit or whatever. That could happen very easily.

Several of the women described changing their approach to the activities in their life. For example, taking more time or not rushing all the time. This account was from the woman who tripped on her sweater and broke her wrist: "I am watching it better. I don't rush the way I usually go. Maybe I will get over that."

From these statements, slowing down may not be a permanent behaviour change. Several other women were more committed to the proposed change in lifestyle. One woman detailed the following account of her change:

But I find one thing that I must not do is to leave anything to the last minute, and rush. I get very, very shaky and nervous if I have to push myself too far. And I usually try, if I go out one day, to more or less rest up the next day.

The above account was from the woman who had experienced 12 falls in the past. This woman had developed ways of balancing the activity in her life.

Another woman also talked about a slower pace. She had experienced two falls in the last eight months. She did not
know the cause for her falls. As a result of her worry over more falls, she hoped that a slower pace would help to prevent them. She indicated that she had always moved fast to get all the things done that she had to do. She described the worry, and the slowing of her pace of activities:

So, I keep on, but worrying, back in my mind, although the physio that came to the house said to just relax and don't rush; that might have a certain amount to do with it.

When asked how it felt to slow down, she replied that she was learning to slow down. This woman viewed slowing down as a coping behaviour to prevent more falls. Ultimately, it was also a behaviour to protect her level of activity and independence:

And so I just have to stop and think a little bit of myself. And it isn't only of myself, but my family, because if I, you know, I'm ill, it's more work for them.

From the data analysis, it was also interesting to note that several women identified ways of walking that might prevent further falls. Here, problem-solving skills were quite evident. Besides slowing her pace, the woman who had fallen 12 times described her conscious approach to walking:

If I remember to lead with this leg, you see my right leg is my weak leg and sometimes I step down on that and
then it just goes on me, and I just collapse, I don't have any warning; and that's what happened this last time on the bus. I went down on my right leg. But, if I remember to use this leg, then I usually make it all right. So far, so good.

The woman who fell while opening the fridge door also talked about reminding herself to walk in a certain way. Even though this behaviour was not specifically related to this fall, she had obviously been thinking about it:

What I think is, I don't when I'm tired maybe raise this foot as high as I should and what I always say to myself is, "Raise your feet, raise your feet." I don't think I raise that left foot.

It was evident, from these accounts, that prevention of further falls was an important issue for these elderly women.

**Plans for the Future**

As a result of the fall, several women in the study began to contemplate and make plans for the future. This planning was viewed as a new coping behaviour in response to their perceived need for care and support. This planning was clearly related to their loss of independence and their desire to not be a burden to family and friends. There were varying degrees of acceptance to placement as some of the women talked about their plans.

One woman talked about planning a tour of the facilities
with some of the women in her Senior's Complex. She appeared to approach the issue of nursing home placement in a matter-of-fact way: "Well, sometimes that's why I think that you know we've all got to face it; we'll probably end up in a nursing home." When asked if she had any feelings of what life would be like in a facility, she responded:

Well, I'm not too, a lot of people dread it. I don't really. I think if you get in a halfway decent place, you have to make your own way. I mean, have your own interests and just do the best you can. Really, I wouldn't go with family.

This woman had made no definite plans for placement.

In contrast, two women talked about their plans for personal care home placement. One woman had her name placed on a list before she left the hospital to return to the community. The other woman was considering this option during the first interview with her. She had strained her back during her fall and had spent three weeks in bed after her discharge from hospital. During the second interview, she indicated that she had made some arrangements for placement with the Long Term Care coordinator.

Both of these women talked about moving to the facility once they were more independent. The following accounts illustrate this point: "I'm going--I am going into a nursing home when I get better; I've got my name in"; and:
I want to get better enough to gather up what I want to take with me and go into a nursing home. I don't want to go in right now; I want to get on my feet.

The notion of getting better contradicted the information that people entered facilities once they were no longer able to care for themselves. When this was explored further with the women, the second woman responded that she wanted to make the decision at the right time. She wanted to see if there was going to be any improvement in her functional status. It was a big decision for her as she had lived in her present apartment since 1964.

Despite the fact that the women talked about placement as inevitable, there appeared to be some ambivalence about this option as the time for the decision drew nearer. This ambivalence may have reflected their hope for recovery. It may also have been related to the adjustment between their perception of themselves as independent versus the fact that being in a facility meant that they would now require some assistance with their care.

Use of Social Support

In response to their perception of their decreased independence, the last coping behaviour that was described was the use of social supports. The social support came from various sources such as neighbours, friends, family members, and homemakers. The homemakers were from the government Long
Term Care programs or private companies. One subject also talked about her private cleaning lady.

The theme of social support use was divided into two different categories. The first category was the type of help. The second category was the expectations for the help that was provided in their homes.

The first category of the type of help was easily represented on a continuum. The continuum ranged from one end of accepting formal supports (home care) to the other end where help was only provided by informal supports (family and friends).

At the end of the continuum where the main support was home care, the women talked about not wanting to burden family or friends. One woman talked about not being a burden to her friends:

They are my friends, okay, but I don't want to call. They have things to do with their children or whatever. They have a life to live too. I don't want them to get involved in that. Plus, they live quite far away from me, so I don't want to get them involved in that or disturb them.

Another woman talked about her fear of becoming a burden to her family:

You know, I can get on because I've got the walker and I've got the girl in and I've made myself able to do,
because I didn't want people to, I didn't want to have to go and live with my daughter and ruin her life up. On the middle of the continuum, several women talked about receiving home care and some help from their friends and family. One woman described this experience:

Oh, I am helpless. There's a girl at the end of the hall; she's not well. I don't like calling on friends to wait on me. You know, I don't want to bring them in on my troubles.

When exploring these feelings further, she stated that some of her friends had volunteered their help:

A chap brings groceries. Another friend will be driving me to my doctor's appointments. I don't want them to do anything like helping me. I couldn't ask my friends to do what the homemaker's doing for me. I don't want my friends to have total responsibility for my care.

Home care was then viewed as a compromise so that her friends could assist her, but, at the same time, not have total responsibility for her care.

At the other end of the continuum were the women who relied solely on the help from their friends or family. One woman described her experience of relying on her daughter and cleaning lady after her discharge from hospital:

I was so tired of people, as I told you. I never had a public ward, or a 4-bed, whatever you call it, in my
life before, and I was so tired of people—listening to them talk about their ailments and everything, that I couldn't put up with a homemaker and I happened to have a good cleaning woman, and so we coped.

Reciprocity appeared to be an important determinant of whether to ask a friend for assistance. One woman stated that relying on her friends and family was part of their reciprocal relationship: "They just swamped me with their kindness and almost—I can't believe it. Oh, this is wonderful." Her friends had assisted her with numerous tasks such as household chores, meal preparation, shopping and personal care. When asked how she felt about her friends providing support to her, she stated: "I would do the same thing for them. They say it's time you got home care; you've been so good to us. So it is very mutual."

Another woman described the reciprocity in her relationships with the neighbours in the block:

There are people in the building that will help, you know; we help each other quite a bit. I've got two gals down the hall, Jehovah's Witnesses, and I've always been kind of leery of them, but you know, they're so nice, they'll do anything; if I want help, they'll do anything. We try to help each other.

Another example of reciprocity was the woman who decided to accept home care to alleviate being totally dependent on her
friends. The theme of reciprocity was important as the women decided who to ask for assistance. It was interesting to note that the involvement of friends or family was dependent on the women's perception of their relationship with these different people. The elderly women's autonomy was important in the decision to involve family or friends.

The second category within the use of the social support theme was defined as expectations of the help. Since 5 of the 8 women received home care, the expectations of the help was primarily related to this service. However, there were also some examples of expectations from the women who relied solely on family and friends. It was interesting to note that most of the women mentioned the race of the homemakers. For several women, this was an important issue because they had difficulty communicating with the homemakers. The woman who had laid in bed for three weeks after her discharge from hospital described this experience: "They are all Filipino; they are very hard to make out." This communication problem was complicated further due to the lack of continuity in sending the same homemaker to the woman's home. She described this experience:

And another thing, I resent is first you'll get a different one every time and you have to tell them, holler from here in the kitchen where things are. Well now, the little one that came this morning, she knows,
she's been here about five or six times. She knows where things are, but they don't give you one person and they don't know; you have to go into a big discussion and they can't find things.

Another woman talked about her communication problems with her Spanish cleaning lady. Even though lack of continuity was not a problem in this private arrangement, the communication was a source of frustration:

Just having to accept my little cleaning girl. She's from—I forget—not Spain, but some place south, and she's Spanish and doesn't speak English very well. And so sometimes when she goes shopping, she wouldn't bring back the right things. That's the only frustration I had.

The lack of continuity of homemakers also was a problem for several of the other women in the study. These comments were not specifically related to any communication issue. One woman who was receiving homemakers on a daily basis described this experience: "And they were nice too but I've got used to L., and I like R., and I hope she'll be able to stay with me." When asked to explain further why it was important to have the same person, she responded: "It is, for she gets to know where everything is and my way and her way."

From these accounts, the women expressed frustration in
receiving home care help from people whom they could not communicate with. As well, it was important to have continuity of homemakers. The continuity of homemakers was also important for communication and ensuring some familiarity with the elderly women's routines in the home.

Another important expectation of the homemakers was that they be good housecleaners. Here, the women commented that they were nice girls but they remained critical of the girls' housekeeping skills. The 102-year-old woman described her homemaker:

She's a nice person but she leaves much to be desired on housework the way I do it myself, but then, I am a fussy old duck. I like things done right (whispers) and I like to work.

Here, this woman's expectations for herself were passed on to the homemakers.

One woman commented on their lack of training which she believed to be the major problem. As a result, they were poor housekeepers:

I have this girl, comes in once a week and does the vacuuming and a few other jobs, and I have everything to put away when she goes. They don't train them, you know. I don't know why, I don't know why they don't train them properly. She's a very nice little girl, very willing to do things, but when they're finished,
they just drop everything and then it's up to you to go
and straighten things up, and put things away.

It was apparent that the homemakers' lack of skills was
another source of frustration for the women in the study.

Another expectation of the help received was that they
show some respect for the women's way of managing her
household activities. From the interviews, there appeared to
be evidence of the elderly women exerting or trying to
maintain some control. This maintenance of control was
referred to earlier in this paper. One woman described her
organization of the tasks that required completion. She was
relying on her friends and family for support:

The girls all phone, asking can they help? And I have
everything lined up. Cornflakes box that needs
opening, to butter that needs cutting, and it is all
lined up and they go right to it.

Another woman described her experience with the
homemakers from a private agency:

Well, I guess they get sort of annoyed with me. But, I
go out in the kitchen and say, "Oh, heat this leftover
chicken up in this package of bouillon, chicken
bouillon." I try to tell them how to do things which i
guess they don't appreciate.

During the course of the interview with this woman, she
had opened five containers in her fridge, trying to find the
margarine. She had stated that this place no longer seemed like her own. When asked how it felt to have people come in and do things for you that you were used to doing on your own, she responded:

But my knife drawer, I have one drawer for silver, my silver and the other drawer for utensils, and I have got a lot of knick-knacks or utensils. Some of them are never used but they were all mixed in with the silver. That annoyed me. My towels in my hall, folded just so, just like they are in the store or shops. Well, they just fold them and throw them up.

When asked if she wanted the homemakers to respect her ways, she replied:

Well, they're all nice girls, really, but they're young. They're all nice girls. I haven't any complaint about them. But, I am fussy, I guess; fussy old maid. (Laughs). But, you know, I will be 80 next week and you are set in your ways.

Here, the woman described how she told the homemakers how to do things but she was reluctant to admit that this was the way she wanted things done. Also, there was a feeling of not wanting to complain about the service because she required the service: "I am very thankful that they come in; someone to come in."
Summary

In summary, this chapter has presented the results of the data analysis. Both the fall and treatment within the Health Care system resulted in a change of routine for these women, upon their return home. The change in the routine was due to the physical and psychological consequences of the fall.

The change in routine resulted in threats to the elderly women's self-esteem. The themes that were identified as part of the self-esteem concept were independence, activity, and autonomy. All of the women in the study described how their degree of independence was affected after the fall. The ability to meet one's physical and emotional needs was valued highly by all the women. Some women reported a loss of confidence after the fall. Other women reported that they required assistance with their personal care or in the management of household tasks.

All of the women described their activity level prior to the fall. Activity was an important component of their self-esteem. Despite the different types of activity, the women perceived them all to be important. The women's level of activity changed after the fall. This was a source of concern for the women in the study. Autonomy was the last theme that the elderly women described. Autonomy, or self-determination, was important to these women. The data
revealed three different processes of decision-making that the women encountered after their fall. As well, it was important for the women to have adequate medical information about their health status.

The second concept was adaptation. The women used coping behaviours in order to cope with the threat to their self-esteem. Some of these behaviours were emotion-focused coping, while other behaviours were problem-focused. There was a wide range of behaviours that were used by the elderly women. The different categories of behaviours included the following: (a) use of faith/positive beliefs, (b) compliance, (c) maintaining control, (d) prevention, (e) planning for the future, and (f) use of social support. Some behaviours were used in past life-events. Other behaviours were learned in response to the fall and change in routine.

This chapter has presented the findings of this study. In the next chapter, these findings are discussed and related to the current research and theoretical findings that are currently available.
CHAPTER FIVE: DISCUSSION OF THE FINDINGS

Introduction

This chapter presents a discussion of the study's findings. Here, the findings will be more fully explored in conjunction with the theoretical literature and research findings currently available. The last chapter will discuss the implications for nursing research, education, and practice that arise from the study's results. Chapter Six will also include the study's summary and conclusions.

Kleinman's Health Care Systems Model (1978) provided the framework for exploring the elderly women's explanatory models for falls. As mentioned in Chapter One, the explanatory models contained interpretations of the resultant physical and psychological consequences of a fall. These interpretations influenced the women's perceptions of the need for care and support as they returned home from the hospital to live alone. Several major themes emerged from the data analysis as the elderly women described the need for care and support.

Fall as a Significant Event

Each woman perceived the fall as both a significant and unexpected event in their lives. They described the changes in routine at home resulting from the fall and its physical and psychological consequences. One major consequence was
the description of the threat to their self-esteem after the fall event. In their own unique ways, the women adapted to the changes in routine after the fall event.

The process of perception and adjustment to life events is well-documented in the literature. Hanley and Baikie (1984) provided a breakdown of stress factors that were relevant to the findings from the elderly women. The four categories of attack, restraint, loss, and threat were believed to be useful in helping to understand the relative difficulty of adjusting to different life events.

Attack was viewed as an external force which produced discomfort (Hanley & Baikie, 1984). In this study, the fall was included in the attack category. Restraint constituted the external restrictions on activities which were necessary for the satisfaction of basic human needs. From the elderly women's descriptions, the change in routine, upon their return home, was relevant to this category. Loss was defined as the removal of external circumstances which individuals relied on to satisfy their needs. An example of loss, from this study, was the loss of activity the women experienced after the fall. This activity or productivity was viewed as an important way to satisfy their need for self-esteem. Finally, Hanley and Baikie (1984) defined the threat as any event which warned of possible future loss, attack, or restraint. Here, the possibility of more falls and their
physical and psychological consequences posed a threat to the elderly women in this study.

The importance of the fall event to the women was also congruent with Lazarus and Folkman's (1984) studies on coping. Their work on the coping process revealed that its dual goals of problem-resolution and emotion-regulating brought in to play the cognitive, affective, and behavioural response systems of the individual. The cognitive system was the first to be engaged when the person was exposed to the stressor, such as the fall event. The individual attempted to discern the significance of the stressor in terms of his or her well-being. As a result, the stressor was interpreted in one of four ways: as a threat, as a source of harm, as a loss, or more as a challenge. Again, the perception of the fall event was important in determining the women's adaptation to the resultant changes in their life.

Self-Esteem

Self-esteem was one of the major concepts identified during the data analysis. As discussed, the elderly women described threats to their self-esteem resulting from the fall event. Independence, activity, and autonomy were identified as important themes within the self-esteem concept. These are significant findings and fit well with the theoretical work on self-esteem.

Before discussing these individual themes, it is
important to provide a definition for the concept due to ambiguities in the literature. Self-esteem has been the focus of theoretical writings in psychology and sociology since the 1930s (Mead, 1934). A review of the literature highlights important points to be included in the definition. Self-esteem is a dynamic feeling that reflects the degree to which an individual accepts, respects, and/or values him or her self (Mead, 1934; Rosenberg, 1985). Self-esteem is influenced by the reflected appraisals of significant others (Cooley, 1964; Sullivan, 1953), and by the individual's feelings of competence and worth related to his effectiveness in society (Felker, 1974; Taft, 1985).

Independence, activity, and autonomy were important components of the elderly women's self-esteem. These findings related to self-esteem were supported in the literature. Kaufman (1986), in her work, found that these themes were an important part of self-esteem for the elderly individuals. Her sample consisted of 60 men and women over the age of 70. She concluded that these themes were based on important values for that generation or birth cohort. A birth cohort referred to all individuals born during a certain time-frame. She stated that these values emphasized the individual's conformity to shared and fairly explicit indices of social worth. The individuals within the cohort stared common ideals derived from common experiences. These
values were evident in the women interviewed in this study.

Independence was viewed as the ability to provide for one's own physical and emotional needs. From the rich descriptions, it was evident that the physical and psychological consequences of the fall posed a threat to the women's perceptions of themselves as independent. The women described the assistance that was required with activities upon their return home from hospital. Examples included shopping, meal preparation, and personal care. This study concluded that independence was an important component of the women's self-esteem. This was a significant finding and was supported by the literature (Hirst & Metcalf, 1984; Kaufman, 1986). In fact, independence was viewed as the most important aim of the majority of the elderly population regardless of their state of health (Culbert & Kos, 1971).

Activity was the second theme identified during the data analysis. The elderly women viewed activity as another important component of their self-esteem. Several women described their past working lives. All the women detailed their present-day activities. These activities were varied. Examples included the provision of support to others, social functions, and solitary craft work. A significant finding was the perception that all activities were meaningful. Another important finding was that the women experienced decreased opportunities for activity due to the physical and
psychological consequences of the fall. As a result, they perceived threats to their self-esteem.

The importance of activity to the women's self-esteem was supported by the literature. Research on activity has been on-going since the early 1960s. During this time, important links have been established in the relationship between activity and self-esteem (Neugarten, Havighurst, and Tobin, 1968). Today, activity remains an important value in society. The tendency remains to describe a person's identity in terms of his or her work role (Kaufman, 1986; Stahmer, 1986). It remains an acceptable measure of human worth and thereby affects feelings of self-esteem.

The finding that all activities, not just work-related ones were perceived to be meaningful, was also supported in the literature. Perceptions related to meaningfulness are shifting away from traditional work activities (Coleman, 1990). Society is now approaching a time in human history where leisure time pursuits, voluntary community work and creative expression are becoming more important.

Autonomy was the last important theme that emerged as the women described their experiences after the fall event. This was the last component of their self-esteem that was identified in this study. Autonomy, or self-determination, meant that individuals were respected as decision-makers about their own care (Matteson & McConnell, 1988). There
were several significant findings in this study related to autonomy. Firstly, the women described situations where decisions about their medical care were made solely by health professionals. Examples from the data included not receiving any formal supports upon discharge home and unwanted visits from a physiotherapist. Here, the women's autonomy was threatened by their lack of involvement in the decision-making process.

The second significant finding was that the women felt that they lacked adequate medical information about their health status. Several women arranged their own medical follow-up for the purpose of obtaining more information. This lack of medical knowledge was perceived as a threat to their autonomy.

These findings were congruent with the literature review on autonomy. Wright (cited in McElmurry & Zabrocki, 1989) described autonomous decisions as: (a) those based on the individual values, (b) utilizing adequate information and understanding, (c) free from coercion or restraint, and (d) based on reason and deliberation. Based on these criteria, all individuals need to be involved in the decision-making process about their medical care. Decisions about health care are no longer the sole prerogative of health professionals (Reilly, 1989). Instead, they must involve the individual, significant others, and health professionals.
Several studies also supported the importance of the relationship between autonomy, perceived control, and self-esteem (Berkowitz, Waxman, & Yaffe, 1988; Langer, 1983; Rodin, 1986).

Langer (1983) studied perceived control in a group of nursing home residents. One group of residents was addressed by an administrator who emphasized their autonomy. This group was encouraged to make decisions for themselves, given decisions to make, and given responsibility for something outside of themselves. A second group of residents received a different speech from the same administrator. This speech stressed the staff's responsibility for their care and management in the home.

Of the first group, 93% felt happier, became more active, and experienced a feeling of competence. In contrast, 70% of the second group became more debilitated within a 3-week period. Langer (1983) concluded that increasing environmental control, thereby fostering autonomy, was related to increases in self-esteem for the study's participants.

Berkowitz et al. (1988) made similar conclusions. Here, community-residing individuals who participated in decision-making, and advocating for their own needs, scored higher on tests measuring self-esteem. Once again, lack of involvement in decision-making resulted in lower scores on the self-
esteem tests. Therefore, these two studies supported the findings that the women experienced threats to their autonomy when not involved in their medical care decisions.

The second finding, regarding the importance of medical information in making autonomous decisions, was also supported by the literature. Less-informed individuals were particularly vulnerable to engaging in health decisions in which information deficits were a serious concern (McElmurry & Zabrocki, 1989). Here, an individual's autonomy was threatened by this type of process.

As described in the literature, the issue of ageism is important in determining many of the aforementioned conditions for autonomous decisions (French, 1990; Matteson and McConnell, 1988). As well, ageism has a powerful impact on the larger concept of self-esteem. Ageism is defined as the process of systematic stereotyping and discrimination against people because they are old (Butler, 1975). Older persons are often stigmatized as being lonely, absent-minded, senile, dependent, irritable, and possessing poor health (Terpstra, Terpstra, Plawecki, & Streeter, 1989).

Ageism remains a problem in our society, and because nurses reflect the views of society in which they live, they may hold negative views about the aged (Burnside, 1990). One study by Knowles and Sarver (1985) documents that baccalaureate students in a university program least
prefer patients over 75 years of age. Even though, nurses have not been found to be any more negative than other groups (Maddox & Tilley, 1988), it remains difficult to assess an elderly individual's values when negative stereotypes are held.

Self-esteem of the elderly is then affected by society's view toward them. This comment pertains to the aspect of the definition that refers to the reflected appraisals of significant others. These appraisals are important since all the women in this study received treatment within the Health Care System.

**Adaptation**

Adaptation was the second concept that emerged from the data analysis. This concept has also undergone exhaustive research. Due to its magnitude, the discussion of adaptation will be restricted to the different methods of coping that were identified in this study on elderly women.

The process of adaptation or coping was defined as the "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141).

In this study, the women used a variety of behaviours to cope with the fall event and resultant change in routine. Examples of coping behaviours from the findings were use of
positive beliefs, maintaining control, compliance, prevention, planning for the future, and use of social supports. As described in the literature, coping behaviours were determined by the person's resources (Lazarus & Folkman, 1984). There were several major categories of resources. They included physical resources (health and energy), psychological resources (positive beliefs), competencies (problem-solving and social skills), social support, and material resources.

Inherent in the study's findings were two different types of coping. Use of positive beliefs represented one type of coping. In contrast, the second type of coping involved more problem-solving behaviours. For example, problem-solving was evident as the women described their compliance to medical regimes, preventative steps taken to prevent the reoccurrence of another fall, and planning for the future. This distinction between coping behaviours was supported in the literature. The two types of coping were problem-focused and emotion-focused (Folkman & Lazarus, 1980).

Problem-focused coping behaviours were similar to strategies used for problem-solving (Lazarus & Folkman, 1984). These included defining the problem, generating alternative solutions, weighting the alternatives in terms of their cost and benefits, choosing among them, and acting. As
well, problem-focused coping also included strategies that were directed inward, such as motivational or cognitive changes. Examples encompassed learning new skills, finding alternative channels of gratification, and developing new standards of behaviour.

Emotion-focused coping was directed at lessening emotional distress and involved strategies, such as distancing, escape/avoidance, self-control, accepting responsibility, use of positive beliefs, and seeking social support (Lazarus & Folkman, 1984).

The findings from the study concluded that the elderly women used more problem-focused than emotion-focused coping. This finding was significant in that it was related to the perception of the women regarding the changeability of the situation. Research has been conducted to determine the extent to which individuals used these different types of coping (Folkman & Lazarus, 1980; Folkman, Lazarus, Drunkel-Schetler, DeLongis, & Gruen, 1986). The results concluded that the type of coping depends firstly on the primary appraisal or the personal significance of the encounter. The importance of primary appraisal of the stressor was already discussed in the earlier section on the fall as a significant event. Secondly, the type of coping was also contingent on the secondary appraisal of the event. This involved options for changing the person-environment relation. One study
showed that problem-focused coping was more probable when conditions were appraised as amenable to change (Folkman, Lazarus, Pimley, & Novacek, 1987). Therefore, the findings from the elderly women were congruent with the literature.

The use of social support was a coping behaviour described by all the women in this study. As a result, the study's findings, in relation to this behaviour, will be discussed in detail.

Social support encompassed the "emotional support, advice, guidance, and appraisal, as well as the material aid and services that people obtained from their social relationships (Ell, 1984, p. 134). The two categories of support were informal and formal. As well, it should be noted that use of social support was included in both emotion-focused and problem-focused behaviours (Lazarus & Folkman, 1984).

One finding from the study was that the women described assistance received from informal supports such as family and friends. Several women described their reluctance to accept formal supports such as homemakers. The literature supported this finding that elderly persons drew initially on aid from informal supports followed by additional aid from formal agencies and organizations (Chappell, 1985; O'Brien & Wagner, 1980).

Another interesting finding was that the women described
their fear of becoming a burden to family members or friends. Due to this feeling, they accepted formal supports. As it pertained to family members, this finding was not supported in the literature. Contrary to the women's belief that accepting help would decrease the burden for families, studies have shown that the provision of home care does not lessen the family's involvement in their care (Chappell, 1985; Shapiro, 1986).

Accepting social support from friends was another decision. One significant finding related to this decision was the importance of reciprocity in the women's relationships. This particular finding was supported by the literature (Rook, 1987; Tilden & Weinert, 1987).

Reciprocity was a significant finding from this study. Due to the importance of reciprocity, the elderly women knew the type of assistance that could be requested from certain individuals. Although this finding was related to the discussion on autonomy, it was also supported by the literature. Rook (1987) stated that reciprocity was dependent on the previous relationship with the friend, and the type of support or social exchange required. Exchange referred to any of the following types: companionship, instrumental support such as shopping, and emotional support.

Another significant finding from the study was the
women's description of their encounters with the home helpers. In having the homemakers come to their homes, the women experienced problems with communication, due to language barriers. As well, the service lacked continuity, in that the women dealt with several homemakers throughout one week. The women were also dissatisfied with the homemakers' work performance. These were important findings. Research was found that dealt with home nursing in terms of service needs, continuity of care, educational preparation of nurses, and client satisfaction (King, 1986; McNeese, 1988). However, there appeared to be a paucity of research on homemakers. This was interesting since the homemakers were the primary care workers for several of the women who received formal supports.

The last important finding was related to the women's responses to the homemakers. They began to exert some control and told the homemakers how to complete tasks in their home. It appeared that the women's autonomy and independence were further threatened by the homemaker's actions. This finding was supported by the literature. Again, Langer's (1983) study on autonomy and control was relevant here. Rowe and Kahn (1987) stated that social support appeared to either increase or decrease the autonomy and control of the recipient. Teaching, enabling, and encouraging were autonomy-increasing modes of support.
Constraining, "doing for," and warning beyond the requirements of the situation conveyed caring but they taught helplessness. Again, there was a dearth of research on the types of support provided by homemakers.

Summary

This chapter provided a summary of the major findings of the study. The findings were discussed and supported by current research and theoretical findings.

This chapter began with a discussion of the significance of the fall event. It was followed by the discussion on self-esteem. The findings related to the themes of independence, activity, and autonomy within the self-esteem concept were then presented. A brief discussion on ageism was also included in the discussion of self-esteem.

The process of adaptation was presented as it related to the study's findings. The different types of coping resources were reviewed. This was followed by a discussion on the problem-focused and emotion-focused coping behaviours that were used by the elderly women. The use of social support was discussed in detail since all the women used this behaviour. This discussion was followed by a presentation on the importance of reciprocity in social relationships. Finally, the women's experiences with the homemakers from formal programs was discussed.
CHAPTER SIX: SUMMARY, CONCLUSIONS, AND IMPLICATION FOR NURSING

Summary Conclusions

This study is designed to describe the need for care and support as perceived by women aged 75 years and older returning home to live alone after hospitalization for a fall. Falls are a significant problem for these women who constitute the fastest growing segment of the Canadian elderly population. Falls have numerous physical and psychological consequences. In many cases, these women return home to live alone after hospitalization for a fall. A review of the literature indicates that the studies on falls were mostly epidemiological in nature. There are no studies that addressed the physical and/or psychological consequences of falls in terms of their effect on the perceived need for care and support of elderly women returning home alone. In many situations, the individual's perceived need for care and support is not only misunderstood, but the perceptions are not even addressed. Studies on social support indicate that elderly persons draw initially on aids from informal supports. As well, increased age and functional capacity play a role in the use of formal supports.

Kleinman's Health Care System Model (1978) provides the direction for the purpose and methodology of the study. This
model conceptualizes the medical system consisting of three distinct but interrelated arenas: the popular, the professional, and folk arenas. The arenas are where sickness is "experienced and reacted to" (Kleinman, 1978, p. 86). The popular arena is composed of the family context of sickness and care, as well as the social network and community activities. The professional arena is composed of medicine, nursing, and other professionals, whereas the folk arena consists of non-professional healing specialists.

Kleinman (1978) states that explanatory models (EMs) can be elicited from individuals in the three different arenas. The EMs are used to understand the etiology, symptoms, pathophysiology and treatment of the illness event. The EMs of professionals are most likely to denote the disease aspects of sickness. In contrast, the EMs in the popular arena are more likely to include the experience of the illness event. As a result, the EMs used by individuals in the different arenas may not agree with each other. This may result in care consisting of incongruent objectives and outcomes as the individual enters the professional arena for treatment. In conclusion, Kleinman's Model provides direction in describing the EMs of elderly women as they relate to the perceived need for care and support in the community after a hospitalization for a fall event.

In order to describe the EMs, the research design of
phenomenology was chosen. In the attempt to understand the lived experience, eight women subjects were recruited who had experienced a fall event resulting in a hospitalization. All the subjects were recruited through the Vancouver Health Department. The women were 75 years of age and older, living alone in a house or apartment which was not part of a care facility in the City of Vancouver. As well, they were alert and oriented to time, person, and place with no significant cognitive impairment prior to admission or following discharge from hospital.

Data were collected through the use of unstructured tape-recorded interviews. The interviews took place in the subject's home. Five of the subjects were interviewed twice, and one subject was interviewed three times for a total of 14 interviews. Several telephone calls were also made to the subjects throughout the course of the study. Four trigger questions were used to guide the initial interviews. As the data analysis proceeded, the trigger questions were revised, based on the common themes emerging from the data. All interviews were transcribed verbatim to ensure an exact account of the phenomenon. Data analysis was done following the steps outlined by Giorgi (1985). Common themes were noted and coded accordingly. Subsequently, the themes were clarified, validated, and discounted in subsequent interviews with the subjects. In this process, the perceived need for
care and support from the elderly woman's experience was described. The perceived need for care and support once the women returned home to live alone was ultimately influenced by the fall event and treatment within the Health Care System. The findings are complex and inter-related and summarized in the following manner:

1. The elderly women in this study perceived the fall as both a significant and unpredictable event in their life. The fall event resulted in a change of routine at home once they returned home to live alone. After returning home, the women described threats to their self-esteem.

2. Autonomy, activity and independence were important components of self-esteem that were threatened by the fall event and resultant change in routine.

3. The women identified activity as an important part of their self-esteem. After the fall, the women experienced decreased opportunities for activity due to the physical and psychological consequences of the fall. This was perceived as a threat to their self-esteem.

4. The women wanted their autonomy respected. They experienced threats to their autonomy. They had decisions about their care made for them by health professionals. As well, they wanted more information about their health status.

5. The elderly women used behaviours to cope with the threats to their self-esteem. According to the appraisal of
the situation, different types of behaviours were used. These included use of positive beliefs, compliance maintaining control, prevention, planning for the future, and use of social support. These specific behaviours encompassed both problem-focused and emotion-focused coping strategies.

6. The use of social support was a coping behaviour used by all the women in the study. Reciprocity of exchange was important in the women's use of social support from friends.

7. The women in this study encountered difficulties with the social support from the formal programs. The women experienced problems with (a) communication due to language barriers, and (b) a service that lacked continuity or the ability to send the same homemaker to them on an ongoing basis. As well, there were problems with the women's expectations for the homemaker's performance. These problems were also perceived as a threat to their autonomy and independence.

The women's description of their need for care and support once they return home has numerous implications for nursing research, practice, and education. These implications will be addressed in the following sections.

Implications for Research

The elderly women who fell described threats to their self-esteem upon their return home. Ultimately, these
threats affected their perception of the need for care and support in the home. Several women described their dissatisfaction with the homemakers from the formal support programs. It was obvious that this service did not meet their perceived need for care and support in the community.

Homemakers are the lowest paid and least educationally-prepared members of the health care team. Yet, these individuals were considered to be the primary caregivers for several women in this study.

There remains a paucity of research that deals with the attitudes, motivations, knowledge, skills, and education needs of these workers. As well, research is lacking on their assessment and communication skills. Furthermore, research is required on the relationship between the individual's need for support (objective and perceived), the support received from the homemakers, and the effect that support has on other predictors of success such as control and autonomy. The findings from this study concluded that the elderly women perceived threats to their independence and autonomy resulting from the homemaker's actions. Consequently, the women exerted control in order to cope with these threats.

Research is required in the aforementioned areas, since there is an increasing movement to maintain more frail, elderly individuals using homemakers in the community.
setting. This information would have several policy implications. Firstly, this information would have implications for planning the type and amount of supervision that is required for these workers in caregiving situations. Secondly, the educational needs of these workers would be documented, thereby ensuring that appropriate educational programs are established for them. As a result, homemakers may be perceived as meeting an elderly person's need for care and support in the community, rather than posing a further threat to it.

The last implication for research relates to the area of autonomy and stereotyping of the elderly. Stereotyping of the elderly among health professionals has been documented in the literature (Maddox & Tillery, 1988; Penner, Ludenia, & Mead, 1984). However, nurses working in long-term care settings have been the major focus of this type of research. Since all the women were assessed in an Emergency department, it is crucial to conduct research on these nurses' attitudes towards elderly individuals. This research may help to expose a hidden source of negative stereotyping of the elderly.

In conclusion, further research is required on the education and training of homemakers as they continue to play an important role in care of the elderly in the community setting. As well, further research is required on the
attitudes of the nurses working in Emergency Departments towards the elderly.

Implications for Practice

In order to understand the perceived need for care and support of elderly women after a fall event, it is important to gather information on their value systems. In particular, it is important for nurses to learn about an individual's values as they relate to feelings about falls, acute and chronic illness, loss of functional ability, and expectations for health care. In this study, the women's values reflected aspects of their self-esteem. These values were fundamental in understanding the elderly women's perceived need for care and support in the community.

In the present Health Care System, most patient information is gathered on patient assessment and history forms. However, most of this information is focused on the physical and functional aspects of individuals. Information about an individual's values also needs to be documented and communicated to all nurses involved in the client's care. The inclusion of this information has implications for the formulation of health assessment forms within both institutional and community settings.

In order to provide care that promotes the autonomy of elderly women after a fall event, the nurses must ensure that adequate medical information is provided to these
individuals. As well, all health professionals need reminding that decisions involving the clients' health care are no longer the sole prerogative of health professionals. The aforementioned are two important conditions for autonomous decisions-making by individuals. Nurses and other health professionals require inservices on the ethical principle of autonomy. As well, nurses require education about the concept of advocacy in the practice setting. In many situations, the nurse may need to assume the role of patient advocate to ensure that autonomous decision-making occurs. This promotion of autonomy for elderly women will help to meet their perceived need for care and support as they return home after a hospitalization for a fall.

Nurses need to be aware of the importance of reciprocity in the social relationships of elderly women. This reciprocity was important as the women described their perceived need for care and support in the community. Therefore, it is a crucial point to remember as nurses discuss with elderly women the decision to involve their friends as a support in the discharge plan. The women need to be consulted about who to phone and what to request of that person. This finding may have important policy implications for the provision of formal supports to those women who do not want their friends involved in the discharge plan.
Health professionals also need to increase their awareness of the importance of their actions in supporting the self-esteem of elderly women. The importance of autonomy has already been discussed. Nurses, in their interactions with the elderly, are able to provide the reflected appraisal of significant others. As discussed in Chapter 5, this is one source for self-esteem feelings. Nurses can provide acknowledgement for accomplishments or newly-regained self-care tasks. As well, they can assist individuals in identifying strengths and positive aspects of their self-concept. Besides providing verbal feedback, unspoken actions are also important in providing the reflected appraisals. Therefore, nurses must become cognizant of their facial expressions, body language, and voice tone when interacting with the elderly.

It is important for nurses to learn the meanings of events to elderly women. From this study, the meaning of the fall event had a tremendous influence on the women's perceived need for care and support as they returned home alone after a hospitalization for a fall. This meaning transcends the reasons for the fall or the report of the fall from an outside observer. An understanding of the fall event is important in the process of assessment and the formulation of nursing care objectives in the care of elderly women.

In conclusion, the implications for practice include
four recommendations for nurses. Firstly, they must assess and document the values of elderly individuals. Secondly, nurses must remember the importance of reciprocity in the social relationships of elderly women. Thirdly, the role of nurses in promoting the self-esteem of elderly individuals is addressed. Lastly, nurses must begin to increase their understanding of the fall event as elderly women return home alone.

**Implications for Education**

Over the last 15 years, there has been increasing emphasis on the study of Gerontology by the nursing profession. Despite this focus, there remain many negative stereotypes of the elderly within the profession.

The curriculums in nursing schools provide opportunities for students to care for the elderly. However, many of these situations involve caring for the elderly with many physical and cognitive limitations within institutional and community settings. A greater focus on the well elderly is required within the nursing school curriculum. Here, beginning practitioners would begin to learn about the values of this generation. This would help to eliminate some of the stereotypical views of the elderly. As well, the experience in caring for the well elderly would help to promote more positive attitudes toward the aging process.

Besides providing a curriculum focus on wellness in
aging, it is important that there be adequate faculty prepared at the master's level in gerontological nursing. Here, the students would benefit from the expanded knowledge and skill levels of the gerontological clinical nurse specialist within the practice setting. As well, the students would observe role-models on which they could pattern their own behaviours in learning sensitive care to the elderly.

In conclusion, there needs to be more emphasis on wellness in order to eliminate negative stereotypes of the elderly among beginning practitioners in the nursing profession. As well, nursing students require more opportunity to learn and work with masters-prepared clinical nurse specialists in gerontology.
References


Shapiro, E. (1986). Patterns and predictors of home care use by the elderly when need is the sole basis for admission. *Home Health Care Service Quarterly, 7*(1), 29-44.


Appendix A

Consent Form

Title of the Study:
Hospital to Home: What is the perceived need for care and support of elderly women hospitalized for a fall?

Purpose:
The purpose of this study is to describe the need for care and support as perceived by women aged 75 years and older returning home to live alone after a hospitalization for a fall.

Investigator:
Sharon Galloway

The purpose of this study has been explained to me by Sharon Galloway and I agree to participate in this research project. I understand that this study involves two to three interviews of 30-60 minutes duration in my home and that the interviews will be tape-recorded. I understand that my involvement in the study will be confidential and that my name and any identifying features will be deleted from all sources of information. I understand that I may refuse to answer any questions and may withdraw my consent at any time without risk to future and present health care. If I have any further questions about the study, I understand that I may contact Sharon Galloway at xxx-xxxx for clarification. As well, I understand that I may contact the supervisor of the project (Jo Ann Perry) at xxx-xxxx with questions at any time.

I acknowledge receipt of a copy of this consent form.

Signature

Date ____________________________ 1991
Appendix B

Letter of Information

My name is Sharon Galloway. I am a Registered Nurse currently working on my thesis for the Master of Science in Nursing at The University of British Columbia. I am studying the perceived need for care and support of elderly women who return home to live alone after a hospitalization for a fall.

This letter is an invitation for you to participate in my study. You are under no obligation to participate and if you choose to participate you may withdraw from the study at any time. The health care that you receive will in no way be affected by your decision to participate or not participate.

If you are interested in talking with me about your experience upon discharge from hospital, I would like to meet with you in your home approximately two to three times. Each interview will last for 30 to 60 minutes. On the initial interview, I will ask questions about your concerns for care and support at home after a hospitalization for a fall. Subsequent interviews will be approximately four weeks later and will provide an opportunity for you and me to clarify and expand on the information that you initially shared with me.

Each interview will be tape-recorded so that I may listen to what you are saying. As well, I will take some written notes. All information that you share with me is confidential; the tapes will be numbered so that your name will not appear on them and a code will be used when the tapes are transcribed. Access to the tapes and typed transcripts will be limited to my thesis advisors, my typist, and myself. You may request erasures of taped information at any time and at the completion of the study, all tapes will be destroyed. All written material arising from this study will maintain your anonymity.

Participation in this study is voluntary. It is hoped that the information provided will help nurses to better understand the need for care and support in the community for elderly women who fall. Participants who are interested will be sent a summary upon completion of the study.

If you are interested in participating or have further questions regarding the study, please call me at xxx-xxxx. The supervisor for this project is Jo Ann Perry. Her office phone number is xxx-xxxx. When your nurse gives me your name, I will phone you to clarify any questions you have and to inquire about your interest in participating. I look forward to speaking with you.

Sincerely,

Sharon Galloway
Appendix C

Trigger Questions

1. How do you feel you are managing at home since the hospitalization?

2. How has the fall affected your daily life?

3. How has the fall affected your need for assistance or help at home?

4. How do you feel the fall has affected your need for care at home?