Autonomy, Choice, Patient-Centered Care, and Hip Protectors: The Experience of Residents and Staff in Long-Term Care

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Abstract

The purpose of this study was to examine long-term care (LTC) resident and staff perceptions on the decision to use hip protectors and identify the factors that influence attitudes toward hip protector use. Staff ($N = 39$) and residents ($N = 27$) at two residential care facilities in British Columbia, Canada were invited to participate in focus groups on fall prevention and hip protector use. A total of 11 focus groups were conducted. Using framework analysis results show that residents and staff shared concerns on aesthetic and comfort issues with hip protectors. Residents also generally felt they did not need, or want to use, hip protectors. However, they also had desire to be cooperative within the LTC environment. Staff underscored their role in advocating for hip protector use and their desire to protect residents from harm. Practice considerations for facilities wishing to promote hip protectors within a patient centered framework are highlighted.

Keywords

long-term care; decision making; patient-centered care; autonomy; hip protectors

I think everybody's responsible for themselves. And sometimes we just slack off and get hurt.

(Older LTC resident commenting on hip protector use)

Autonomy is the right to self-determination based on a respect for an individual's ability to make informed decisions regarding personal choices. In recent years, there has been a push to recognize the importance of respecting the autonomy of residents in long-term care (LTC) facilities (Boyle, 2008; Kane, 2001; Knight, Haslam, & Haslam, 2010). Concurrently, resident mobility, fall, and injury prevention have also become key areas of focus for LTC

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Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

administrators (Scott, Higginson, Sum, & Metcalfe, 2010a; Scott, Wagar, Sum, Metcalfe, & Wagar, 2010b). Doyal and Gough (1991) suggest that to be minimally autonomous is to “have the ability to make informed choices about what should be done and how to go about doing it” (p. 53).

Falls represent a significant public health concern and cause more than 95% of hip fractures and 60% of head injuries in adults above age 65 years in Canada (Scott et al., 2010a). Approximately 20% of older adults hospitalized for hip fracture will die within 1 year and only 50% will regain their prefracture level of mobility and independence (Empana, Dargent-Molina, Bréart, & EPIDOS Group, 2004; Wolinsky, Fitzgerald, & Stump, 1997). The majority of older adults living in LTC (60%) will suffer at least one fall per annum (Stevens & Olson, 2000), with many residents experiencing multiple falls (Scott et al., 2010a, 2010b). Hip protectors typically consist of soft- (i.e., foam rubber) or hard-shelled (i.e., rigid plastic) pads that cover the proximal femur, embedded in a garment or undergarment. In the event of a fall, hip protectors are designed to minimize the amount of energy absorbed by the proximal femur on impact, either by diffusing forces away from the bone to surrounding soft tissue (hard shelled), or by absorbing energy in the pad material itself (soft shelled; Cameron et al., 2010; Robinovitch et al., 2009).

There is a growing awareness among LTC staff of the need to apply fall and fall-related injury prevention evidence to practice, including the use of hip protectors. However, there is a gap in literature as few studies have investigated residents’ autonomy and choice with respect to falls prevention options and hip protector use, specifically. To date, the focus in the hip protector literature has been predominantly quantitative, through the use of survey methods, focused on ways to improve residents’ compliance with hip protector use through staff motivation and training (Burl, Centola, Bonner, & Burque, 2003; Honkanen et al., 2007). Research related to hip protector traditionally underscores main issues related to wear compliance. Thus a substantial gap remains regarding best practices for hip protector use and especially within a patient-centered framework. We contend that insight into compliance with hip protectors is but one part of improving prevention of fall-related injuries. The second and equally compelling component is how to best balance attempts to prevent fall-related injuries while at the same time honoring residents’ right to choice and autonomy in decision making.

Therefore, we use in-depth qualitative methods to address this gap by capturing the experiences of staff who promote hip protectors and residents who may or may not want to wear hip protectors. These voices are not otherwise heard when more traditional quantitative approaches are adopted. In short, this article addresses a new and important area of inquiry, hip protector use using qualitative methodologies within a patient-centered care framework.

Fracture Prevention and Hip Protectors

Falls on the side, particularly for institutionalized older adults with low bone mineral density, are more likely to result in fracture of the proximal femur (Aspray et al., 2006). Furthermore, many LTC residents cannot elicit useful protective responses, like putting one’s hands out quickly and absorbing energy in the upper limb, in the event of a fall

(Robinovitch, Normandin, Stotz, & Maurer, 2005; Sran, Stotz, Normandin, & Robinovitch, 2010). Accordingly, residents of LTC are nearly four times more likely to sustain a fracture of the hip than community-dwelling older adults (Ytterstad, 1999).

Although hip protectors have the potential to prevent up to 80% of all hip fractures (Cameron et al., 2001; Forsen et al., 2004b; Harada, Takemura, Tokuda, Okuizumi, & Niino, 2001; Kannus & Parkkari, 2007), many residents are unwilling to comply with their use (Parker, Gillespie, & Gillespie, 2006; Sawka et al., 2005). Numerous issues related to uptake and adherence have been reported including discomfort (Bentzen, Bergland, & Forsen, 2008a; Burl et al., 2003; Cameron et al., 2001; Doherty, Glover, Davies, & Johnson, 2004; Hubacher & Wettstein, 2001; Milisen et al., 2011; O'Halloran et al., 2007; Sawka et al., 2007; Taverner-Smith & De Vet, 2006; Woo et al., 2003), development of unwanted side effects such as heat rash and redness (Bentzen et al., 2008a; Bentzen, Forsen, Becker, & Bergland, 2008b; Cameron et al., 2001; Doherty et al., 2004; Forsen, Sandvig, Schuller, & Sjøgaard, 2004a; Milisen et al., 2011; Taverner-Smith & De Vet, 2006), dislike of their appearance (Forsen et al., 2004a; Hubacher & Wettstein, 2001; Thompson, Jones, Dawson, Thomas, & Villar, 2005), poor understanding of fracture risk (Chan et al., 2000), difficulties donning and doffing hip protectors due to physical frailty (Bentzen et al., 2008a; Chan et al., 2000; Doherty et al., 2004; O'Halloran et al., 2007; Taverner-Smith & De Vet, 2006; Woo et al., 2003), and a resulting loss of daily living independence, especially with regard to toileting (Taverner-Smith & De Vet, 2006). There are also benefits to hip protector use. Cameron et al. (2000) have reported that hip protectors improve falls self-efficacy and users feel more confident that they can perform tasks safely.

Autonomy, Choice, and Person-Centered Care

Older adults living in LTC represent one of society's frailest populations. LTC residents often struggle with managing multiple chronic conditions and social isolation (Aneshensel, Pearlin, Levy-Storms, & Schuler, 2000; Teeri, 2006). Within LTC, more than 75% of residents have some type of cognitive impairment (Proctor & Hirdes, 2001), which creates additional challenges to providing care due to the related communication, functional, and behavioral problems (Sachs, Shega, & Cox-Hayley, 2004).

In this article we examine resident and staff perceptions regarding the decision to use hip protectors with specific attention to resident autonomy in decision making. Research that examines patient autonomy in health care decision making is predicated on a respect for patients' rights to autonomy and self-determination (Abramson, 1988; Brindle & Holmes, 2004; Coulton, Dunkle, Haug, Chow, & Vielhaber, 1989; Dubler, 1988; Guadagnoli & Ward, 1998; Stacey, Henderson, MacArthur, & Dohan, 2009). There are several complex philosophical arguments that underpin the notion of decision making, balancing resident autonomy, and providing person-centered care (Agich, 2003; McCormack, 2004; Perkins, Ball, Whittington, & Hollingsworth, 2012). The key principles of person-centered care include a focus on the following: treating persons, not diseases or disabilities; understanding that individuals have unique histories and preferences; eliminating dehumanization; maintaining dignity and autonomy; and, recognizing the centrality of relationships (Brooker, 2008). Supporting person centeredness includes respecting an individual's right to be

involved in making everyday life decisions. Central to this is the right to exercise choice and decision making in relation to routines, personal care, and the treatment of personal space.

Current efforts to strive for more person-centered caregiving are based on the idea that knowing residents as individuals and being responsive to their needs and preferences will lead to better outcomes for residents and caregivers. At an institutional level, this is the basis for flexible policies that provide residents choices regarding their sleeping, eating, and bathing schedules. At the interpersonal level and the core of any successful person-centered intervention are caregivers' relationship skills, communication skills to elicit personal information from residents, cognitive skills to see how this information can be applied in caregiving tasks, and behavioral skills to enact these insights (Burgio et al., 2000; Pietrukowicz & Johnson, 1991). This is the conceptual lens that guided this examination of hip protectors.

With a growing emphasis on injury prevention in LTC and interest in patient-centered care practices, it is important to better understand the challenge of balancing the benefits of hip protector use with residents' choice to wear (or not wear) hip protectors. Thus, through in-depth focus group interviews, we examine resident and staff perceptions regarding the decision to use hip protectors (McCormack, 2004). We focus specifically on the factors that influence resident and staff use of hip protectors. We offer practice considerations for facilities wishing to promote hip protector use embedded within a patient-centered framework.

Design and Method

This study is part of a larger mixed methods Technology for Injury Prevention in Seniors (TIPS) program of research that examines the use of technology to prevent falls and fall-related injuries in two LTC facilities in British Columbia (see www.sfu.ca/TIPS). Ethics approval was obtained from the University of British Columbia, Simon Fraser University, and Fraser Health Authority Research Ethics Boards.

Participants

All staff and residents at two participating residential care facilities in British Columbia were invited to participate in focus groups on falls prevention and hip protector use. A total of 11 focus groups were conducted between 2009 and 2011 in two residential care facilities with best practice guidelines that strongly endorse the use of hip protectors by residents as an injury prevention mechanism. There were different attendees at each focus group session; the moderators (JSG, LH) were trained qualitative researchers who conducted all focus group interviews. Staff and resident group focus groups were conducted separately. All participating residents were cognitively functional and provided informed consent to participate.

Staff participants ($n = 39$) were residential care aids ($n = 24$), nurses ($n = 3$), recreation therapists ($n = 4$), rehabilitation assistants ($n = 3$) and physiotherapists ($n = 5$). Staff members who participated were mainly female ($n = 31$) and had worked in the field between 6 months and 30 years (see Table 1).

Resident participants ($n = 27$) were mainly women (70%), which reflected the composition of residents in LTC. The age of participants ranged from 72 to 91 years with a mean age of 87.8 years. The majority of participants had not suffered a serious fall (only 2 participants had a fall requiring a trip to the emergency department and/or hospitalization) but with the exception of 3 participants they all indicated that they had fallen recently. Each focus group was comprised of a mix of residents who wore hip protectors and residents who did not (24% were currently wearing soft-shelled hip protectors, while 87% were aware of them). Within the 2 participating LTC facilities, soft-shelled hip protectors are offered to residents on admission for a cost of approximately \$80.00 CAD dollars.

Procedures

Focus group size ranged from 4 to 12 participants and each session lasted 20 to 50 min. Each participant participated in one focus group interview. On average the resident focus groups were 15 min shorter than the staff focus groups. The first two sets of focus groups, conducted in 2009 and 2010, centered on hip protector use and other fall prevention technologies. The third set of 4 focus groups conducted in 2011 centered on hip protector use, specifically uptake and adherence to wearing them. An inductive, semistructured approach guided focus group sessions. The questions were designed to understand hip protector use, decision making, and patient-centered care in injury prevention. Questions for staff included “How do you prevent resident injury in the LTC where you work?” “Do you believe that hip protectors are beneficial?” “Do you encourage residents to try them?” “What do you think are residents’ main concerns?” “How do you deal with refusal to wear hip protectors?” Questions for residents included “Has anyone spoken to you about fall prevention or hip protectors?” “Why do you or why don’t you wear hip protectors?” “What are your main concerns about hip protectors?”

Focus group sessions were audiotaped and data were transcribed by a professional transcription service. Observational field notes of the focus group interviews were taken by JSG and LH and captured observations of the environment, nonverbal reactions of participants, and visual assessments of the older participant’s mobility and stability.

Data Analysis

Focus group data analysis involved a number of interconnected stages to reduce, organize, and interpret the independent and interdependent opinions and perceptions engrained in the data (Kidd & Parshall, 2000; Rabiee, 2004; Ruff, Alexander, & McKie, 2005).

Transcripts were reviewed using a framework analysis (Pope, Ziebland, & May, 2000; Rabiee, 2004) that included four stages: familiarization, thematic identification, charting, and interpretation. Initially, two researchers read all transcripts in their entirety to establish a sense of the interviews as a whole. Through a series of 4 meetings, the same two researchers identified a preliminary thematic framework based on key issues, concepts, and themes. A trained research assistant then coded all of the data. The thematic framework was applied to all data and it was rearranged into groups of similar excerpts. Summaries were developed by the two researchers for each grouping. Nvivo 8.0 software was used to organize and code the transcripts.

Comparisons were made between and within the groupings (constant comparison) until data were sorted into the appropriate thematic content (Charmaz & Byrant, 2007; Glaser & Strauss, 1967). Relationships among themes, the original research objectives, as well as other themes that surfaced during the analysis process were considered to develop final categories.

Strategies used to establish rigor in this study included engaging with the research team for peer debriefing (via team meetings and smaller focused discussion about the developing themes), memo writing throughout the analysis process, and recording an audit trail of decisions made throughout data collection and analysis (Bradbury-Jones, 2007; Cutcliffe & McKenna, 2004; Koch, 2006).

Results

Residents

Three primary themes emerged from within resident transcripts: (a) residents' concerns with the physical aspects of hip protectors, (b) residents' assessment of their need (or lack thereof) for hip protectors, and (c) residents' desire to be cooperative within the LTC environment.

Residents' Concern With the Physical Aspects of Hip Protectors

They bulge out of the side of their ... if they're wearing slacks, they bulge out the side of the slacks, and it doesn't look pretty.

Residents had both practical and aesthetic concerns with regard to hip protectors. Consistent with research on hip protector compliance, many residents found hip protectors to be an obstacle when trying to engage in activities of daily living. For example, one resident noted, "Because I have a bladder problem and the length of time it takes to take that extra article down can mean the difference between making the toilet and not making it." In many instances, residents also found hip protectors to be uncomfortable, "I never could stand nylons so I guess ... maybe that's got something to do with it."

However, it was not just the inconvenience and discomfort of using hip protectors that were displeasing to residents. Many of them commented on the aesthetics of wearing hip protectors. A number of residents spoke about their bulky appearance and noticed them on other residents, "Oh, yeah, I know the people in my unit that are wearing them, they're very noticeable, they have sponge in them. It's quite thick, so they protrude, even past their hip." The thought of wearing hip protectors evoked great discomfort in residents who did not want to look bigger: "It's making you look bigger than what you are. Those things look hideous on some people." The use of hip protectors caused concern for residents who did not want to be singled out or even laughed at: "but they look funny, and, look, I wouldn't want anybody laughing at me." There were no positive comments on physical aspects of hip protectors. Two residents currently wearing hip protectors did, however, note that the protection provided by hip protectors was worth it even though they "did not look good." Both male and female residents were concerned about the aesthetics of hip protectors.

Residents' perceived need (or lack of) for hip protectors

I'm very steady and I'm sturdy and I walk a lot and so I don't think I'd ever need them.

Many of the residents did not see the need for hip protectors, as they did not identify as being frail or "at risk" for falling. Most residents, even those with obvious mobility constraints (i.e., using an aid, trouble sitting or standing, shuffling feet), described themselves as not needing hip protectors: "... so far as I know, I won't have one because I'm very sturdy. But if I became prone to falls, I would wear them." Interviewers noted the fragile appearances of many residents who attended focus group interviews (i.e., unsteady gait, osteoporotic hunch, shaky hands, etc.). Even those residents who had a fall did not view hip protectors as necessary as represented in the following dialogue (M = Moderator; R = Respondent):

M Have you tried them at all?

R Yes, I've tried them on, but—

R Didn't wear them long enough to find out.

M On and off again.

R Yes, [laughs] that's right.

M And have you ever had a fall?

R What kind of a fall?

M Did you fall when you were out walking ever or in the bathroom?

R Sure, everybody does that.

M And you're not worried about breaking a hip or hurting yourself?

R No.

M No?

R If you're going to hurt yourself you'll do it no matter where you are.

There were several participants who spoke about other residents who wore hip protectors and identified them as frail and unsteady and really "needing them." It was observed that these residents also appeared frail and unsteady but did not characterize themselves in this way. One resident spoke at length about his wife who wore them because she had dementia and needed them but he indicated he did not need them as "he was fine."

Residents' conceding to hip protector use

I just know it has to be worn whether I want to wear it or not.

While many residents refused to wear hip protectors, others conceded to hip protector use. These individuals either saw the value in wearing hip protectors or felt obliged based on pressure by staff. For example, in the following case the resident conceded to the use of hip protectors but was reluctant to elaborate on why.

R I'll have to get used to them.

M Okay, and you think you'll get used to them in time or—

R Like I say, I have no choice.

Similarly another resident spoke about wearing hip protectors reluctantly.

M Do you wear hip protectors?

R I have been, but I don't really want to.

M You don't want to? Do you not like them?

R Well, not that I don't like it but, I mean, I could do without it.

M Yeah? You don't think they help you?

R I don't think so, really.

M Why don't you like to wear them?

R I don't know.

LTC Staff

There were three primary themes within the staff transcripts: (a) staff awareness of issues with respect to wearing hip protectors, (b) their role in advocating for hip protector use, and (c) their desire to protect residents from harm.

Staff awareness of the aesthetic issues

the residents ... they just find them too bulky.

Staff expressed awareness of the practical and aesthetic issues for residents. In many instances, they even “understood” why residents refused to wear hip protectors. They commented on both the physical discomfort of wearing hip protectors, “they are quite tight,” and also the aesthetic issues related to them, “they just make their hips look wide.” The predominantly female staff was extra sympathetic to female residents who they suggested would be “concerned with their appearances, not wanting to look fat.” While most staff was sympathetic to residents’ concerns with hip protector aesthetics, several staff members seemed rather despondent and disinterested in the concerns of the residents. Staff also spoke at length about the pressure of time and the competing demands in their jobs, indicating that hip protectors were one of many concerns or tasks during a regular work day.

Staff as advocates for hip protector use

If they say refuse then I go, “well, if you fall it protects your hip bone and it’s good for you.” It takes a few minutes but then they go, well, put it on. Sometime they refuse, then we have to follow that as well.

Despite recognition of the physical and aesthetic issues related to hip protector use, staff spoke at length about their role in advocating for the use of hip protectors with residents. They offered numerous examples of how they deal with hip protector refusal and noted their role in respecting residents’ wishes: “Here they have preference, right. We have to follow them.” Staff expressed that residents are generally “very good with it [hip protector use]” and indicated that a few residents refuse to wear hip protectors, “but it’s not very many refuse, hardly once in a while.” What was unclear was which staff members discussed hip protectors with residents. The care aides in attendance discussed their role in assisting resident to doff and don protectors but did not directly discuss their role in discussing the benefits of their use.

Staff perceptions of protecting residents

Because they can’t do anything without your help, so you just do it [put on hip protectors] and that’s—

It was evident that staff believed a core mandate of their job was to keep residents safe—to help protect them. Many emphatically described doing the “right thing” to keep residents safe. However, this often resulted in staff going beyond advocating for the use of hip protectors to deciding on their use. This was particularly true for residents who could not communicate and/ or had compromised cognition. For example, one staff member discussed the difference between those that were “independent” (could overtly refuse) and those who could not or did not communicate:

... here, people are more independent and alert compared to other dementia floors, total care. So in total care you can put whatever you like to protect them from fall or any injuries. But here you have to follow them. You can put it on, they refuse, you can ask one or two times. And afterwards, it’s [off again].

Other staff members questioned whether residents’ should be given a choice in wearing hip protectors: “They have to. They have no choice. You wear it.” For some staff, their desire to “protect” residents translated to a blanket policy on use of hip protectors. While staff did not discuss administration at all, they did indicate that safety was extremely important. The following dialogue demonstrates the tension between staff who believed a particular resident must wear hip protectors (in the name of safety) and the resident’s obvious refusal. The resident often removed the hip protectors at night demonstrating her dislike of them.

She will say, “No, no, I don’t ... don’t put them on me. Don’t put ...” and then most of the time when, you know, in the morning we come, it’s sometimes she takes it out, put it under the bed and she’ll put her pajamas on, though. Sometimes she put it in the drawer.

While some staff encouraged use of hip protectors, others came across as mandating their use at all costs, in particular those staff members who noted that safety was essential in the

LTC environment. Some staff members also suggested that in time some residents do eventually concede to the use of hip protectors.

Discussion and Conclusions

There is a delicate balance between respecting the autonomy of residents in long-term care facilities and caring for their safety. While it is well established that, if worn, hip protectors are an effective means to prevent fracture, residents expressed concerns with the physical aspects of hip protectors and questioned the need to wear them. Supporting person centeredness includes respecting an individual's right to exercise choice and decision making in relation to personal care. Thus the difficult choice that caregivers make each day regarding hip protector use by residents warrants further discussion.

Many residents who were part of the focus groups insisted that they had never experienced a fall and/or felt very steady on their feet so did not require a hip protector; they viewed the use of a protective device (in particular one that is not aesthetically appealing) as unnecessary. This is consistent with research on falls prevention programming. For example, when falls prevention programs are targeted at older populations they are often rejected as unnecessary and patronizing and not personally applicable (Yardley, Donovan-Hall, Francis, & Todd, 2006). This notion is reflected in Becker's (1994) work, which shows that older adults do not acknowledge their frailty or limitations. In many cases there was disconnect between how "fragile" or unsteady a resident appeared and their own perception of whether they could benefit from the protection provided by a hip protector. Researchers Gilleard and Higgs (2002) and Tulle (2008) assert that ageing bodies have been constructed as posing a challenge to agency and identity. Featherstone and Wernick (1995) identify the "mask of aging" phenomena whereby older people do not identify with their aged face and instead, view their reflection as a betrayal of the "real," younger self. This contributes to disruption and disembodiment of oneself. This, in turn, creates disconnect between one's perceived fragility and the potential applicability of using a protective device such as hip protectors (Robinovitch & Cronin, 1999). Perkins and colleagues (2012) note that older residents often fear being labelled and as a result often hide impairment, shun assistance and the use of assistive devices. Based on our findings, a first step in the path to hip protector use may be to guide residents toward recognizing their health limitations—followed next by acknowledging the benefits of hip protector use. In addition, there is a need for improved product design. Hip protectors need to be slim, inconspicuous, and accommodate those with incontinence.

While many residents did not see the applicability or utility in wearing hip protectors, they spoke about their desire to cooperate within the LTC environment. They did not want to cause disruption or be perceived as a nuisance. They spoke about over time conceding to the use of hip protectors and feeling that they had "no choice" but to wear them. We speculate that this was due to the repeat offering, urging, and in some cases insistence by care staff. In some cases, residents may have come to recognize the value in hip protector use, but more commonly residents felt they had little choice. Lack of choice, or the perception of lack of choice, threatens a person-centered care environment where respect for individual choice is key.

The LTC facilities where this research was conducted have best practice guidelines that strongly endorse the use of hip protectors by residents as an injury prevention mechanism. So while staff had an awareness of the aesthetic issues related to hip protectors, they also recognized their professional role (and the expectation) to advocate for the use of hip protectors. Staff acknowledged injury prevention as an essential component of their role and saw hip protectors as a tool for injury prevention (despite the obvious aesthetic shortcomings). This belief was deeply engrained in staff care practices such that in some instances, staff would insist on the use of hip protectors even when residents had explicitly declined their use. Where this was particularly apparent was with the most frail residents and residents with cognitive impairment. For example, staff expressed that it was “easier” to ensure hip protector use on the dementia units. These findings clearly illustrate the tension between a strong commitment by caregivers to safekeeping and violating a resident’s right to choice and autonomy.

Research shows that residents in LTC who are involved in decisions about their care are more socially involved, active, happier, and more comfortable; contrasting those who live “in a home” with those who “feel at home” (Knight et al., 2010). When residents are unable to make informed decisions about their care or express their preferences, staff and family members are forced to make judgments about what they believe the resident would prefer. These proxy decision makers have to balance what they believe is the best care option for the resident with what they know about the resident personally. While our study illustrates that this is often not an easy task, it also points toward necessary improvements in policy on the use of hip protectors in LTC.

Implications for Research and Practice

At the individual level, person-centered care is based on trusting relationships and open communication between staff and residents. Ultimately, individuals retain the right to exercise choice and to decision making. Furthermore, a trusting relationship means respecting the choice of a consenting adult even when their choice places that person at risk (Randers & Mattiasson, 2004). If we accept this basic premise, it suggests that although staff must discuss injury prevention and hip protector use with residents, it is the right of residents to choose whether or not to wear hip protectors. This concept is not straightforward as the ability of a resident to provide consent may change over time. This speaks to early engagement with residents and their families (or proxy’s) to better understand and enact individual preferences even if older adults are no longer able to clearly communicate them.

Residents likely need to understand and *accept* their own vulnerabilities before they view hip protectors as necessary or relevant to them. Early and ongoing discussions about hip protector use should occur with residents and their families. As part of these discussions, residents should be engaged in conversations about their perceptions of risk and the benefits of hip protector use (balanced against the life changing nature of a hip fracture, for example).

At the institutional level, person-centered care means having policies that are effective but flexible to account for individual schedules and preferences (Burgio et al., 2000; Pietrukowicz & Johnson, 1991). This means that policies need to support staff to work in an

environment that allows them to respect individual choice even when residents make a choice contrary to what best practice policies might suggest.

In conclusion, in the context of hip protector use in LTC, it is important to acknowledge the delicate balance between respecting the rights and choices of older residents and the demands and potential tension confronting caregiv-ers who protect residents' safety. To address this, staff requires training on safeguarding individual choice and autonomy as well as on injury prevention and best practices. This complex reality might also suggest that qualified counselors (social workers, physiotherapists, occupational therapists, or psychologists) be made available to guide these residents through accepting the limits of their physical ability and adopting behaviors that protect them from injury.

Limitations and Future Research

We interviewed residents who were able to consent to be involved in research. Given that upward of 75% of LTC residents have cognitive impairment (Proctor & Hirdes, 2001), limiting the sample to those who could provide consent excluded a large contingent of older adults residing in LTC. Future studies that engage residents who require proxy consent would serve to further advance our understanding of the specific needs of this group. Furthermore, adopting techniques such as observational analyses would allow researchers to report on the experience of wearing hip protectors for those with cognitive impairment. These collective efforts would further the knowledge base for caregivers who work with older adults in LTC to better meet the needs of residents. We also note that LTC staff are often fearful of expressing information that may appear as a complaint for fear of repercussions to their employment situation and similarly residents do not want to appear as complaining. Again, observational analyses would help augment interview data.

Acknowledgments

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by team grants from the Canadian Institutes of Health Research (CIHR; Grant Nos. AMG-100487 and TIR-103945).

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Victoria Scott is the Senior Advisor for Fall and Injury Prevention with the BC Injury Research and Prevention Unit and the Ministry of Health (MoH), Director, Centre of Excellence on Mobility, Fall Prevention and Injury in Aging (CEMFIA), and Chair of the BC Fall and Injury Prevention Coalition. She also holds an academic position as a Clinical Associate Professor with the School of Population and Public Health at the University of British Columbia (BC). Dr. Scott assists the MoH in transferring knowledge from fall and injury prevention research initiatives into policy development.

Stephen N. Robinovitch is a professor and Canada Research chair in the Department of Biomedical Physiology and Kinesiology, and the School of Engineering Science, at Simon Fraser University. His research focuses on improving our understanding of the cause and prevention of falls and fall-related injuries (especially hip fracture) in older adults.

Table 1

Participant (Staff) Demographics.

Gender	N	%
Male	8	18
Female	31	82
Job title		
Care Aid	24	61
Nursing	3	8
Recreation	4	10
Occupational therapy/physiotherapy	3	8
Rehabilitation therapy	5	13