

SAGE Research Methods Cases Medicine & Health Submission for Consideration

Case Title

'Going Along' or 'Sitting Around With?' Go-Along Interviews with Older People in Hospital to Understand Experiences at Transitions of Care.

Author Name(s)

Dr Natasha Hardicre

Author Affiliation & Country of Affiliation

Yorkshire Quality and Safety Research Group, Bradford institute for Health Research, Bradford Teaching Hospitals NHS Foundation Trust, England, UK.

Lead Author Email Address

Email: Natasha.Hardicre@bthft.nhs.uk

Discipline

Medicine [D23]

Sub-discipline

If you chose Medicine, Public Health, or Nursing as discipline, pick sub-discipline from the relevant list below. There are no sub-discipline options for Dentistry.

Geriatric Medicine [SD-MD-10]

[For Public Health: choose sub-discipline]

[For Nursing: choose sub-discipline]

Academic Level of intended readership

Intermediate Undergraduate

Contributor Biographies

Natasha Hardicre (PhD) is a sociologist by background who has worked in applied health research for the past five years within multiple teams at Bradford Institute for Health Research (BIHR), part of

Bradford Teaching Hospitals NHS Foundation Trust. Some examples of her work include: qualitative research to explore the experiences and perspectives of different patient groups, including stroke survivors and older people; contributing to the development of complex interventions to improve care; designing evaluations for research projects, including an embedded process evaluation of a clinical trial for a complex intervention for stroke survivors; facilitating workshops for co-production of interventions or to elicit requirements and perspectives from multiple stakeholders. Before joining the BIHR, Natasha taught modules on sociological theory, and research methods at the University of Leeds. Her PhD used multiple methods to explore how people demonstrate love to each other, and how this relates to social solidarity and morality. Her ongoing research interests include: understanding the context within which healthcare is delivered, in order to develop interventions that work within those contexts; co-production of interventions; evaluation; and the multiple forms of ‘work’ that people do when they provide and/or receive care.

Published Articles

Hardacre NK, Birks Y, Murray J, et al. (2017) ‘Partners at Care Transitions (PACT)—exploring older peoples’ experiences of transitioning from hospital to home in the UK: protocol for an observation and interview study of older people and their families to understand patient experience and involvement in care at transitions. *BMJ Open* 7(11).

Abstract

This case study draws on a longitudinal focused ethnography, which utilised semi-structured interviews, observation, and ‘Go-Along’ interviews (GAIs) to explore the experience of older people as they transitioned from hospital to home. This was the first time that the researchers had undertaken GAIs. This case study shares insights into the potential benefits and challenges of using this method, especially within healthcare settings.

‘Go-Along’ interviewing is a person-centred, interactive and participatory method, focusing on understanding participants’ experiences in real time, within changing contexts. The rationale for including GAIs in the study was to elicit thoughts, feelings, and perspectives from older people about their care at transitions, within the context in which care was being delivered and at the moment of experience. The hope was that this method would provide insight into thoughts and emotions that may otherwise remain unconscious or unsaid. The plan was that researchers would accompany participants at key transitional moments and conversations would be recorded digitally and supplemented by field notes. However, the reality of hospital care meant that this was very challenging to achieve practically. Despite collecting over 150 pieces of data, only X were from GAIs. Nonetheless, this method generated insights that may otherwise not have been directly observed or discussed. Moreover, *attempting* to ‘go along’ with patients in hospital actually highlighted the sedentary nature of hospital care. Difficulties notwithstanding, the author urges researchers to consider this method, especially to gain access to data where time and location are likely to impact experiences.

Learning Outcomes

By the end of this case, students should be able to . . .

- Understand how Go-Along interviews were used within this research study;
 - Describe some benefits and drawbacks of the method
 - Identify key barriers to conducting Go-Along interviews within healthcare settings
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Case Study

[Insert your case study here. The main body of the text should be between 2,000 and 5,000 words.]

Note: Headings and sub-headings add structure to the body of your case, enhance online discoverability and make your case easier to read on screen.

Each main section with a top-level heading must be followed by a Section Summary. Each Section Summary should consist of 2-3 bullet points, written out as full sentences, succinctly encapsulating the preceding section.

Suggested headings:

Project Overview and Context

Over the past decade the length of hospital stays have reduced (NHS Digital, 2016). This confers benefits for patients and healthcare services but can also result in an increasing dependence on care outside the inpatient setting. This means that ‘discharge’ from hospital is more likely to be a stage in a process involving the *transfer* of care, rather than being an end-point of care. The movement and transfer of care from hospital to home (or other intermediate care setting) – sometimes referred to as the ‘transition period’ – is likely to require input from multiple people and services, in order to meet patients’ needs. According to Williams et al (2015) this requires co-ordination of services and good information transfer between healthcare teams. Unfortunately, harm can occur when such co-ordination and reliable and effective transfer of care are not successful.

It has been estimated that 1 in 5 patients experience an adverse event in the immediate post-discharge period (Forster, 2003). Indeed, according to Healthwatch England (2017) the ‘discharge process [from hospital] is going wrong’. As the highest users of the NHS, we know that older people are at greater risk of adverse events during the transition period from hospital (NHS Digital, 2016; Forster, 2003; Williams, 2015) and poor patient and family caregiver experiences have also been well-documented in the literature (Allen, 2017). However, much of the research undertaken in this area is done in the post-discharge period and relies on recall of past experience, rather than exploring peoples’ experiences of care at the time that they are receiving it. With this in mind, we set out to explore the experience of older people from admission to hospital, through discharge and beyond. This study was the first part of a larger five-year programme of research (Partners At Care Transitions – PACT) funded by the NIHR (National Institute for Health Research) which aimed to develop an intervention to improve the care of older people at transitions.

Section Summary

- Transitions of care can be a risky point in a patient’s care pathway – approximately 20% people experience an adverse event in the post-discharge period.
- Older people, as the highest users of the NHS, may be disproportionately affected by adverse events.
- Current research shows that patient experience at transition from hospital to home is poor. However, much of the research that has been done has been undertaken in the post-discharge period. Our study aimed to explore older patients’ experiences of transition from hospital to home, at the time of experience and within the context of care delivery.

Research Design

In May 2018 myself and two other co-researchers, began a longitudinal focused-ethnography (Knoblauch, 2005) which aimed to follow 30 older people aged 75+ during their hospital stay and at home. The aim was to recruit patients at or close to admission and follow up with them throughout their stay and post-discharge. Data collection was flexible with regards to timing, but was broadly organised around five ‘episodes’:

1. Upon, or shortly after, admission to hospital;
2. Shortly prior to and/ or during discharge from the admitting hospital;
3. A day or two after discharge in the home or intermediate care;
4. Several weeks after discharge;
5. Three months after discharge or on readmission if sooner.

Research methods included observation, individual semi-structured interviews, and ‘Go-Along interviews’ (GAls), the latter of which was new to all three researchers.

Observation was chosen in order to gain insight into behaviour in its natural setting (Silverman, 2009). In particular, we wanted to explore the work that is done to deliver care. We also wanted to explore the ways in which individuals experienced and were involved in their care. Observations were both ward-based – looking at the general activities of wards and the staff working on them – and also observing individual patient care. Observational work was supplemented with discussions with staff and patients about the things that had been observed. Observations were recorded through researcher fieldnotes.

Interviews were conducted at multiple time points and explored patient experiences of being in hospital, transitioning home, and any post-discharge care they received. We also asked people about their experiences and preferences of being involved in their care. Interviews were either digitally recorded or captured through researcher fieldnotes.

‘Go-Along’ interviewing is a participatory and interactive method that aims to accompany individual informants on outings within a given context. Through observation and questioning, researchers can explore the participants ‘experiences, interpretations, and practices’ within their environment (Carpiano, 2009). By researchers participating in a journey with informants, GAls have the potential to be a more active approach to understanding the importance of time, place and context than other methods, such as non-participant observation and traditional interviewing, which might depend on recall or be more open to misinterpretation. Go-Along interviews enable researchers to “examine how physical, social, and mental dimensions of place and space interact within and across time for individuals” (Carpiano, 2009: 264) and participants act as ‘navigational guides’, co-constructing the interview (Garcia et al, 2012). Within our study we wanted to explore ‘transitions’ of care – a process which necessarily involves movement through time and space – and so utilising a method that incorporated time and space into the means of enquiry seemed like it would be beneficial. We aimed to conduct GAls with participants at key transitional moments, such as ward

moves, at discharge and movement through the healthcare system as part of receiving care. Data from GAs were recorded through field notes and researcher reflective accounts. Sometimes these were notes written during conversations and included quotations from participants e.g. 'Walking with Philip, 81 from ward to lift and talking about his care in hospital. He said "*There's some advantage of being middle class (which we are) and having a knowledge of the system because of my background in pharmacy. I feel like I get better treatment. I don't think it's conscious but I think it happens regularly*"' (extract from fieldnotes); descriptive accounts of what was happening and what could be seen e.g. 'People approach nurses station to ask for updates and to ask for locations of patients... the phone rings a lot!!' and 'On the wall there are five boards that act as communication aids to facilitate communication between staff: Staff board – who is working where... discharge board, admission board, transfers board, TCI clipboard...' (extracts from fieldnotes); and reflective accounts written by the researcher after the observation/interaction e.g. 'Doris (pseudonym) seems generally well and very upbeat. She manages her homelife well and has tried to be involved in her own care in hospital, but without putting herself at risk (e.g. calls people in the night to take her to the toilet , but does it herself during the day...)' (extract from reflective account).

Ethical Considerations

There were multiple ethical considerations within this study. Firstly, we were recruiting older people aged 75+ who had just been admitted to hospital – this meant that they were likely to be acutely unwell or injured, may lack capacity to consent, and/or be approaching end of life. As a group we felt that it was important to include the voices and perspectives of vulnerable people (e.g. people with dementia), not least because they may be at increased risk of adverse events post-discharge. However, we also didn't want to place excessive burden on people. As a group we decided that we would recruit patients that lacked capacity to consent to research, as long as they had someone to support them in the research process and who was also willing to participate in the study. On these occasions we approached relatives to ask if they would consider acting as a consultee for patients and agree to participate in the study. With regards to patients at the end of life, we decided to exclude them from the study for two reasons: firstly, we did not want to place additional burden on them; secondly, end-of-life care pathways are much more prescribed than other care pathways and so 'transitions' of care are likely to be different for this group of people, than the general hospital population.

Another ethical consideration was how participatory to be when undertaking research and/or what to do if we witnessed or thought someone was at risk of harm. To mitigate these risks, we had a team of clinicians who worked within the participating NHS Trusts, who could provide advice and help researchers escalate problems should safeguarding issues arise. We also agreed as a team that we would be as non-participatory as possible, so as not to disrupt clinical care or treatment, but would remain flexible and sensitive to the context and preferences of the participants and staff. The research underwent review and approval by an NHS Research Ethics Committee.

Section summary

- The study was designed to use methods to explore older people's perspectives about being in hospital and transitioning home. We took a longitudinal approach to understand how experiences and perspectives changed over time.
- Observational work and semi-structured interviews were supplemented with a more participatory and interactive approach to data generation – Go-Along interviews – to understand experiences within context.
- Ethical considerations included who to recruit to the study and how best to care for participants who were likely to be feeling unwell or may not have capacity. We also decided

to maintain a flexible and sensitive approach to data collection, always being guided by the study participants and the staff delivering care.

Research Practicalities

32 patients aged between 76 and 99 years old (average median age=84) were recruited from six hospital wards from three hospitals within two NHS Trusts in West Yorkshire, North of England. Recruiting wards specialised in older peoples' medicine, stroke care, respiratory care, and elderly orthopaedics. 18 family members were also recruited to the study. All participants provided written informed consent before taking part in the research.

Because we were working across two hospital trusts, we split the work according to Trust. The other two researchers both worked across wards within Trust Two, whilst I worked across two hospitals in Trust One. This enabled us to create and maintain good working relationships with ward staff. Over time staff became comfortable with our ongoing presence on the ward and seemed to become less self-conscious than they had been at the start of the observational work. Fostering good relationships with staff facilitated access to research participants and opportunities to observe hospital processes and care delivery; it also meant that staff shared their perspectives with us and this was a rich source of data.

Because patients were unwell, as researchers we were guided by clinical staff with regards who was eligible for the study and who was well enough to approach. Initial introductions were done by ward staff but all recruitment and consent procedures were done by the researchers. This was an important way to begin building a relationship with participants. As researchers, we ensured that we followed up with the participants that we had recruited – this enabled us to build and maintain trust and rapport with our participants. In my experience, this facilitated honesty and openness between researcher and participant and this generated good data; it also enabled us as researchers to care for our participants. We were able to be flexible to their individual situations and the participants I worked with seemed able to communicate their needs to me and I was able to adapt the research process to minimise burden. For example, I was able to defer visits when participants shared with me that they felt unwell.

Conducting research in constantly changing and busy environments can be extremely challenging. I was often based on wards that were consistently understaffed and also very busy. As an extra person on the ward, I often felt like I was 'in the way' and although I attempted to minimise this wherever feasible, it wasn't always possible without abandoning data collection. There were a couple of occasions where my presence was disruptive, and it felt that the ethical thing to do in that situation was to suspend data collection and leave the situation. However, most of the time, staff and patients were extremely accommodating and facilitated my presence. There were also times when both the process of observing, and also what I was seeing, caused me discomfort. For example, knowing how busy ward staff were, it was sometimes uncomfortable to see someone struggling and not be able to help. On other occasions I witnessed patients really struggling with what was happening to them and I knew I was powerless to change anything for them; the desire to help, coupled with the inability to do so, was sometimes deeply uncomfortable, especially as time continued and my relationships with my participants deepened. Spending hours doing in-depth inquiry in often challenging circumstances was a tiring experience and there were times when I experienced 'fieldwork fatigue'. I think this is an often-unacknowledged aspect of qualitative data generation, especially when working with ethnographic methods. Regular peer support from other researchers within the study team and the wider research group were really important.

Section summary

- 32 patients and 18 family members were recruited to the study.

- Spending time with participants and with ward staff fostered good relationships, facilitating access to patients and data collection opportunities. It also generated rich data by creating rapport and trust between researchers, participants and other people involved in the study.
- Conducting fieldwork within complex and busy settings such as hospitals can be challenging for researchers. Getting support from other researchers is useful to help you navigate the personal challenges of ethnographic work, especially over time.

Method in Action

Out of the three of us, I was the only researcher in our team to conduct any GAIs. The other researchers reported having no opportunity. Having limited opportunity also reflects my own experience of attempting to organise and do any GAIs.

The aim was to recruit patients to the study and ‘follow’ them throughout their journey. However, ‘following’ them was often difficult, in part because of the time constraints associated with recruiting and conducting research with multiple participants at the same time; this meant that it was difficult to spend a long time doing observational work with any one person – it often felt like you were sat waiting for something to happen and when there are multiple other participants to see, this was not always feasible. The key barrier to conducting GAIs, however, was the way hospital work itself is organised.

I wanted to accompany patients at key transitional moments and from speaking to participants, these seemed to be concrete transitions such as ward moves and discharge, but also included smaller ‘transitions’ such as moving from location to location within the hospital to receive tests, treatment or care. Unfortunately, the timing of these things occurring was often so unpredictable, it was almost impossible to plan to accompany patients. One patient, Pearl¹(91), moved hospital wards five times during her stay three week stay – only two of these were planned and communicated to Pearl and her family beforehand; on occasion, myself and her daughters would turn up to visit Pearl to find that she wasn’t there. Many ward moves, even those planned and communicated to patients often occurred late at night or were spontaneous and based on sudden bed and/or staff availability. Patients reported being surprised by ward moves, which would frequently occur whilst they were sleeping and who were informed of the impending move by the porter who had come to transfer their care to another ward.

There were also occasions when transitions were planned and I arranged to accompany patients throughout their journeys. However, things rarely seemed to occur as planned, especially in hospital. Transfers were frequently delayed – sometimes by weeks, not hours, or happened much sooner than anticipated. One of my participants, Frank, was told in the morning that he needed to stay in hospital for a few more days to check he responded well to the change of medication. He was given a provisional date for discharge and agreed that I could accompany him from hospital to home and conduct the GAI. However, when I arrived on the day of discharge, he wasn’t there. After speaking to staff I discovered that he had been discharged on the day that he had initially been told that he needed a longer stay. When I spoke to Frank about his experience, he told me that a couple of hours later a nurse had come to help him pack away his things because an ambulance was on its way to pick him up. This was a relatively common experience for patients and also myself as a researcher who was trying to follow patients.

Another common experience when attempting to ‘go along’ with patients was that a lot of hospital care, including care at transitions involves lots of sitting around waiting; on a number of occasions

¹ All patients names in this paper are pseudonyms.

'sitting with' replaced 'going along with'. This in and of itself was a useful insight into patient experiences because it exposed me to long periods of time where nothing *appeared* to be happening. Interestingly, when I was conducting the ward-based observation, I was aware of lots of activity happening 'in the background'. However, it was only through sitting and waiting with patients that I realised that there is a disconnect between what is happening and what patients *know* about what is happening. I also gained insight into the sedentary nature of being in hospital. Much of what patients were doing – largely waiting for care to be delivered to them - was done whilst sitting or lying down. However, even on occasions where 'movement' was involved, these rarely involved movement from *patients*, unless they declined offers of equipment such as wheelchairs or trolleys. Instead movement tended to be done on *behalf* of patients e.g. porters wheeled (still sitting) patients around the hospital in wheelchairs or on beds.

Despite the difficulties of conducting GAIs, I did manage to conduct four GAIs with four patients (two ward moves, one discharge, and one occasion where the patient left the ward for a scan and returned to the ward later that day. Two examples of 'go along' interviews conducted within this study are outlined below.

Example One: 'Nowhere to Sit'.

I conducted a GAI with participant Philip (81) and his wife at discharge from the hospital. I had planned to attend Philip's discharge, which was originally planned for a few days in the future. However, Philip's discharge was unexpectedly brought forward and I happened to be on the ward in the morning at the time when this was communicated to him. I spent the rest of the day with Philip as he waited for the discharge process to occur, including waiting for his take home medications to arrive from pharmacy and waiting for the discharge letter from the doctor. During this time, Philip was preparing to go home by collecting all his belongings together and changing into his daytime clothing. However, whilst preparing to leave, it became apparent that Philip's belt had gone missing and this meant that his trousers were too loose and were posing a trip hazard when he walked. One of the healthcare assistants working on the ward noticed that Philip was struggling with his trousers and made him a makeshift belt out of bandages and this meant he could walk safely without his trousers being too long/falling down. I then observed the nurse-led discharge process and shortly after that was complete I was able to ask Philip, and his wife who had joined him, about his thoughts and feelings on the discharge conversation – it was useful to be able to ask those questions whilst the conversation was fresh in their heads. After the nurse had completed her discharge instructions she asked Philip and his wife to complete a Friends and Family Test' feedback form. I asked them to talk me through their answers as they completed this paperwork; it was useful to get their insight into what feedback they had given and why.

I then accompanied Philip and his wife from the ward down to the main reception of the hospital where they got a taxi home. Walking the route through the hospital with Philip gave me access to his experience that I don't think would have mattered to him enough for him to tell me about, but was nonetheless a feature of his discharge experience. I had walked the same route from that ward to reception on multiple occasions, but walking it with Philip facilitated me seeing it in new ways. Philip had been admitted to hospital with a chest infection and he was still struggling with shortness of breath, especially when he walked. This meant that he needed frequent rests to catch his breath. However, what became noticeable as we walked down the corridors, took the lift, and navigated the ground floor concourse was that there were no seats at all for patients to rest on. This meant that when Philip wanted to take a short break during his walk, he had to stand and lean against the wall. This was not something I had experienced, because walking that same route doesn't require me to take frequent breaks or to rest against the wall. As an able-bodied, well person, I took the lack of furniture for granted. It wasn't until I was experiencing it with someone else that I began to see how we needed to use the space differently. I wondered if the design of the environment had taken into

account different bodies and their capabilities? I suspected not. Whilst Philip could have waited for a porter and used a wheelchair to get to the reception area, this relies on staff and equipment availability. Moreover, having spent almost two weeks sitting in a chair or bed, Philip wanted to walk by himself. However, the design of the environment did not facilitate independence, rather it promoted reliance on services. This was an interesting insight that I had not got from any other aspect of the research. Once I was sensitised to this, however, it was something I was able to look out for.

Example Two: Waiting can be distressing

The second example describes my interaction with a 96-year-old patient, Emeline, who was admitted to hospital after a fall. I had not originally planned to conduct a GAI with this patient as there seemed minimal opportunity for transitions. However, on one occasion when I was sitting with Emeline, a porter arrived at her bedside and told her he was taking her for her scan. Emeline had no knowledge of this scan and was reticent to leave the ward, though she finally agreed to go with the porter. I asked if I could accompany her and she agreed. The porter and a healthcare assistant transferred Emeline into a wheelchair and we began the walk to the part of the hospital where the CT scanner was located. Emeline was still unsure about what was happening to her and began to question the porter. Unfortunately, he had no knowledge of her care and so was unable to provide her with any answers; this was a source of frustration for Emeline, who became more flustered as the conversation progressed. This was something I had observed with other patients on other occasions – oftentimes patients don't ask the correct people the questions they need answering resulting in them never being answered. Once we arrived for the scan Emeline refused the scan. I waited with her whilst a doctor came to persuade her to have the scan, though she still refused. Once the doctor had left, she asked me to explain it to her again. At this point knowing how participatory to be became challenging. However, I responded to her questions by asking how she felt and what she understood about what was happening to her and I listened to her answers and concerns. I was careful not to be persuasive, rather I wanted to be empathetic and supportive of her perspective. However, this seemed to help Emeline and she agreed to have the scan as long as I stayed with her. I agreed to this and she had the scan. Unfortunately she found the scan very distressing and as soon as it was over she wanted to get back to the ward. The staff in the department called for a porter but were told that there would be a very long wait. Emeline was then moved to a 'waiting area' until a porter could collect her – this area was completely bare, dark, and unwelcoming; it seemed like being put in a corner of a room behind a curtain. It was not very dignified. The longer we waited the more distressed Emeline became. Eventually she began shouting for staff and was crying by the time they arrived. They told her there was nothing they could do to speed up a porter. After a few minutes, staff became frustrated at Emeline's distress. Eventually they asked me if I would be able to take her back to the ward. This was not my role as a researcher and I was reticent about undertaking activities that hospital staff should do. However, I also felt that the ethical thing to do was to respond to Emeline's distress and help if I could. I agreed to take her and together we made our way back to her ward. Her relief was palpable and when we said 'goodbye' that day she said that she had 'deep gratitude' for my help. It felt like the right decision at the time.

There are lots of things that we can take for granted when we are outside an experience. I don't think any of the staff that day intended to cause distress to Emeline. However, lack of communication, not being listened to, and being made to wait in an unwelcoming area all contributed to a poor experience for Emeline. Had I not accompanied her on this part of her journey, I would not have had any insights into her experience, as I am not sure she'd have known where to start if she'd been explaining it to me. 'Going along' with Emeline was beneficial for my research, but also on this occasion, for Emeline herself.

Section summary:

- 'Following' patients can be difficult, especially when they don't move very much! Oftentimes 'going along' was replaced by 'sitting with'.
- Accompanying patients can generate useful insights by providing first hand insights into the ways in which other people experience things.
- Go-along interviews can raise ethical challenges, especially when you are called to increase your participation in a situation. This can be a difficult role to inhabit; flexibility and sensitivity are required.

Practical Lessons Learned

There are four key lessons I learned from working with a new and relatively novel method, especially doing so in a healthcare setting.

Firstly, participatory methods within a complex setting such as hospitals can be challenging to undertake because you're dependent on the provision of services in order to undertake the research and things change so frequently and often without warning; this can make it difficult to plan data collection. Planning to accompany patients rarely worked out in practice, even when plans were in place and agreed upon. This meant there were some missed opportunities to conduct a GAI, because I hadn't planned to be with the patient during the times when transitions happened, or they happened outside of the times I had planned to attend. However, having the experience of intending to attend something and then 'missing' it still enables you to attend to the experience of that event in a way that I don't think you would if you were not aware that you'd missed it. I found myself asking participants to walk me through their memory of the event (e.g. discharge) and I don't know if I would have gone into the detail I did, had I not been trying to capture something akin to data that would have been generated by a GAI. In order to maximise data gathering in future studies, I think it would be useful to spend larger chunks of time with participants in order to capture more action as it happens. This may also provide a justification why a smaller sample size is preferable to a larger one – it facilitates being able to spend more time if there are fewer participants to follow.

Secondly, even though go along interviewing rarely went according to plan and fewer GAIs were conducted than had been planned/anticipated, attempting to conduct them provided key insights e.g. without trying to attend and accompany patients during ward moves or at discharge, I may not have had the same insight into the amount of waiting involved in being in hospital; the changeable nature of plans concerning patients, and the lack of communication about these changes to patients; and the sedentary nature of hospital care. One of the key findings from trying to do GAIs was that 'sitting with' often occurred more than 'going along with' – the amount of sitting that people did in hospital was something that may not have been as apparent, had I not experienced it with them. Thus, even when methods appear to not be 'working' in practice, they can still generate useful insights. Is there such thing as a failed method in qualitative research? This experience of attempting to work with a method despite being challenging suggests that even 'failed' methods can be useful data generators.

Thirdly, participatory methods such as GAIs can be difficult to navigate ethically. As noted in the example above, sometimes boundaries about a researcher's role can become blurred and making decisions about the extent to which you should participate in the experience of the participants can be challenging. It is important to remain flexible and sensitive to the needs of the people and environment. At times this will be mean withdrawing, recognising that your role as researcher is an unnecessary or unhelpful disruption. At other times, it may feel like the ethical thing to do is meet the needs of participants by becoming even more of a participant. Researcher experience and

sensitivity is vital in these situations. Being able to debrief after difficult encounters is also very helpful and the role of peer support for researchers should not be underestimated.

Finally, when GAIs are conducted, they can generate some unique insights and provide a glimpse into otherwise unseen or unarticulated experiences. The importance of space and movement within that space can easily be overlooked within more traditional methods, even within observational methods, especially when the observational work is non-participatory. The participatory and interactive nature of GAIs meant that I saw things that I may not otherwise have seen, but I was also able to ask participants about their experiences as they were experiencing them. I was also able to see and experience things that were familiar to me, in unfamiliar ways. As with the example of walking down the corridor with Philip (outlined above), although I had walked down that corridor multiple times, and my experiences had been unremarkable, walking with Philip – at his pace – made me notice things I hadn't noticed before. I also think that his experience came alive in a way that it would not have done had he merely been describing it to me afterwards – in fact, I'm not sure he would have told me about it all. Despite the difficulties of conducting GAIs, there are multiple potential benefits. Including them in a 'suite' of methodological choices can enable researchers to gather rich data, otherwise not collected.

Section summary:

- Undertaking participatory methods such as GAIs can be challenging within complex settings, where things are often unpredictable and susceptible to change.
- Even when things don't go to plan, understanding why or why not can provide unique insights into processes – it's all good data.
- As an interactive and participatory method, GAIs can be difficult to navigate ethically. Sensitivity, flexibility and responsiveness are vital. As is researcher peer support.
- GAIs can generate unique insights by providing perspectives that are unseen by the researcher and may otherwise be unarticulated by participants. It can allow you to see familiar things in unfamiliar ways; GAIs provide new ways of seeing and this can generate rich and useful data.

Conclusion

Go-Along interviews can be challenging to conduct, especially in contexts where, neither researcher nor participant, have control over the environment or what happens to them. Because I was trying to accompany patients on journeys that were organised by the healthcare service, it was difficult to make plans and sometimes opportunities were missed because plans were changed. However, when GAIs were conducted they generated unique insights that I don't think would have been gained using more traditional, non-participatory methods. I would recommend researchers consider the use of GAIs, especially when time and space are key aspects of your research. However, I would also recommend consideration of the method even when these are not features of the research question. This is because it is easy to take-for-granted time, space, and place – until it seen through the eyes of others we do not necessarily have good insight into what and is not relevant in our environment or context. In the future I would use GAIs in conjunction with other methods, as I did in this study. Having a smaller sample size would have been useful, to enable more responsiveness to changes and I think this may have resulted in more GAIs being conducted. As a method, they are not without challenge, but within this study their potential utility outweighed the drawbacks and they contributed to the generation of rich qualitative data about the lived experience of older people as they moved through the hospital and back home again.

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Classroom Discussion Questions

1. What are the potential benefits and drawbacks of using a participatory and interactive method, such as 'Go-Along' interviews?
2. If you had been the researcher in the situation with Emeline, what would you have done? Do you think the researcher did the right thing?
3. What were the key barriers to undertaking research within healthcare settings? What, if any, are the additional barriers to conducting 'Go-Along' interviews within healthcare settings?

Multiple Choice Quiz Questions

1. Should researchers ever become involved in the situations that they are observing? (Please provide justification for the answer you give).
 - A. YES
 - B. NO
 - C. MAYBE/IT DEPENDS (Correct)
 2. Are Go-Along interviews always easy to conduct?
 - A. YES
 - B. NO (Correct)
 3. Researchers undertaking qualitative research in healthcare settings should:
 - A. Follow a strict protocol in order to minimise disruption to care and protect patients and the researcher.
 - B. Do whatever they need to do to collect the data.
 - C. Have processes in place to protect the researcher and participants but remain flexible and responsive to participants and the context within which research is being conducted. (Correct)
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Declaration of Conflicting Interests

The Author declares that there is no conflict of interest.

Further Reading

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