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**“I’ve just got to ask you some questions”: an exploration
of how nurses and patients accomplish initial nursing
assessments in hospitals.**

Aled R. Jones

*A thesis submitted to the University of Wales in partial
fulfilment of the requirements for the Degree of Doctor of
Philosophy in Health Science.*

**School of Health Science
Swansea University**

2005

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Abstract.

“I’ve just got to ask you some questions”: an exploration of how nurses and patients accomplish initial nursing assessments in hospitals.

Nurse-patient communication and interaction has long been written about as one of the most important ingredients of good quality patient care. Furthermore, nurse-patient interaction during the initial assessment interview, which occurs when a patient is admitted into hospital, has been promoted in nursing literature as an important first step towards building a meaningful and therapeutic relationship with patients. This present study is the first study of its kind to investigate, in detail, the interaction between hospital nurses and patients during the initial assessment or admission interview. Data collected include audio-recordings, observations and documents relating to the interview.

Applying the techniques of conversation analysis, the study reveals how certain rules of normal conversation, a style of talk to which the assessment interview is favourably compared to in nursing literature, fail to apply during assessment interviews accomplished on busy hospital wards, and offers original empirical evidence to show what actually happens. The study demonstrates, for example, that nursing assessment interviews can only be understood as products of the contingencies of the interview situation, and not, as is usually assumed in the nursing literature, the unmediated expressions of nurses and patients. The description produced by the analysis is of encounters which, despite differences related to the individuality of the contexts of the interviews, are remarkably similar in structure and organisation.

The implications of this study stem from the fact that CA has made visible the weakness of the links between nursing theory, policy, and the situated working practices of nurses in the real world. The implications for theorists and policy makers are that a little more realism in their work may make for more sustainable and usable strategies and policies. In light of this, future nursing research which focuses, as this study does, on the actual practices of nurses and health service users has an important contribution to make as a bridge between practice and policy/theory.

Nurses undertaking initial assessments of patients need to be aware of the limitations imposed on the patient when undertaking assessments as “question-answer” sessions. Instead nurses would do well to encourage patient participation during the interview through, for example, providing the patient with a copy of the paper-work being completed, a move which would foster a more open and less restrictive style of interaction.

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Chapter 1 - Introduction.

During the year ending 2003-04 approximately 12 million patients were admitted to hospital for in-patient care within the National Health Service (NHS) in England and Wales, with a record number of 35% of patients needing hospital admission and assessment being emergency cases (Department of Health 2004 p.5, Welsh Assembly Government 2004a). Each of these patients admitted to hospital has their care needs assessed by a registered nurse (RN)¹. Hospital admissions and the associated nursing assessment can therefore be seen to form a significant part of nurses' routine daily work pattern in hospitals.

The broad aim of this study is to explore the production, communication and storage of information which is generated by nurses and patients during a patient's admission into a hospital ward within the NHS. The principal domain for the production of this patient information which is used in the planning of nursing care is the initial assessment interview which is usually accomplished through the talk of two participants, the nurse and the patient. The information once produced is formally stored in nursing documentation, which has a function 'of recording what has happened and communicating that to colleagues' (Cole 2000 p.114). Therefore, the initial assessment interview and the nursing documentation being the main areas for the production, storage and dissemination of patient information upon hospitalisation will serve as the main sources of data for this study.

A qualitative approach to this study was taken as it offered, through conversation analysis (CA), a means of integrating data sourced from different

¹ The figures are those quoted for "Admission episodes" where only the first episode of care in each hospital stay is counted. As patients may be transferred between hospital wards during an "admission episode", the number of nursing assessments performed *may* well exceed the number of admission episodes.

people, institutions and texts. The challenge and highly rewarding activity of qualitative research is best encapsulated by Mason (2002a p.1) who believes that

Through qualitative research we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understanding, experiences and imaginings of our research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate.

In all, Mason's thoughts regarding the considerable potential of qualitative research gets to the very heart of my research endeavour and the decision to undertake a qualitative study owes more to the utility of the method rather than an adherence to an anti-science, or anti-quantitative stance seen occasionally in the social sciences and nursing research (Williams 2002).

The reasons for studying the production and management of information produced during nursing assessments are numerous. Firstly, the assessment of a patient's needs is forwarded by many as being *the* important area of nursing work to be performed upon a patient's admission into healthcare (Faulkner 1996, Edwards 2000, Latimer 2000). Furthermore, the assessment interview has been said to involve a 'special working relationship' (Chapman 1983 p.90) between the patient and nurse, being the 'starting point in any nurse/patient relationship... where a nurse's time and skill are required to reveal the patient' (Fitzgerald 2002 p.163).

Effective communication and interaction by nurses has long been considered a fundamental component for assessing or "revealing" patients' health needs, as Collins and Parker (1983) stated over 20 years ago 'The completeness of the nursing history depends on the effectiveness of communication' (p.70). More recently Crawford and Brown (2004) discuss that much of nursing, but especially the assessment process, is about 'good communication and an acknowledgement of the central role of the client's perspective' (p.13).

As might be expected, communication and interaction between nurses and patients is an area that has attracted much attention from nurse researchers and writers, however little is known of the communication and interaction specifically during the crucial time of the patient's hospital admission/assessment, and this provides another reason for undertaking this study.

As will be discussed in the literature review in Chapter 2, the research on nurse-patient communication is of variable quality, with much of the work documenting frequency and type, rather than the actual content or quality of communication. As a result there is a lack of research that records and transcribes the detail of nurse-patient interaction during the accomplishment of nursing work. The literature to date also largely ignores the contribution of the patient to the interaction (see Jarrett & Payne 1995, Caris-Verhallen et al 1997), with patients often conceptualised as passive or submissive in the face of overwhelming professional power of the nurse. Thus an overall strategy of this study is to present particular data and their subsequent analysis that specifically fills in some of these gaps in nursing research on assessment and communication.

This study also provides an opportunity to compare nurse-patient communication with policy initiatives such as those released by the World Health Organisation (see Salvage 1993) and more recent national policy directives and statutes (Department of Health 1995, 2000a, 2000b) all of which strongly promote good communication between professionals and patients in the drive towards improvements in the quality of healthcare delivery. Policy strategies within Wales also encourage a more active role for patients within healthcare consultations and decision making, an example being the document 'Putting Patients First' (Welsh Office 1998) which states that 'increasing attention must be paid to involving patients

more in decisions about their care and to providing adequate information on which to base those decisions' (p.26).

These policies and others like them appear to incorporate the Audit Commission's recommendation from a decade ago that encouraged health care professionals to 'develop an awareness of the patient's point of view' (Audit Commission 1993). Developing an appreciation of the patient's viewpoint also features prominently in nursing textbooks as a characteristic of good nursing practice when assessing patients (Chapman 1983, Schober 1993, Graham 2000), as well as being a statutory requirement for enrolment onto the professional register for nurses (Department of Health 2000a). The connections between health policy, nursing literature and ideology and statutory requirements are explored in Chapter 3 as potential factors which shape contemporary nursing practices when admitting and assessing patients.

Taking a CA approach to the study makes it possible to explore questions of the work and performance of both nurses and patients during nursing assessment interviews. As will be discussed in Chapter 4, CA encourages the researcher to search the data for ways in which participants take up and share the meaning of their dialogue by keeping in mind that meanings are not predetermined by words or context, but are jointly constructed and shared during the interaction.

This approach to data will allow analysis to compare and relate – with all due precautions – the *in situ* interpretations and comprehension of the nurse and patient that unfold during the accomplishment of the practical goal of completing the assessment interview. Therefore by shifting the focus of this study to include the patient's role in the interaction I will attempt to explore the previously mentioned

assumption of patient passivity within nurse-patient interaction (Jarrett & Payne 1995, Caris-Verhallen et al 1997).

CA researchers have traditionally avoided in-depth observational data but as studies of talk and interaction have become increasingly concerned with more specialized forms of social activity, such as interaction in institutional settings where task or role based activities are undertaken, it has been widely recognized that it is necessary to augment recorded materials with some sort of ethnographic fieldwork, usually participant or non-participant observation. Chapter 5, therefore, provides a detailed description of the locations within which the research was undertaken. It is anticipated that this description will provide the reader with an insight into the clinical areas within which data collection took place by providing both a visual-spatial description of the clinical areas as well as a chronology of events during a patient's admission and assessment.

Following on from the broad discussion of the location of the research and some of the practices of patients and nurses, chapter 6 forwards a more typically CA exploration of the spoken conduct of patients and nurses during assessment interviews. The aim of this is to clarify how nurses and patients conduct initial nursing assessments with specific reference to their methods and strategies of communication, for example it will be demonstrated that the words nurses choose, and general spoken approach to assessment can have an influence on the discourse style of both participants.

The data and discussion contained in Chapter 7 extend the focus of the previous chapter and show how nurses organize and manage the routine work that needs to be completed during assessment interviews. One of the themes which emerge is that concerning an asymmetry of opportunities and knowledge which exists within

nursing assessment interviews. In this chapter as in others, detailed analysis of the participants' talk is provided as a safeguard against the premature invocation of such concepts as "asymmetry" and "professional control" so often warned against in the CA literature.

Drawing impetus from Manning's (2002) assertion that qualitative data is fundamentally ironic in as much as that 'what appears is not what is' (p.73), it was realised early on in the study that the reality of initial nursing assessments is not confined to talk, it also exists in the working arrangements of the institution, especially within the institution's documents. For that reason, chapter 8 is concerned with how the institutional realities of working practices and documentation are evoked, manipulated and even transformed in and through interaction. The intention here is to view the record as more than an inert repository of information.

Through examining the documentation which is read, written and produced during and after the initial assessment interview an opportunity is presented to explore the patient's assessment as depicted in nursing records. Added to this, various practices of reading and writing the documentation during initial patient assessments will be explored for their influence, or otherwise, on the construction of relevant patient identities which may have diverging consequences for the type and amount of information that is produced and recorded during assessment.

It is envisaged that nurses, similar to members of other specialized speech communities such as medicine (Heritage 1997), psychics (Woofitt 2001) or care-staff (Antaki et al 2002) do more than simply reproduce individual's terms, accountings, and assessments of their problems, instead nurses reformulate the patient's responses into different terms – into a discourse consistent with the nurse's perspective.

The nursing documentation exists for the purpose of both nurse-nurse communication as well as communication potentially with a range of health professionals. There is little previous research examining to what extent the patient's narrative or voice is present or transformed in nursing records, although an extract from the NHS Plan (Department of Health 2000b) provides an interesting insight into how the UK government portrays the current and future contribution of the patient's voice in the NHS:

Patients are the most important people in the health service. It doesn't always appear that way. Too many patients feel talked at, rather than listened to. This has to change. NHS care has to be shaped around the convenience and concerns of patients (Department of Health 2000b, p.91).

Thus, the results of the analysis of nursing documentation will be explored to review the degree to which patient-nurse communication and the patient's voice particularly, may change in other communication contexts, such as nurse-nurse communication through documents.

In chapter 9, conclusions are based on the analytic chapters. They concern the nature of the ongoing activity during assessment interviews, the constituents and distribution of control in consultation and the linking of the data to the ideals expressed in nursing literature and policy. The implications of the study for nursing research, for the study of institutional interaction and for nursing practice and policy will be discussed, whilst recognising the study's limitations.

To summarise, the two pronged aim underlying this study is to explore the production, communication and storage of information during patients' admissions into hospital and to introduce a dialogue between these findings and nursing theories, ideologies and policies. Furthermore, I will aim to explore how nursing assessments and admissions are "worked at" and "performed" in practice, how the patient and

nurse accomplish “doing being a nurse”, “doing being a patient” and “doing an initial assessment interview”, to paraphrase an expression from Sacks (1992).

Chapter 2 - Nurse-patient communication and interaction – a review of the literature.

Nursing literature widely acknowledges that communication is the principal medium of nursing care, a realisation that has led researchers to invest considerable time and energy in exploring the nature of both verbal and non-verbal communication. Over the last 30 years or so research has been conducted in a variety of clinical areas such as psychiatric in-patient units (Altschul 1972, Whittington & McLaughlin 2000), cancer care (Bond 1983, Wilkinson et al 1998), care of older adults (Armstrong-Esther et al 1989, Nolan 1995), medical and surgical nursing (Macleod Clark 1983, Mallett & A'hern 1996), community nursing (Sefi 1988, Gerrish 2001) and intensive care units (Ashworth 1980, Elliott & Wright 1999) to name a few. These studies point out that successful communication is essential in achieving good results in nursing care, but provide little evidence through their findings that nurses are effective communicators with patients whilst rarely evaluating the effects of nursing communication on actual patient outcomes.

Recent policy initiatives (Welsh Office 1998, Department of Health 2000 b,c; National Assembly of Wales (NAW) 2001, Welsh Assembly Government (WAG) 2003a,b) have also emphasised that nurses' communication with patients and the public is essential for high standards of care in the NHS. The link between good communication skills and effective healthcare is enshrined in the NHS plan (Department of Health 2000b), which stipulates that effective and competent use of communication skills with patients will be a pre-condition of all health professionals' qualifications who deliver care in the NHS. Similarly in Wales, recent reforms (WAG 2003a) put patient and public involvement at the centre of Health Service care delivery, a strategy which is 'critically dependent on using appropriate

communication processes and having staff with the right skills and competencies' (WAG 2003a p.54).

The majority of the research studies which explore nurse-patient communication or interaction attempt to analyse the dynamics of "actual" interaction between nurse and patient, for example observing or tape recording how often patients initiate conversations with nurses (Bond 1983, Dennison 1995), the extent to which nurses interact with patients outside of routine care giving and the management of emotive episodes of talk by nurses and patients (Thomas 1994, Jarrett & Payne 2000, Hunt & Meerabeau 1993). Other research concentrates on studying interaction as a means of delivering nursing care, but does not document much, if any, of the detail of interactions (see Menzies 1960, Stockwell 1972, Rundell 1991, Latimer 2000).

Interestingly the predominance of research on "actual" nurse-patient interactions differs in focus from the work concerning doctor-patient interaction, where the research in doctor-patient interaction focuses primarily on the extent of patient satisfaction with medical communication (Ong et al 1995, Ruusuvaori 2000). Within nursing research, however, there is little attempt to gain the patient's view regarding satisfaction with nurses' communication, leading some authors to conclude that the patients' contribution has been largely ignored in this area of nursing research (Jarrett & Payne 1995, Caris-Verhallen 1997 et al).

A further contrast with medical research and thinking in this area is the absence of specific models of "ideal" nurse-patient interaction such as those offered to doctors (e.g. Makoul 2001). The absence of such models in nursing research and literature may be a direct consequence of the lack of research on the satisfaction of patients regarding their interactions with nurses. Some insight, albeit minimal, into

patient satisfaction is offered through general satisfaction surveys of patients on discharge from hospital, such as McColl et al (1996) who indicate that, on the whole, patients are satisfied with nurses' communication but that some patients surveyed (23.6%) reported a problem with the information received from nurses regarding their care.

The void created by the absence of research based ideal models of nurse-patient interaction has partially been occupied by nursing texts which offer more general guidance on the importance of, and the best approaches, to communication with patients. Recently published nursing textbooks and journals are full of the importance of communication in the delivery of high quality patient care, typical examples being Manley (2000 p.35) who states that 'for the provision of quality care effective communication is crucial', whilst Peel (2003 p.971) similarly captures the sense of the importance of communication in nursing when commenting that 'Well honed communication skills in the nurse are essential'. However, when taking a more long term perspective on the literature these exhortations from recent textbooks can be seen to be echoing similar claims made in nursing over the last twenty to thirty years that communication and interaction with patients and their families is at the core of good nursing practice For example, the following extract from Collins & Parker (1983 p.64) links interaction between nurses and patient with service to humanity:

'Nursing is a form of service to humanity which is essentially concerned with the interaction of human beings - the nurse or the nursing student, with her (*sic*) patients and their relatives, her (*sic*) colleagues, and all those other persons working with the patient for his (*sic*) benefit'.

However, the realities of nurse-patient interaction presented in nursing research spanning this time and from a variety of different clinical areas provides an incongruent view of interaction compared with the values expressed in nursing textbooks and nursing policy. Studies by Macleod-Clark (1983), Whittington &

McLaughlin (2000) and Bowles et al (2001), and many others discussed in the following section suggest that nurses may not be such effective communicators when compared with the values stated in the nursing literature, which is of some concern since the literature argues that the quality of care delivery by nurses is conditional on the quality of nurses' communication. Considering the (largely) negative research findings on nurse-patient communication, then questions are inevitably raised regarding the quality of care given to patients.

2.1 A review of the literature and research – nurse-patient communication.

As already noted nursing assessments are predominantly accomplished via communication between the patient and the nurse. The aim of this section of the literature review is therefore to critically explore research conducted in the area of nurse-patient communication and interaction, and in so doing locating the current research study within the wider context of prior scholarship in this area.

The writing of the review has been guided by Wolcott's (1990) advice that literature review sections within PhD theses should not be a repository for students to lump and dump the relevant literature, but instead literature should be selected as needed 'in the telling of the story' (ibid, pg 17). Telling the story of nurse-patient interaction therefore provides the rationale for this literature review, this is best served through firstly focussing on the clinical areas covered by researchers e.g. nursing older adults, community nursing, palliative nursing. In this way a picture of communication and interaction throughout nursing is gradually revealed, accompanied by critical commentary on the methodological issues which arise.

Surprisingly there is no published literature review providing an overview of research into nurse-patient communication/interaction, although authors such as Jarrett & Payne (1995), Caris-Verhallen (1997) and Chant et al (2002) have all

produced useful but limited reviews of the literature. This finding therefore also provides a rationale for reviewing the broad cross section of research seen here, as the need for a comprehensive review of the literature is considered overdue. It is also noted in the literature that much of the writing in nursing texts, research and policy largely ignores the potential influence that variable clinical settings and situations can have on communication and interactional opportunities between nurses and patients. Presenting the review of research in this way questions the taken for granted assumptions presented in such texts that nursing practice is universal regardless of its context, assumptions which have contributed to difficulties in producing realistic accounts of nurse-patient interaction.

2.1.1 Communication and nursing older adults.

It has been suggested that older adults entering healthcare confront nurses with distinctive problems (Wright 1988), and that, in turn, these problems require ‘communicative abilities, empathy and concern’ (Caris-Verhallen et al 1997 p.915). It is unfortunate therefore that the majority of the studies in this area (Armstrong – Esther & Browne 1986, Armstrong – Esther et al 1989, Armstrong – Esther et al 1994, Nolan 1995) have focussed on the frequency of interaction by nurses and patients rather than on the actual effectiveness of the communication event.

For example, the number of nurse-patient interactions were compared according to patients’ level of confusion or lucidity (Armstrong – Esther & Browne 1986, Armstrong – Esther et al 1989, Armstrong – Esther et al 1994) or their status as respite, short stay or long stay patients (Nolan 1995). Overall no clear picture emerges of which group of patients receives the most interaction and conversation with nurses as Armstrong-Esther & Browne (1986) and Nolan (1995) suggest nurses interact more

frequently with lucid patients, whereas Armstrong-Esther et al (1994) discovered that nurses interact mostly with “demented” (*sic*) patients. Each of these 3 studies conclude that many older patients are inactive during their time as hospital in-patients, a finding which is linked to the low levels of nurse-patient interaction outside of routine patient care such as washing or feeding.

More regarding the detail of nurse interaction with older adults is captured by Davies (1992) and Thomas (1994) who both investigate the differing verbal communications used by trained and untrained nurses during the course of their work. Davies discovered through content analysis of taped interaction that the range of verbal strategies used by both types of staff are broadly the same, but that trained staff use proportionally more verbal strategies that promote the patient’s dignity and independence.

Similarly, Thomas also discovered a difference in the content of trained nurses’ communication compared to untrained nurses, with trained nurses spending more time encouraging self-care and giving detailed explanations about care than untrained nurses. However, Thomas reveals that it was the different methods of organizing nursing care that had the greatest effect on the type of interaction. Both trained and untrained nurses on wards using primary nursing as a method of organizing nursing care demonstrated statistically significant differences in the occurrence of patient centred interaction compared to nurses working on wards where task orientation or team nursing approaches were used to organize nursing work². Untrained nurses on all wards spent a significantly larger percentage of time ($p=0.03$) in verbal interactions with patients compared to trained nurses, although there were

² Primary nursing, team nursing and task allocation nursing will be looked at in more depth in the next chapter. Advocates for primary nursing claim that this method of organizing nursing work focuses more on the patient’s needs rather than the nursing tasks that need completing, similar claims are made by advocates of team nursing, whereas task allocation has little support in the literature although there seems to be elements of task allocation in care delivery in many places (Bowman 1995, Latimer 2000).

variances in levels of interaction dependent on the time of day e.g. trained nurses spent more time interacting with patients in the evening.

In contrast to the other studies, Hewison (1995) undertook a purely qualitative study of nurse-patient interaction on a 24 bedded ward within a small hospital for the care of elderly people. The aim of this observational study was to examine encounters between nurses and patients 'in which power is exerted through language' (p.75), and the effects this has on patients. Interactions between nurses and patients were recorded verbatim as handwritten notes by Hewison, who proceeded to demonstrate through data extracts how nurses have interactional power over the patients they are caring for, power which they use to exert control over patients through, for example, the use of persuasion. As in the studies above, most of the interactions observed by Hewison also largely related to the completion of routine tasks such as washing and dressing patients rather than being 'open and meaningful communication' (p.75).

The research conducted within care of older adults therefore suggests a picture of nurse-patient communication as predominantly initiated by nurses and occurring during care related tasks. However the external validity and the extent to which these study findings can be generalized has to be questioned due to the small sample sizes used in the studies, although the studies do appear to have a satisfactory degree of ecological validity in that the descriptions of the clinical areas within which the research occurs closely resemble 'people's everyday, natural social settings' (Bryman 2001, p.31).

Furthermore questions of reliability and face validity need to be foremost when considering Armstrong-Esther & Browne (1986) and Armstrong-Esther et al (1994) structured observation schedules as no figures for reliability of the schedules are presented. Face validity may be established 'through asking other people whether

the measure apparently reflects the content of the concept in question' (Bryman 2001, p.72), but no indication is given by the authors of any checks on the validity of the schedule which appears to have been devised from the work of unspecified 'previous researchers' (Armstrong-Esther et al 1994 p.266). Although on first reading it appears that the same observation schedule is used in both of these studies, the reliability of the tool is also problematic as the original number of patient behaviours in the scale is added to in the most recent study, a move which questions the stability of the measure being used (Bryman 2001).

Problems associated with not fully explaining the procedures when developing the observation schedule may explain the lack of replication of this study in similar studies such as Nolan (1995). The observation schedule in Nolan's study is tested for reliability between observers, although no statistical evaluation occurred to measure the degree of agreement over the coding of items by the two researchers. Issues of validity are also taken seriously through piloting of the original observation schedule, and the accuracy of the time sampling strategy used was favourably compared to observations undertaken in real time.

A lack of replication or comparison between similar studies is also evident in the work of Thomas (1994), who fails to acknowledge a previously similar study by Davies (1992). Both authors observed trained and untrained nurses interacting with older adult patients on wards and both go some way to ensure validity of their observation frameworks through independent checks of the observation categories (Davies 1992), and pilot testing of observation categories and checks for observer drift (Thomas 1994). However an opportunity was missed by Thomas to critique and, where possible, build upon the previous work by Davies in this area.

Hewison (1995) in taking a more qualitative approach to collecting and analysing data, stated that the ‘underlying assumption’ (p.76) of the study was that ‘the language used in interaction reflects power. . . .it reveals the power dimension inherent in the encounter’ (p.76). Such a clear statement regarding the researcher’s assumptions could be congratulated as demonstrating much valued reflexivity within the qualitative research process, but could also render the study as reductionistic in its treatment of communication as the quantitatively inspired work reviewed above. Although Hewison did not seek to “reduce” the observed nurse-patient interaction into frequency counts of types of acts, through limiting or reducing the analysis of interaction to the pre-formulated category of “nurses’ power” Hewison produced results that were consistent only with that formulation.

Some of the data extracts used by Hewison undeniably demonstrate nurses asserting themselves within interaction in what may be construed as a powerful way. However, some of the data extracts reveal a problematic tendency to fixate meanings without reference to the communicative abilities of both participants leading to explanations which emphasise the nurse’s input into the interaction, at the cost of ignoring the patient’s contribution to the interaction. For example,

Gillian	Do you want something to eat? You know it’s important you have something to eat because you’re diabetic.
Mrs Moss	[no response]
Gillian	How about a cup of tea, would you like a cup of tea?
Mrs Moss	[nods]

(Hewison 1995, p.79)

Hewison’s analysis of this data extract results in the conclusion that nursing power is exerted through persuasion, which has a negative consequence for the patient’s freedom of action during the interaction and, more broadly, during their stay in hospital. However, the act of restricting the analysis to reveal examples of “nursing power” within interaction overlooks other possible explanations of the interaction. For

example, rather than seeing nurses as imposing power on passive patients an alternative analysis would be to initially look at the extract as interaction between two individuals, both of whom are active within the interaction, unless there is clear evidence to the contrary within the data (an approach that will be used throughout the analysis in this study).

Analysing the extract in this way leads to possible insights regarding the “power” that patients can also exert within interaction, notably in this extract the powerful effect of the “no response” by Mrs Moss to the nurse’s offer of something to eat. The no response forces Gillian (the nurse) to try again with an offer of a cup of tea, which in turn gains a favourable response by Mrs Moss. It could be strongly argued therefore that Mrs Moss in this extract is at least equally powerful as the nurse, if not more powerful, as she influenced the course of interaction away from a discussion of something to eat which presumably she had little interest in, to an offer of a drink which she found acceptable.

In merely imputing the concept of power into the analysis the researcher is at risk of becoming the powerful presence within the interaction, a position which paradoxically reflects and replicates within the research process the original concern posed by Hewison regarding power differences between nurses and patients. In addition, when the analyst takes a highly critical stance towards the discourse of one participant, or a sympathetic stance towards another, it can sometimes result in the lack of a detailed examination of what the speakers are saying. This has been described by Antaki et al (2003 p.5) as ‘under analysis through taking sides’ which is a particular danger when the analyst’s desire to sympathise or censure overcomes careful analysis and can lead to the sort of simplification demonstrated by Hewison that is the antithesis of analysis.

Detailed transcription of the tape recordings and the suspension of pre-analytical assumptions are some of the strategies adopted here, offering a different perspective from some of the strategies used to research nurse-patient interaction which are discussed in this section in an attempt to improve understanding via analysis.

2.1.2 Communication within critical care.

Communication in critical care areas provides numerous challenges to nurses as the patient's communicative competence is potentially restricted by severe illness, variable consciousness levels and the machinery/technology associated with critical care nursing. The wide scope of critical care nursing is reflected in the research studies reviewed here, with studies from intensive care and high dependency units, accident and emergency departments and post anaesthetic recovery.

The earliest study in this area is Ashworth's (1980) exploration of nurse-patient communication on 5 Intensive Care Units (ICUs) using non participant observation and staff interviews (n=112). The observations revealed that nurses' communication with patients overwhelmingly occurred during the completion of tasks and occupied only 14% of the observed time available to nurses. Overall, the content of 71% of all communication was connected to the patient's illness and associated illness-related tasks that needed to be completed e.g. suctioning of the patient's airways. Socially related communication, orientation and reassurance accounted for the remaining communication, this accounting for only 4% of the overall observed time.

Baker & Melby (1996) repeated Ashworth's study with a much reduced sample (interviews with only 5 staff nurses) and having slightly modified Ashworth's original observation schedule, although details of, and reasons for the change are not

given. Findings were similar to Ashworth in that most communications with patients were task related, however nurses spent only 5%, compared to the already low 14% seen in Ashworth's study, of the time available communicating with patients.

In both these studies the responsiveness of the patient was a strong predictor of whether nurses interacted with patients, with the more responsive patients receiving more interaction. Similar findings were revealed by Mallett's (1990) study of post anaesthetic patients in a recovery department where social conversation was seen to increase commensurate with the patient's recovering conscious levels. Mallett comments that the progressively social nature of the talk as the patient wakes up could serve to 'normalise the situation and dispel any anxiety the patient may have' (ibid p.52).

Both Rundell (1991) and Elliott & Wright (1999) also found that most nurse-patient communication was linked to the performing of clinical tasks and that the clinical status of the patient determined the extent and type of interaction. Rundell's study of high dependency patients revealed that, as the patient's condition improved, so did their 'interactive privileges' (p.174). Patients who were closest to discharge status experienced quantitatively and qualitatively different levels of interaction with nursing staff. For example, not only did these patients experience more time in conversation with the nurses compared to less well patients, but the nature of the interaction was more personal and sociable and less task related. Interestingly however a change in the patient's "imminent discharge" status i.e. patient's discharge being delayed or cancelled due to an unforeseen event, would have a subsequent negative effect on their interactional privileges.

In contrast, Elliott & Wright's (1999) study of intensive care patients found that the more critically ill the patient the greater the quantity and length of

communication with a nurse, with the longest uninterrupted interaction timed at 9 minutes as opposed to a longest of almost 6 minutes for more stable patients. Taken as a whole, nurses appeared to communicate with their patients for less than 2% of the time available. Equally, Byrne & Heyman's (1997) observational data from an accident and emergency unit suggests that the more critically ill patient has more communication with nurses than the patient with minor injuries. Interestingly when more time was available for nurses to communicate with all patients they tended to undertake non nursing activities such as portering duties which effectively kept them too busy to talk to most patients.

On the whole the observational data from critical care areas suggests that only a very small proportion of time is spent by nurses in interaction with patients, even though the majority of ICU nurses who were interviewed by Ashworth (1980) and Baker & Melby (1996) report that communication with patients in intensive care units is an important, or very important, part of their work.

The observation schedule developed by Ashworth (ibid) originated from published work and drew upon the author's own experiences as an ICU nurse and was extensively piloted before hand. However, reliability checks of the observer's data recording were not implemented as it was 'not felt to be feasible' (Ashworth 1980, p.43) within the constraints of an ICU bed space to have 2 observers present simultaneously. This is a point of some significance in Ashworth's study, as it is in Baker & Melby's (1996) abridged replication, in view of the fact that in studies using structured observation 'validity presupposes reliability' (Bryman 2001 p.169).

The use of video tapes in the qualitative studies by Mallett (1990) and Rundell (1991) provides an interesting variation to other data collection techniques used in critical care research. Reliability and validity are areas that Kirk & Miller (1986)

suggest have received little attention in qualitative research whilst other writers (Denzin & Lincoln 1998) reflect on the irrelevance of such concepts to the qualitative research endeavour. Issues of validity and reliability are of particular concern however in nursing research where questions of what constitutes appropriate “evidence” for practice are apposite. A qualitative study therefore should be accountable for its quality and its claims, or as Mason (2002a, p.7) explains qualitative research, ‘should not position itself beyond judgement, and should provide its audience with material upon which they can judge it’.

Transcribing data from video tapes (or audio tapes as is the case in the present study) is one way of ensuring that audiences can judge the quality of the claims made by the researcher and conform closely to Silverman’s (1993) reliability checks for qualitative research as they provide detailed and publicly accessible representations of social interaction. Rundell (1991) however only chose to view the tapes ‘several times’ (p.173) without transcribing, whereas Mallett (1990) transcribed the tapes fully as she stated that ‘Viewing the raw data is insufficient, even after repeated observations, to locate accurately phonema (verbal and non-verbal actions) which occur within conversations’ (p.47). No recording devices were used by Elliott & Wright (1999) who relied on attempting to write down verbatim the conversations of nurses and patients, whilst simultaneously timing the duration of the interaction and making a note of the nurse’s activity at the time of speaking! The authors did however recognise the limitations of this rather laborious data collection technique and acknowledged an effect on the quality of the study:

‘Moreover given the practicalities of transcribing at source and timing each interaction the total time spent verbally communicating in 4 hours may not be highly accurate (Elliott & Wright 1999 p.1419)’.

The verification by an external researcher of the data collected goes some way to address issues of validity but there is little detail of this, or of assurances regarding inter-rater reliability. Similarly, neither Mallett nor Rundell pay much attention to rigour in the data analysis section, such as checks on analytical categories by colleagues or other researchers external to the study. On the same note, minimal information regarding the observational data collected by Byrne & Heyman (1997) is given in their article which was ostensibly written regarding the interview phase of their study, even though results of their observations are discussed throughout the results section.

2.1.3 Communication in palliative care.

Of all the research reviewed it is the area of communication within palliative care nursing which has been most studied, possibly unsurprising as good communication between nurses and patients is considered 'a central aspect of palliative care' (Wilkinson et al 1998 p. 13). Studies of nurses' communication with palliative care patients can be divided into those which attempt to describe the interactions through qualitative methods (e.g. Webster 1981, Dennison 1995) and those which have both described the interaction and subsequently attempted to statistically measure change in the quality of interaction after training nurses in specific communication skills (e.g. Booth et al 1996, Wilkinson et al 1998).

Seven of the thirteen studies reviewed use qualitative methodologies to gather data on nurse-patient interaction, however only one study (Jarrett & Payne 2000) has been published in the previous 10 years, with the majority of studies appearing during the late 1970's and early 1980's. It is also possible to note an interesting change over

this time period in the analytical approaches of researchers to the study of nurse-patient interactions in palliative care.

For example, the early studies (McIntosh 1977, Knight & Field 1981, Webster 1981, Bond 1983), all of which were hospital based, describe how nurses avoid discussing potentially emotive issues regarding the terminally ill patient's diagnosis, prognosis or treatment through occupying themselves with completing physical tasks on the ward or through diverting patients' requests for information to medical staff.

The completion of physical care tasks also dominated the content of interaction when nurses spoke to patients. This appeared to be a strategy used by nurses to minimise or nullify interaction, as concentrating on the task at hand seemed to successfully convey the message to patients that nurses 'could not be expected to talk as well as work' (Webster 1981 p.1001).

During interviews in each of the studies (McIntosh 1977, Webster 1981, Bond 1983: with the exception of Knight & Field 1981) nurses disclose that they deliberately avoided in-depth interactions with cancer patients to avoid inflicting further worry or anxiety onto patients who were perceived to be suffering enough already. What is surprising in these studies is that they fail to discuss their findings fully in relation to Menzies (1960) work which found that the nursing ethic and culture (at that time) was such that social defence systems restricting the formation of meaningful relationships with patients were utilised by nurses to evade the full experience of anxiety provoked by psychological stress in other people. Thus avoidance of in-depth interaction with cancer patients was seen by Menzies as a coping mechanism which helped nurses come to terms with patients' illness related anxiety.

In contrast to these early studies in this area, which considered the lack of communication especially around details of terminal illness as indicative of nurses' promoting anxiety avoidance for both themselves and patients, both Hunt & Meerabeau (1993) and Jarrett & Payne (2000) take a different approach. Both studies discuss that the lack of open expressions of emotion by patients regarding their terminal illnesses may not be completely due to the avoidance tactics employed by nurses, but may be attributable to the patients' 'English reticence' (Hunt & Meerabeau 1993 p. 121) and the understanding by patients that 'being pessimistic was unhelpful and detrimental to the patients' recovery and general ward atmosphere' (Jarrett & Payne 2000 p.89). This emphasis in the analysis on patients *choosing* not to openly express emotion introduced the notion of patients as active rather than passive within interaction, a novel idea, at the time in nursing research.

The more recent revisionist approach seen in the above work has re-interpreted avoidance of talk around emotive subject areas as a characteristic of the culture and (ethnic) personality of English patients, and as being willingly co-constructed by staff, patients and relatives who all equally control and maintain contributions in an attempt to preserve optimism. The claim made by both sets of researchers is that "external" factors, such as the patient's culture and preferences, all contribute to the context of interaction and are not suspended by the mere hospitalisation of individuals, and should therefore be presented on an equal footing with issues regarding the nurses "internal" psychological factors when researching interaction.

Another study which has an analytical approach more inclusive of context is Dennison (1995). This study, through using a mixed method approach to data analysis of interactions during the administration of chemotherapy to patients, describes

interactions as mostly initiated and controlled by nurses, with the content of discussions consisting mostly of nurses' information giving, with only rare opportunities for the discussion of the patient's feelings or understanding of the illness and treatment.

However, the suggestion by Dennison is neither that nurses block or evade such discussions, nor that patients and nurses construct interaction purposefully to avoid in-depth discussion of potentially emotive subjects, but that the technical nature of the talk between nurses and patients reflects the highly technical and potentially dangerous nature of the procedure of administering chemotherapy. This study attempts to pay proper attention, as do other later qualitative studies in this area, to the fact that interactions do not occur in isolation but are part of, and influenced by, the surrounding organisation and work place.

The effect of the workplace environment is also considered in some of the quantitative studies (Wilkinson 1991, Booth et al 1996). In a study of nurses working in either a specialist cancer care hospital or a district general hospital Wilkinson (1991) found there to be a significant relationship ($p=0.001$) between the extent to which nurses used facilitating and blocking verbal behaviours and the levels of positive role modelling behaviours and perceived managerial support by superiors in the work environment. This is also supported by Booth et al (1996), who found that hospice nurses less frequently used blocking behaviours to limit patient disclosures ($p=>0.005$) when they perceived they had the support of supervisors who cared for their welfare.

Therefore, the inference made by the authors is that of a causal relationship between the perceived positive managerial style of ward sisters and an increase in positive communication behaviour of the nurses on that ward. However, inferences

about such relationships need to be approached with care as the causal direction may go both ways i.e. the positive management style of ward sisters *may* lead to nurses interacting more with patients, but it *may* also be that it is the nurses' committed and caring attitude to patient care that influences the ward manager's style of leadership.

Therefore inferences of relationships between variables need to be based on sound reasoning and there is some evidence of this. For example, the "hands on" sister on ward F, 'where the best communication took place' (Wilkinson 1991 p. 687) in terms of least amount of blocking behaviours and most facilitation of patient concerns, regarded the psychological care of patients as having high priority but also encouraged staff to work independently which seemed to result in an increased confidence and sense of security in the ward nurses. Contrary to this, wards that paid very little attention to the patient's psychological needs were typified by authoritarian management style of the ward sister who rarely carried out nursing care for patients.

Interestingly, ward F was located in a district general hospital and outperformed the specialist cancer hospitals with regards to the overall quality of communication between nurses and cancer patients; it was also the busiest of the six wards utilized in the study.

Each of Booth et al (1996), Heaven & Maguire (1996) and Wilkinson et al (1998, 1999) discuss the evaluation of a communication skills programme designed to improve nurses' communication skills with palliative care patients. Pretest, post-test and follow-up scores were compared for improvements in nurses' assessment skills. Overall, in each of the studies the pre-test scores demonstrate that participating nurses discussed mostly physical aspects of the patients' illness and only briefly, if at all, discussed the psychological or emotional needs of patients.

Following training there were improvements seen: Booth et al (ibid.) report weak improvements overall in communication with significant difference ($p < 0.002$) only in the use of the desirable skill of asking open questions, a finding also supported by Heaven & Maguire (1996) with a slightly weaker probability of < 0.05 . Paradoxically however, the increased use of open questions in both studies coincides with an upsurge in blocking behaviour used by the nurses to limit patient discussion of worries and concerns raised in response to the open questions. This would seem to negate any increase in openness of interaction brought about by the change from closed to open question. Interestingly Wilkinson (1991) also notes an increase in nurses blocking patient disclosures, but this significant increase was related to the type of cancer the patient was presenting with, as nurses found it most difficult to communicate and cope with patients being admitted for a recurring cancer compared to newly diagnosed patients and patients admitted for palliative care.

More widespread improvements in nurses' interactions with patients were noted by Wilkinson et al (1998) and in the subsequent follow up (Wilkinson et al 1999). Of the 110 nurses who participated in this study significant improvements ($p < 0.0001$) were seen when comparing pre-test and post-test mean scores of the areas, such as the nursing assessment of the patient's social and psychological needs, an indicator according to Wilkinson et al (1998 p.20) that 'nurses felt more confident to address these areas after training'. Although improvements were seen in the performance of 90% of the nurses following communication training, for 10% of the nurses training had little or no effect, or in some cases nurses' performance worsened.

Improvement or deterioration in the nurses' interactions were measured via a nine stage rating scale which was seen to have high degree of inter-rater reliability, however no consideration of the validity of the rating scale was provided. In particular

there is a lack of discussion regarding possible problems with the internal validity of the study caused through the testing of nurses interactions pre, mid and post course. Specifically, what is known as the “testing threat” to internal validity relates to the possibility that subjects become more experienced at taking a test or may become more sensitised to the researcher’s aims, especially if subjects perform a pre-test (Burns and Groves 2001, Bryman 2001). The presence of a control group which were only tested post-course, not included in Wilkinson’s studies, could have helped to discount the chances that subjects were demonstrating changes in their interactions as a result of over-exposure to the testing/rating scale, rather than overall changes in the nurses’ interactions. The lack of patient consultation whilst developing the rating scale, or during the evaluation of the nurses’ interactions, also poses a problem in terms of the meaningfulness of the measures used during these studies.

2.1.4 Communication in mental health nursing.

Psychiatric nursing in the UK has a long history of being influenced by humanistic and psychotherapeutically inspired theorists such as Peplau (1990) and Barker et al (1997). Thus, it is with some surprise that the research design used to explore nurse-patient interaction within psychiatric nursing is mostly limited to structured observational studies that count occurrences of certain types of interaction, with only minimal consideration given to the content of the interaction.

In one of the first nursing research studies carried out in the UK, Altschul (1972) studied patient-nurse interaction with a view of investigating the nature of contacts between individual nurses and individual patients. Participant observational data was recorded, such as duration of interaction and whether the interaction was initiated by the nurse or patient. Some insight into the content of the interaction was obtained through the researcher asking the nurses as soon as possible afterwards for

information about the interaction, no attempt was made however to elicit patient feedback.

Data was collected during 1965-66 from 4 wards within 1 hospital, and a total of 40 nurses participated. The mean interaction time per patient was 21.4 minutes which constituted 1.1% of the total observed time, and nurses were seen to initiate 69% of the interactions. Altschul also points out that a considerable proportion of patients did not interact with nurses at all during these times, and that there was variation in the amount of interaction between patient and nurses depending on diagnosis, with those patients suffering from organic disorders gaining the most interaction and those with depression the least.

The inquiries with nurses regarding the content of the interaction revealed that over 77% of the interactions consisted of either communication occurring during the performing of physical care tasks (35.1%) or superficial social conversation (42.6%) about topics such as television programmes or sporting events. Confusingly only 'very few' (Altschul *ibid* p131) interactions where the patient's personal or psychological problems were the subject of conversation were observed in the 'psychological problems' category, with the majority of the interactions in this category appearing to consist of patients seeking out nurses for company or reassurance. This suggests that a separate category for clearly defined interaction concerning psychological problems would have been beneficial resulting in less ambiguous results.

The framework for Altschul's study was finalised following a preliminary 200 hour period of observation, although no mention is made of a pilot study which was replicated by the main study, neither is there an attempt to statistically verify any of

the inter-relationships implied in the results section e.g. the relationship between patient diagnosis and interaction.

Problems with accurate categorisation of interaction also appear to afflict certain parts of Macilwane's (1983) study of 24 neurotic female patients and their interactions with nurses on 4 wards. Of 200 dyadic interactions that were taped, 80 interactions could not be located by the 4 independent judges (who had agreed to undertake the task) within the original behavioural categories developed by the author. A further 4 independent judges, in an attempt to resolve the issue, were recruited to re-categorise the remaining 80 interactions within a new instrument, unfortunately strong disagreement remained and 30 interactions remained unclassified at the conclusion of the study. With no statistical testing of the classification instrument and results, the reliability and validity of this study is considered as being low.

The lasting impression made when reading through these early nursing research studies is of the lack of suitability of the methods chosen to answer the research problem and that in these early studies of interaction, where it is obvious that the research question is not yet clearly formulated or the relationships being examined are not yet explicit, a different approach may have been preferable.

As with Altschul's work and the studies carried out in general hospitals, the results of Macilwane's study indicate that overall interactions between nurses and patients were brief and clustered around meal times and drug rounds. Interestingly a close comparison emerged with some of the other studies considered elsewhere in this review as nurses' interactions, although classified as primarily administrative in nature, also reflected the prevailing therapeutic regime and the degree to which staff felt supported, with the best level of interaction in a teaching hospital with generous

staffing and a focus on non-physical therapies, the worse level of interaction on units with poor staffing levels, frequent management changes and physical treatment ideology.

Holyoake's (1997) observational data and results are similarly restricted by a study design that has low levels of validity and reliability. Non participant observation of qualified and unqualified nursing staff working on an acute admission psychiatric ward was undertaken using an observation checklist designed and briefly piloted by the author. There is no discussion of validity and reliability checks and statistical analysis is descriptive at best. The main aim of the study was to find out who initiated the interaction (nurse or patient) and for how long the interaction lasted. Findings of the study were that nurses initiated two-thirds of interactions with patients, the average length of interaction was 2.4 minutes and that nurses interacted with patients, on average, for 76 minutes during the 240 minute observation period.

Discovering the proportion of work time that psychiatric nurses spent in one-to-one communication with patients was also the main aim of Whittington & McLaughlin's (2000) observational study. The participants of the study consisted of a total of 20 qualified nurses who were observed for the duration of one shift. The categories in the Nurses Daily Activity Recording System (NURDARS) that was especially developed for the study were 'derived from scrutiny of earlier studies and from knowledge and informal observation of similar ward settings.' (Whittington & McLaughlin *ibid* p.261). Pilot studies were carried out as were reliability and validity checks with the assistance of a team of 4 nurses, exact details regarding these parts of the study are not given however.

Overall less than half the working day (42.7%) was spent in patient contact with only 6.75% of the day spent in one-to-one interaction with patients that was

potentially therapeutic, a similar finding to Altschul (1972) who found that nurses engaged in one-to-one interaction approximately 8% of the time. It was evident that ‘talking and reporting to other staff’ and ‘office administration’ had high priority on the wards as these activities occupied almost 33% of the available time.

2.1.5 Communication in medical and surgical nursing

This section consists of studies that were undertaken in a variety of medical/surgical settings including a haemo-dialysis out patient clinic (Mallett & A’hern 1996). Firstly consideration will be given to Stockwell’s (1972) study which has been labelled as groundbreaking and a “classic” within UK nursing research (Macfarlane 1984, Rafferty & Traynor 2002), both for the methodological approach taken (the first nursing research study in the UK to use methodological triangulation and Grounded Theory) and for the dramatic attention the study drew ‘to the inadequacies of nurse-patient interaction (MacFarlane 1984 p.3).

Stockwell’s study set out to gain information about nurse/patient interaction, with particular attention being paid to whether the degree of patient popularity influences any aspects of nursing care given to the patients. Through a combination of both qualitative and quantitative data collection and analysis Stockwell demonstrated that the patients whom nurses described on being interviewed as enjoyable to care for were able to communicate readily and share humour with nurses, as well as express a desire to get better. Patients that nurses least enjoyed caring for included those with communication problems such as a non-fluent English speaking person or a patient suffering from a medical illness or symptom, such as dementia or dysphasia, which restricted communication.

The advantage of Stockwell’s study over many of the others reviewed here is that having established that the perceived degree of patient’s communicative

competence was directly linked both to patient popularity (as perceived by the nurses), and the extent to which nurses enjoyed caring for patients, the study was extended to review the effects of these on the quality of nurse-patient communication and interaction.

What Stockwell found was that “popular” patients received rewarding behaviours which included nurses allowing a more personalised interaction with patients. The “unpopular” patients however received what Stockwell termed as deterrent behaviours which included nurses ignoring the patients’ verbal requests and using sarcasm in their interactions with patients. Overall within the study the nurse-patient interactions were mainly task initiated and conversations with patients were considered by many as not constituting work with the result that many nurses were discouraged from interaction with patients due to the danger of being judged as “slacking” by their colleagues. However, if the nurses did stop their work to chat to patients they would choose those patients they “enjoyed” caring for.

Stockwell also found, in common with many other studies, that nurses’ communication with patients occupied only a small percentage of the time available during an observation period, and that when communication did take place the topic of the talk largely revolved around tasks that needed to be completed.

Finding similar results, Macleod-Clark (1983) used both video and audio tape to record interactions occurring on a surgical ward where a total of 22 nurses made up the convenient sample. Both student and qualified nurses were enrolled into the study but their exact numbers within the sample is not given. On average within a 2 hour recording session the mean duration of interaction was 1.71 minutes between patients and qualified staff and 2.01 between student nurses and patients, this was not a statistically significant difference between qualified and student nurses. Only 1.3% of

the conversational content related to psychosocial/emotional matters whilst 82% of all interactions occurred during tasks such as drug rounds and the filling in of charts, with the remaining 28% occurring in the absence of specific nursing activity. The use of closed questions by nurses dominated the interaction (75%) whilst leading questions (16%) and open questions (9%) were used less frequently; however many of the open questions were asked without giving time to patients to answer and nurses often asked a succession of questions without waiting for a reply.

Based on these findings Macleod-Clarke concluded that nurses on the whole showed little use of skills that encouraged communication, whilst also highlighting many examples where nurses appeared skilled in blocking or discouraging communication.

The quality of the findings in this study is bolstered by the use of independent verifiers throughout the (rather convoluted) data analysis. The validity of the findings are apparently supported through 'high levels of inter-coder reliability' (p.44), although no statistical calculation is given as verification of the reliability. Macleod-Clark (ibid.) states in the concluding discussion that future researchers will not have to concentrate on the quantitative aspects of nurse-patient communication as the knowledge of it's 'paucity and limitations' (p.35) is at this point complete. Interestingly this suggestion, albeit in all probability not intended as a blanket recommendation, appears with hindsight highly optimistic and has yet to be fully realised over 20 years later.

The study of humour within nurse-patient communication by Mallett & A'hern (1996) offers a very different methodological approach to the other studies mentioned in this section and within the review as a whole. Mallett & A'hern take a largely qualitative approach to the study of nurse-patient interaction by using a

mixture of 'ethnomethodological ethnography and conversation analysis' (p.675), although there is also some use of non-parametric statistics in the analysis of the distribution of humour across sessions and different patients.

The data was collected in a haemodialysis unit via audio-visual recording with a total of 5 patients participating in the study. It seems the researchers recorded a total of 126 haemodialysis sessions with these patients although the exact number and duration of data collection sessions is not clearly stipulated. Overall the data analysis suggests to Mallett & A'hern that humour and laughter is integral to haemodialysis sessions and is utilised by participants to achieve particular social actions. Patients are specifically described as using humour to achieve a number of different communicative actions, with examples given of the use of humour by patients to highlight anxieties, to disagree with nurses and to avoid potential conflict with nurses. The analysis hints at the complex nature of nurse-patient interaction especially when scrutinised in detail through the use of CA, as humour is seen as being constructed by both nurse and patient as an interactional device which smoothes over some of the difficulties encountered within treatment situations.

2.1.6 Communication in community nursing.

Up to this point one of the clear themes that has been identified within the review is that of communication between nurses and patients being both restricted to, and defined by, the task(s) of nursing work on a hospital ward. For example, the "task based" context of the interaction between nurse and patient appears to be instrumental in determining the physical location of the communication that unfolds e.g. many studies have commented on the fact that nurses tend to confine communication with patients to times when they are engaging with the patient in some physical care task such as a medication round, mealtimes or washing patients. The task related

background to nurse-patient communication appears also to influence the duration and topic of conversation: communication is often brief and rarely patient-centred, with nurses avoiding or blocking patients' attempts to introduce a topic of discussion other than that which concerns the task in hand.

Community nursing significantly changes the backdrop of communication to the patient's home and takes interaction out of the hospital ward and its trappings. Almost predictably therefore, two of the studies reviewed here (Hunt 1991, Sefi 1998) see some change in the nature of nurse-patient communication as the interaction moves away from hospital and into the patient's home.

Both studies highlight that nurses (Hunt 1991) and health visitors (HVs) (Sefi 1988) initially adopt an unhurried approach to visits that appear to be unrestricted by external constraints such as the ward related tasks discussed above. On the surface therefore the general feel to the communication is akin to that of a social visit, with an emphasis on promoting informality and friendliness seen as nurses and HVs accept cups of tea and both parties used Christian names.

However in both studies the need to fulfil the work related purpose of the home visits became more apparent in the communication styles as the visit progressed. This is highlighted by Hunt (1991) who discusses that nurses reverted to a more formal interview style of communication once the informal opening sequences of the visit had eased both parties into the apparent purposes of their visits. Sefi (1988) also describes that although initially the visit was superficially informal the task of form filling 'occupied considerable lengths of time in all cases' (p. 8) resulting in the overwhelming use of question-answer sequences by HVs to achieve this end.

In both studies the change of communication style from informal to formal elicits a change in the status of the visit from that of a social visit to a professional-lay

encounter. Therefore the immediate environment of a home visit initially influences the nature of the interaction making it a distinct form of communication compared to hospital based interaction. However, the tasks linked to the visit soon results in a style of interaction which resembles hospital based interaction, with the nurses and HVs controlling the topic of discussion and the extent of patient initiated discussion within the interaction. Therefore, although on the surface it appears easy to take the interaction out of the institution, it is considerably more difficult to take the institution out of the interaction.

The wide ranging study by Gerrish (2001) focused on communication difficulties experienced by South Asian patients and their carers during district nurses' visits. A total of 291 nurse-patient interactions were observed, where 54.4% of the sample population had little or no understanding of spoken English. Of the many issues raised by this study there are a few that are directly relevant to this review of the research, mainly that where there was an absence of interpreters for those patients and carers who had difficulty in conversing in English, this had a direct negative effect on the quality of the care received by the patients.

For example, the language barriers between nurse and patient/carer suggested that the content of advice on matters such as compliance with treatment regimes might not be fully understood and that psychological care of patients and carers was also limited. Relying on family members to interpret in the absence of a professional interpreter offered a line of communication between nurse and patient/carer. But this itself was not unproblematic as the use of family members as interpreters had implications regarding confidentiality and disclosure of sensitive information, with female carers and older patients particularly disadvantaged in this way.

As in all of the studies reviewed here the effect of communication on the quality of nursing care is paramount in the discussion of Gerrish's findings. In the same way as the hospital based researchers have found that nurse-patient interactions that are rushed or linked to the completion of clinical tasks leads to information about the patient's experiences being badly lacking, Gerrish found that the insufficient use of professional interpreters in community settings compromised the quality of care in respect of privacy and confidentiality and severely restricted the detailed understanding of the patient's perspective of his or her health needs.

The three studies reviewed thus far in this section are generally of good quality, drawing upon relevant samples and demonstrating clearly the development of analysis from the data. The findings in each of the studies is firmly grounded in the data and related back to the original research question. Hunt's (1991) methodological discussion and analysis are somewhat at variance however, with a claim made in the aims of the study that 'ethnographic theories' (p.931) were used to analyse the conversations (the types of theories were not expanded upon) whereas much of the analysis appears to rely upon ethnomethodological techniques. This has an effect on the overall quality of the study as the reader is left in some doubt as to the exact methodological approach employed in the study.

2.2 Communication – an overview of the relationship between nursing practice and research.

The initial studies of nurse-patient communication date back to the early 1970's and are followed by a steady stream of research which has contributed both to an understanding of nursing care delivery and of the organisations within which nurses practice. The early studies, such as Altschul (1972) and Stockwell (1972), are rightly regarded as classics of their time, groundbreaking forays by UK nurses into the academic discipline of healthcare/nursing research. However, put simply, much of the research reviewed here has been of questionable quality.

Perhaps the most serious charge against the published research on nurse-patient communication is that it has failed to build upon existing work in the area of nurse-patient communication. On many occasions published research on nurse-patient communication fails to make connections with earlier studies which address similar topics or touch on similar conceptual issues, although it appears that nursing is not alone in this (see Griffiths' (2003) review of Medical Sociology publications over the last 25 years).

For a relatively neophyte research discipline such as nursing this is an aberration, as a recognised criterion by which a research based profession should be judged is the extent to which researchers have built upon previous knowledge in their work and their success in connecting their findings with previous knowledge (Murphy et al 1998). The lack of connection between published works affects the quality of data analysis, with studies lacking both overall coherence and depth of discussion. This is a particularly worrying situation for a profession striving to implement an "evidence-based" approach to its practice in an attempt to improve the quality and effectiveness of patient care.

However, even taking the weaknesses of the research into account the act of revisiting and reflecting on the studies in the literature review enables a picture to emerge of current practice and comparisons with practices of the past. Overall, little appears to have changed in nursing practice over the last three decades, in as much as there appears to be an overwhelming task focussed approach adopted by nurses when communicating with patients (Ashworth 1980, Macleod Clarke 1983, Armstrong-Esther & Browne 1986, Nolan et al 1995, Elliott & Wright 1999, Whittington & McLaughlin 2001). Added to this the instigation of affective or socio-emotional communication by nurses appears to be at a minimum in most of the studies reviewed, with nurses also appearing to be uncomfortable when this type of interaction is instigated by patients (McIntosh 1977, Webster 1981, Wilkinson 1991, Dennison 1995, Heaven & Maguire 1996, Booth et al 1996).

Over thirty years after the first attempts by researchers to evaluate nurse-patient interactions there appears to be little desire within nursing to discuss the establishment of research based standards for good communication within specific areas of nursing. It may be that nursing communication exists in clinical areas too diverse to be standardised, and this seems to have led to nursing texts and policies discussing communication in a way that ignores diversity within nursing practice.

Overall there appears to be little evidence of research findings having an effect on communication in nursing practice, a concern expressed by many authors (Bircumshaw 1990, Le May et al 1998, Tierney 1998). Others, such as Freshwater & Broughton (2001), also acknowledge the lack of research application in nursing practice and call for further resources and policy initiatives to be developed for the successful integration of practice, theory and research in nursing. However, reasons for the lack of progress in using research in nurse-patient communication over the last

30 or so years may lie at a deeper level than funding or policy initiatives. These reasons are discussed in the following section.

2.3 The influence of humanistic theories on nursing communication research and practice.

A strange phenomenon within nursing, according to Latimer (2000), is the way 'in which nurse theorists and researchers continually go to other theories and 'try to make nursing fit them' (ibid p.3). An example of this can be seen in the work of American nurse theorists during the 1950's such as Hildegard Peplau (1952) who were heavily influenced by ideas originating from humanistic psychology. This branch of psychology, which has had far more influence on healthcare than the mass of its academic work would suggest (Hayes 2000), emphasises that it is in the nature of patients as human beings to have a deep seated need to make their own choices and to be in control of their own behaviour.

Theorists claim that for nurses to be able to understand patient behaviour in humanistic terms it is essential they discover the patient's unique and individual experiences and meanings of health and illness, which nurses can only access from an attitude of involvement and openness to the total life-world of the patient (Gastmans 1998). The interactive, relational process which develops between the nurse and patient as a result of this prolonged level of involvement leads, according to Peplau (1952), to a distinctly therapeutic relationship which is the foundation upon which both the patient and nurse can develop and flourish as persons.

Peplau's work struck a chord with nurses and she has been widely recognized as formulating the first contemporary theory in nursing, a theory which has greatly influenced the thinking of later theorists as well as the content of nursing education curricula in the UK (Antrobus 1997, McKenna 1997). As a result of Peplau and her

followers' work nursing has, according to Munhall (1982) and Parker (2002) identified itself as a humanistic discipline with the resultant focus on humanistic principles such as patient individuality and patient centeredness enshrined within the nursing process and nursing models (both of which are discussed in the next chapter).

Although it appears that the contribution of humanism to contemporary nursing thinking cannot be underestimated, the influence of humanism as an underpinning force in clinical nursing practice, and more specifically its influence on nurse-patient communication is less than clear, a situation that has led to a number of ambiguities between nursing theory and practice.

Firstly, as Bowles et al (2001) discuss, much of the writing, research and subsequent evaluation of nurse-patient communication is conducted from a humanistic perspective which favours a patient-centred style of communication based on a prolonged nurse-patient relationship. Whilst an evaluation from this perspective may not be problematic when researching nurse-patient communication in primary care or counselling settings where prolonged patient-centred interaction may be the norm, the humanistic approach to communication may not be relevant to all nurses in all areas of nursing practice. Additionally there appears to be some evidence of doubt regarding whether patients value the humanistic approach to healthcare interaction in some care settings with authors suggesting that some patients prefer not to have their "lifeworlds" as the topic of conversation with nurses (Altschul 1972, Hunt & Meerabeau 1993, Jarrett & Payne 2000).

Secondly, the pervasive influence of humanistic principles may also be a factor in the lack of implementation of communication training into nursing practice, (Heaven & Maguire 1996, Wilkinson et al 1998, Booth et al 1999). Reasons for this again centre on the relevance of teaching humanistic principles of communication

skills to all pre and post registration nursing students regardless of whether nurses have the clinical need, or the patients' agreement to apply these skills fully (Brereton 1995, Bowles et al 2001).

The charge against the previous teaching of, and research into, nurse-patient communication therefore is that academics and researchers have used a theoretical and rather abstract standard (humanistic communication) as a "taken for granted" universal model for nurse-patient communication, without considering the naturally occurring complexity inherent in the organisation of such talk.

Taking a slightly different tack but on the same theme, the tendency not to transfer what is taught into clinical practice may also operate on a personal, rather than a practical or theoretical level. This is highlighted by Heaven and Maguire (1996) who demonstrated that nurses *did* follow the taught principles of "good" (humanistic) communication skills in asking patients open questions regarding their illnesses. However, as an obvious consequence of asking open questions, patients disclosed intimate details of their illnesses to these nurses, who in turn blocked any further patient attempts at intimate conversations by resuming a closed question approach in order to protect themselves from being further involved in the patient's suffering.

Similarly nurses in Booth et al (1996) avoided asking open questions of hospice patients for the reason that they regarded the questions as being personally intrusive and claimed that the avoidance of searching questions was a form of kindness to patients. There is some suggestion nonetheless that nurses who have attended training courses or who work in a supportive environment characterised by sympathetic management are more likely to communicate in a more patient-centred way (McIntosh 1977, Wilkinson 1991, Booth et al 1996).

Thus, humanistic theories have had a strong influence on the development of nursing scholarship and theory, and nursing education has integrated it wholeheartedly into nursing curricula. Humanistic theory has also shaped much of the evaluative research of nurse-patient communication, all of this regardless of the fact that humanistic theories appear to have had little influence on practising nurses' style of communication with patients, which appears more likely to be affected by a variety of more mundane, personal, work related and managerial issues rather than nursing theory. These insights into the variance, or dissonance, between humanistic ideals and the realities of nursing practice were particularly helpful in clarifying data, which were initially puzzling, regarding the apparent awkwardness of the communication style adopted by nurses when interviewing patients during assessments, points that will be further discussed in chapter 6.

2.4 The use of theory in nursing and the problem of homogenisation – the effect on nursing practice and research.

It is important to stress that the issue here is not with the use of *any* “theory” in nursing, or the attempted application of humanistic approaches to nursing practice *per se*, indeed the use of theory and the social sciences within nursing is acknowledged as having significant, positive implications for the quality of patient care. Instead the problem appears to be that nursing unequivocally adopts what it sees as “good ideas” without fully considering how practical workplace circumstances might promote or constrain the implementation of those ideas.

Put another way there is a lack of reciprocity between theory and nursing practice, with the result that aspects of a theory such as Humanism, are employed within nursing academia and research without due consideration of “locally” created nurse-patient interactions proceeding across countless clinical environments on a day

by day, minute by minute basis. A problem created by the homogenising approach to nursing seen in writing, research and policy is that such attempts to standardise practice across nursing disciplines has the effect of ignoring the local and specific nature of nursing practice. Obviously this also has an effect on the way the patient's experience is represented within nursing literature as the homogenisation of nursing leads to the homogenisation of the patient. This argument has recently been the focus of the critical stance taken by some towards the humanistic inspired concept of patient-centred care, *the* ideological cornerstone of nursing and healthcare over the last few years, which has been criticised as being casually applied within health policy initiatives into all areas within nursing, with the effect of perpetuating poor standards of care as it is applied regardless of the need of specialist requirements such as those of older people or the critically ill (Nolan et al 2004). Therefore, it appears that not only has nursing become a homogenised entity within nursing literature but so has the patient.

It is acknowledged here that it may be possible, or even necessary at times to formulate global or universal statements about nursing practice, the realities of nursing practice are such that any attempt to construct a grand theory of nursing at a specific level e.g. regarding nurse-patient interaction, is doomed to failure due to the incredibly heterogeneous profession that is nursing. This "messiness" of nursing practice sits uneasily next to nursing writing which focuses on explaining how "nursing" should be done.

2.5 Summary and Conclusion

To conclude, the majority of research conducted over the last 30 years or so shows nurses' basic communication skills amounting to little more than task focussed and

largely perfunctory interactions with patients. This is worrying, especially considering that during this time the focal point of nursing communication has moved towards humanistic ideologies and principles such as patient-centeredness. A significant proportion of the research discussed in this chapter suggests that nurses spend little time in meaningful communication with patients even though other studies such as Ashworth (1980), Mackay (1992), Armstrong-Esther et al (1994), McLaughlin (1999) and Whittington & McLaughlin (2000) clearly demonstrate that nurses rated talking to patients as one of the most important aspects of their job.

The main reason given for the discrepancy between the belief in the importance of communication and the lack of communication in practice is that nurses claim not to have enough time to sit and talk to patients (Ashworth 1980, Bond 1983, Byrne & Heyman 1997, Whittington & McLaughlin 2000, Latimer 2000), even though Wilkinson (1991) found that out of the 6 participating wards in her survey the ward which had the best communication with patients was also one of the busiest. Observational research shows registered nurses spend most of their time during a shift participating in indirect patient care and talking to each other in handovers or writing in the nursing records (Altschul 1972, Hendrickson et al 1990, Ricketts 1996, Jinks and Hope 2000, Whittington & McLaughlin 2000), or undertaking tasks which could and should have been delegated to non-nursing ward staff (Ball and Gladstone 1987, Tierney 1992, Bowman 1995, Byrne & Heyman 1997).

Any conclusive statements regarding the state of nurse-patient communication need to consider that, in general, the nursing research to date has been unconcerned with the specifics of everyday conduct and talk. Instead researchers have been more concerned with various quantifications or typology of talk, mainly ignoring that the processes and practices of nurse-patient interaction may well be a domain to be

studied in its own right. However, the quantitative research on nurse-patient interaction, especially the earlier studies, can rightly be described as weak in terms of validity and reliability. Furthermore, nursing researchers seem to have had limited insight into the suspect quality of the research being produced judging by the assertions discussed earlier by Macleod-Clarke who held that the state of quantitative nursing research by the early 1980's was sufficiently strong to have identified most of the limitations hampering nursing interactions with patients.

The situation, with the aid of hindsight, appears to be that the lack of consideration given to the use of qualitative research at this early stage of nursing research in the UK, which has been shown to be particularly advantageous in areas where research questions are not clearly formulated or relationships have not yet become explicit (Tripp-Reimer 1985, Murphy et al 1998), has held back the development of high quality quantitative research in this area.

A further oversight related both to the under-use of qualitative research methods and the general lack of coherence in this area of nursing research has been that researchers have had little to say about how interaction works, treating the accomplishment of interaction as an invisible or inscrutable part of the communication between nurses and patients. There has been little interest therefore in fundamental issues concerning, for example, how nurses and patients understand one another in interaction and, just as importantly, know that they share these understandings.

Consideration should also be given to the lack of fit between the disparate nature of nursing practice and the nursing ideology often used in the teaching of communication skills and in research to evaluate practice, and that it is unlikely, and undesirable, that there is a "one-size fits all" model of communication for nursing.

The approach to research endorsed here is to distinguish *how* nurses and patients communicate, and what communication methods and strategies are selected, or not, during the accomplishment of nursing work. Collecting and analysing naturally occurring data, in this case the talk of nurses and patients, provides an insight into the dynamic features and complexity of social interaction in itself without first placing it within the constraints of theory. Given direct access to the data in this way, readers can follow through the logic of any of the analyst's interpretations as well as proposals about how they were produced.

There is little doubt that effective communication skills and interaction is a very important ingredient in establishing and maintaining an effective nurse-patient relationship, the first step of establishing the relationship usually having been taken during the initial nursing assessment which will be considered in more depth in the following chapter.

Chapter 3 –A review of the factors that shape the nature of initial nursing assessments in the UK – the nursing process, health policy and documentation.

The aim of this chapter is to present material which discusses the broader background against which initial nursing assessments are performed in the UK. Hospital nursing involves registered nurses, student nurses and unqualified/auxiliary nurses working to multiple agendas within a complex location. Initial nursing assessment is a recurring element of student and registered nurses' work, competing for the nurses' time with other demands such as patients' needs, doctors' orders, managerial objectives and a nursing discourse that stresses the care of patients as individuals.

As a result of the numerous demands on nurses' time, many organisational devices and reforms over the past 25 years have been designed by, and for nurses, to assist in making ward life more predictable, standardised and controllable. However it has also been suggested that, rather than being designed to assist the nurse, many of these recent reforms of healthcare and nursing have been designed to 'emulate industrial models of productivity improvement' (Aiken et al. 2001, p. 51), a claim reflected in recent UK health policy language (see the *NHS plan*, Department of Health 2000b) which targets 'financial efficiency and cost containment' (p.39), whilst acknowledging the healthcare recipient as a 'consumer of health services' (p.26).

What is undeniable is that nursing practice in the UK has changed dramatically over the last 25 years, particularly with registered nurses relinquishing caring work at the bedside (to care assistants/auxiliary nurses or informal carers) as they take on more medical and managerial tasks (Walby et al 1994, Gregor 1997, Latimer 2000, Budge et al 2003). What is of interest is that against this backdrop of constant reform of healthcare delivery, the practice of initial assessments of patients

on hospital wards seems to have remained a constant and largely unchanged feature in the daily work of student and registered nurses. This chapter describes and explores the development of initial nursing assessment as a distinct form of nursing work and goes on to examine key areas which significantly shape the nature and completion of this work, an exercise that will assist considerably with the interpretation of the data and findings presented later in this study.

3.1 Recent developments in ward based nursing care –policy initiatives the “new NHS” and “new nursing”.

Successive UK governments’ agenda for modernization of the NHS has had profound effects on nursing and patient care (Antrobus 1997, Bradshaw 2003, Hewison 2003, Richman and Mercer 2004). The current government’s policy initiatives expressed through the *NHS plan* (Department of Health 2000b) has been described as the most radical series of reforms to the NHS since its formation in 1948, with nurses representing a pivotal figure for its success or failure (Nolan et al 2004). With particular reference to this study, changes within the *NHS plan* provide a challenge to authoritative, paternalistic approaches to work and interaction from professionals towards healthcare users, and imply the emergence of consumer-led standards for care within the process of the ‘new NHS unfolding’³ (Department of Health 2000b, p.16). It could, however, be said that nursing anticipated the consumerist-led changes first heralded in *The Patient’s Charter* (Department of Health,1992) and built upon in the more recent *NHS plan* through the introduction of the concept of “new nursing” (Savage, 1995; Almond 2001).

New nursing was conceived partly as an attempt to strengthen the relationship between patient and nurse, especially as nurses increasingly gained specialist

³ The word “new” appears 290 times within the 144 pages of the NHS plan.

knowledge in their drive towards an elite professional status. The move towards new nursing has been adopted into nursing curricula by educationalists and endorsed by nursing bodies such as the Royal College of Nursing and basically describes a shift to a wider interpretation of care which embraces the concepts of caring for, and caring about patients. Conceptualised in this way, nurses and nursing in the 21st century should value caring through partnerships with patients and carers, whilst also encouraging patient autonomy where possible (Tait and Higginson 2001).

Enabling patient partnerships and patient autonomy demands that nurses possess the relevant interpersonal skills to form a close and therapeutic relationship with patients. The development of the required level of rapport and maintenance of such relationships demands much work on the part of nurses, adding to the invisible, emotional work that is generally unrecognised in nursing (Staden 1988, McQueen 2000).

The work expected of the “modern” nurse to develop a sense of closeness with the patient is in direct contrast to nursing practice of the past where a professional barrier was maintained between nurse and patient, partly with the help of organizing nursing work in terms of tasks and reducing the opportunities for potentially emotional interactions with patients (Menzies 1961). More recent research reviewed in the previous chapter indicates that this may not entirely be a practice of the past (Nolan et al 1995, Caris-Verhallen 1999, Whittington and McLaughlin 2000). Thus, while the values expressed in policy and nursing ideology suggest a closer working relationship between patients and nurses, the literature and research relating to the actual work of nurses questions the recognition and successful application of these values in nursing practice.

3.2 The ways in which nurses work.

The way in which nursing work was managed up to the early to mid 1980s resulted in the division of patient care into a series of individual tasks (such as washing, feeding, toileting) which were then allocated to different nurses by the nurse in charge of the ward at that time. The effect of this approach to organising patient care (known as task allocation) was that no one nurse was recognised as being responsible for the total care of individual patients, which intentionally or not, emphasised a lack of nursing accountability for the quality of care for any one patient and the nurses' emotional distance from the patient.

In recent years, especially since the early 1980s, there has been a move to change the allocation of nursing work tasks so that the care of individual patients is provided on any one shift by the same nurse. Abandoning task allocation is seen as a "holistic" shift in the division of labour on hospital wards, shifting more towards an emphasis on the patient as an individual and away from an emphasis on the task to be performed (Marks-Maran 1978, Lawler 1991a).

In particular, task allocation of nursing work appears to have been replaced in the UK with work regimes more in tune with the stated values of nursing. These work regimes include approaches known as team nursing, patient allocation and primary nursing. These approaches involve fewer nurses in the daily care of individual patients, and importantly with respect to this study, gives the responsibility to one nurse, or a small team of nurses for the overall assessment, planning, implementation and evaluation of care during the patient's stay on that ward. There needs to be some caution, however, when condemning task allocation to the history of nursing practice as there is still evidence of its continuing importance in the organisation of nursing

practice (Payne et al 2000), and as already mentioned communication between patient and nurses largely revolves around the completion of tasks.

Generally speaking the claim made by the critics of task allocation is that a closer therapeutic relationship is more possible the fewer nurses involved in the patient's care (Redfern and Evers 1995, McQueen 2000). As seen with the advent of new nursing and the publication of *The Patient's Charter*, the retreat from the task allocation method of organizing patient care could be seen as a further example of nursing initiated change pre-dating, or being in tandem with, health policy initiatives. For example, the concept of the named nurse enshrined in *The Patient's Charter* (Department of Health 1992) was introduced by the then Conservative government in an attempt to identify a named, qualified nurse responsible for the care given to individual patients, a policy initiative which strongly emulates the more patient-centred work allocation systems such as primary nursing.

Indeed, Steven (1999) speculates that the government based the ideology of named nursing on research reports circulating at the time regarding primary nursing. However, Steven (ibid) also highlights the lack of rigorous research concerning named nursing whilst also detailing the methodological flaws that beset much of the literature about primary nursing, highlighting that, for example, two wards described to researchers as using primary nursing (and where job satisfaction was found to be high) were in reality practising forms of team nursing. Furthermore, Steven states that while other researchers have found that primary nursing offers an increased quality of care compared to team nursing, they failed to mention that team nursing within the same studies scored higher in relation to meeting the psychosocial needs of patients.

Nursing literature and policy therefore strongly suggest that, rather than the distant professional relationship of the past, nurses should become more emotionally

involved with patients. The 1992 modification of the *Code of professional conduct* governing registered nurses in the UK to include some extra clauses such as:

... work in an open and cooperative manner with patients, clients and their families, foster their independence and recognise and respect their involvement in the planning and delivery of care (UKCC 1992)

demonstrates that the ideology of the nurse-patient relationship as a partnership of equals has also successfully been integrated into the professional regulation code for nurses and midwives. However, while nursing literature, policy and the code of conduct re-position nursing as a more therapeutic, patient-centred endeavour, there are tensions at the heart of modern health care which affect nurses perhaps more acutely than any other group of health professionals.

Across the UK and beyond nurses commonly express increasing concern about their ability to deliver quality care as a result of decreasing staffing levels, inappropriate skill mix and altered organizational design of the NHS (Fagin 2001, Budge et al 2003). Added to this Jinks and Hope (2000) identify that the role definitions and functions of RNs are in a state of constant flux. A major contributor to this constant state of change has been the reduction in junior doctors' hours (NHS Management Executive 1991), changes that have resulted in role diversification for RNs into areas previously reserved for doctors, leading to a situation where, according to some, RNs are content to follow doctors in the abandonment of the bedside (Latimer 2000, Kinley et al 2001).

Therefore, changes in the tasks which RNs now undertake have resulted in personal care tasks, such as bathing, dressing, and feeding being increasingly allocated to auxiliary nurses or Health Care Assistants (HCAs), in an attempt to increase the time available to nurses to perform "professional" (rather than domestic) tasks. However, RNs do still perform tasks that have always been traditionally in the

domain of the RN, such as patient assessment, but nursing assessment now has to compete for time with the much more technical tasks previously conducted by doctors such as venous cannulation and diagnostic testing (Kinley et al 2001, Brooks and Brown 2002, Budge et al 2003).

The situation appears to be that although it is often cited that “nurses” administer 80% of patient care (Tait and Higginson 2001), it appears that specific types of care are rapidly being shifted onto non-registered nurses’ shoulders such as HCAs, who have been widely employed in various settings to fill the gap left through decreasing junior doctors hours and increasing the scope of professional nursing practice. In certain studies however the picture of exactly what RNs do appears less than clear, as there still appears to be some overlap between the two roles, with HCAs performing tasks deemed to be in the sphere of the RN, and RNs continuing to engage in activities considered to be the responsibility of HCAs (Tierney 1992, Thornley 2000).

A different form of uncertainty is expressed by Liaschenko and Peter (2004) who feel that the drive for professionalism and adoption of traditional medical tasks in nursing confuses the role of nursing and physician and competes with the natural sense of altruism seen in nursing, whilst also taking nursing away from those it ‘has intended to serve’ (p. 490), echoing Latimer’s earlier point regarding nurses abandoning the bedside.

To recap, therefore, RNs have been engaged since the 1980s in a move towards individual and holistic delivery of patient care, a movement supported in nursing literature, policy and professional regulatory codes of practice. More recently however it appears that broadening nurses’ professional boundaries to encompass work previously in the realm of medicine has led to some reduction in the amount of

basic care given to patients by RNs, whilst increasing the amount of technical/medical tasks nurses perform on patients.

3.3 The effects of the changing roles and relationships in nursing.

In practice the cumulative effects of policy and professional changes combined with changes in ward based working strategies, as well as demographic changes of an aging population both in terms of patients and nursing personnel, has led to nurses facing unprecedented pressures and challenges in the workplace. The question that will be considered here is what effects this has had on nursing work which will lead on to a discussion of the area of nursing work of primary interest to this study, that of the initial assessments of patients.

As already seen in this chapter, much has been written regarding the many changes within healthcare over the past quarter century, but little in the way of research has been found that explores the effects of these changes upon nurses and their work practices. Two studies that have sought to explore these effects are briefly discussed in this section.

Staden's (1998) study of 'the emotional labour of caring' (p. 147) found that the increase in organizational/managerial demands designed to increase individualised patient care had the opposite effect in practice as an associated increase in paper-work took precedence over delivering individual patient care whilst also leading to an increase in the routinization of nurse's work. During in-depth interviews the nurses said that they believed the changes in working practices forced them to considerably routinise their work and hampered their efforts to get to know the patient well.

Supporting this view is Waterworth's (2003) study of nurses' time management strategies. Waterworth found that nurses perceived themselves to have

insufficient time due to, amongst other things, what they saw as unneeded changes in working practices linked to policy developments. Routinization of nursing work was the most common strategy used by time-pressed nurses, and prioritising the needs of the organization was an integral part of the nurses' routine in comparison to the individual needs of patients which were given a low priority. Waterworth concluded that the strategies used by nurses to manage time can have adverse consequences for patients, particularly so when the strategies may lead to and perpetuate less effective care systems. The effects of time on the nature of nursing practice will be further explored, with particular reference to initial assessments in chapter 6 where both Waterworth and Staden's work will be considered further in the context of this study.

In summarising a return will be made to the opening page of this chapter which discussed that regardless of the climate of change which has existed in the NHS over the last 25 years, one aspect of nursing care which (remarkably) appears to have remained invariable or untouched is that of the initial nursing assessment. As will be considered in the next section, initial assessments are especially worthy of consideration as they have long been accepted as an opportunity for nurses to create a good first step in establishing rapport with patients. However, in view of health service changes there is clearly the need for a contemporary analysis of the current circumstances relating to initial assessments within the "new NHS" which is committed to shorter hospitalisation time for patients, a commitment which may put added pressure on the initial assessment as a meaningful communication event as shorter hospital stays have been seen to limit the time for forming rapport between patients and nurses (McQueen 2000).

3.4 A review of the literature and research – initial nursing assessment.

Assessments are performed by nurses to gain information for the effective planning and delivery, of actual or potential care to patients, and as such it has been suggested that assessment is ‘arguably the most important stage in nursing’ (Harris *et al*, 1998: p. 303), and should form the basis for any planned nursing intervention (Barker, 1987).

Initial nursing assessments occur as individuals are “admitted” into nursing care, be it in a hospital, or in a community setting. The simultaneousness of the patient’s entry into healthcare with the need for nurses to gather assessment information regarding the individual, has led to the synonymous and transposable use of certain terms to describe these activities. Nurses in this study for example state that they are “admitting a patient”, “assessing a patient”, “doing the nursing history”, “interviewing a patient” - with each term relating to the same activity. The interchangeability of terms associated to nursing assessment is also seen in nursing texts such as Chapman (1983 p.90) who states that ‘the assessment part of the nursing process is carried out as soon as practical...the interview should take place as quietly and as privately as possible...this is called taking a nursing history’. More recently Fitzgerald (2002 p.163) discusses that ‘although assessment is usually associated with the first encounter of nurse and patient, when a history is taken on admission, the process of assessment can and should continue throughout the nurse/patient relationship’.

As pointed out in both extracts initial nursing assessments of patients are performed as the first part of the nursing process, a system by which nurses assess, plan, deliver and evaluate nursing care which was first introduced into the UK in the early 1970s.

3.5 The Nursing Process

Assessment is the first of four (or sometimes five) stages of the nursing process, followed by the planning, implementation and evaluation of the care delivered (Yura and Walsh, 1983). Roper *et al* (1996) described the four steps of the nursing process as a 'method' (p.14) of providing individualised patient care, continuing to state that:

Universally, the term 'nursing process' is recognized as describing a systematic approach to nursing which comprises a series (or cycle) of steps (or stages) which, most commonly, are referred to as assessing, planning, implementing and evaluating (p.14).

This concept of nursing as a cyclical process, rather than a distinct set of actions, was first developed in the United States of America (USA) in 1955 (de la Cuesta, 1983). By 1977 the nursing process was being implemented at hospital level throughout the UK, albeit somewhat disappointingly due to, amongst other things, the poor management of its introduction by healthcare managers. Subsequently implementation of the nursing process in the UK 'has proved to be difficult' (Allen, 1998: p. 1224) with a less than anticipated positive effect on UK nursing practice (Bowman *et al* 1983, de la Cuesta 1983, Dingwall *et al* 1988, Jolley and Bryczynska 1992, Bowman 1995, Griffiths 1998, Mason 1999).

The current conception of the nursing process is that of a benevolent nursing activity that aims to render patient care more individualised or person-centred (Johnson & Webb 1995). This conception however has the effect of unintentionally, but effectively, obscuring the fact that the adoption of the nursing process has also served a political purpose on both sides of the Atlantic. It has been claimed that the nursing process, as well as being forwarded as means of co-ordinating the delivery of individualised nursing care has simultaneously been pivotal in nursing's drive towards professionalisation and empowerment by establishing a domain of autonomous

practice similar to that enjoyed by medicine (Porter 1998), moves which were partly due to increasing disaffection with nurses' lowly occupational status (Dingwall *et al* 1988, Salvage 1992, Jolley and Bryczynska 1992).

As Hart (1994) discusses, the drive towards professionalisation associated with the implementation of the nursing process in the UK had been vigorously supported by the nursing establishment including amongst others the Royal College of Nursing (RCN) and the nursing press, especially the weekly nursing journal the Nursing Times. The RCN's interest in this field seemed to resonate with nurses evidenced particularly in the considerable increase in its recruitment in the 1980s, as through issues such as the nursing process and nursing models the RCN 'helped articulate the aspirations of many influential groups of nurses and the idealism of many students and junior trained staff' (Hart 1994, p155).

It appears, therefore, that the nursing process has been employed by the profession of nursing to draw upon notions of empowerment for both the professional and the patient. Nurses are considered to be empowered as the nursing process offers an occupational strategy of professional autonomy for nurses to alter their clinical standing as it challenges the previous medical monopoly over diagnosis and prescription. Empowerment is offered to patients as nursing care following the nursing process should be based upon the concepts of respect, mutuality and collaboration.

However, claims of the empowering potential of the nursing process appear to have little basis in evidence from research studies, either for patients or nurses, as queries are raised regarding the incapacity of the nursing process to deliver individualised nursing care (Hiraki 1992, May 1992, Johnson & Webb 1995, Allen

1998, Latimer 1998), or an increase in the power base of nursing as an occupational group (Dingwall *et al* 1988, Latimer 1995).

Regardless of the doubt which surrounds the effectiveness of the nursing process in delivering improvements in nursing care, nurses practising in the UK, as indeed across the 32 European regional World Health Organisation (W.H.O.) countries have traditionally been taught and encouraged to use the nursing process (Salvage 1993). Of note is McKenna's (1997) thoughtful contribution which highlights that there is nothing inherently "nursing" regarding this process of decision making, as all health care professionals could claim to use the four stages of assessment, planning, implementation and evaluation in their care of patients. According to McKenna (*ibid*) what makes the process a nursing process is that it depends on nursing models and nursing theory to 'structure and guide' (p.164) the nurse through the process, especially for the 'client assessment' (p.165) stage.

3.6 The Nursing Process and nursing models – their development and influence on assessments.

Riehl and Roy (1980 p.6), in one of the earliest books dedicated exclusively to the subject of nursing models, commence their discussion of nursing models by citing Johnson's (1975) view that '[a] conceptual model for nursing practice is a systematically constructed, scientifically based, and logically related set of concepts which identify the essential components of nursing practice together with the theoretical bases for these concepts and the values required in their use by the practitioner'. Put simply, Riehl and Roy state that nursing models make up a set of general ideas and concepts which aim to assist nurses in their practice through providing them with a systematic approach to assessing, planning, implementing and evaluating individualised patient care.

Unfortunately putting things simply is a rarity in much of the writing about nursing models and nursing theory, the complexity of the terminology seemingly being too much for the theorists themselves who have difficulty deciding what counts as a theory, a model or both, as McKenna (1997 p.15) demonstrates:

Callista Roy's work on adaptation (1971) has been seen as a conceptual framework by Williams (1979), a grand theory by Kim (1983), an ideology by Beckstrand (1980) and as neither a model or a theory by Webb (1986). Dorothea Orem's work on self care (1980) has also been the object of some semantic indistinctness. Suppe and Jacox (1985) believe Orem has constructed a conceptual framework, Johnson (1983) prefers to view it as a descriptive theory, Rosenbaum (1986) favours the title macro-theory, and the Nursing Theories Conference Group (George 1985) recognizes it as a conceptual framework' (all works cited in McKenna 1997).

Tierney (1998) discusses with unintentional irony that nursing models were first developed in the U.S.A. by nurse theorists who were attempting to seek agreement on a unified worldview, or model of nursing which Kitson (1985) contends offered both professional status and scientific credibility to nursing. The strong suggestion emerging from the literature is that existing explanations of a world view of nursing may actually demonstrate that there is no one agreed world view.

Some consensus does exist however, according to Fawcett (1989) and Kershaw (1992), who claim that regardless of earlier difficulties there is considerable agreement between nurse theorists regarding the central concepts or 'metaparadigm' (Fawcett 1989 p.6) of the discipline of nursing – these being person, environment, health and nursing. This claim of consensus is itself rebutted by Rose & Marks-Maran (1997), who demonstrate that both the unchallenged acceptance of the nursing metaparadigm and the subsequent claim of consensus within nursing are founded upon a rather selective review of the literature by its proponents such as Fawcett and Kershaw. Rose & Marks-Maran (ibid, p.152) summarise their position by stating that:

It is easy to see that, if an idea is presented as generally accepted, more and more of those concerned will begin to accept it too.

before proceeding, perhaps rather predictably by now, to offer a 'new view of nursing' (p.142) which moves away from previous paradigms and the ideas of the past. This is somewhat disappointing of Rose & Marks-Maran who, after making a valid argument against the over-preponderance of theories, forward another theory of nursing none of which appears grounded in, or tested by, published research.

It is suggested here that the views of Meleis (1995) and Stevens-Barnum (1994) be considered as they argue that it matters little whether we call these things nursing models or theories, and that too much time has been wasted debating the differences. Instead nursing should move towards concentrating on substance and not on circular debates concerning terminology.

As well as their largely U.S. origins, another similarity between the nursing process and nursing models is their stated commitment to the individualised assessment and care of patients. Individualised nursing care, as discussed in chapter 2, has its roots in humanistic approaches to caring and has been a much applauded central tenet of good quality nursing practice since the 1970's. The fervour is such that some writers such as Fitzgerald (2002 p.161) have defined the values of individualised nursing care as the direct opposite to unprofessional nursing care characterised by 'routine service in which all people are treated the same according to their grouping (e.g. age or diagnosis) and where nurses are required to follow protocol rather than make decisions'.

There has also been a strong case made for the individualising of nursing assessment in publications originating from academic, practice and policy/regulatory areas. For example, the nursing regulatory body's Code of Conduct (NMC 2002, p.2) endorses an individualised approach to nursing as it begins with the statement 'as a registered nurse...you must respect the patient or client as an individual' whereas the

advancement of individualism via the drive towards consumerism in healthcare has been promoted heavily in UK healthcare policy and nursing literature over the last two decades (Department of Health 1989, 1995, Antrobus 1997, Almond 2001),

Much literature has been published that lends weight to the argument that the use of nursing models, in synergy with the nursing process, is a crucial factor in ensuring the delivery of a high-quality, individualised nursing assessment of patients when they are admitted into hospital (Faulkner 1996, Roper et al 1996, Ash 1997, Fitzgerald 2002). Writers such as Heath (1998) comment that nursing models and the nursing process provide a decision making framework whereby patients are seen 'as individual psycho-social beings rather than homogenous groups with disease based medical needs' (p.290). An occasional dissenting article appears, such as Littlejohn (2002), by those who are not so convinced by the moves to integrate nursing theory and healthcare policy into areas of care such as initial assessments, especially as Littlejohn states there is only a flimsy evidence base (which will be discussed further in the next section) for suggesting that they deliver improvement in nursing care, concluding that nurses:

have been expected to accept, without question, the wholesale imposition of concepts such as the nursing process, nursing models, care planning, and the named nurse.... it is galling to discover the lack of empirical evidence to support these concepts in themselves. (p.39).

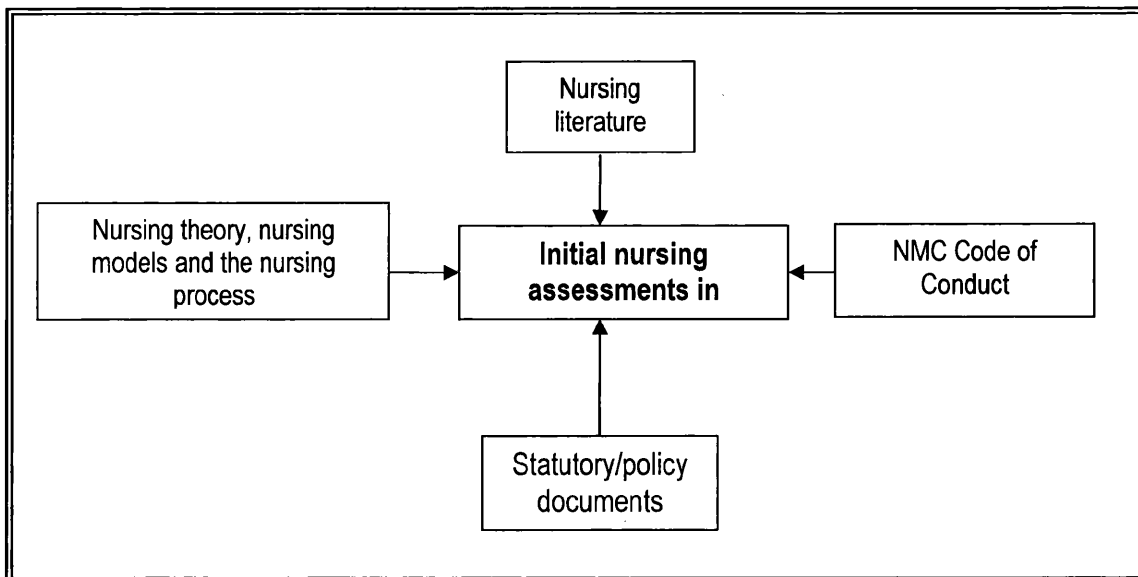
To summarise therefore, the use of the nursing process and models, allied to policy changes has presented a challenge to nurses in that it demands that assessment and subsequent care planning and delivery of care be in the joint ownership of the care giver and the care receiver. The integration of nursing models into nursing practice in the UK mirrors that of the nursing process in many ways, with similarities in their geographical/historical development, and in the positive initial claims made by theorists in support of their use in nursing practice. Perhaps the inter-dependency

of nursing models and the nursing process, allied to political and managerial will within nursing, explains both their longevity in nursing literature and nursing practice despite a lukewarm reception from practising nurses and the lack of supporting evidence. Without doubt the adoption of the nursing process and nursing models into UK nursing practice has had a profound effect on the nursing practice of assessing patients.

3.7 Assessment in nursing: a problematic concept.

As discussed in the previous section and illustrated in figure 1, initial nursing assessments in the UK are influenced by numerous factors that exist external to the nurses' practice areas, such as the debates of nurse theorists, regulatory bodies such as the NMC and healthcare policy.

Figure 1 – some factors that influence initial nursing assessments.



However, writers such as Harris *et al* (1998) and Latimer (2000) state that neither the research nor the theoretical underpinning of research into the actual practice of initial nursing assessment is well advanced, echoing Vincent's (1975) account thirty years

earlier of the lack of agreement in nursing on the meaning of terms such as assessment. The lack of clarity surrounding nursing assessment is also commented upon by Savage who states that: 'the literature on this topic is somewhat confused with the same terms used with differing definitions' (Savage, 1991: p.314), and Roper *et al* (1996) who assert that 'there is some dubiety about what assessment includes' (p.52). The state of uncertainty in the literature may also have an effect on nursing practice where patient assessment is 'often poorly carried out' (Walsh, 1998 p.47).

The literature on nursing assessments appears to take three main forms:

- a) nursing assessments of patients' general needs - including initial and on-going assessments (Kratz 1979, Aggleton & Chalmers 1986, Barker 1986, Raya 1995, Roper *et al* 1996, Ash 1997, Griffiths 1998, Walsh 1998, Latimer 1998);
- b) nursing assessments of specific patient problems such as chest pain (Meurier 1998, Jacavone & Dostal 1992), pain (Camp & O'Sullivan 1987) or anxiety (Heikkila *et al* 1998, Shuldham 1995);
- c) and the cognitive component of nursing assessments (Hurst 1993, Crow & Spicer 1995, Crow *et al* 1995).

As the focus of this research is *initial* nursing assessment of patients, most of the literature reviewed will be concerned with this. The literature on "condition-specific" assessments and the cognitive factors behind assessments will be considered where relevant when it offers a related perspective on broader matters surrounding the issue of initial assessment.

My separation of the literature into these three main areas above is a deliberate stance as a fundamental problem of the nursing literature, as discussed above, is the lack of distinction given by some authors to the type of assessments nurses perform. Even though assessment is a nursing intervention that is widely applied in a variety of

different healthcare scenarios, nursing assessment suffers the same fate as nursing interaction and nursing care in general (as discussed in chapter 2) in that it is often written of as a homogeneous intervention regardless of context. As a result a large degree of implicitness is present within the writing typified by the generic use of the word “assessment” for a variety of purposes that are not clearly articulated in the literature. This appears to be a general tendency in nursing literature noticed by, amongst others, Adam (1996) who commented that:

Nurses sometimes define words in a restricted sense and then proceed, within the same context, to attribute to those words a much broader meaning (p.121).

Regardless of the fact that the obverse is the case with the literature reviewed here, in that nurses define assessment broadly instead of acknowledging the restricted sense of the nature of assessment(s) in practice, the general point made by Adams is otherwise sound.

Harris *et al's* (1998) paper is indicative of how nursing texts use the term assessment inaccurately or universally, often to suit their own ends. The authors firstly state that assessment is a ‘household’ (p.303) concept in nursing, a stipulation which is, unfortunately, used by the authors as a licence to treat it as such within their research study. An example of the effect of this lax approach to conceptual accuracy can be seen in Harris *et al's* (brief) literature review, which instead of discussing the research regarding their main area of interest namely ‘systematic ongoing assessment’ (p.303), most of the papers are about initial assessment, for example, they cite authors such as Roper *et al* (1992) and Barker (1987).

In fact, Barker’s work is contextually very different as it concerns initial assessment in psychiatric nursing, a totally different form and function of assessment from the ongoing Physical Assessment Framework under review by Harris *et al*. As Hayakawa (1963) rather effusively, but emphatically, states ‘the ignoring of contexts

in any act of interpretation is at best a stupid practice. At it's worst, it can be a vicious practice' (p.2).

The significance of accurately discussing the circumstances of nursing assessments is further highlighted in this extract from Benner's (1984) study which considers, amongst other things, novice and expert nurses' initial and ongoing assessments and decision making skills:

Often the perceptual grasp of a situation is context dependent; that is, the subtle changes take on significance only in light of the patient's past history and current situation (p.5).

The extract from Benner's work suggests that nursing assessments are context dependent. This is an important point for two reasons. Firstly, the different contexts within which an initial assessment is situated compared to all other type of nursing assessment reinforces the need for it to be discussed and studied within its own right, rather than it being interchangeably studied and discussed with other types of assessment. Secondly, initial nursing assessments are important as Benner argues that once the initial assessment is complete, the context and situation of all other assessments are somewhat dependent upon the initial assessment.

However, Latimer (1998) takes issue with what she sees as the somewhat narrow contextual focus of Benner's study. Latimer is particularly critical of Benner for naïvely describing both initial and ongoing nursing assessment as primarily a heroic endeavour based upon the purity of the experts' "clinical" gaze or "decision", which exists independently of the day-to-day context of nurses' daily working lives. Latimer insists upon the pragmatic nature of assessments in nursing, forwarding the financing of patient care and the waiting list system as examples of equally important contextual factors in the accomplishment of nursing assessments.

Overall, there is broad agreement between the authors in terms that they both see nursing assessments as context bound, continuous and skilled. Indeed, the criticism of Benner as naïve is slightly harsh when one considers the differences in the interpretation of context within nursing assessment is due in the most part to the varying approach taken to the respective studies (Benner's phenomenology and Latimer's ethnography). In effect, the logic of Latimer's argument applied to her own position may reveal an equal degree of naivety if she accounts for nursing assessment only in terms of the pragmatic and the material. The problem with Benner's study as seen by Latimer, is the inappropriateness of a purely phenomenological approach to researching organisational behaviour as it is seen as an approach which fails to fully take account of contextual factors, whereas Benner may claim that researching the individual, rather than the organisation *per se*, was her main priority. There is sufficient room in nursing research for these two strong research studies, and sufficient room within the study of nursing assessment for a plurality of explanation.

In summary, it appears that a challenging concept within nursing literature has been the accurate usage of the terms assessment and initial assessment. However, it seems essential for nurse researchers and writers to comprehend that the circumstances within which initial nursing assessments occur are sufficiently different to warrant its examination as an aspect of nursing work in its own right. This has long been the stated position for some theorists, such as King (1971), who describes interaction during initial assessment as the unique first step of the 'dynamic process' (p.92), which influences all other interactions between nurses and the patient, a view also more recently expressed in Dougherty and Lister (2004 p.25), who's manual of clinical nursing procedures has been adopted by the NHS trust as the basis for nursing practice policies. Chapter 2 of Dougherty and Lister's manual jointly discusses the

nursing procedures of 'Communication and assessment', on the basis that 'Assessment is impossible without the ability to communicate, using both verbal and non-verbal skills to explore, and allow expression of, the patient's feelings' (p.36). What becomes further apparent upon reading this chapter is that the initial nursing assessments of patients is an area of nursing practice that has attracted a considerable amount of debate and opinion, which unfortunately has not stimulated a similar level of activity in terms of nursing research in this area.

3.8 Nursing assessment – a review of the research.

This section will focus on the research undertaken into nursing assessments within the UK in an attempt to clarify what is currently known about this area of nursing practice. The earliest study to be found was conducted by Price (1987) who sought, through use of qualitative research methodology, to 'identify the ways in which student nurses formulate an assessment of a patient on admission' (p.699). Unfortunately, the article itself reports little in terms of this broad aim, instead concentrating upon differences between the elements of assessment taught to the students and the realities of practice, and the effect of variables such as the patient's gender or age on the length of the assessment interview.

For example, students interviewing older adults who were judged by students to be surly or critical of nurses would markedly reduce the length of the interview and increase the proportion of closed questions asked. These interviews were described by Price (ibid) as strongly structured and mechanistic, with students explaining to the patients that the assessment questions were necessary 'for the paperwork' (p.703) an approach which was seen to be contrary to the expected practice of appraising the patient 'as a person' (p.699), and an approach that makes a strong appearance in my

data which will be discussed in chapter 6. There is no discussion in the paper regarding how the students classified the patients as surly/moody, and the degree of agreement between students and researcher regarding this. Added to this there is no detailed discussion of the specific differences in assessment with patients from the same age group of a more “cheerful” outlook.

Without these types of discussions it is impossible to evaluate whether the interactions were indeed markedly different based on the moods of patients and student nurses, or what an assessment interview with a less surly patient was like. In concluding Price demands, amongst other things, an urgent review of nursing assessment skills, demands which, on the evidence to be presented in the findings chapters, have been largely unmet by nurses to date.

As in Price’s study, Reed and Watson (1994) take a qualitative approach to investigate the impact of the medical model on nursing practice and assessment, this being particularly important as since the introduction of nursing models it has been assumed that the medical model has been superseded. The significance of this paper, however, is in its comparison of the initial and ongoing assessment of elderly patients’ mobility on short (STC) and long term care (LTC) wards, rather than its contribution to the debate about nursing models. Interestingly, the status of the patients/wards as short or long term care seemed to affect assessment of patients. On STC wards for example assessing a patient as an individual was seen as fundamentally important in the process of getting patients back to wellness. However, on LTC wards, assessment was given a low priority and described as an administrative, routine or legal requirement, but also assessments were viewed as an ‘irrelevant task’ (p.62) as patients had already been assessed elsewhere.

The perceived irrelevance and routine nature of patients' assessments which had previously been conducted elsewhere was also commented upon by Davis et al (1994), who found that nurses in one particular hospital 'did not "own" the assessment' (p.966) of patients as every patient underwent an assessment on an admissions ward before being allocated to other wards for the remainder of their stay. The overall tendency within the sample of 42 sets of assessment documentation reviewed was that the individuality of the patient was not reflected by nurses '*despite* using a structured approach' (p.965 – my emphasis) to their assessment documentation.

This final point by Davis et al, regarding a structure to the assessment documentation is interesting in that the use of the term '*despite*' by the authors implies that they see structure within assessment documentation as a factor which would normally promote the individuality of patients. Davis et al do not explain their thinking here, but it is possible that their presumption of the positive co-relationship between structured assessment documentation and expression of patient individuality is based on the fact that the structure corresponds to Roper et al's (1992) model of nursing that was used on all wards making up the sample. This may well be a reflection of the time when Davis and colleagues wrote their paper, a time when it was presumed that the mere incorporation of nursing models into assessment documentation was sufficient to promote the individuality of patients. A discussion of the uncertain relationship between assessment documentation, structure and patient individuality will be presented alongside data from this study in chapter 8⁴.

Many of the other points made by Davis et al, such as the lack of emphasis regarding the psycho-social assessment of patients compared to bio-medical

⁴ Especially section 8.2.

assessment, is also made by Griffiths (1998) in her study of how nurses described patient problems. Griffiths reviewed assessment documentation and audio recordings of the end of shift reports which also demonstrated that there were no qualitative differences in the assessments of patients, which would have been expected given that the wards were using different nursing models (Roper et al and Orem's model) with different theoretical assumptions regarding practices and expectations within the nurse-patient relationship. Overall, Griffiths reported a basic lack of sufficient recording of patient problems in the documentation (also seen in this study, discussed in chapter 8) and both wards appeared to be 'working in accordance with a medical model' (p.975), the chosen nursing models having little impact on problem identification or description.

The findings of Davis (1994) and Griffiths (1998) that show nurses apparently neglecting to assess patients' psycho-social needs during initial nursing assessments is also commented upon in several other studies. Latimer's (2000) ethnographic study of the conduct of nursing care comments that patients' feelings and perceptions were rarely if ever recorded during initial assessment, and that the method of assessment used by nurses appeared 'very different' (p.113) from the holistic models encouraged in nursing literature and policy as patients experiences and histories were fragmented into traits and parts. A similar distinction between the actualities of nursing practice and the stated values of nursing assessment expressed through models and philosophies of nursing is made by Wimpenny (2002). In this interview study which echoes many of the others reviewed in this section as well as findings in subsequent chapters, RNs described using models during initial assessments merely as 'headings to remind yourself' (p.350) that helped with documenting care rather than signifying a

philosophy of care, a view that is well summarised by another RN's quote 'we kind of have the paperwork but we don't have the understanding' (p.350).

Bowman (1995), who observed as well as interviewed RNs, reported that nurses saw the nursing process and nursing assessment as task related, routine and ritualistic with 'little, if any, involvement of patients or relatives in their care programme' (p.157). Against the backdrop of these studies of actual initial nursing assessment which show nurses under performing compared to the expectations published in the nursing literature, Kinley et al's (2001) mostly positive evaluation of nurses' assessment skills is conspicuous. However on closer inspection this study compared, via a randomised controlled trial, the pre-operative *medical* assessments of registered nurses (labelled by the study's authors as ATNs or Adequately Trained Nurses) with pre-registration house officers (PRHOs). Overall there was equivalence between ATNs and PRHOs and the study demonstrated no reason to inhibit the development of fully nurse-led pre-operative assessment, thus relieving junior doctors of some workload whilst simultaneously expanding the base of nursing practice further into the dominion of what was once medical work.

Although Kinley et al's report provides a largely positive set of results in terms of the potential contraction/expansion of the work of medicine/nursing, the conclusion reached was that neither ATNs nor PRHOs performed particularly well during pre-operative assessments. In summarising the results of the studies discussed in this section it appears that nurses performed satisfactorily when undertaking initial assessments in the role of a surrogate doctor, a role largely consisting of recording the patients' medical details and ordering and reviewing laboratory results (e.g. blood tests). Nurses however performed less well when performing nursing assessments which operate on the principals of patient-centeredness and holism, although even in

these less positive studies nurses did a much better job of assessing the patients' medical needs compared to their psycho-social needs.

Although many of the authors (Bowman and Latimer in particular) offer wide ranging analysis of multiple data sources in their research, none provide the in-depth analysis of actual interaction during nursing assessment interviews offered in my study. What has emerged from this literature review is that the in-depth analysis of interaction offered here through taking a CA approach to the study of initial nursing assessments, together with analysis of both observational data and nursing assessment documentation is an innovative approach to studying this area of nursing practice.

This study will allow new insights to emerge regarding what is described in the literature as one of the most important events during the hospitalisation of the patient, but an event which registered nurses, on the strength of the research reviewed here at least, appear ambivalent towards both in their attitudes and their practice compared to nursing literature and policy.

Before moving on to consider the data collected and analysed for this study the role of documentation in nursing assessments will be considered through a review of some of the published research and literature. This review builds upon the findings of the previous literature reviews of communication and assessment presented to date, and offers an opportunity to examine an additional and important area which contributes significantly to the performance of initial nursing assessments.

3.9 The role of record keeping and documentation within nursing assessments.

The opening sentence of the "Guidelines for Records and Record Keeping" produced and published by the Nursing and Midwifery Council states that 'Record keeping is an integral part of nursing and midwifery practice' (NMC 2002 p.7). Furthermore the

guidelines proclaim that good record keeping helps to protect the welfare of patients and clients by promoting:

- high standards of clinical care
- continuity of care
- better communication and dissemination of information between members of the inter-professional health care team
- an accurate account of treatment and care planning and delivery
- the ability to detect problems, such as changes in the patient's or client's condition, at an early stage. (p.7).

As one would expect from the statutory regulatory body for nursing and midwifery, the NMC guidelines on record-keeping cover a wide range of ethico-legal considerations, such as patient confidentiality and access to records, whilst also considering more practical considerations, such as the requirement for nursing records to be readable on any photocopies. An item within the guidelines of particular relevance for this study is one which states that:

As a registered nurse or midwife, you have both a professional and a legal duty of care. Your record keeping should therefore be able to demonstrate a full account of your assessment and the care you have planned and provided' (p.10).

The importance of the nursing record and record keeping during initial assessment is also reflected in nursing literature which variously describe good record keeping as 'essential' (Parkinson and Brooker 2004 p.37), of 'fundamental importance' (Moloney and Maggs 1999 p.51) and of 'great importance' (Pennels 2002 p. 294). Even though these exhortations commonly appear in the literature over the last 20 to 30 years, and minimum standards for record keeping have been circulated by the nursing and midwifery regulatory body since 1993⁵ (UKCC 1993), a strong suggestion emanating from the research studies and evaluative reports in this area is that there are grounds for improvement in the quality of nursing records in general, and the quality of documenting nursing assessments in particular.

⁵ The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) was superseded as the regulatory body for nursing and midwifery by the Nursing and Midwifery Council (NMC) in 2002.

Indeed, a cursory glance at the nursing research literature points to the fact that there appears to be reluctance by nurses on a global scale to sufficiently document patient care in general, with studies from Canada (Howse and Bailey 1992), Australia (Heartfield 1996), Germany (Ammenwerh et al 2001), Wales (Davis 1994, Griffiths 1998), England (Hale et al 1997), Scotland (Hay and McClymont 1995), Northern Ireland/Eire (Mason 1999, Murphy et al 2000) all reporting inadequate record keeping by nurses. Of note from the perspective of this study is the UK research from Hale (1997), Griffiths (1998) and Murphy et al (2000) who all found to varying degrees that nursing records do not provide a complete picture of patients' initial assessments, the interventions provided, or their effects.

Similar conclusions have been reached by organisations outside of nursing such as the Audit Commission (1995, 1999) who criticized the poor standard of record keeping throughout the NHS, and the Health Service Ombudsman (HSO 2003) who found fundamentally poor nursing care in the cases upheld between April and September 2003 summarising that

Poor communication between professionals and carers, inadequate nursing observations and poor record keeping also featured in many of the cases I saw. Nursing staff should reflect on the adequacy of their assessment of patients, risk management, care planning and implementation, and the level of documentation needed to provide a full and contemporaneous record of events (p.iv).

However, a cautious note is struck by Moloney and Maggs (1999) and Currell and Urquhart (2004) regarding the quality of the research produced in the area of nursing records. Both sets of authors carried out systematic reviews of research into nurses' record keeping, recording systems and care planning which were published in English between 1987-1997 (Moloney and Maggs) and 1971-2002 (Currell and Urquhart) . No studies were deemed of sufficient quality for inclusion in the review

by Moloney and Maggs (1999) when considered against the stipulated inclusion criteria, whilst 8 trials were included by Currell and Urquhart (2004).

As a consequence of the lack of credible research the hypothesis presented by Moloney and Maggs, 'that care planning and/or record keeping in nursing practice has no measurable effect on patient outcomes' (ibid p.51), could neither be accepted or rejected. Currell and Urquhart's study at least resulted in a substantive conclusion namely that there was no evidence of effects on practice attributable to changes in record systems from, for example, paper-based records to computerised or so-called "e-records".

Both studies concluded that there was a paucity of studies of sufficient methodological rigour to yield reliable results in this area, and that the research undertaken so far may have suffered both from methodological problems and faulty hypotheses. Moloney and Maggs recommended that a major international study be commissioned, preferably a randomised controlled trial (RCT), whereas Currell and Urquhart recommended that qualitative nursing research to explore the relationship between practice and information use, could be used as a precursor to the design and testing of nursing information systems. In order to deliver on these recommendations there would need to be a sea-change in attitudes within nursing and healthcare research as there is little current investment, financial or academic, in either major international RCT nursing studies or robust qualitative studies focussing on the analysis of documents and texts as used by nurses in their daily work.

The neglect by researchers of textual sources is not exclusive to nursing research however, a point made by Atkinson and Coffey (2004) who write that many qualitative researchers produce accounts of complex worlds as if they were devoid of writing or texts. It would be misleading to suggest that documentary analysis is

completely absent from qualitative nursing research, however the scarcity of such work coupled with the limitations in the scope and quality of the studies means there is only minimal understanding of the production and consumption of written records in nursing practice.

That so little is known about such an important part of nursing might be considered lamentable and highly regrettable in view of the damning conclusions of the Ombudsman Reports discussed above, and of other such reviews of practice such as Mental Health Inquiry (MHI) Reports. One such MHI Report (Freeman et al., 1996 cited in Prior 2003) criticizes the dearth of history taking documentation by nurses of a patient who murdered a 4 year old child. The report was particularly critical of the nurses' use of the Roper-Logan-Tierney model for assessment which the Report's authors considered unsuitable for assessing psychiatric patients both in general terms, and in the specific case under review. The overall message from the evidence supplied in reports and research into nursing practice is that nurses are failing to record sufficiently detailed information regarding the patients receiving their care, and that this has implications for the provision of quality patient care.

In view of the limitations of record keeping practices in the NHS the notion of the "Electronic Patient Record" (EPR), or e-record, has been forwarded as a means of overcoming some of the problems associated with the current paper-based healthcare record, such as the lack of continuity of care and patient access to information (Dept. of Health 2000b). Similarly the Welsh Assembly Government (WAG) see the current paper record as 'antiquated...and frustrate effective record keeping and potentially threaten the quality of care and patient safety' (WAG 2003a, p.59) promising instead to deliver a transparent system of electronic medical records which will improve patient care as well as involve patients more fully in the design of their own care.

Whilst there can be no doubting that these policy initiatives are well meaning, recent (but limited) research suggests that there are no differences in patient outcomes between computerised and paper based systems (Daly 2002) and no differences in the overall quality of the nursing documentation showed (Ammenwerth 2001).

Computerised or e-records were also seen as more time consuming in both of these studies which is worrying considering the findings of interview studies, such as Mason (1999) and Murphy et al (2000), who both found that nurses considered the *paper* record currently in use as too time consuming to properly complete. Policy initiatives to date seem not to have fully acknowledged the variety of evidence which suggests that nurses are largely indifferent to the value of the patient record, electronic or otherwise, as a component of good nursing practice and has failed to equate good patient records with good nursing practice (Hale 1997, Mason 1999).

In the light of these finding this study takes a different approach from the current view in nursing research which largely perceives healthcare records as mere stores or resources of patient information, unmediated by organizational processes. Instead this study will attempt to clarify the procedures involved in producing and constituting nursing records during assessment interviews, in the hope that exploring the actual practices of nurses will contribute some understanding of where the breakdown occurs between the accepted premise that good records contribute to good patient care and the reality where record-keeping is seen as time consuming and non essential to good practice.

3.10 The analysis of documents in nursing research.

Documents in a variety of organizational settings such as schools, industry and healthcare are used to 'fix aspects of current events and actions for future inspection'

(ten Have 2004 p.88). Nurses appear to be aware of “future inspection” of patient records, as studies from Allen (1998), Mason (1999) and Ormrod and Casey (2004) all discuss that nurses view the primary function of documentation as being mainly a defence, or a resource when faced with litigation or audit. This view tallies with the overall attitude in healthcare that sees health records merely as simple repositories of facts and detail about patients which can be used as resources for audit, research, teaching, policy making or indeed legal defence if need be.

In itself there is little at fault with the attitude that the contents of nursing records provide a useful resource for a variety of means, and much will be learnt about nursing through looking at the contents of documents in chapter 8. However, as Atkinson and Coffey (2004) point out, organisations and researchers must also take into account not only the contents of records, but also the role of recording and retrieving such information within the organisation. In particular documents are often used within organisations to create a certain kind of predictability and uniformity, which means that persons and courses of action are reconstructed in terms of the categories and rules of the organization itself. Prior (2003, 2004) makes a similar point stating that documents function not merely as simple repositories of facts and detail about subjects, but that they actively structure the nature of subjects.

These insights regarding the relationship between documents and their effects on how subjects are structured and reconstructed was useful when I read through the nursing records produced as a result of the assessment interview, and compared these to the tapes, transcripts and observations of the assessment interview which provided the information for inclusion in the nursing records. Particularly useful were the analytical insights (chapter 8 also) that resulted from noticing the effects on initial assessment interaction of the largely standardized format of nursing assessment

records, a format which appears similar in other hospitals across the UK (see Roper et al 1996, Faulkner 1996, Latimer 2000, Kenworthy et al 2002).

To summarise, the nursing literature reviewed demonstrates an uncertain relationship between nurses and the satisfactory completion of nursing records with effects on the care given to patients. Literature from the social sciences, such as Atkinson and Coffey (2004) and Prior (2004) establishes that documents can have effects on interaction, serving as basic materials for the construction of personal biography, and indeed for the construction of identities within institutions. On the strength of this it became compelling to see documents not simply in terms of their contents but also to see how documents functioned to mediate the social relationship between nurses and patients during initial assessment interviews. The fact that no studies were found in the nursing or social science literature that have considered the use of documents *in situ* by nurses, or the effects of documentation on the nurse and patients' verbal and non-verbal conduct during assessments further reinforced the need to include an element of this in this study.

3.11 Discussion.

In this, and the previous chapter, a great deal of empirical research on institutional practices such as communication and record keeping has shown there to be a gap between the theory and practice of nursing. The point of critically reviewing the studies in this was to determine what researchers have already discovered about nursing practice, and whether nursing practice follows the practice ideals set by the nursing theory, model or concept, or whether some aspect of nursing practice is counterproductive in terms of these ideals. Through reviewing the literature it has become apparent that nursing practices are not accomplished merely by following

theories, models or concepts, principally because theories and models are general idealizations written by nurse academics, whereas the practice of nursing is carried out *in situ*. Theories and concepts related to nursing practices appear to consist of ideals and visions of the “best possible situations”, whereas actual institutional practices constantly deal with a range of cases that do not reach such ideals (Peräkylä and Vehvilainen 2003).

Furthermore, institutional practices always involve aims that are not articulated as “goals” or “ideals”, but nevertheless fundamentally organize the actual practice of nurses. For example, interviewing and “processing” all of the patients being admitted by the end of the morning shift was a strong factor in the organization of the practices of nurses in this study. Similarly, not passing any admissions on to the late shift, where possible, was considered “good” nursing practice by the nurses on the wards, but this type of goal or ideal is hardly ever considered in theory or model development.

As previously discussed normative models and theories or quasi-theories about interaction form a large part of the knowledge base of nursing. These models and theories can be found in professional texts, in training manuals and in written and spoken instructions delivered in the context of professional training or supervision. Peräkylä and Vehvilainen (2003 p.727) call these models and theories ‘professional stocks of interactional knowledge (SIKs)...(by which) we mean organized knowledge concerning interaction, shared by particular professions or practitioners’. Peräkylä and Vehvilainen (2003) challenge CA researchers to abandon the traditional distance towards descriptions of the practices of professional practitioners such as nurses and, instead, squarely address the theories or concepts

that are held by the practitioners as valid and consequential. This does not mean that CA research should be bound or guided by such theories. However, practitioners – as well as academics – will have more interest in interactional research if researchers can systematically articulate the relationship of their findings towards these theories, a point not always appreciated by conversation analysts (Pilnick 1999, ten Have 1999).

In this study I propose to accept the challenge and promote a new way of thinking about this relationship between SIKs and nursing practice. This study will therefore explore sequential structures of interaction and seek a dialogue with SIKs, building upon the methodology developed in conversation analysis with the aim of creating a relation between the results of interaction analysis and the SIKs which will begin to close the research-theory-practice gap discussed during the literature review with regards to communication and initial assessment research.

Before moving on to the next chapter and a more in-depth discussion of the findings of this study, we need a more detailed concept of professional SIKs. By professional stocks of interactional knowledge we have already seen that Peräkylä and Vehvilainen (2003) mean organized knowledge (theories or conceptual models) concerning interaction, shared by particular professions or practitioners. SIKs have normative and descriptive elements, and they vary in conceptual clarity and sophistication – some SIKs involve full-blown theories, whereas others involve models or concepts of less comprehensive types. Peräkylä and Vehvilainen (ibid) suggest that SIKs can be classified along the two dimensions:

1. *Degree of detail in terms of interaction.* There are detailed SIKs, such as Family Systems Theory in counselling, which offer detailed and extensive descriptions and prescriptions concerning the interaction between professionals and clients. In the case

of Family Systems Theory, these descriptions and prescriptions concern the ways in which the professionals ask questions and deliver other interventions to the clients.

However, there are also less detailed SIKs, which offer only patchy descriptions and prescriptions. For example, the concepts of “patient-centeredness” or “promotion of patient independence” in nursing and healthcare theory do not involve *detailed* descriptions concerning the ways in which the patient centeredness or patient independence can be realized in the actual interactions.

2. *Degree of penetration into praxis.* In some cases, the professional practice is dependent on the SIK and would not exist without it. For example psychoanalytic practice is thoroughly structured with reference to the theoretical ideas of the respective SIKs – ideas such as “free association”. However, there are also contingent SIKs, which involve maxims and ideals relevant and consequential only occasionally in the actual interactions. Again the ideas and models of learner-or patient-centeredness provide examples. The professional practice of nursing, medicine and education are not fully dependent on these ideas as, for example, nursing interactions can also be accomplished and recognized without any reference to the ideas of patient-centeredness.

In the approach taken here the research focuses on sequential structures of interaction *and seeks a dialogue* with SIKs. It is hoped that through using CA a more detailed picture of interaction between nurses and patients will appear that can be compared *vis-à-vis* current nursing SIKs, whilst also suggesting some of the missing links between the SIK and actual practices.

In general, the nursing research to this date has been unconcerned with the specifics of everyday conduct and talk, instead being more concerned with various quantifications or typology of talk, mainly ignoring that the processes and practices of

nurse-patient interaction may well be a domain to be studied in its own right.

Researchers have had little to say about how interaction works, treating it as an invisible or inscrutable part of the communication between nurses and patients. There has been little interest therefore in fundamental issues concerning, for example, how nurses and patients understand one another in interaction and, just as importantly, know that they share these understandings.

Therefore a conversation analysis approach to interaction is both interested in *what* was said but is also concerned with *how* talk is produced. Nurses' and patients' ability to grasp the world within which they interact and participate is dependent on their capacities, skills and resourcefulness as social interactants. Talk is the fundamental resource through which interaction and participation between patient and nurse is made possible, and within talk the business of healthcare and nursing is managed, the identities of participants are asserted, and social structures reproduced.

However the reality of nursing assessments is not confined to talk as assessments also exist in and as documents. Medical notes in doctor-patient consultations have been seen to form a strong influence on the participants' talk as they are oriented to continuously by the doctor and occasionally by patients (Heath 1986, Robinson 1998, Ruusuvuori 2001). Nursing notes therefore need to be analysed for the ways in which their content and presence shape the talk.

Little is known about how patients give verbal accounts of their problems to nurses and how the nurses in turn respond and record the account. The result is that there is a better understanding of the dynamics of nurse-patient interaction and record-keeping as it is conceived at the theoretical or policy/state level than how it actually operates at the workplace level.

In using CA researchers, rather than simply stipulate the meaning or significance of particular utterances in the light of existing literature, policy or their own personal intuition, can inspect subsequent actions in order to determine how the participants themselves are responding to, and displaying their understanding of, each other's conduct.

Chapter 4. Methods used to gather and analyse the data.

The data collected for this study originates from what ten Have (2004) describes as the ‘three styles of qualitative research’ (p.12) – interviews, documents and natural observation, although the data from interviews was not generated in the usual “researcher as interviewer” format. The combination of different qualitative data sources is often highly productive and the essential rationale followed here is that, in using a number of different information sources to tackle a question, the resulting answer is more likely to be accurate (Smith 1996).

As such the data collected for this study, details of which are given in table 1 below, included the tape-recording of initial patient assessment interviews, the observation of the interview and of the ward work prior to and after the assessment interview, and the photocopying of the nursing documentation produced as an outcome of the assessment interview.

Table 1. Details of data collected.	
Type and sequence of data collection.	Amount of data collected.
1. 7 periods of 5 hours observation of working practices (totalling 35 hours) on the 5 participating wards prior to recording the assessment interviews.	175 hours of observation, 45 assessment interviews observed during this time.
2. Audio recording and observation of assessment interviews on the 5 participating wards.	27 assessment interviews collected, consisting of 621 minutes of audio recording and observational data (10 hours 21 minutes). Average length of assessment interview = 23 minutes.
3. Photocopying and reading of nursing documentation.	25 out of the 27 assessment documentation photocopied. The outstanding 2 copies were those of patients had been transferred to other wards when I returned a couple of days later to photocopy the notes.
Total = 185 hours 25 minutes of observational data, 10 hours 21 minutes of audio tapes and 25 copies of patients' notes.	

Utilising both the written, verbal and non-verbal data produced by patients and nurses during the assessment interview provides a fuller picture of the assessment interview than if these were taken individually. This is particularly important as this study is interested in the processes through which the interview – as a social event – can turn conversation into nursing or patient information, and how assessment instruments within the documentation used by nurses are made relevant in this process. This material also allowed me the option to compare and contrast ways in which patients' assessments and identities were configured in different locations and by different nurses and patients. However, before accessing patients and nurses, ethical approval and the approval of senior nurses within the trust was sought for the project.

4.1 The process of gaining ethical approval

The participants for this study were drawn from the population of acute hospital beds within one hospital trust⁶. Access to the population of patients was gained through contacting the senior nurse at each of the hospitals used, more details of which will appear in the following sections. Prior to accessing hospital wards, nurses and patients ethical approval had to be gained from the Local Research Ethics Committee (LREC).

There were 2 sets of related but separate ethical and moral questions confronting me at the beginning of this study. Firstly there were the broad questions of ethics and morality raised by myself that included examining personal and professional effects of the study, secondly there were the ethical questions posed by the LREC through their approval forms and formal interview with the panel. The personal questions were basic but necessary in nature and explored aspects such as to what degree was I undertaking the study from a personal gain perspective as opposed to advancing knowledge and understanding of nursing practice. Whilst personal gain

⁶ A fuller discussion of the hospital trust and wards will be provided in Chapter 5.

and the advancement of knowledge are not mutually exclusive, I felt it important that the latter was sufficiently strong enough in itself to complete the rigours of completing a part-time doctorate. However the advancement of the knowledge base of any academic discipline recedes in importance when raising a young family.

Questions regarding the moral consequences of subjecting family members to a prolonged period of my writing a doctoral thesis were also confronted, a time which saw personal gain overshadow more altruistic reasons for undertaking this study.

Overall however as a registered nurse I felt strongly influenced by certain fundamental motives throughout the study, such as wanting to improve the situation of hospital based nurses and patients through completing an extended exploration of nursing work. At the same time I was anxious to minimise the burden on nurses and patients that my presence might cause, and to reduce any impact on the quality of a patient's stay in hospital. I felt this study achieved both of these ends – there was no obvious reduction in the quality of patient care due to my intrusion whilst in the long-run some contribution has already been made from this study (Jones 2000, Jones 2003 a,b) to the knowledge base from which nurses can draw to question and hopefully improve the standards of patient care.

Having thought through some of these initial matters the LREC forms were completed and sent. The process of completing these forms involved drafting information sheets and consent forms for use with patients and nurses (see Appendix 1). The aim of the information sheets was to inform the potential participants of the nature of the research with a view to gaining informed consent, but also to promote the integrity of the researcher. Added to this details were given regarding the safe keeping and disposal of the information collected, as advised by the 1998 Data

Protection Act. In particular assurances were given regarding the stored personal details being:

- Fairly and lawfully processed
- Processed for limited purposes
- Not kept longer than necessary
- Secure

Following a brief interview with the LREC panel, where the main topic of discussion was when members of the panel sought clarification of the practical steps to be taken to ensure confidentiality of the information taken from the hospital and of the security of the tapes. They were informed that any means of identifying the patient was to be erased prior to copies of the nursing notes leaving hospital and the tapes were securely kept at all times. Satisfied with this, the panel granted permission to proceed with the study on the proviso that minor changes to the wording of the information letter was made.

Regardless of the assurances made to the participants regarding the worthiness of the study's aims I was conscious that patient's privacy would be invaded at a particularly sensitive and vulnerable time of their lives i.e. on admission to hospital. To protect the patients from feeling further vulnerability it was clearly stated on the information sheet that participation, or not, in the study would not jeopardise their care whilst in hospital. Furthermore feelings of vulnerability by the nurses, that may have arisen through being tape-recorded during their working day, were acknowledged in a similar way by giving the nurse the opportunity to withdraw their data from the study at any time.

Being a novice researcher I was struck by the willingness of individuals to volunteer for the study, something that other researchers have since shared with me as a phenomenon that they too have experienced. The nurse in charge of the shift would

alert the patient before I saw them of the fact that a researcher was present on the ward and ask whether the patient would mind being approached to discuss the study and give consent. The nurse would give the patient the information letter to read in the mean time. Often patients at this stage, before reading the letter, would tell nurses that they were willing to participate in the study. Regardless of this the research protocol was followed of gaining consent from the patient only following a discussion of the study. None of the patients approached in this way refused to participate in the study, and none at a later date requested that the data be withdrawn from the study.

Nurses were recruited to the study in a different way primarily as I had already spent some time observing on the ward, the nurses were aware of the study and who I was. During the initial period of observation on the ward which preceded the period of tape-recording many nurses, similar to the patients, volunteered as participants prior to reading the information letter. Although it was good to get an early indication that nurses were willing to participate in the study I delayed getting final consent until the time those nurses were to formally become part of the data-set. At that time the nurse in charge of the ward would indicate which, if any, of the patients being admitted that morning would be suitable for inclusion in the study, and who the nurse admitting the patient would be. At this point I would seek out that nurse, introduce myself if need be, and present an information sheet if the nurse had not already seen a copy. Having given the nurse some time to read the letter I would return and ask whether they would agree to participate by signing the consent form. Again none of the nurses approached refused to participate in the study, or have subsequently requested their data to be withdrawn.

4.2 Gaining access to patients and nurses

As Flick (2002) states, a research project is an intrusion into the life of an institution with no discernible immediate pay-off for its members. Thus, the first tentative steps in negotiating entry to the institutions and ultimately gaining access to the wards, and the nurses and patients who populated them, were taken before the LREC documents were submitted. The first steps consisted of a letter to the Directors of nursing in each of the hospitals that were to be used as sites for data collection, followed by a face-to-face meeting with each of those individuals. The initial letter consisted of details of the study which were further explored during the meeting, at the end of which each Director of nursing gave conditional approval for the study to proceed once ethical approval was granted. The provisional approval of the senior nurses was mentioned in the LREC application, giving it added potency.

Directors of nursing were subsequently notified of the LREC approval and arranged further meetings with senior nurses from some of the acute trusts within the hospitals. It was at this stage that individual wards were first identified as possible areas for data collection, the process of identification starting with my giving details of the sort of data I was interested in (i.e. assessment interviews with patients being admitted to hospital). The senior nurses would then suggest a number of wards and ward managers that I could contact for an exploratory meeting to discuss participation in the study and the practicalities of data collection. The senior nurses would state that they foresaw no reasons why participation in the study would be a problem, but to contact them if it was. Overall I was unsure of the degree of communication between the senior nurses and ward staff prior to my arranging a preliminary visit to the wards.

Upon visiting the wards details of the study including ethical and “managerial” approval, which had been sent ahead to the ward managers, would be

discussed and physical locations for data collection considered e.g. placement of Dictaphone for recording, noisy areas of the ward that may prohibit recording, suitability of patients, etc. Sending the details of the ethical and managerial approval to the ward managers ahead of the initial meeting was a deliberate ploy to facilitate access by demonstrating that the study had been endorsed by other people. However, I was also aware that on the other hand that the support of “higher authorities” may produce some distrust. The discussions with the ward managers and ward staff was constantly a balancing act between these two positions.

Each of the wards approached agreed to participate in the study and dates were agreed at the end of these meetings for a period of observation where I could become further acquainted with the working of the wards and staff members. The role taken at this time was that of “the visitor” – appearing in the field to gather knowledge through observing and questioning, for example, the routines of assessing patients on each ward.

Once this initial period of observation was completed an agreement was reached with the ward manager on a commencement date for data collection of the assessment interviews themselves. In general the process, from the initial letters to the Directors of nursing onwards, proved to be very smooth in terms of getting agreement and co-operation from all parties.

4.3 The sample

The time needed in transcribing and analysing data limits the possibilities for covering large samples in CA studies, unless working in a team of researchers who can share the burden. Whilst the aim, as a solitary researcher, was not to recruit large numbers of participants there was, however, still the important need to consider which hospitals, wards and individuals should be recruited into the study in order to achieve

a good understanding of the relevant issues. The aim of the sampling strategy was to produce a relevant range of initial assessment cases from a range of contexts which would enable cross-contextual comparisons and build a well-founded argument, inductively based in data regarding the initial assessment and interaction in hospital settings.

The process of selecting a relevant sample involved making direct links between the sampling strategy, the data analysis and the type of argument that was to be constructed. For example as data analysis would proceed through the use of detailed transcripts of nurse-patient talk, individuals and locations needed to be selected that ensured, as much as possible, the unfettered recording of the interaction.

It also became apparent that, as I was interested in explaining how the process of admission interviewing works, a range of settings should be investigated in the interests of contextual sensitivity, and so that the assessments could be presented as related or comparative, but not representing directly, a 'wider population or universe' (Mason 2002a, p.123). In general the sampling strategy was developed to provide an important backdrop against which some aspects of the data were read and interpreted.

Consideration of the importance of generalization and representation within this study resulted in the selection of a group of wards and people that broadly represented other populations that the researcher wanted to say something about i.e. acute hospital nurses and patients in the process of being admitted. In essence a close match was sought between the entity studied and the entity which I wanted to "generalize" about.

The careful selection of a sample leading to generalization also favourably affects the degree of reliability in findings. Not all researchers who utilize qualitative methodologies are interested in the issues of generalization and reliability. For

example, ethnomethodology which is closely linked to CA is largely unconcerned with these issues, since it believes that observable social phenomena are too tied to a specific place and time to be generalizable. Kirk & Miller (1986) suggest that generalization and reliability have received little attention in qualitative research and that the attention is long over-due, whilst other writers (see Denzin & Lincoln 1998) reflect on the irrelevance of such concepts to the qualitative research endeavour.

However the position taken here with regards to generalization or transferability of findings is akin to Peräkylä's (2004) statement that it is possible to describe CA data of social interaction research in terms of reliability and validity and Hammersley's (1990 p.56) proposition that validity and reliability are important in qualitative research which functions 'to produce *knowledge* that is of public *relevance*' (original emphasis). Viewed in this way, it is compelling to see that issues of generalization and reliability need to be of particular concern in nursing research where questions of what constitutes appropriate "evidence" or knowledge for practitioners *and* public are apposite.

It is also acknowledged that the act of deriving "evidence" for nursing practice from qualitative research can be problematic, suggesting as it does that evidence, which is often presented as an objective, truthful but yet neutral body of information can be drawn from methods of data generation which are both flexible and sensitive to the social context in which the data is produced. However I believe that qualitative research should be accountable for its quality and its claims or as Mason (2002a, p.7) puts it, qualitative research 'should not position itself beyond judgement, and should provide its audience with material upon which they can judge it'.

Problems with generalisability do however exist when the findings of this study are compared to practices in other areas of nursing such as psychiatric, learning

disabilities or children's nursing. The lack of generalisability to these areas is largely attributable to the acknowledgement of the multiple and often unpredictable ways in which context shapes practice, combined with different tools used for assessment interviews and the broader relationship between nurses and patients within the different branches of nursing: for example children's nurses may use the family centred nursing framework (see Casey 1988) for assessing patients, whereas learning disabilities nurses may use models such as the OK Health Check (Jackson and Gilbert 2003), and the use of these assessment frameworks may result in significant differences to the processes used by nurses caring for adults. For this reason the claims made regarding generalisation to other areas of nursing are limited.

Nevertheless, Peräkylä (2004) urges conversation analysts to approach generalization from a different direction to the usual 'distributional understanding of generalizability' (p. 296), suggesting instead that the question of generalisability within studies of institutional interaction can be discussed in terms of the concept of possibility. As already mentioned this study of assessment interviews of adult patients cannot be directly generalizable to every arena within which nursing assessments exist. However, the results of my study can be considered descriptions of assessment or interviewing techniques that are *possible* across a range of settings.

More specifically, the study describes in detail how these assessment interview techniques were made possible, the types of turn-taking that was managed by the participants, turn designs, sequencing of topics, and so on, needed in order for the participants to complete the assessment interview. The study showed how these practices are made possible through the participants' actions, and as possibilities the practices described in these studies are very likely to be generalizable as there is no reason to think that they could not be made possible by nurses in the UK. In this

sense, this study produced generalizable results, not generalizable descriptions of what any nurse does with their patients, but they are generalizable descriptions of what any nurse, with his or her patient, *can* do, given that he or she has the same array of interactional competencies as the participants in this study have.

The sites of study consisted of 2 hospitals, hospital X and Y. Observational data and audio-recordings were collected from a total of 27 assessment interviews between the two sites, comprising of data from a neurology ward (6) and a cardiology ward (6) from hospital X whilst data from hospital Y was collected from 2 surgical wards (12) and a medical ward (3). In addition to this is a total of 35 hours of observation on each ward prior to data recording (total of 175 hours), where a further 45 assessment interviews were observed. All nurses were qualified, with the exception of five nurses in the sample who had passed the academic and practice component of their nurse training but were working out the remainder of their student contracts before commencing their registered nurse's contract.

The selection of patients depended on the judgement of the nurse in charge of the shift, and whether the patient was clinically and medically fit to be approached for participation. Issues such as clarity of speech of the patient was a potential exclusion criteria but the circumstance did not arise where I had to make a judgement regarding excluding potential participants on these grounds.

The selection of the nurses for participation was completely dependant on the selection of patients, in that, the patients selected for the study would have been allocated a nurse according to the physical location of the patient's bed on the ward and which nurse was "looking after" that section. As a result I often had no direct say in the selection of nurses. Occasionally, however, a choice was offered from a number of assessment interviews being conducted, and in cases such as these I would choose

an admission by a nurse that I had not previously recorded. As a consequence of this, and of the large numbers of staff to choose from in each area, no nurses appear more than once in the data set. Similarly no patient appears more than once in the data.

The data was transcribed as soon as possible after collection and this together with the period of observation on the wards prior to data recording partly assisted in determining the overall sample size as it became apparent that, as Flick (2002) describes, ‘nothing new emerges any more’ (p.65).⁷

4.4 Methods of data collection

As already mentioned in the opening paragraphs of this chapter the data collected for this study includes audio tapes of nurses talking to patients during initial assessment interviews, observational data of assessment interviews and the assessment documents produced as an outcome of the nurse-patient interaction. Further descriptions of the data collection methods will be provided in the following sections.

4.4.1 Interview talk and tapes.

The popularity of interview methods among qualitative researchers is striking and interviews are considered to be the most widely used methods of data generation in the social sciences (Gubrium and Holstein 2002, Mason 2002b) and healthcare research (Murphy et al 1998). However, as mentioned above, interviews are not utilized in this study in their “conventional” data collecting sense, which has historically seen the researcher use informants as a resource ‘for discovering and authenticating things occurring outside the interview’ (Seale 2004 p.108).

⁷ It is acknowledged that this version of data saturation forwarded by Flick is, on its own, a rather insufficient and questionable grounding for determining the amount of data collected. Further decisions regarding the amount of data collected are also discussed in section 4.4.1.

Instead of using interviews as a resource for discovering thoughts about nursing assessments, the actual initial assessment interviews of patients by nurses upon hospitalisation are utilized here as topics in their own right. Thus, rather than asking nurses and patients about their experiences of doing, or being, assessed in hospital it was decided to gain an understanding of how nursing assessment interviews are “done” through tape recording and passively observing nurses and patients actually doing assessment interviews as they “naturally” occurred in hospitals. Naturally occurring data are acquired from situations which exist independently of the researcher’s intervention and derive from a desire to represent the world as it is, compared to researcher-provoked data which would not exist apart from the researcher’s intervention and is seen as imposing artificial structures onto data collection (Hammersley 1989).

When characterised in this way naturally occurring data has frequently been represented in the literature as being of superior or of purer quality to data that is researcher-led or provoked. However as Hammersley and Atkinson (1995) and Silverman (2005) discuss the traditional opposition between naturally occurring and researcher-provoked data should not be taken too far as no data are ever untouched by human hands and both exist as part of “society”.

For example the argument could be made that the process in this study of gaining consent from both participants and preparing the tape recorder could distract somewhat from any claims regarding the “pure” and naturally occurring status of the data. However, CA researchers consider data to be broadly naturally occurring if it is not produced solely for the purpose of the study (Psathas 1995). The perspective taken *within this study* is that collecting naturally occurring data is preferable to other types



of data collection as it offers access to nursing assessments occurring as “natural”, normal or routine irrespective of the researcher’s need for data.

A further benefit of collecting naturally occurring interactions is the critical insight such studies provide into those other kinds of research methods often used in nursing research, such as traditional interviewing techniques where, as Atkinson and Heritage (1984 p.2) point out, the verbal report of interview subjects have often been ‘treated as acceptable surrogates for the observation of actual behaviour’. However, the distinction between what people say during interviews and what they actually do in practice has long been a critique of the use of interviews as a source of data on external realities. Stimson and Webb’s (1975) study was one of the first to throw considerable doubt on the ways in which interviews have conventionally been used in healthcare research. An important finding from this study was the discrepancy between the interview accounts that patients gave of their consultations with GPs and the actual observations which the researchers made of the consultations. In particular, the interview accounts of patients took the form of the patient being cast as actively challenging the decisions of the mostly incompetent GP, while the observations found the patients to be passive and reluctant to challenge or question doctors.

Interestingly however, Stimson and Webb focussed upon what patients were actually doing when they tell such stories to interviewers, arguing that the stories are best understood as a ‘vehicle for making the patient appear rational and sensible and for redressing the imbalance between patient and doctor’ (p.97). This analysis offered a welcome alternative to the presentation of interview data as a mirror reflection of the realities that exist in the social world. As Miller and Glassner (2004) discuss the problem of presenting interview data as reflective of some “truth” in the world is that

it fails to take into account that interviews are context specific, or invented, to fit the demands of the interview.

Bearing a close resemblance to this standpoint is the critique of interview responses from a social desirability perspective. Although it is conceded that problems of social desirability are evident in other forms of social research, in the context of interviewing it means that an answer that is perceived to be socially desirable is more likely to be endorsed than one that is not (Bryman 2001). The concept of social desirability struck a particular chord when reviewing the literature with regard to nurse-patient communication. As discussed in the literature review chapter a significant proportion of studies reviewed consistently suggested that nurses spend little time in extended or meaningful communication with patients even though it appeared that they had time to do so (e.g. nurses spent 1% Altschul 1972, 5% Baker and Melby 1996, 14% Ashworth 1980 of the time observed interacting with patients). However studies which interviewed nurses' about their attitudes towards communication with patients such as the studies above and Mackay (1992), Armstrong-Esther et al (1994), McLaughlin (1999) and Whittington & McLaughlin (2000) clearly demonstrate that nurses rated talking to patients as an important part of their job, and a task which time constraints limited.

In terms of social desirability a possible reason for the discrepancy between actions and words could be that "communicating" with patients is a valued part of nursing and that, under interview conditions, choosing to state so, or claiming lack of time as mitigation for not communicating, are more socially desirable positions compared to an outright rejection of the value of talking to patients. The heightened sensitivity surrounding exactly what, or whom, interview data represents has recently led to a spate of counter arguments attempting to reclaim qualitative interviewing as a

robust data collection method for social researchers (Mason 2002b, Miller and Glassner 2004, Holstein and Gubrium 2004).

Ultimately, it is both futile and counterproductive to try to assess whether any method is always “better” or “worse” than any other, the pertinent question instead being which approach is most appropriate to answer the questions being posed. Thus the final selection of recording the assessment interviews as a data collection method was taken after consideration of the strengths and weaknesses of possible alternatives such as qualitative interviews and following consideration of the lack of existing data sets of transcripts of nurses talking to patients during assessment interviews.

The lack of data on nurse-patient interaction can result in problems when attempting to understand the reality of nursing work. As Fairclough and Wodak (1997) state the use of naturally occurring data is essential within organisational research as language both constitutes and is constituted by social practices. In this respect, organisations are continuously created and re-created in the acts of communication between organisational members, rather than being independently “out there” and this communication, as far as possible, needs to be captured as it happens rather than being filtered through other means.

Most of the activity during initial nursing assessments principally emanates through and during talk between the nurse and patient during the interview which was recorded via a handheld Dictaphone with an integral microphone (Philips Professional Pocket Memo 494). The Dictaphone was placed as unobtrusively as possible so that the parties were not too distracted by its presence. Following the placement of the tape recorder the researcher as a rule did not intervene in the interaction until the completion of the interview whereby the tape was switched off and the participants thanked for their co-

operation. The only occasion that this usual pattern was disturbed was when the tape ran out during one interview and the batteries during another. The fact that the Dictaphone had an internal microphone and was battery powered meant that there were no cables in view and that the 12 cm by 6 cm Dictaphone was not visually intrusive.

CA is insistent on the use of recordings of naturally occurring data as the empirical basis for analysis. Sacks (1984 p.26) outlines the rationale behind using recording equipment stating that

such materials had a single virtue, that I could replay them. I could transcribe them somewhat and study them extendedly – however long that might take. The tape recorded materials offered a ‘good enough’ record of what happened. Other things, to be sure, happened, but at least what happened on tape had happened.

Sacks (ibid) stressed the value of recordings as a resource that could be analysed and re-analysed, moreover arguing that naturally occurring data represented an infinitely richer resource for analysis than the products of imagination or invention. The latter comments made their appearance in an intellectual context in which invented data were the stock in trade of language and communication researchers. However CA continues to stress that the use of recorded data is central to recovering the detail of interactional organization and that all forms of non-recorded data – from memorized observations to all forms of on-the-spot coding – will inevitably compromise the linguistic and contextual detail that is essential for successful analysis.

The use of recorded data therefore serves as control on the potential fallibilities of recall and, in turn, ensuring that analysis will not arise from data based on selective attention or recollections. According to Silverman (1993) tapes, and the transcripts of the tapes’ contents, have three clear advantages compared with other kinds of qualitative data: they are a public record, they can be replayed and transcripts improved and they preserve sequences of talk.

I was also conscious of the potential charge that data based on audio recordings may be seen as incomplete as it leaves out important elements of communication such as facial expression. The decision to observe the assessment interview as a non-participant was taken in order to (partially) counter the accusation of incompleteness. However, following Sacks (1992, cited in Silverman 1993), I also recognise that the idea of totally complete data may itself be an illusion. The collection of audio-visual data via video recording could have offered the best of both worlds in terms of giving audio and visual data of the interview itself. However the researcher would need to be present to set the camera up and ensure that the technical aspects of the recording were good enough, and this itself may be problematic if claiming the interaction to be completely naturally occurring (see the section below on observation for further discussion on degrees of participation). Ultimately video recording was considered impractical due to issues of setting up an adequate recording space in a busy ward where patients were often “hot-bedded” i.e. a bed was vacated by the previous patient literally minutes before the patient being admitted would take up occupancy making it very difficult to set-up a video camera, tripod, ensuring adequate focussing etc.

Conversation analysis therefore places a great deal of emphasis on the use of extracts from detailed transcripts of naturally occurring interactions in its research (transcription will be discussed in the data analysis section). However a downside to gaining such a level of data accuracy and detail is the amount of time that is required to accomplish a full transcription of the data. For this study, on average, it took 2 ½ hours to transcribe every 10 minutes of interaction, in total a period of approximately

155 hours was taken to transcribe the 621 minutes of taped data, bringing with it a mild but random onset of repetitive strain injury to my right hand.

Writing on the related theme of time management and data collection Peräkylä (2004) discusses that, as CA studies aim to produce descriptions of recurrent patterns of social interaction and language use, the question of how much data to record is of some importance. Whilst a large data set has definite advantages, the answer to the question of how much data to collect seems partly to lie with how much a single researcher, as opposed to a team of researchers, can transcribe and analyse.

There appears to be, if anything, some reluctance in the CA literature to discuss, in detail, what constitutes an adequate data set. Instead the writing on this matter proceeds in terms of generalities, such as Heritage (1995 p 399) who states that CA collects data involving a 'spread of cases... that appear to embody a conversational practice or procedure'. Similarly Drew et al (2001) discuss that CA looks for recurrent and systematic patterns within 'an appropriate number of the kind of interactions under investigation' (p.60). The data, as Drew et al explain further, should however consist of a number of different practitioners and patients in order to guard against idiosyncratic styles and to ensure that findings are generalizable.

Overall the data collected for this study contains a spread of cases of a specific kind of interaction which contains little in the way of idiosyncratic styles, which allied to the observational data, nursing records and the time intensive data transcription and analysis provided the rationale for determining the overall amount of data collected.

4.4.2 Nursing records and documents.

The neglect of data from documents in workplace studies has had the effect that occupational settings are implicitly represented as devoid of written forms. It is therefore vital in social research, according to Atkinson and Coffey (2004), to give documentary data due weight and appropriate analytic attention. In the context of this study nursing records and various items of documentation have both a visible and an audible presence within assessment interviews and were collected not as peripheral to the main data but as representing an area of considerable interest in themselves. In parallel to the above discussion of the “natural” status of the interview data, the expression ‘natural documents’ (ten Have 2004 p.88) can be used to refer to the documents collected here as they are produced as part of current societal processes, that is not for the purpose of the research project for which they provide the data

Having read about and participated in assessment interviews it became apparent to me that documents constituted a written domain which was closely linked with the spoken domain, and to some extent appeared to organize events during assessment. Even though every assessment interview has its local interactional management which can be heard in the recording, the claim made here is that the full logic of the interaction is only derivable in tandem with consideration of the role of documentation. This viewpoint has latterly gained popularity in CA research, leading Peräkylä (2004 p.287) to assert that it is ‘important that the conversation analyst carefully collects and uses all the relevant documents, along with the recordings’.

Assessment documentation is a rich data source not least for the manner in which it simultaneously describes the admitting nurse’s version of the health and illness history of the patient as well as providing an insight into the assessment event itself. Added to this is the fact that in each of the assessment documents collected here

there is (supposed) to be sufficient information to enable any nurse to form a judgement regarding the needs of the patient upon hospitalisation and in that sense, such documents can function as meaning-making devices (Prior 2003) by nurses.

Many of the *caveats* surrounding the use of documentation in social research discuss the extent of the accuracy and integrity of historical records and the subsequent limitation on the claims researchers can make about documentation especially when the provenance of records is unclear (Scott 1990, Prior 2003, ten Have 2004). Atkinson and Coffey (2004) also warn researchers that one cannot assume that documentary accounts are accurate portrayals of events, an insight which limits the extent to which documents can be used as evidence about the social world in which they exist. However the use of documentation in this study transcend these dilemmas as the provenance of the documents' production is indisputable. Added to this these documents *can* be studied, to a large degree, in terms of being a fair reflection of events as the corresponding transcripts of the interview and observational data provide a comparative frame. The combination of the three different types of data therefore provide a robust defence against some of the perils of using documentary data as well as providing valuable insights into the actual practices through which documents are produced and used during nursing assessments.

During the data collection phases of the study the documents were photocopied on each of the wards and any detail by which the patient could be identified was removed prior to taking the documents from the hospital and to my office.

4.4.3 Observation and "field methods".

CA researchers have traditionally avoided in-depth observational data, instead using audio recordings and the subsequent transcripts as sufficient evidence of how

elements of social life are locally accomplished through talk and interaction. In particular, the avoidance of observational data within CA studies of interaction was traditionally endorsed in the belief that over-attention to the detail of such matters as the place and identities of interaction, such as “hospital wards” or “doctor’s office” could ‘obscure much of what occurs within those settings’ (Maynard and Clayman 1991, p. 406-407). However as studies of talk and interaction have become increasingly concerned with more specialized forms of social activity, such as interaction in institutional settings where task or role based activities are undertaken, it has been widely recognized that it is necessary to augment recorded materials with some sort of ethnographic fieldwork, usually participant or non-participant observation (Tapsell 2000, Heath 2004, Rapley 2004).

The comments made by Rapley (2004, p.387) in his discussion of the valuable contribution of CA to social research particularly struck a chord:

For those that focus on interactions that occur in different places at different times (such as nursing work in a hospital ward), a period of ethnography may be essential in order to establish what might be relevant to record.’

This approach to combining CA and observational research, it could be argued, goes some way to align current CA studies of work with the original writing of Sacks et al (1974), who first introduced CA to a wide readership noting that

conversation is always ‘situated’ – it always comes out of, and is part of, some real sets of circumstances of its participants (p.699).

Unfortunately the increased complementarity of data produced through recordings of interaction and observational techniques is not always picked up on in qualitative research textbooks such as Mason (2002a) and Flick (2002), who continue to present CA as hostile to other data sources. Presenting CA in such a narrow way ignores opinions within CA studies of work-place activities, such as that the blend of observation and recordings present opportunities for rigour that may elude direct

observational techniques alone, and that many aspects of organizations cannot be directly or easily caught on tape but grasped through ethnographic fieldwork (Drew and Heritage 1992).

The use of recordings, transcripts and observational data as core data across a range studies is a further counter to the argument that CA data collection is a rather insular affair fixated on mechanical recordings of talk alone. A clear example of audio recordings utilised as core data, and ethnography being used as a background resource is Maynard's (1983) CA study of court room interaction whereas, on the other hand, Griffiths' (2002) clearly states that her ethnographic (rather than 'mainstream CA' p.216) study of humour in a health care setting uses extended data extracts from recordings of case meetings to convey a better sense of the form and sequencing of interactions.

Whilst both of these studies are different in their analytic aims, each successfully considers how institutional discourses are broadly organized and how, for example, power and knowledge are implicated in them. Both studies, through consistently demonstrating the relevance of the research materials collected to the underlying research question, also implicitly recognize and respond to Sharrock and Anderson's (1986) point that the mere use of additional research materials has, in itself, no intrinsic value.

Thus a variety of data was collected in this study through 'field methods' (ten Have 2004, p.127) – observations, note taking, documents perused and copied, were all used to sketch the overall features of the setting, the main characters and the general proceedings, while the audio recordings were collected to identify the conversational strategies used to actually “do” the assessment interview.

The need to undertake observation became clear during preliminary visits to clinical areas in preparation for writing the research proposal. Apparent, in particular, during these visits was the complexity of activities undertaken during assessment interview and the range of distributed activities which feature, sometimes only momentarily, in the accomplishment of the work in question. Reading studies from a range of workplaces which had included observational data further reinforced in my mind the potential contribution which observational data could make to the study. These studies have led to a better understanding of doctor-patient work particularly in areas of previously taken-for-granted practices, shedding light on the ways in which people coordinate tasks with the actions of others, how participants monitor each other's conduct and its relevance, and how the use of various artefacts shapes and constrains interpersonal communication (Heath 1986, Zimmerman 1992, Boden 1994, Robinson 1998, Ruusuvuori 2001, Heath 2004).

Although nursing literature seems to understand the importance and potency of non-verbal communication within nurse-patient interaction (Le May 2004, Sully and Dallas 2005), nursing research seems to have overlooked the fact that gestures and other forms of bodily contact arise in interaction, and that nurses frequently use artefacts, such as patient records when talking to patients. Overall, non verbal communication is often neglected within studies of nurse-patient interaction as is the fact that in a busy hospital setting it is not unusual for aspects of the physical environment to become relevant within the course of the social activities.

As illustrated in table 1 (page 93), observational data was collected during 2 different stages of data collection. Firstly, seven episodes consisting of 5 hour periods of observation were conducted on each of the wards (totalling 175 hours of observations during which 45 assessment interviews were observed). These episodes

occurred prior to the actual audio recording/observations of the assessment interviews and entailed the observation of morning shifts from 9am to 2pm on the selected wards, with the aim of establishing an understanding of the activities and the various tools and technologies which featured before, during and after the accomplishment of the assessment interview. I also had some prior knowledge of assessment and admission procedures from my time working as a registered nurse, as well as from discussion with, and ward visits to, nursing students who I was supervising in my role as a lecturer in nursing.

May (1997) states that the researcher's role when observing will vary depending on the aim of the research and this was the case during the two distinct periods of observation during this study, these varying roles will be briefly considered here.

Gold (1969) identified four "master-roles" which the observer may adopt. These are complete participant, participant as observer, observer as participant and complete observer, each of which offers the researcher a different level of engagement with those being observed, although in each the researcher is the medium through which observations are collected.

The role which best approximated to the aims for the initial observation period on the ward (prior to recording the assessment interviews) was that of participant as observer. This role is relevant for researchers wishing to know and understand more from people within the setting regarding rules, roles and relationships within the setting observed, but who may not desire full immersion into the organization as required of the complete participant observer (May 1997). In the role of the participant as observer, therefore, both the researcher and those being observed are

aware of the researcher's interest, which may lead initially to some uneasiness and wariness on the part of those being observed.

As Gold pointed out the uneasiness diminishes as the researcher's presence becomes more familiar. This I found to be true of my periods of observation on each of the wards used here. At first the staff, although welcoming, appeared overly conscious of my presence and occasional periods of writing in my notebook (fieldnotes were written when appropriate on the ward and were re-read and clarified at the completion of each shift). This took the form of staff members constantly checking if I was "ok" and whether they could get me anything, as well as jokingly mentioning, as in one case in particular, that they would love to see what I was writing about. In this case, as in similar instances, I informed the nurses that they could read my notes at any time, prompting on each occasion a declination. These episodes, performed early on in the observation period and in a "joking" manner, served to ease some of the wariness between the observer and the observed, whilst seeming to lessen the perceived threat posed by the observation period. During the continual negotiation at this time between proximity and distance, transparency and disclosure, the approach taken was that of non-threatening openness and honesty with all during the observation period.

Unstructured, non-participant observation best sums up the approach taken to observing the assessment interview itself, an approach described as the complete observer by Gold. This role completely removes the researcher from observed interactions and is epitomized by the simple recording of behaviour (May 1997). According to Bryman (2001) unstructured observation does not, as its name implies, entail the use of an observation schedule for the recording of behaviour. No

observation schedule was used to guide data collection in this study, however I didn't simply observe in an unfocussed way in either of the observation periods. Firstly the observation was focussed on the working practices of the nurses on the wards during a morning shift, with particular reference to the work relating to the admission of patients. The observation during the assessment interviews was focussed, for the most part, on the use of such non-verbal communication as gestures and body posture, together with collecting observations on whether written nursing or medical records were used for particular purposes during interaction.

Therefore the plan for the observation of the assessment interview was to be as unobtrusive as possible and out of the line of sight of the participants during the assessment interview. Observation without participation in the interaction was therefore the aim and, on the whole, this aim was achieved. It may, however, be worth noting Mason's (2002a) comments that researchers cannot fail to participate in some form, even if there is complete lack of involvement in the field. To précis Mason's point, the researcher's attempt to be non-participative will have some effects on those involved as they cannot control how they are perceived by others. In view of this even the most non-participative of observers who for example set up a video-recorder or use CCTV data in hospitals which would require the prior notification of individuals will lead to some degree of participation in the research field, all of which seems, to some extent, to undermine the traditional continuum between complete participant and complete observer as discussed by Gold.

It seems recent literature (Carolan 2003, Pellat 2003) considers that the researcher being aware of the potential effect of their own biographies in the research process is more important than the extent to which the researcher believes themselves

to be participating or not (if we follow Mason's logic of course this distinction is, to some extent, redundant). Coffey (1999), in making a similar point, suggests that active reflexivity by the researcher should disentangle how the researcher's presence shapes the research processes of data collection and analysis. Reflexivity was described by Mead (1934, cited by King 1996 p.175) as the 'turning back of the experience of the individual upon (her- or himself)' and by Delamont (1992) as 'a social scientific variety of self-consciousness' (p.8).

The aim ultimately was to collect layers of data that both captured the complexity of the activity which would help to disassemble aspects of the social and organizational conventions as used by the participants themselves during assessment interviews. There were obviously times during data collection that the researcher and researched intermingled and this would have had an effect on the research process, but on the whole I observed at a distance and as unobtrusively as possible. There were moments where Koch's (1998) comment that the researcher and the researched cannot meaningfully be separated rang true which made me more aware that my role as a neutral researcher had to be clearly identified. For example, occasionally I felt what Collins (1998) called a "confessor" when nurses said such things as 'Just between you and me...' about a variety of subject matters both related and unrelated to the research being undertaken.

Although most of the time the relationship between the researcher and the researched was that of benign strangers, these occasional instances where nurses saw me more as a confidante made me reflect on my status as either an "insider" in the nurses' eyes due to my previous status as a hospital based nurse, or an "outsider" due to my current status as an university lecturer. My reflections at this time were

confused somewhat, rather than clarified, by the literature in this area as being a confidante could be seen as confirmation that nurses saw me as an outsider and thus was not viewed as an internal threat within the organisation (Bonner and Tolhurst 2002), or alternatively nurses saw me more as a colleague and insider and therefore felt able to confide (Hand 2003). Some of these issues are covered further in this section and elsewhere within this study; but on the whole I attempted to present myself to nurses and patients as a person with a foot in both camps, a compromise of sorts which I also kept close during data analysis.

Furthermore in terms of reflexive research practice, the principle of 'ethnomethodological indifference' (Edwards, 1997 p.63) has a powerful influence within CA, and was a principle I attempted to follow throughout the study. Ethnomethodological indifference recognises that it is not for the analyst to endorse or condemn practice, rather the aim is to study the workings of talk and practical actions during the accomplishment of everyday business and then, as in the case here, compare the workings to the ideological position adopted by the profession. This provided an additional dimension to reflexivity as it counteracted personal preferences and influences which may have occurred during the research process, and liberated the researcher from the burden of approving/condemning practice of nurses. I attempted (successfully most of the time) to communicate my ethnomethodologically inspired indifference to the nurses and patients during the study in the hope that this would dispel any ideas that I was "looking" for something in particular during the study, or that I was carrying out some sort of a quality audit of communication. It was hoped that all participants would thus behave in their usual ways, and there is nothing to suggest that they didn't.

However, researcher effect, where participants change their usual behaviour when observed/taped by a researcher is a possible limitation in any study (Bryman 2001). The extended period of time spent observing on the ward and building an understanding of nurses' practices over time provided useful data but also offered a possible counter to researcher effect as time spent observing prior to tape-recording allowed some familiarity to emerge between myself and the nurses. Due to the nature of the study it was not possible to do the same with patients, whilst additionally patients may have been more submissive or compliant during interviews as they may have thought this would be better for the nurse concerned, although none of the nurses commented that patients behaved atypically during my periods of data collection.

A further set of limitations concerns the acute settings in which the study was conducted, and the participants involved. For example, even though the sample included patients with both acute and chronic illnesses very few instances in the data concerned patients' who were being assessed for long term, or palliative care. The "acuteness" of the locations for data collection is evident in the data itself and therefore cannot be representative of the interactive practices of nurses and patients in other settings.

4.5 Data analysis techniques

Language and conversation is of great importance for social researchers who have an interest in making sense of society and culture. One of the most exciting developments in health research over the past 30 years or so has been the interest in the analysis of discourse between patients and nurses. Distinctive approaches have emerged from different disciplinary locations and different theoretical traditions, and there is now a huge variety of perspectives that lay claim to the name "discourse

analysis". The term "discourse" is used to refer to all forms of talk and texts, whether they be naturally occurring conversations, interview material or written texts. While approaches to discourse analysis vary, there is some common ground and all approaches share a common understanding of language as an object of inquiry.

For example, two such approaches to analysis namely Conversation Analysis (CA) and Critical Discourse Analysis (CDA) both share an interest in detailed and sophisticated analysis of text or talk. Both have a special interest in naturally occurring text or talk, acknowledge the context-dependency of discourse, recognize the relevance of an interactional dimension of language, attend to sequential phenomena in text or talk and, in general, examine order and organization of expression, meaning and action at several levels of analysis. Few analysts in both fields reject basic functional principles that claim that discourse and its structures are accomplished as specific social acts – that is, to get things done in social contexts. In contrast to other approaches in the humanities and the social sciences, such as quantitative content analysis, survey research or experimental testing in the laboratory, both CA and CDA advocate a detailed study of the structures of text and talk and their interactional and social functions (van Dijk 1999).

However there are some basic differences between CA and CDA which give both their distinctive style or method of doing research on language and interaction, matters which contributed somewhat to the decision made to utilise CA, rather than DA in this study. These differences generally refer to the way both approaches attend to the context of talk and texts.

In CDA there is no hesitation in examining text and context separately, and once a feature of context has been observed, postulated or otherwise identified, CDA may be used to explore whether and how such a feature affects, or is affected by,

structures of text and talk. Also critical discourse analysts, unlike conversation analysts, make use of their social knowledge that being e.g. black, and/or a woman will most likely be evident in the way people write and talk. The major point that CA makes is that such contextualization should not be pre-supposed, but that it needs to be proved by attending to what social members actually say and do. If not, contextualization is pointless because of its discursive irrelevance. The following section will provide an outline of how CA analyses talk and interaction.

4.5.1 Background to CA

The roots of CA lie in ethnomethodology which takes as its focus of attention people's practical, common-sense reasoning in everyday life and, as such, is fundamentally concerned with the notion of social life as an accomplishment (Bryman 2001). CA and ethnomethodology (EM) therefore involve a fascination with the local production of social order and reality and explore how it becomes finely crafted and intimately ordered through talk and interaction. Seen in this way social order is not seen as a pre-existing force constraining social individual action, but as something that is worked at and accomplished through interaction.

Whilst several authors such as Bryman (2001), Flick (2002) and Rapley (2004) document the close relationship between CA and ethnomethodology others, most notably ten Have (2004), take a more critical and arguably more contemporaneous view of the state of affairs acknowledging that 'there is a certain ambiguity, and even ambivalence, in the CA/EM relationship... There are now quite a number of publications in which CA is criticized from an ethnomethodological perspective.' (p.25). One example used by ten Have to illustrate an increasing divergence between CA/EM is that CA studies tend to show a stronger orientation to an investigation of quite commonly occurring phenomena (in this case nursing

assessments), while EM is prone to focus on the particulars of specific times, places or forms of life.

A further point made by ten Have strikes a chord of recognition when he states that many practitioners of CA, especially those with a non-sociological background, seem to see to see it as an independent discipline to EM. Whilst meeting with several individuals over the last few years that practice CA, many of whom come from a non-sociological background, little or no mention is made of EM in discussions of the analytical methods used by CA. Although many researchers would acknowledge an early developmental relationship in the past between CA and EM, the position seems to be that over the last couple of decades CA has been developing apart from what was going on in EM.

4.5.2 Assumptions of CA and the study of institutional talk.

A substantial part of the development of CA over the last two decades has been the significant and growing corpus of studies, in both the U.S. and Europe that has begun to focus on interaction in institutional settings where more or less official or formal tasks are undertaken. Courtroom trials, media interviews, job interviews and doctor-patient interaction are all examples of the interactions studied. The initial (and on-going) approach to the study of institutional interaction was comparative in nature, with the basic forms of mundane talk discussed in earlier CA research by Sacks and his colleagues, constituting a kind of benchmark against which other more formal or institutional types of interaction are recognized and experienced. As a result of the early studies of talk in institutional settings, three distinctive features of this type of talk have been forwarded by Drew and Heritage (1992):

1. Institutional interaction normally involves the participants in specific goal orientations which are tied to their institution-relevant identities: nurse and patient, teacher and pupil, etc.
2. Institutional interaction involves special constraints on what will be treated as allowable contributions to the business at hand.
3. Institutional talk is associated with inferential frameworks and procedures that are particular to specific institutional contexts.

An unique 'fingerprint' (Heritage and Greatbach 1991 p 95-6) for each kind of institutional interaction is created by these special features, being made up of specific tasks, identities, constraints on conduct and inferential procedures that the participants are oriented to in their interactions with one another. Searching for these features initially during the analysis of the data assisted in the formulation of early ideas regarding the institutionality of the interactions collected.

Implicit within this way of thinking is the important idea that, relative to ordinary conversation, institutional interaction usually involves a reduction in the range of interactional practices deployed by the participants, and a specialization of the practices that remain (Drew and Heritage 1992). A further assumption is that talk within institutions such as schools, law courts and hospitals are relatively recent inventions that have undergone a great deal of social change. Conversation, by contrast, exists and is experienced prior to institutional interaction both in the life of the individual and in the life of the society (Heritage 2004).

Another methodological aspect of CA concerns the interrelationship between talk and social structure. Schegloff (1992) observes that researchers of interactional data readily acquire a sense of the social identities of individuals (e.g. gender, occupational role, power etc) – a sense that, as Atkinson (1992) points out, can be

overwhelming in institutional talk. The question raised by Schegloff concerns how the sense of identity can be translated into empirically warranted findings, given that any individual can be factually described in many ways (e.g. female, Caucasian, nurse, ward manager, daughter, mother are all factual identities that can be correctly ascribed to many individuals within this data set). On a related matter, Wilson (1991) discusses the dangers of a too hastily assembled conclusion that particular and obvious institutional identities are informing courses of action, something which nurse researchers have been prone to do in the past (see discussion in literature review of Hewison (1995) for an example of this).

As an alternative to using competing “factual” identities in the analysis of interaction Schegloff (ibid p 107) raises the issue of ‘relevance’ for analysts to work at i.e. the factual identities ascribed to participants of talk are only relevant if they can be shown to be grounded in the here and now of what has just been said during interaction. Not, then, merely characterizing or categorising participants of institutional talk as male/females, young/old, nurse/patient or interviewer/recipient, but that, for those individuals at that moment those sociological variables are relevant for producing and interpreting conduct in the interaction. For the conversation analyst they are there, in effect, when they are there for the participants. This is cogently summed up in Drew and Heritage (1992 p 21) thus:

CA researchers cannot take “context” for granted nor may they treat it as determined in advance and independent of the participants’ own activities. Instead, “context” and identity have to be treated as inherently locally produced, incrementally developed and, by extension, as transformable at any moment. Given these constraints, analysts who wish to depict the distinctly “institutional” character of some stretch of talk cannot be satisfied with showing that institutional talk exhibits aggregates and/or distributions of actions that are distinctive to ordinary conversation. They must, rather, demonstrate that the participants constructed their conduct over its course – turn by responsive turn – so as to progressively constitute and hence jointly and collaboratively realize the occasion of their talk, together with their own social roles in it, as having some distinctively institutional character.

Therefore, in conversation analytic research on institutional interaction a central question of validity considers the grounds on which the researcher claims that the talk focussed upon during analysis is in any way connected to some institutional framework (Peräkylä 2004).

With reference to this, rather than taking for granted that interaction between nurses and patients is institutional in character as it occurs in a hospital, I was more concerned to show that analytically relevant categories or identities such as “nurse” or “patient” are grounded in empirical observations that show the participants themselves are demonstrably oriented to the identities or attributes in question. As a result of not taking for granted that nurses’ talk and identity during assessment was pre-determined in advance I was able to show that nurses orientate to other “non-nursing” identities during the assessment interview to facilitate the completion of the assessment interview. I was also aware of any claims concerning the institutional character of talk made in terms of importing institutional context such as “professional dominance” into data analysis, as it may have resulted in the premature termination of analysis with the effect that inherent organization within the talk was not understood.

As the nature of the institutional talk must be induced out of data, the specific details of interaction cannot be ignored as insignificant without damaging the prospects for coherent analyses. Thus, importance is stressed in CA on transcribing the fine-grained details of the interaction.

4.5.3 Transcription and attention to detail

Attention to fine detail during the transcription of data is an essential ingredient of CA work, providing for highly detailed and publicly accessible representations of social

interaction. However the aim in CA is not simply to transcribe the talk and then discard the tape in favour of the transcripts. As Hutchby & Woofitt (1998, p.73) state 'transcripts are not thought of as "the data" but as a convenient tool for reference'.

The practice of transcription does, however, represent a distinctive stage in the process of data analysis itself, rather than simply a process of writing down the words that people exchanged. The process of transcribing for this study involved writing down in as close detail as possible such features as the precise beginnings and endings of turns, overlaps in turns, the duration of pauses and the stresses and extensions found in individual words or syllables. Capturing this apparent "messiness" of interaction as it actually occurred was aided by the use of an orthography (see appendix 2) designed for use in CA studies by Jefferson (1984). To further enable accuracy in the transcription process repeated listening to the original recording was essential, which in turn led to the researcher gaining a more detailed understanding of the participants' interaction.

One way which audiences of CA research can judge the quality of the claims made by the researcher is via the detailed transcripts produced. One advantage of this study was that working with tapes and transcripts eliminates many of the problems that, for example, ethnographers have with the reliability of unspecified accuracy of field notes and the limited public access to them (Peräkylä 2004). The tape recordings and transcripts produced here conform closely to Silverman's (1993) reliability checks as they provide detailed and publicly accessible representations of social interaction.

4.5.4 Limitations of CA.

As discussed above CA attempts to achieve understanding from the perspective of those being studied, rather than importing elements into the analysis of talk that are not specifically grounded in the participants' own terms. In response, non CA researchers have consistently argued that an attempt to study conversations purely in the participants' own terms is methodologically naïve, and nigh on impossible (cf. Billig 1999, especially p.546), whilst others see it as an unnecessarily 'limiting stance' (Bryman 2001, p.359) to completely illegitimise an interpretive understanding of social action gained as a result of an in-depth understanding of a culture. Bryman adds a further admonishment to CA for seeking participants understanding exclusively in sequences of talk when, in fact, social actors often share a mutual knowledge of contexts which is largely unspoken.

These perceived limitations imposed on analysts using CA may explain the dearth of nursing research studies since the mid-eighties. It may also explain why CA has not entered the mainstream of nursing research methods in the way that, for example, the "contextually rich" methodologies such as phenomenology or ethnography have. Other possible reasons for this may include thoughts along the lines that phenomenology and ethnography were seen as an approach more compatible with the epistemological and "political" needs of nursing during the 1980's (see Lawler 1998). On a related theme CA has been seen as being overly empirical or scientific for qualitative purposes, subsequently being avoided and deemed unfashionable for nursing research at a time when it was attempting to establish itself with a qualitative research identity.

On a more prosaic note it may be that CA has been avoided as the analytical process is seen as overly time consuming or tedious (Flick 2002). Also the fact CA

was (and still is) rarely utilised within nursing research in the United States of America which has traditionally influenced the nursing research agenda in the UK and beyond (Lawler 1991b, 1998) is a moot point which can be added to the list of possible reasons for the under-utilisation of this method in nursing research.

The highly focussed, detailed nature of conversation analysis is also a possible limitation as it means that analyses are time consuming and that any one study involves working with a relatively small database. Because of this, one study cannot hope to capture the whole range of interactive procedures that operate within a setting (Heritage 1995, Peräkylä 2004). Also because data concern naturally occurring events rather than experimentally induced or controlled ones, it can be difficult to assess the impact of certain factors or to describe the full range of particular events.

However the very detail of naturally occurring events that CA offers can be helpful in disseminating research to nurses, especially considering that the utilization of research by nurses is often problematic as it lacks relevance to the real day to day work of nurses (Parahoo et al 2000), echoing a related point made by Le May et al (1998) who found in their qualitative study of research utilisation by nurses that the lack of generalisability of some nursing research was cited as a significant factor by participants for the existence of a research-practice gap.

4.5.5 A framework for analysis.

In this section I attempt to offer a more discursive explanation of the framework used for the analysis which led to the findings which will be presented in the following chapters. Gerson and Horowitz (2002) observe the widely held view that there can be many paths to the same destination in qualitative research, a view that has led several authors (Murphy et al 1998, Shaw 1999, Mason 2002a, Flick 2002) to argue that

qualitative analysis should be systematically and transparently constructed by researchers, as this will lead to a 'clear analytic story' (Flick 2002 p.238). The main recommendation for researchers which emerges from reading these texts is summarised by Mason (2002a, p.186) who states that making analysis 'transparent effectively means that you should be demonstrating to others how you reached your arguments – how you "got there" and how you checked up on yourself in the process'.

This urge for transparency/clarity in explaining the analytical decisions made by the researcher appears to occur as a direct response to anxiety regarding the potential role of subjectivity during the analysis and writing up of qualitative research. Guba and Lincoln (1994) appear to first suggest transparency as a counter to subjectivity with the idea of dependability in qualitative research, arguing that to establish the merit of research studies researchers should adopt an auditing approach which includes grounding analytic assertions in various forms of evidence and reflection. An auditing approach also entails ensuring the complete records are kept of all phases of the research process including data analysis decisions. In this tradition therefore instead of describing actual empirical results, I will begin by presenting some basic observations which have served as the basis for organizing the analysis.

CA is characteristically co-operative (Silverman 2005), and some of the analysis presented in this study originally germinated in group data sessions held in York, Edinburgh and Swansea. Group data sessions are situations in which researchers co-operatively analyse data extracts and discuss their observations. ten Have (1999) describes a typical group data session as progressing when 'participants are invited to proffer some observations on the data. ...Then anyone can come in to react to these remarks, offering alternatives, raising doubts, or whatever' (p.124). However ten Have also makes clear contributions within group data sessions, rather

than being random and chaotic, should be grounded in the data at hand or supported by published research.

In York and Edinburgh the participants in the group data sessions were from a range of academic and disciplinary backgrounds e.g. psychologists, sociologists, doctors, nurses, health care researchers, ethnographers, conversation analysts, interviewers and quantitative researchers. Each participant was either a full member or an invited guest of an Economic and Social Research Council (ESRC) funded seminar group with an interest in methods for analysing patient participation in health care consultations and brought data and their own analytical skills from countries such as Finland, the United States of America as well as from within the UK.

I was fortunate enough to be a permanent “core member” of the group and subsequently attended all of the ESRC events. The group met six times over the period 2001-2003 and proved to be an invaluable sounding board for my on-going thoughts and analysis regarding this data set. The group data sessions added to the reliability of the analysis as they offered a possibility to check upon the analysis made privately and to compare and contrast my personal observations with those of the other members of the group, most of which had many years experience of CA and health care research and were at Senior Lecturer or Professor level within their home institutions⁸.

Reviewing the data with reference to the CA literature was a similarly iterative process. At first basic conversational rules were considered. These included fundamental theoretical positions on conversations (Garfinkel 1967, Heritage 1984, Sacks et al 1974, Schegloff 1992), the impact of change of state tokens, positioning

⁸ At different stages of my data analysis I was able to share my transcripts and analytical ideas with Dr. Paul Drew, Prof. John Heritage, Prof. Anssi Perakyla and Dr. Johannah Russuvuori all highly experienced and proclaimed practitioners of CA. Others within the group that offered much in the way of non CA critical comment included Prof. Nicky Britten, Prof Ken Gilhooly, Dr. Fiona Stephenson and Prof. Ian Watts.

markers and related utterances on the progress of talk (Button 1991, Sacks 1984), and identified phenomena specifically related to information exchange such as pursuing a response (Pomerantz, 1984). The next line of reference material related to like situations, such as community nursing interviews (Sefi 1988), medical interactions (e.g. Mishler 1984, Silverman 1987), psychology interviewing (Antaki 1999), market research interviews (Houtkoop-Steenstra 2000), courtroom interaction (Atkinson and Drew 1979) and counselling interviews (Peräkylä and Silverman 1991). These are considered as like situations as each sees interaction occurring around information exchange within what could be considered as institutional talk.

Another form of interaction requiring information exchange, the request for emergency service response (Zimmerman 1992) was of particular interest, and is briefly reviewed here. By closely examining the features of telephone calls to emergency dispatch centres for medical or other emergency assistance, Zimmerman (1992) noted that the overall shape of such calls is the product of how both the participants – the call taker at the dispatch centre and the caller – manage the call-processing requirements and policies of the dispatch organization. As a consequence of the requirements and policies of the call centre Zimmerman demonstrated that, notwithstanding the potentially vast variety of caller's unique concerns, emergency calls have an underlying range of organizational similarities which are locally achieved and managed resulting in characteristic patterns of activity associated with the organization. Whilst the whole study demonstrates how both parties orientate their interaction to getting the organization's work done, it also shows that the interaction is structured around a situation which results in the request for help by the caller, and the response to it by the dispatcher.

Zimmerman's study provided an interesting framework for examining the nursing assessment interview, a decision borne out also by Bergmann's (1993) comments that the study may fit a larger set of service encounters than those enacted in emergency call centres including interaction between patients and a variety of healthcare practitioners. In this vein, leading on from Zimmerman, the initial nursing assessment interview can be thought of as a service encounter between nurse and patient consisting of one single activity, the patient's need to be admitted into hospital and the nurse providing a service that meets this need.

Seen in this way, the patient's description during the interview of the reasons for hospitalisation and its effects on their daily living activities is analysable as a request to the nurse for help with the patient's problems, and the subsequent delivery of nursing care may be perceived as the nurse's response to the patient's request. Thus the patient's need for hospitalisation and nursing care is one situation to which both parties become orientated during the interview, an interaction which is managed through general conversational mechanisms such as turn taking.

However, the emphasis on general conversational mechanisms should not be taken to suggest that the interaction during initial assessment interviews is akin to "normal conversation", as it became apparent during the periods of observation that the overall conceptual frame for the assessment interview is based on an account which is managed through a nursing model of care and the policies for documentation at both a local and national level. A similar situation is mirrored in Zimmerman's study where the implementation of organizational policies and objectives are undertaken using the machinery of conversational organization to do the interactional work that the organization's aims require. As Zimmerman (1992, p.460) states 'in this

way the organization gets *done*, and the characteristic patterns of activity associated with the organization are produced’.

The review of Zimmerman’s paper led to consideration of the initial nursing assessment as an altered form of “normal conversation” and further reading revealed work on ‘quasi-conversations’ (Peräkylä and Silverman 1991) in healthcare settings, which are an institutionalised speech exchange system where there is some variation demonstrated between broadly similar interactions which enables the participants to meet the needs of the patient and the externally given constraints e.g. time limits, placed upon the interaction. Further reference material on similar types of institutional interviews and interactions were also reviewed (e.g. Boden 1994, Heritage and Stivers 1999, Tapsell 2000, Ruusuvuori 2001). Cumulatively these papers led to an understanding of the situated nature of the interaction under study, bearing in mind that the activity involved a particular set of people co-producing an event under a particular set of circumstances.

In practical terms because little is known about how nurses communicate with patients during initial assessment interviews the analysis of data was started by reading through the transcriptions, and examples of conversation sequences were collated and compared in a search for recurrent patterns and structures that were common to some or all of the assessment interviews. For example, I made collections of each specific turn structure observed in the data and comparisons of these patterns and structures with those found in similar studies of interaction in other disciplines served as a resource in the analysis. Within each data set the variation in the conversational patterns within the assessment interviews was very minimal, thus deviant case analysis remained marginal in the study although cases are presented in chapters 6 and 7. Deviant case analysis refers to examining the data for episodes

where “things go differently”, most typically cases that do not fit within the suggested pattern of interaction (Peräkylä 2004).

Early on during the study it became apparent that to fully portray the character of the initial nursing assessment interview as an institutionalised speech event entails much more than the specific application of the turn taking machinery used in traditional CA. In order to account for this, it was decided to turn to more traditional ethnographic concerns.

Strictly speaking traditional CA does not refer to ethnographic detail in the analysis. The focus is on the action of talk regardless of the social setting. Both Silverman (1993 p 141) and Moerman (1988 p x) argue for a close relationship between ethnography and CA in cultural studies. In contrast to the canons of traditional CA, Moerman (1988 p.x) takes the position that CA studies combined with ethnography can demonstrate how people can be both active agents and observed objects within a given setting – ‘informed by context and sensitive to purpose’.

Silverman and Gubrium (1994 p.4) approach the problem of combining CA with ethnography by cautioning against doing everything at the same time without ‘muddying the water’. I follow their suggestion here by initially undertaking the analysis of observational data (chapter 5), followed by a fine detailed analysis of nurse-patient talk (Chapters 6 to 7), before completing with an analysis of observational, documentary and spoken material (chapter 8), which probably falls under the rubric of “doing everything at the same time” although it is hoped that this avoids muddying the water as predicted by Silverman and Gubrium above.

One specific reason for including observational data into the analysis of initial assessments was that the beginning and the end of the activity of “doing an initial assessment” defied clear boundary. Often the patient’s assessment would begin prior

to the nurse meeting the patient, and in the case of patients having visited pre-assessment clinics, information collection relevant to the assessment would begin days or weeks before meeting the nurse. However once the patient and nurse finally met in person there were clear boundaries to the assessment *interview*. The start of the interview saw the nurse sitting next to the patient and either introducing themselves or explaining what they were about to do, and the interview ended with the nurse leaving the patient's presence whilst giving some verbal indication that the interview had come to an end.

Seen in this way the boundaries of the interview are quite easily defined in this study as there were no cases where the patient started the assessment interview without waiting for the nurse to introduce themselves and/or introduce the nature of why they had sat next to the patient. Likewise, there were no cases of the patient bringing the interview to an end before the point where the nurse announced, either verbally or through other actions such as collecting the notes and walking away, that the interview had terminated.

Once I had identified the sequences to be studied and extracted the turn designs commonly used during an initial nursing assessment interview these were arranged into chapters. The sequential order of the interviews were followed in organizing the contents and a separate chapter was written on non-verbal behaviour and the use of documentation.

Chapter 5 – setting the scene

Gubrium (1991) has noted that within healthcare specific areas exist to some extent as separate and distinct from the broader and larger cultural contexts of the organization of which they are a part. In view of this, it is possible that wards within the same hospital and NHS trust, although sharing similar official missions and staffing structures may vary considerably, for example, in terms of organizational history, ambience and management style. A recommendation for researchers that follows on from Gubrium's argument is that when researching nursing practice across a variety of clinical areas, a specific sense of the places within which nursing care (and nursing assessments specifically) exists needs to be developed, even when those areas exist within and share the same hospital building.

Further consideration was given to Gubrium's point when it became obvious that, although the data for this study was being collected from within one NHS Trust, there was on the surface at least, considerable variation between the locations in terms of the specific clinical areas and the work practices of staff (a fact also borne out in the recent Commission for Health Improvement report of the NHS Trust⁹ which stated that the experience of being a patient or a member of staff varied considerably across the Trust, and that, for example, the 'standard of cleanliness, hygiene, décor and facilities varies extensively across the Trust'). Consequently, rather than assuming a generic model of hospital wards and practices because they happen to share the same building, the aim of the following section is to describe something of the actual working environments from which data was collected for this study.

This chapter is also presented to counter the accusation made by several authors that CA researchers produce an empty universalism by abstracting from

⁹ For reasons of confidentiality the reference for this report has been withheld.

particular societies and their historically and culturally specific circumstances (Billig 1999, Taylor 2002). The debate regarding observational data within a CA inspired study of institutional talk has been discussed at length in the methods chapter¹⁰, and elsewhere in this study, and this chapter exists as an extension of the principle that social research (and CA research specifically) benefits not only from a consideration of the words and gestures used during talk, but also from considering the broader social organization within which talk exists.

Thus, rather than abstracting a single line of talk from a lengthy transcription with no details regarding the origins of the talk, a valuable way of understanding assessment interviews seemed to be to attempt a micro-analysis of the interaction against a backdrop of knowing (something) about the clinical setting. The benefits of this approach can be considered through, very briefly, delving into a simple example from an excerpt used below from the chronology of an admission to ward R.

We know from the chronology that at 11.55am the nurse asked the patient who was showing signs of fatigue, a question about whether the patient had experienced any falls in the days and weeks before hospitalisation. Rather than relying solely on one source of data to help analyse what is happening here I am in the fortunate position of being able to turn to several sources of data to build a better understanding of the participants' conduct.

Firstly, the field notes contain the description that at 11.55 the patient was showing visible signs of tiredness (yawning, posture, frequent changes of position) and that the nurse, through asking questions and writing and reading the assessment notes in the gap between the patient's answer and the next question (the gaps being heard on the tape recording and measured in the transcript) appeared not to have

¹⁰ See section 2.1.3 in particular

detected the patient's fatigue. Secondly, observation and discussion with the ward staff prior to this data recording had clearly indicated to me how important the risk assessment of potential falls were, and that in the overall context of the admission it was seen as important (for the nurse manager in particular) that nurses record this information as it reflected the organization's commitment to patient safety. Thirdly, the transcript of the admission interview generated a detailed account of the verbal actions that took place before and after this section of the assessment and could be compared to the other transcripts produced during this study. The layers of data, when all taken together, helped enormously with building a sense of the interview, especially when several months following transcription, early analytical insights were being re-drafted into more concluding thoughts.

The aim of this chapter therefore is to assist the reader in building a sense of the assessment interviews undertaken. A brief insight is provided into the clinical areas within which data collection took place by providing a visual-spatial description of the clinical areas as well as a chronology of events during a selection of assessment interviews. The assessments have been chosen as they are largely typical of the overall data set. These descriptions, in turn, will enable the reader to place the fine grained analysis of the structure of talk presented in subsequent chapters alongside an, albeit limited, insight into the broader milieu of the interaction.

5.1 A description of the NHS trust, the hospitals and wards Q and R.

The first stage of the study was carried within a NHS Trust which provided both hospital and community health services for 250,000 people concentrated upon a city in the south of the U.K. The Trust's income totalled approximately £240 million, employing a staff of approximately 7,000 personnel. The Trust consists of 9 hospitals

with over 1800 beds, providing many specialist services to the public in the immediate locality and beyond.

Both hospitals where data was collected are situated on the outskirts of a city, providing 1450 out of the total of 1800 beds within the Trust. Both are also involved in the undergraduate and post graduate training of a wide range of healthcare professions including, nursing and medicine, as well as Professions Allied to Medicine such as clinical laboratory staff and radiology practitioners.

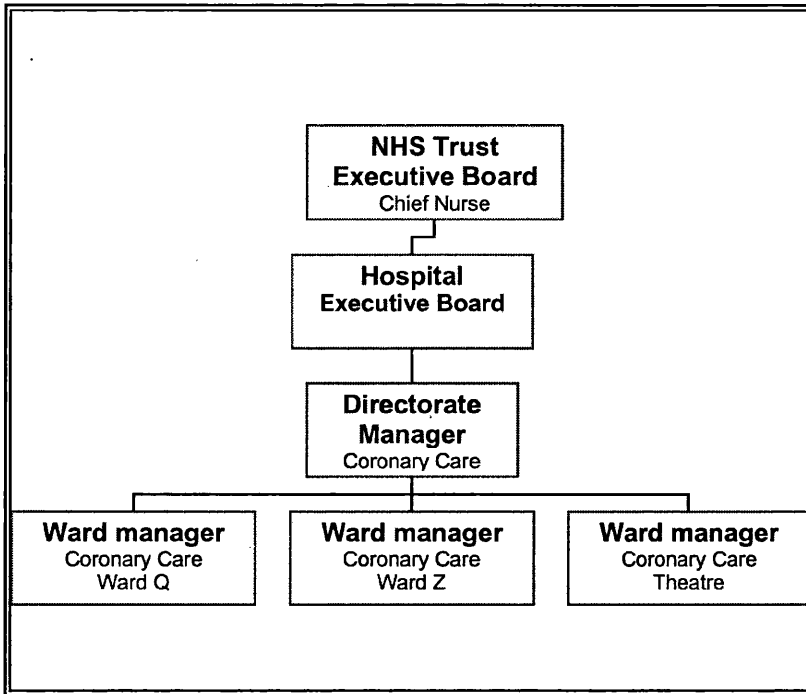
5.2 Hospital A - wards Q and R.

Hospital A has 850 beds which provide both specialist and generalist care. The range of specialist services, namely Renal Medicine, Neurology and Palliative Medicine are delivered to patients both within and in bordering trusts, whereas the District General Hospital component is delivered to a more local population and encompasses a Coronary Care Unit, several General Medical sub specialties (e.g. urology, diabetes medicine), a trauma and orthopaedic service and a range of general surgical specialties. Hospital A is also the site of a major Accident and Emergency Department which is progressing toward designated major trauma centre status for the area.

Hospital A is divided into individual directorates, each with its own managerial structure and administrative support which are accountable to the hospital's executive board, who are in turn accountable to the trust's executive board.

This is a typical management structure for all directorates within the trust, and is illustrated in **table 2**.

Table 2. Trust management structure.

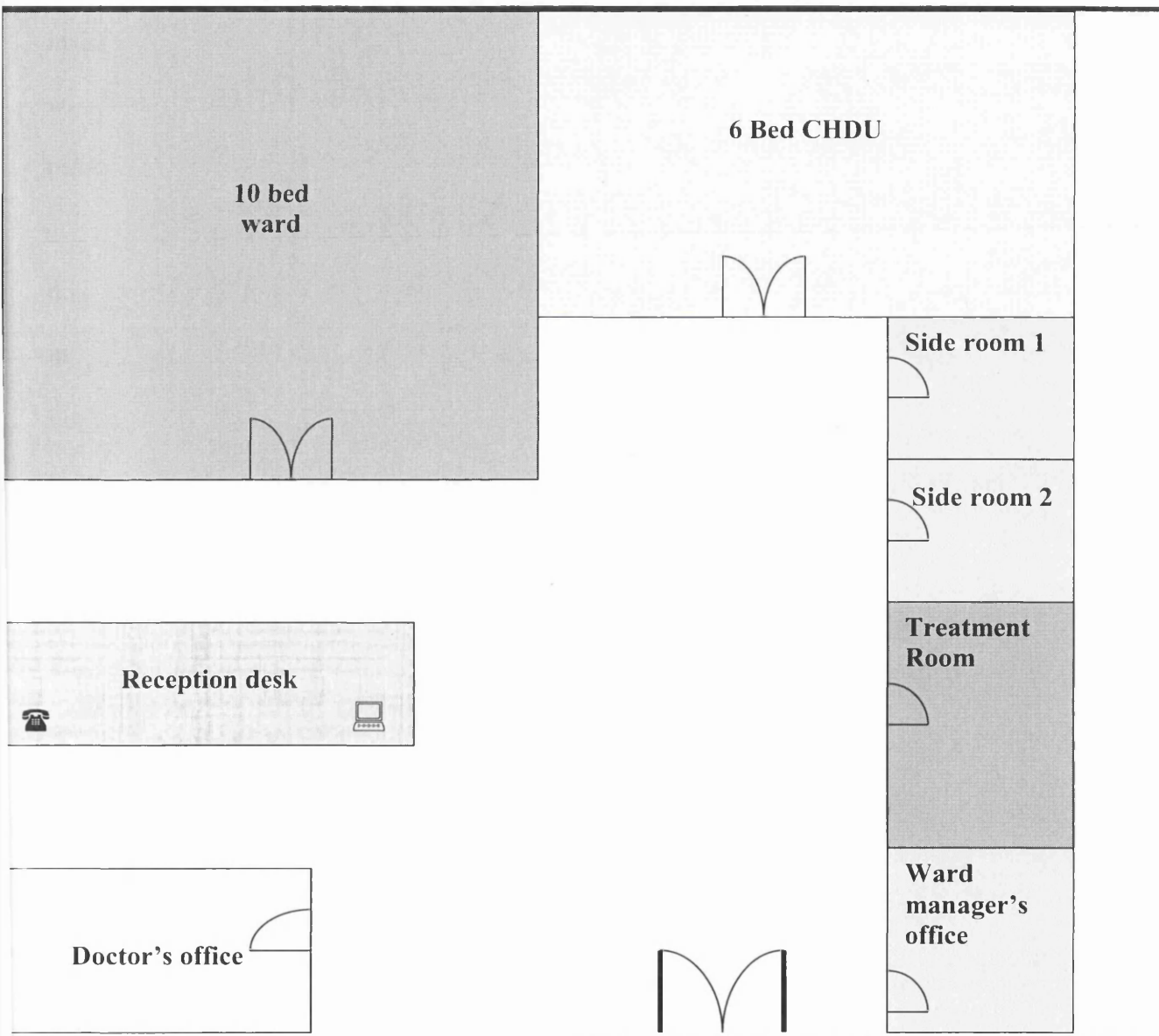


The following sections provide a more detailed overview of the wards which feature in this study, as well as details of some of the observational data collected during initial fieldwork in these areas.

5.2.1 Ward Q.

Each directorate within Hospital A has a number of wards allocated within it e.g. the Coronary Care directorate has 2 cardiology wards (one of which being ward Q), a Cardiology High Dependency Unit (CHDU) and a Coronary Care theatre/radiology suite.

Figure 2. Layout of ward Q.



Ward Q, from which some of the data was collected for this study, is a 21 bedded cardiology ward which also houses a 6 bedded CHDU (see **figure 2** for diagram of ward layout), and most of the emergency admissions are taken to the CHDU for initial assessments by nurses and doctors. The patients arriving on this ward are a mixture of planned admissions and emergency admissions from within the Trust, but also from District General Hospitals situated in nearby NHS Trusts. Emergency admissions in the Coronary Care directorate are deemed to be those patients who need detailed monitoring following a recent event such as a myocardial infarction, or requiring monitoring following an invasive procedure such as the widening of a blocked blood vessel, an intervention undertaken in theatre with the patient being given a local or a general anaesthetic.

During fieldwork on ward Q all but one of the patients (n=6) were admitted directly to the CCHDU, where nurses and doctors were able to scrutinise the patient in more detail than on the ward. In response to a national shortage of critical care beds there was an upsurge during the late 1990's in acute care wards such as ward Q which also had a designated critical care area such as a CHDU. This move was facilitated by the NHS Modernisation Agency with details appearing in the Department of Health (2000) strategy document entitled "Comprehensive Critical care", which aimed to improve access, experience and outcomes for patients with potential or actual need for critical care.

As figure 2 illustrates ward Q is divided into the 10 bedded "main" ward, 2 individual cubicles and the 6 bedded CHDU. The reception desk is located in the middle of the ward and serves as the "nerve centre" for the whole of ward Q. The following extract from the fieldnotes collated during a period of observation clearly demonstrates the role of the reception desk in the admission of patients:

The admission process began before the staff nurse met the patient. This pre-admission interview activity was centred on the ward's reception desk, where typically, the ward receptionist would sit answering the phones and dealing with paperwork and the general administrative running of the ward. This area is where visitors of all descriptions head for on arrival to the ward. The patient's medical and nursing notes, and most of the ward's paperwork, is kept in the vicinity of this desk. A few spare chairs around the desk are periodically occupied by a variety of healthcare professionals such as physiotherapists, social workers and doctors, but most of all by nurses. This, without any doubt, is the hub of the ward in terms of information generation and gathering. It is geographically central within the ward space, but it also has a centrality in the working lives of the staff on ward Q determined by the patient information that enters and occupies this space, acting as a form of "docking station" for all those who seek patient data. The assessment seems to begin here as this is where most pieces of patient information exist at any one time. Background, "red-tape" information regarding the admission of the patient is sought from a variety of sources around the main desk, questions from the RN such as "Who's he under?" (to the receptionist - enquiring about the name of the Consultant), "Where is he?" (to the Health Care Support Worker – enquiring as to the whereabouts of the patient) are answered. The medical notes are looked for also, but not found.

From the reception desk it is possible to observe patients in the CHDU through large windows to the left of the central doorway. The placement of the large windows and the proximity of the reception desk to the CHDU is a common layout of wards in UK hospitals. This enables the surveillance and monitoring of patients and nurses, a design which can be considered to form a crude Panopticon (Foucault 1976), which gives precedence to the observation and control of individuals and their illnesses over privacy.

It is the close monitoring of the patient's physical condition which dominates the CHDU bed-space and defines it as "different" from the conventional ward bed-space. Each bed in the CHDU has a computer monitor linked to it, where a patient's vital signs (pulse, blood pressure, blood oxygen levels, ECG) is constantly recorded. The readings from these monitors are also transmitted to a monitor placed at the reception desk where staff can observe for changes in vital signs when away from the

patient's bedside. The bed-space also contains a locker for patient property, a high backed chair and an adjustable height table. The patient's nursing notes were kept at the foot of the bed in a blue plastic folder. Several of the patients had drip stands around their bed areas from which bags of intravenous fluid would be hung. In all each bed space had a very cramped feel to it, with the only concession to privacy being a curtain which screens the bed area when required.

The nursing staff from ward Q had periods of rotation where they practiced for 3 months on the CHDU followed by a longer period on the main ward. The ward manager had managerial responsibility for both the ward and CHDU, but the responsibility for organising the duty roster and rotation of staff within the ward and the CHDU has been delegated to a senior staff nurse (known as an "F grade" due to the pay scale associated to a senior staff nurse's post in this Trust). As a result of the rotating periods of work between the ward and the CHDU nurses commented on being more aware of the needs of a cross section of patients being admitted.

Most of the registered nurses I spoke to admitted preferring to work in the CHDU as the environment was more "controlled" and "manageable" due to there being only 6 beds, compared to the 15 beds on the main ward. There were three shifts on the CHDU – the early shift from 07.00 - 14.30, the late shift from 13.45 – 21.30 and the night shift from 21.15 to 07.45. As previously mentioned in the preceding chapter, all of the data was collected during the early shift as most of the patients were admitted during this time.

The staffing levels on an early shift in the CHDU would consist of 2 qualified nurses and 2 unqualified nurses, either nursing auxiliaries (NA) or Health Care Support Workers (HCSW). However when nursing staff shortages were experienced on the Cardiology ward an NA or HCSW would be "borrowed" from the CHDU to

supplement the ward's numbers, nevertheless this would only happen if the nurse in charge considered the workload within the CHDU as being manageable with the decreased staff numbers. As staff shortages on the ward were common during the time of the fieldwork this sort of staff movement would frequently happen, either to cover the busiest time on the ward (7.00 – 11.00), or sometimes for the whole shift.

The flexibility of staff numbers within the CHDU based on the level of need of patients, rather on the traditional ratio of a fixed number of nursing staff to number of beds, seems to have been a forerunner to the current DoH guidelines on critical care nursing staffing levels. The DoH (2001) guidelines, also endorsed by the Royal College of Nursing (2003), state that 'The level of staffing and skill mix required to care for the critically ill should be based on patient need and level of dependency rather than determined by the number of beds within a unit' (p.2).

However the registered nurses would frequently express frustration when staff was moved from the CHDU to the main ward as this would increase their workload, as one nurse explained it "feels like robbing Peter to pay Paul" (fieldnotes). The sense of injustice due to increased workload would increase if there were a number of patients to be admitted into the CHDU that morning. The general question of whether an early shift on CHDU was busy or not was mostly answered in relation to the number of admissions that had arrived during the duration of the shift (fieldnotes – numerous occasions).

The most senior nurse in terms of clinical grade would supervise or "take charge" of the CHDU for the shift (although the nursing grades working on CHDU ranged from the lowest grade nurses ("D grades") to the most senior ward based nurse - the "G grade", this responsibility would not be given to the D grade nurses). When nurses of the same grade were on the same shift within the CHDU then the person

who was most recently “in charge” of a shift in the CHDU would manage the unit. Alternatively nurses would debate the question of who should take charge amongst themselves, a responsibility which some staff would attempt to avoid inducing a fair amount of bargaining between colleagues. There were no nursing students allocated to the CHDU during the time of the field work.

The patients being admitted/assessed in the CHDU are divided between the registered nurses, with the nurse in charge taking an equal amount of patients where possible, where there are an odd number of patients being admitted the nurse in charge would invariably take the least number. Nursing care within the CHDU is delivered via the primary nursing system of organising nursing work, thus, whoever admits the patient becomes that person’s “primary nurse” for the remainder of the patient’s stay within the CHDU.

Primary nursing has arisen within nursing as one of many organisational devices that have been designed to make the individual patient care a standardised and controllable aspect of hospitalisation, as is discussed at length earlier in this study. There were positive effects of primary nursing for the nurse and the patient in terms of continuity of care in the CHDU, where the same nurse was allocated to the same patient on consecutive days. It is also worth mentioning however that it is obviously impossible to say whether the same level of continuity would have occurred without the ward adopting the primary nursing philosophy of care. To gain a more in-depth understanding of patient admission within the institutional work-life of nurses and patients in CHDU, the following extract of fieldnotes documenting my observation of a patient’s admission is presented.

5.2.2 Chronology of a patient's assessment/ admission to ward Q.

10.50am

The "admitting" nurse explains to me that this patient is a "planned admission" to the CHDU. Planned admissions are those who have not presented as emergency cases, instead their admission is planned by the GP in response to a progressively worsening cardiology problem. The patient was to undergo a procedure to dilate a blockage that had accumulated in an artery. This procedure usually results in an overnight stay in hospital before the patient, barring any problems, is discharged home the following day.

There seems to be a routinised element to this sort of admission, the staff nurse that was allocated the task of admitting/assessing the patient says to me - "You'd be better off listening to the admission of someone who's not a cold case, you might get better information". This, gave me an insight into three things: firstly, that there might be a classification of different types of admissions/assessments e.g. typical "cold" case admissions and emergencies admissions; secondly, this nurse saw "cold" cases as more of a routine admission, and unlikely to produce much of interest. Thirdly, it appeared that the nurse did not understand exactly that I was more interested in taping any type of assessment interview rather than more "exciting" assessments; this was ok as I didn't want her thinking too much about how she actually conducted the assessment interview.

Adding to the routine nature of planned admissions is the fact that these patients attend a pre-admission appointment in the outpatient department of the hospital, where the patient fills in a pre-admission questionnaire, has blood taken and is given a brief physical check. It seems to me as a result of this that the nurse seems to "know" the patient well even though she is yet to meet him. This also adds to the air of routine as much information has previously been generated and collected.

Whilst the staff nurse is collecting a variety of information from around the reception desk the HCSW is preparing the patient's bed area and showing the patient around the ward, pointing out location of the bathrooms etc. She also does his vital observations (pulse, blood pressure and temperature). The staff nurse occasionally enters the CHDU to clarify some information with the HCSW regarding the patient, such as "Has he had his ECG done?". Much of the information asked of the HCSW could be answered by the patient, however the staff nurse has not introduced herself to the patient yet, adding to the feeling that the formal part of the admission is yet to start.

11.07am

The junior doctor goes in to the patient's bed area to assess the patient whilst the staff nurse sitting at the reception desk transfers some of the biographical information from the previously completed pre-admission

questionnaire onto the nursing notes. Some of the sections of a pre-printed "core" care plan are filled in, which, I think, should only (ideally) be completed once the patient has been assessed. Earlier on this shift, in response to me saying "these printed care plans are handy" (as they have traditionally been hand written for each patient) a staff nurse in the process of admitting another patient explains (amongst other things) that she is able to predict some elements of the patient care needed prior to the assessment interview due to the repetitive/predictable nature of the procedure and the nursing care required thereafter.

11.20am

At the reception desk the HCSW reports the patient's weight and height to the staff nurse who enters this onto the patient's notes. In the CHDU the junior doctor completes his assessment and returns with the medical notes to the main desk where the staff nurse is still collating information.

11.25am

The medical notes are consulted by the staff nurse for the first time and some information that has already been entered on the nursing notes is verified. The reason for admission is copied verbatim from the medical notes onto the nursing notes ("Patient admitted for angioplasty to his LAD. Coronary angiography showed single vessel coronary disease. 90% proximal LAD stenosis").

The staff nurse leaves the main desk to go to the bedside to perform the initial assessment.

It strikes me now, as it has done previously, how the beds in the CHDU are close to each other with cotton screens/curtains between each bed (see **figure 3** below for an illustration of the bed space layout). Thus, voices and all other noise travels (relatives and patients talking on other beds, monitor noises etc) without much restriction, which gives this area a noisy and bustling atmosphere.

The screens are drawn around the patient's bed. The nurse sits on the bed, slightly to the patient's left who is sitting on a high backed chair next to the bed. They are sitting within touching distance of each other, and are on the same eye level. I'm sitting on the bed as far as possible from the interaction, as the bed area is so cramped I can't move any further away.

At the bedside the staff nurse firstly checks on the patient's identity, address, next of kin etc. before introducing herself and explaining that she will be the care giver until the end of the shift. Not sure if the patients details being checked first so as to ensure that the correct patient was being assessed, or whether this was some sort of firm foundation to base the rest of the interview on, after all the staff nurse did know that this was

the patient in question as she had previously been told this and had pointed him out to me previously.

Both parties demonstrate what is considered to be good non-verbal communication skills - eye contact is appropriate, there is occasional head nodding by both parties which serves to encourage the other party at times. The conversation is only (partially) interrupted once by the HCSW who enters the bed area to take the patient's temperature.

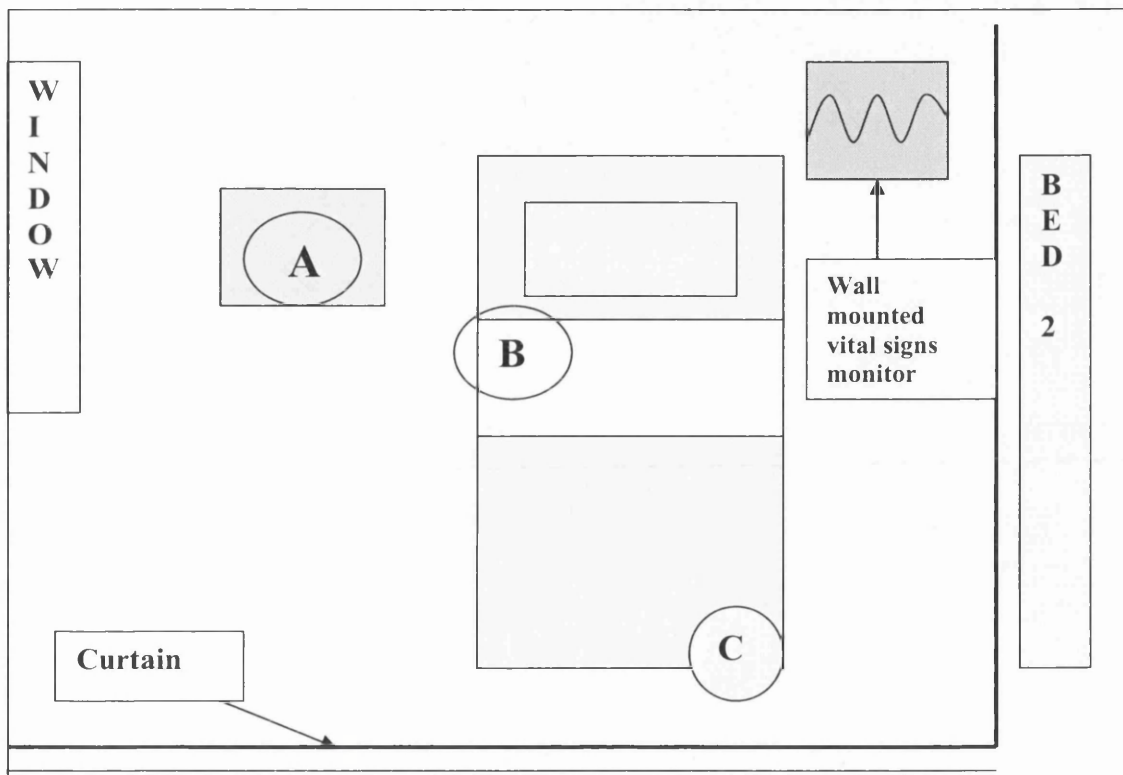


Figure 3 – layout of bed-space CHDU. The patient (A) is sitting on a chair with the nurse (B) sitting opposite on the bed. The researcher (C) is sitting on the corner of the bed. The bed area is cramped as there are numerous drip stands and equipment cluttering the space.

11.40am

Progresses is brisk through the assessment of the patient's bodily functions such as sleep, walking and communication needs, there is little deviation from the information needed to complete the paperwork which is being filled in between the questions. The assessment related questions are completed with the line: 'Righty ho. That's enough about that'. The conversation from here moves onto the afternoon's surgical procedure, and what the nurse's and patients expectations are concerning this. The patient's groin area that has been previously shaved in preparation for the procedure is also checked. The call buzzer is pointed out on the wall behind the bed before the nurse leaves the bed area and walks back to the ward desk. Overall, a professional,

“business-like” interaction, sticking to the agenda of collecting information. The interaction reminded me a little of the process of taking out my car insurance over the phone i.e. lots of questions many of which I thought were largely irrelevant to driving a car, but which I nevertheless answered, and which eventually led to me obtaining the desired product.

5.2.3 Ward R

Ward R is a 28 bedded neurology ward within a large Neurosciences directorate. The majority of this ward’s admissions are planned admissions, either via the neurology out-patients clinic or direct from the patient’s home following an emergency referral from the general practitioner.

The ward is divided into a series of smaller 4 and 6 bedded bays and a total of 4 single occupancy rooms, or “cubicles” as the ward staff call them. The immediate area on walking on to the ward is occupied by a very large desk/reception area. There are several chairs scattered behind the desk, telephones, a couple of computer monitors, lots of paper and writing material and 4 sets of medical notes housed in a storage unit on wheels, otherwise known as the “notes trolley”. There is no doubt, as in ward Q, that this space is the centre-point for the exchange, transmission and storage of information. All of the beds are beyond this desk/reception area, with the effect that anyone wishing to enter the ward has to first pass the desk space. Several members of staff from varying disciplines interact within and occupy this space throughout the day – doctors, physiotherapists, occupational therapists, dieticians, ward receptionist and nurses, to name a few.

No patients occupy this space at any time, it is as though there is an invisible barrier forming a perimeter around the desk to an area roughly 6 feet in diameter from the middle of the desk. No patients or their visitors enter any closer than this without

being “invited”, preferring instead to stand well away until eye contact is made with someone behind or near the desk and then stepping forward.

The ward sister informs me that the allocation of patients to nurses requiring admission on ward R is on the basis of which member of staff “is least busy at the time”. The patients and staff are not allocated or divided into teams or primary nurses as there “are not enough staff”, rather nurses are allocated to work in a specific ward area covering a number of beds. As a result, the ward has a feel of temporary order rather than continuity, as a member of the nursing staff only has ongoing responsibility for a section of the ward for one or two shifts at most. Some continuity was hinted at when it was explained to me that the nurse admitting and assessing the patient became that patient’s named nurse and their name, together with that of the patient and consultant appeared on the head rest of the patient’s bed. However, the subject of the named nurse was never raised or explained during any of the patient assessments, and at no other time was there any reference made to a patient’s named nurse.

Admissions and discharges to ward R may be organised within a matter of hours. The sequence of events that leads to a patient being assessed/admitted by a nurse on ward R is triggered by the decision, normally taken by the medical team during the early morning ward round (7.30am) to discharge a patient. Thus, a ward round may result in 4 beds being vacated, allowing 4 patients to be admitted the same day, with a preference being the same morning. Each of the 4 consultants on the ward had 7 beds each, and a waiting list of patients waiting to attend those beds.

A phone call was made after the ward round by the ward receptionist, or the nurse in charge of the shift, to a waiting list patient/carer informing them of the empty bed. The bed is then occupied as quickly as it is possible for the previous occupier of

the bed to leave the bed area (often discharged patients would be moved to the day room to facilitate the work of washing and changing the bed), and the new patient to arrive. Very rarely does this ward see a surplus of beds, as there are always patients waiting to come in.

When patients attended the ward for admission the empty beds were normally scattered across the ward as patient discharges follow no set pattern. The allocation of a bed for a patient was determined by which nurse is less busy e.g. the patient who arrives first is allocated to a bed space, if available, within the area of the ward the least busy nurse was working in. Only when the patient requires a single bedded cubicle was there any pre-allocation of a patient to a bed. A cubicle was allocated for a variety of reasons, from being a patient on a private medical insurance plan (where a private cubicle was always made available on this ward) to a patient having a particular clinical condition requiring the privacy or isolation of a one-bedded cubicle.

As previously alluded to, new patients occasionally arrived on the ward before the bed space was vacated by the patient being discharged. During instances such as this the new patient would wait in the day room to await the discharge of the patient, where they watched television or read some patient information leaflets or magazines that were scattered around the room. The art work on the walls, the pastel soft furnishings and fashionable, non- NHS standard issue lighting were obvious attempts to design this space differently to the functional design of the rest of the ward. However, the day room was also occupied by a large mechanical hoist for lifting patients and a resuscitation mannequin, both of which undermined somewhat the efforts to make this space an oasis away from the rest of the ward

5.2.4 Chronology of a patient's assessment/admission on ward R.

Due to the nature of neurological disease several of the patients to ward R were admitted on numerous occasions throughout the year. All the patients observed on ward R for this study were, however, first time admissions to this ward. The patient's bed was in a large 6 bedded bay, all the other beds being occupied by other patients. Although all the beds were occupied, the bay was fairly spacious and peaceful, with the immediate bed area partitioned from the rest of the ward during the interview by use of the curtains/screens between beds (see **figure 4** below). The bed immediately to the left was occupied, but there was nobody to the right as this was a corner bed.

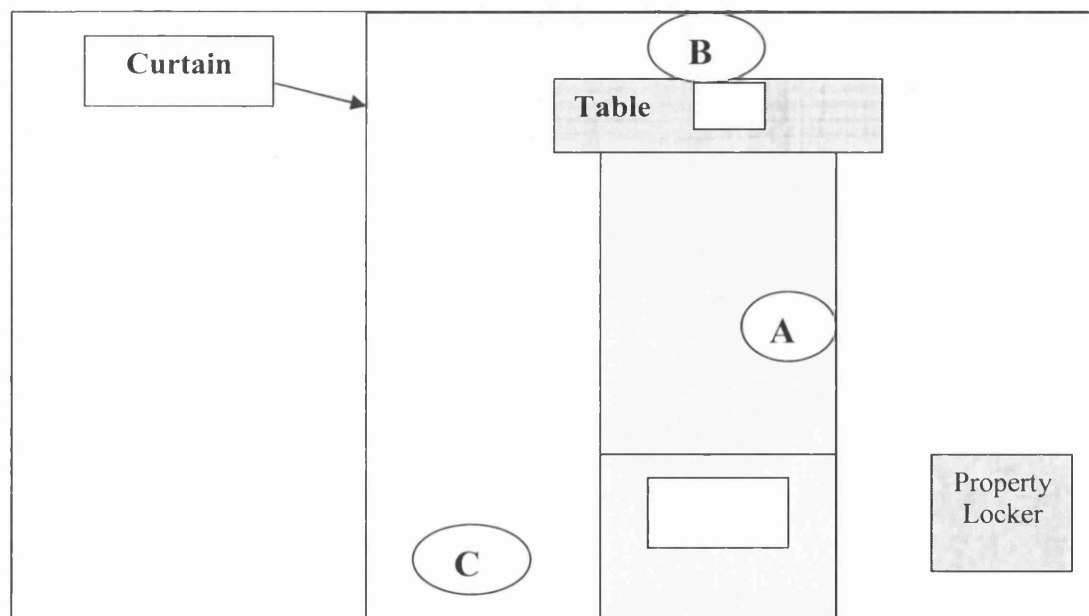


Figure 4 – layout of bed-space ward R. Patient (A) is sitting on bed facing nurse (B) who is sitting behind the table with nursing notes in front of her. Researcher (C) is sitting towards the head of the bed and out of the immediate line of sight of nurse and patient.

11.40am

The patient is invited from the day room to the bedside for the assessment interview with the staff nurse. The patient has difficulty walking so a wheelchair is used for the majority of the short journey. The patient is helped onto the bed and the staff nurse briefly introduces herself before leaving the bed area to find some forms required for the admission.

I find a vacant chair in an unobtrusive position (see figure 4 above). I had already spoken to the patient and her husband regarding my presence at the interview, and the patient had readily signed the consent form agreeing to participate in this research. The patient's husband had also read the information sheet accompanying the consent form - he appeared to be satisfied that everything was in order, before leaving to return to work.

11.43am

The staff nurse returns and sits down behind a bed table slightly to the left of the patient. She proceeds to arrange the mass of forms and other pieces of medical records on the table. The interview commences with a series of questions regarding the patient's biographical information.

As the interview progresses to the assessment of the patient's "breathing", "elimination", "hearing" the staff nurse writes information directly into the nursing notes, an act which punctuates the interaction. The patient complies appropriately with request for information and to such commands as 'can I have a look at your tongue?'

11.50

The medical notes are consulted by the staff nurse throughout the interview, contributing to the length of the gaps between questions and sections of conversation. The patient's speech at times was difficult to hear. Her speech was low pitched, slightly slurred and very hesitant; this was symptomatic of her on-going neurological problems. The patient's occasional inability to respond briskly or accurately to questions prompts the nurse to interject in an attempt to clarify the situation - such a sequence is prompted by the staff nurse's question "Are you mobile?". It feels as though there seems to be pressure of time in these interactions, a feeling that the information is needed quickly, with the minimum of fuss. The staff nurse is looking for specifics such as "Do you have (mobility) aids", "How far do you think?", whereas the patient describes her walking in anecdotal terms "I 'old on", "It's stop and start". The patient answers the nurse's question "How far do you think?" with "hundred yards isn't it". When later reading through a copy of the notes I see that this is the information that gets entered - "Walks short distance approximately 100 yards".

Similar to this is the interaction surrounding the state of the patient's skin. The nurse asks "Any pressure sores on your skin or any broken areas on your skin?" which leads to the reply "I've got a corn", this is not entered in the notes and the staff nurse repeating "you've got a corn" in her next turn has a sense of incredulity about it, that this is not the answer intended when someone asks a question about pressure sores or broken areas. The question is then repeated and clarified; the patient states that she has got a broken area on her leg following an incident "last week".

She then reveals the broken area and the staff nurse demonstrates that this is probably not the accepted version of broken skin when re-asking the question “but no broken areas or dressings”. The staff nurse does however enter the injury to the right leg onto the nursing notes with the words “graze to right leg” under the sub-heading condition of skin. She mentions this to the patient as though to reassure her that it was a valid comment after all.

11.55

The patient seems tired of sitting in the same position and attempts to adjust her posture and position in the gaps between the questions when the nurse is writing in the notes. I feel like I want to give her a hand, get her to rest back on the tower of pillows that are only a few inches away. The nurse is unaware of this and asks the next question – “Have you been falling over?”.

11.58

The admission/assessment interview comes to a close when the nurse, after discussing the patient’s previous hospital admissions, says “That’s it I think”, before moving on to putting the identity bracelet on the patient’s wrist and stating “There we are thank you” before collecting the paper work and returning to the main ward desk to write up the nursing notes. It was noticeable that the overall topical structure of the conversation followed the structure of the documentation (as already seen on this ward and others) - with only the occasional deviation from this set pattern. It was interesting on inspecting the nursing records that were written up after the interview that the nurse notes the patient to be “post-menopausal” – on reviewing the tape recording and transcript of the interaction the patient’s menstrual cycle was not mentioned – an example probably of the use of medical notes to fill in certain areas of information.

5.3 Hospital B – wards S and T

Hospital B is a District General Hospital with nearly 600 beds. The hospital provides several different medical and surgical specialities including acute general medical wards, general surgical, ophthalmology, adult ear, nose and throat and a Radiotherapy department, in addition to a High Dependency Unit, Coronary Care Unit and the Obstetric and Gynaecological Departments. Being in the same NHS trust as hospital A the same management structure illustrated in figure 1 operates throughout hospital B.

5.3.1 Ward S,T and V.

Wards S and T were both 28 bedded surgical wards performing a range of surgical procedures, from those that generally require a short stay of 2-3 days (such as for laparoscopic cholecystectomy) to individuals who require longer hospital stays for operations such as mastectomies (ward S) and oesophagectomies (ward T).

Ward V is 28 bedded medical ward where patients are treated for a range of medical disorders such control of diabetes, acute infections (from bronchitis to a patient returning from a holiday with malaria) and cardio-vascular problems. The layout of all three wards are identical, and interestingly the organization of the nursing staff and nursing work, albeit with patients who have very different medical and surgical needs, is remarkably similar as all three wards use a form of team nursing to organize nursing care.

When discussing with staff members the organisation of nursing work it appeared that the adoption of team nursing as a means of organizing and distributing nursing care on both wards was taken after considering the physical and logistical layout of the ward, rather than considering the ideological or philosophical standpoints which team nursing represents.

Other similarities in both the physical and working structure of the wards are further highlighted in the following paragraphs, which will combine the discussion of the settings encountered on all wards.

When walking onto the ward the main corridor extends lengthways from left to right from a central reception desk where the patients' medical notes are kept, most callers onto the ward are "welcomed" at the desk by the ward receptionists. The central reception desk is a very busy area of the ward, and as the location point for

medical notes, computers and most of the main telephones this is the information centre for most clinical and non-clinical ward business.

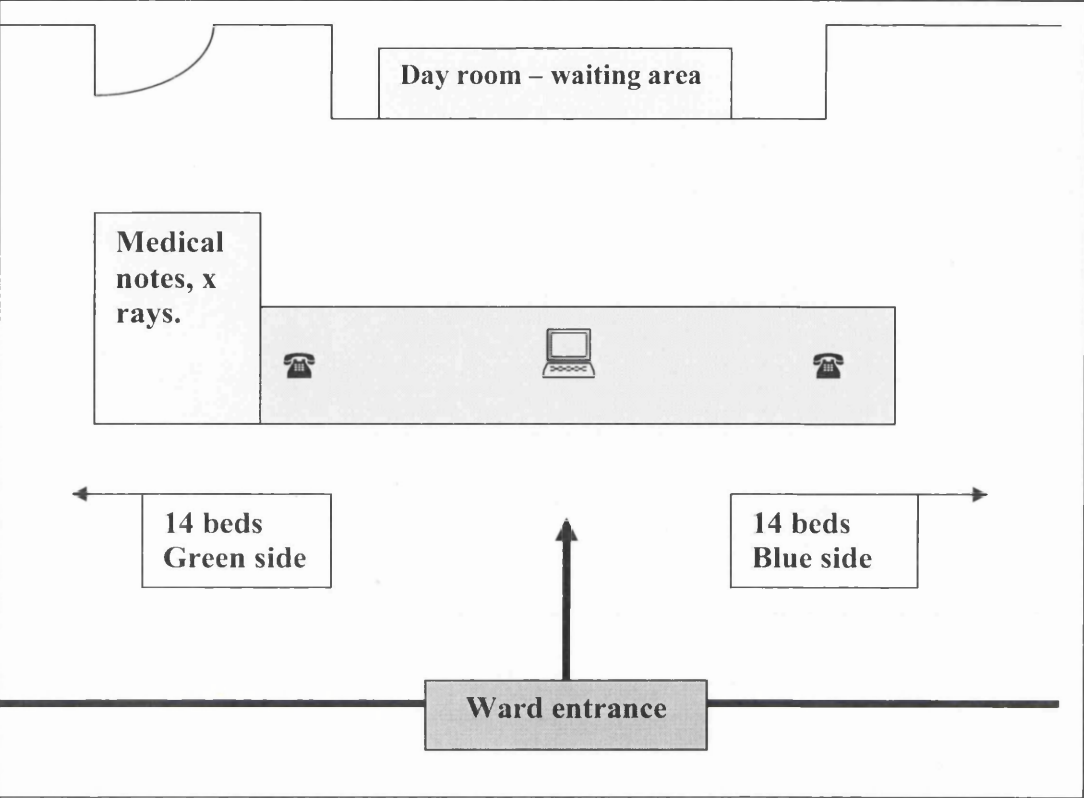


Figure 5 – layout of ward S,T and V: on entering the ward the reception desk acts as a “holding area” for patients being admitted where they are either moved to a vacant bed or to sit in the day room to await a bed vacancy.

For nursing care purposes the wards were divided into a “blue” and “green” side – where the blue team would have responsibility for nursing patients on the right side of the ward, and the green team the left side of the ward (see figure 5 above). Dividing the ward in this way enabled a form of team nursing to take place, where a team of nurses would have ongoing contact and responsibility for the “green” or “blue” patients.

Organizing nursing care in this way appeared to be beneficial for the general running of the wards. An example being when a junior doctor on ward S needed to

discuss a patient's discharge with a nurse the ward receptionist directed the doctor to a relevant nurse after consulting the bed plan to find out which team the patient was in (in this case blue). The nurse who, due to team nursing's emphasis on continuity of care, had cared for the patient over the previous three days was immediately able to provide the doctor with the information required and worked closely with the doctor planning the patient's discharge for the remainder of the shift. The only downside being that the doctor seemed unaware, after 4 weeks of working on the ward, that this was the way nurses organized patient care.

A team for an early shift¹¹ (07.00-15.00) would typically comprise of 2 registered nurses, 2 or 3 Health Care Support Workers and 1 or 2 student nurses. As well as the two teams of nurses per shift there was the nurse in charge (normally the most senior nursing grade on duty) who had overall responsibility for the nursing care on the ward. This individual would not normally be restricted to working on a particular side but would be "floating" (a term used by the wards to indicate that the nurse in charge would simultaneously be overseeing both the blue and green side), however the main area of activity would be around the reception desk. The majority of the time the nurse in charge spent was on planning patients' discharge or transfer, thus enabling the release of beds for the new admissions.

Individuals arriving on the ward for admission would be greeted by the receptionist who would accompany the patient to their bed and inform the nurse in charge, or one of the nurses working on that side of the ward, that the patient had arrived for admission. If there were no beds immediately available the receptionist or nurse in charge would accompany the patient (and anyone else accompanying them—children, grandchildren, spouses, neighbours etc) to the day room immediately behind

¹¹ As was the case with all the other wards the data for this study was collected during the early shift, as this was the time of day the vast majority of admissions/assessments occurred.

the reception desk to wait whilst a bed became available. Occasionally, I noticed patients being admitted and assessed in the day room by nurses whilst waiting for a bed to be vacated, although none of these instances are included in the data set for no particular reason other than I did not get the opportunity to tape/observe one from the beginning.

On arriving at an allocated bed, the patient would typically unpack their possessions into their property locker. Often the admitting nurse would escort the patient to the bed and give them a couple of minutes to adjust to their surroundings, before commencing with the admission interview. Less often the patients would wait in the bed area for anything up to an hour before the admission interview would start, as the admitting nurse would be occupied elsewhere. In the latter case the patient may have had an admission/assessment interview with the ward doctor by the time the nurse came to speak to the patient. Overall however the nurse, more often than not, would assess/admit the patient first.

Some nurses (usually HCSWs, student nurses or night-staff) would prepare the required admission paper work into a “pack” before the patient arrived, and there would be numerous pre-prepared packs situated in a cupboard behind the “nursing station” at each end of the ward. The preparation of these “packs” was seen as a time saving strategy as nurses admitting patients would not then have to search for and collect the numerous individual sheets of paper (e.g. biographical information, medical history and nursing assessment sheets, numerous care plan sheets, vital signs chart, fluid balance chart, manual handling risk assessment form, nutrition intake assessment form, property disclaimer form, ward information leaflet etc.) that make up a patient’s admission notes. In what appears as illogical now as it did then, on one occasion on ward T where there were no prepared admission packs, it took more time

for the nurse to collect the various pieces of paper as it did to actually admit the patient.

The nurses would always have the patients' medical notes at hand before, during and after the assessment interview. If the patient had previously been admitted into hospital the medical notes folder would also contain a previous version of the nursing notes produced during the last hospital admission, however I never saw any of the nurses consult these historical nursing notes. All nurses did however often read the medical parts of the notes during their interaction with patients, especially if the doctor had assessed the patient on the ward prior to the nurse admitting the patient.

On neither ward was there any mention of the named nurse.

5.4 Discussion and conclusion.

The aim of this chapter was to give the reader an insight into broader context within which the assessment of patients being admitted to hospital occurs. The sensitivity felt by some commentators regarding the introduction of context into a discourse or conversation analytic study has been already been addressed in this chapter and elsewhere in this study. The position taken here, and hopefully justified in the reading of this chapter is that the design of a CA study of institutional talk and practices is strengthened through the introduction of observation data, primarily as it makes the study more inclusive in terms of accessing the different layers of the organisation of action surrounding a patient's hospital admission. However, it is also worth pointing out, as Peräkylä (2004) does, that CA studies even with the introduction of observational data do not aim at describing *all* aspects of an organisation (this is, of course, true of any other methodology as well).

The "description of the settings" chapter demonstrates that the contexts within which the study took place were different in terms of the geographical and logistical

layout of the wards. The contexts also varied greatly in terms of the individuals present within them, namely the patients who came from a wide range of backgrounds, ages and health experiences and nurses who similarly came from a wide range of backgrounds, ages and healthcare experiences. Patients also varied from those who had little warning that they would be hospitalised to those who were “booked” for hospitalisation anything from a day to a 2 weeks in advance.

Considering the diversity of contexts and individuals, the admission and assessment procedure was remarkably uniform, with the sequence of events and the information collected and stored largely lacking in any distinctive features from area to area, contrary somewhat to Gubrium’s expectation discussed earlier. I still agree, however, with the basic premise of Gubrium’s position that it is counterproductive to *assume* sameness across different areas within large organizations. Indeed a small degree of difference was observed. For example, the neurology nurses would occasionally put more emphasis in the assessment on the patient’s housing and the need to adapt this to ease neurological effects such as mobility problems, cardiology nurses asked patients about their cholesterol testing, whereas the medical/surgical assessments portrayed no indication of the specialised assessment of patients, despite considerable clinical differences in what the patients presented with.

Overall however, it was interesting to note that this period of observation which started out as an attempt to “capture” (possible) diverse practices during assessment interviews instead presented a picture of uniformity of nursing practices during assessment interviews across a variety of data collection sites. This indicated that nursing’s approach to assessing patients is highly resistant to local variations and that rather than an approach to assessment typified by local nursing practices which had evolved through responding to patients’ individual needs, the nurses’ approach

was much more akin to a patient-processing mentality, not dissimilar to the approaches used by ‘street level bureaucrats’ (Lipsky 1980 p.58) in dealing with ‘heavy case loads and demands for quick decisions’ (p.58).

Lipsky in a wide ranging study of U.S. public service organisations¹² found that members of the public with different life experiences and personalities are transformed into clients through their contact with workers. The transformation of the public into clients is aided through institutions developing routines which aid the management of complexity and make tasks more familiar and less unique. Basically, busy workers ‘developed routines to deal with the complexity of work tasks’ and ‘because of the scarcity of resources relative to the demands made upon them’ (p.83).

As the observational data seemed to present a picture of relative uniformity in the nurse-patient interaction I wanted to be confident that possible differences in the practices of nurses within and between data collection areas were not being overlooked. However, a brief review of the literature (Shaffir and Stabbins 1991, May 2002, Seale 2004) to gain a better understanding of observational research was not particularly helpful. On one hand the literature suggested that, due to the relative short time spent (compared to a purely ethnographic study) in the clinical areas, I might not appreciate subtle nuances between the different areas. On the other hand it was also possible that I did not pick up differences in nurses’ practices due to my over-familiarisation with hospital admissions due to my career background firstly as a ward based nurse, and more recently a lecturer in nursing who often discussed clinical experiences with students.

Therefore, an important “quality measure” provided throughout this study was the multiple sources of data collected, where in this situation the fieldnotes produced

¹² Examples included law enforcement agencies, social security workers, social workers, mental health workers.

during periods of observation on the wards, backed up by the tape recordings and transcripts frequently refreshed and clarified my thinking on this matter. Frequent discussions with my research supervisor were also invaluable in my keeping a focussed perspective on the data that was accumulating, as was her non-nursing background.

Overall conducting observation in the native environment within which assessments occurred provided an opportunity to see people and their behaviour within all their real-world incentives and constraints. It was observed that, through encounters with the institutional “mechanism” and working practices of nursing admissions, diverse individuals are transformed into hospital patients by means of a social process of organizing a patients’ passage through the hospital bureaucracy. The first step was assigning the patient a bed and then a nurse who, in turn, assigns the information gathered from the patient into standardised categories on the assessment documentation used to determine nursing action.

The nurses’ work appears therefore to involve the built-in contradiction that, while expected to maintain the individuality of patients, in practice they process patients in terms of routines and other mechanisms that facilitate work tasks. The fact that nurses develop routines and simplifications in the workplace is hardly cause for comment itself. However, routinization during the admission of patients into hospital care may prove dysfunctional at some point both for the patient and the nurse, and is a situation which compares badly to recommendations made in nursing literature and policy, and for these reasons it is worthy of more consideration.

Upon reviewing all of the data an important interactional effect which seemed to facilitate the largely standardised and mechanistic process of hospital admission appeared to be the way that nurses’ talk related to patients, and the patients’ talk

progressively related to themselves, as though they were categorical entities. This verbal and interactional process required closer examination and in the following chapters CA will be used to display how these categories were constructed and deployed through, and in, the nurses' and patients' talk.

Chapter 6 –The accomplishment of nursing assessment on hospital wards.

'Nursing and midwifery are no longer routinised, task orientated roles; they are patient and client centred, based on holistic, partnership approaches to care' (UKCC 1999, para 2.28).

The following chapters will study the practices of nurses and patients in the accomplishment of what is considered as one of the most important aspects of nursing (Faulkner 1996, Edwards 2000, Latimer 2000), the accomplishment of the patient's initial assessment interview. In terms of the broad aims of the study discussed in the introductory chapter, I will use the discussion to attempt to clarify how nurses currently conduct initial nursing assessments with specific reference to their methods and strategies of communication, in short I will attempt to describe through the use of CA how nursing assessments are 'talked into being' (Heritage 2004, p.222).

The data and discussion contained in the next two chapters will also show how nurses organize and manage the work that needs to be completed during assessment interviews, and what effect, if any, this has on the patients' contribution to the interaction during assessment. As noted in the literature review there is, to date, scant research that discusses the detail of nurse-patient communication within nursing assessment and these chapters attempt to address this gap in knowledge.

It has been recognized by other researchers (Melia 1979, Lawler 1991a) that nurses' work is not easily understood, nor is it easy to research, and in acknowledgement of this the following chapters makes frequent reference to the data collected to clarify any of the points made. Firstly consideration will be given to how nurses introduce and discuss with patients the assessment interview before moving on in the final 2 sections of this chapter to a consideration of the ways in which nurses, through their choice of words, position themselves within the interaction.

6.1 “I’ve just got to ask you a few questions” – nurses introducing the assessment interview to patients.

Each patient entering hospital undergoes an initial assessment conducted by a student or qualified nurse. In non-emergency cases these assessments usually occurred within the first couple of hours of the patient entering hospital. Initial assessments were initiated in all cases used in this study by the nurse arriving at the patient’s bedside carrying the assessment documentation requiring completion, and a set of the patient’s current medical notes if available.

All of the patients had limited experiences of being hospitalised with many experiencing hospitalisation for the first time. In anticipation of such circumstances several authors (e.g. Nolan and Caddock 1996, Crawford and Brown 2004) stipulate that nurses should involve patients as much as possible in the assessment process ‘making them feel that they are full partners in the assessment process, establishing what their hopes and expectations are’ (Nolan and Caddock 1996 p.12). The aim of the following section, then, is to pursue how nurses initiate and introduce the assessment interaction with patients in the hope that it will provide a fuller sense of this genre of talk as a particular kind of nursing work.

The fragments of data seen in extracts 1 and 2 (below) are particularly enlightening in terms of their overall design, especially in terms of how the nurses introduce the patients to the assessment process and the ways in which nurses handle the matter of initiating the assessment interview.

Extract 1 Sa1 – the nurse is in the process of recording the patient’s blood pressure (BP), weight and height in the nursing notes.

29 ((15 seconds – nurse writes the information in the notes and takes off the BP cuff))
→30 n I’ve just got to ask you a few question[ns n]ow
31 p [right]
32 n ok love↑
33 p ye::s
34 ((6 seconds nurse shuffling through some papers))
35 n are you married
36 p yes-↓
37 (1.5 seconds n writes in notes)

Extract 2 Ma1 – the nurse has just taken the patients BP, temperature and pulse, and has sat down with the notes in front of her.

46 n the proc[edure] he’s
47 p [yeah]
48 n explained everything to y[ou]↑
49 p [yes] (.) yeah↓
50 n Righty ho
51 (0.3)
→52 n umh I’ll go through the nursing side of thing[s: with you] (.) later
53 p [alright ok]
→54 n after I’ve asked you the quest[ions]↑
55 p [right]
56 n and um if you want to ask me anything () be able to do so, (.)
57 al::right↑
58 p ye::s
59 (1.8)

In extract 1 the nurse has already approached the patient, confirmed the patient’s identity and, in line 29, is seen completing the task of measuring and recording the patient’s blood pressure (BP), height and weight: tasks which are followed by the nurse’s utterance on line 30 ‘I’ve just got to ask you a few questions now’. The nurse’s use of the narrative marker ‘now’ is interesting as it invokes a direct temporal comparison (Tapsell 2000) between the tasks which the nurse and patient were previously involved in, and the questions which are about to occur. The use of now as a contrast does the ground work of introducing the patient to the fact that the interaction is ‘now’ entering a different phase of nurse-patient interaction characterised by the nurse asking questions, a phase which following the patient’s agreement, consequently begins on line 35.

In extract 2 the nurse has introduced herself to the patient and explained that she is responsible for preparing him to go to theatre that afternoon. On line 46 the nurse checks that the patient has had the procedure explained to him by the doctors ('the procedure he's explained everything to you'), before proceeding on lines 52 and 54 to introduce a temporal distinction similar to that seen in extract 1 between the 'questions' and nursing tasks when stating that she will be going through the nursing side of things 'later after I've asked you the questions' (lines 52-54). As in extract 1 the nurse verifies with the patient that this is a satisfactory state of affairs (extract 1 - line 32, extract 2 – line 57) and the patient responds in both cases with 'yes'. Notable is the fact that neither nurse has mentioned the words assessment or interview in their opening sequences, even though in both cases what is generally regarded within nursing as the "assessment interview" was about to occur.

The utterances in extracts 1 and 2 taken from the opening sequences of the assessment appear to be presented as boundary points within the interaction, with the nurses introducing to the patients that the assessment questions are something different from nursing procedures such as taking a BP (extract 1) or 'the nursing side of things' (extract 2), utterances which underscore that from this point onwards the nurses are "doing questions" or "doing bureaucracy" rather than "doing nursing". Introducing the assessment in this way is significant as Zimmerman (1992) explains that the organization of the opening sequences of institutional interaction provides participants with the space to establish the kind of talking that is going to occur as well as the future character or trajectory of the interaction. It appears that the opening sequences demonstrated in extracts 1 and 2 are used by the nurses to project the characteristics of the talk during the assessment as an opportunity to ask patients some questions, to which the patients acquiesce.

Further evidence seen in extracts 3 to 5 suggest that nurses establish early on an interactional space with patients, within which the nurses' intention is to ask questions, again no mention is made that this interaction amounts to an assessment of the patients' needs.

Extract 3 - Sb2sa 5 – opening sequences - taping starts as the nurse arrives at the bedside

1 n ok Cath alright=
 2 p hiya
 →3 n my name's Lisa ok↑ just going to ask you a hundred
 →4 and one questions
 5 ((n moves table around and sits on bed close to patient with table in
 6 front))
 7 n >>ok<< can you tell me your name and address Cath please

Extract 4 - Sa9 – opening sequences – Patient sitting alone at the bedside – I start taping as the nurse arrives at the bedside

→1 n Mrs Evans do you mind if I ask you a few questions↑
 2 p no no
 3 (2 seconds)
 4 n do you mind if I just clear the table so I can use the table a moment
 5 p oh
 →6 n sorry to be a nuisance
 7 (10 seconds places notes on table and move a few things around)

Extract 5 - Mb5 – examples of the term questions used to describe patient's assessment (pw = patient's wife)

102 n uhm do you live alone
 103 n [no]
 104 p [no]
 →105 n °that's right° I know they're a bit silly these questions but you have to ask
 106 them
 107 p its alright
 108 n type of accommodation
 109 (1)
 110 pw house= ((laughs))
 111 n semi detached
 112 pw no↓
 113 p yeh-uh yeh yeh ((puzzled look towards nurse))
 →114 n what it is you see the reason why we ask these questions because
 115 there could be some elderly people with (interesting?) lives

The most salient themes in the above extracts are two-fold. Firstly each of the extracts sees the nurse, as already discussed above, prepare the patient for a series of questions, a communication event which clearly demarcates the interaction as a

distinctive phase within the nurse-patient relationship and sees the nurse assume the discursive role of questioner/interviewer.

Secondly, the introduction and commencement of this questioning phase of interaction during a patient's admission is seen to be treated by the nurses as a source of difficulty, seen in the extracts when the nurses introduce the questions as an onerous task. For example, in extract 3, the nurse describes the assessment interview as 'just going to ask you a hundred and one questions' (lines 3 and 4). When this utterance is compared to the descriptions of initial assessments and individualised nursing suggested in the nursing literature and policy, the phrase 'a hundred and one questions' certainly serves to down-grade the activity and give it a definite functional, or bureaucratic gloss.

Extracts 4 and 5 also strongly suggest that the nurses may have some difficulty with the format they employ to assess patients. For example extract 4 sees the nurse apologising for being a 'nuisance' (line 6) due to asking 'a few questions' (line 1). An apologetic turn at talk is also offered in extract 5 as the nurse describes the 'questions' as 'a bit silly' (line 105) before creating a distance between herself and the activity by claiming in the same line 'but you have to ask them', implying a situation similarly seen in the nurses talk in extract 1 ('I've just got to ask you') where the nurse's interactional approach to assessments are presented to patients as inevitable and pre-determined rather than self-selected.

Combined with the utterances where nurses present the assessment interviews as a 'hundred and one questions' (extract 3), or a 'few questions' a 'nuisance' (extract 4) and a 'bit silly' (extract 5) the picture that emerges in the nurses' talk is of the assessment of patients being a form of nursing work which is onerous, obligatory and routinised and largely consisting of an institutional task that needs to be performed.

This is interesting when considered alongside findings from other research studies. For example the literature review revealed that over the last 30 years it has emerged that a lack of time for meaningful interaction with patients is a recurrent reason given by nurses for the prevalence of task based as opposed to more therapeutic interaction with patients, and a general lack of time was also a constant source of tension in the clinical areas visited in the course of this study.

Waterworth (2003), echoing the findings of Lipsky's (1980) study of public sector workers discussed in the previous chapter, suggested that time-pressured, hospital based nurses in the UK use a range of time management strategies to cope with time-challenges in the workplace. These strategies include defining the meaning of a situation, or of tasks, as routine or otherwise, in order to determine appropriate actions and interactions they should have with patients. In particular therefore, nurses and public service workers routinise interactions with patients/clients in order to manage tensions produced by time pressure, a finding also supported from other nursing studies from outside of the UK (Bowers et al 2001, Fagerberg 2004).

Research has revealed that the implication of using routinised approaches to patient care as time saving strategy is that nurses have to manage the negative emotions produced when downgrading certain patient care tasks to organizational routines rather than a more individual approach to care. This is clearly demonstrated in Staden's (1998) study of the emotional labour of caring, where nurses when interviewed were acutely conscious of times where the 'power of organizational demands can take precedence over organizing individual patient care' (p.148), a situation which led to internal and external emotional and interpersonal conflict for nurses.

What is suggested in this analysis is that the nurses actions, evident in both their talk and posture (to be discussed in chapter 8), of distancing themselves from the routinised assessment questions through presenting the interaction to patients as an institutionally obligated action, may be a means of nurses handling the internal conflict, or dissonance, brought about through using a routine form filling communication style during assessment interviews, a style of interaction which comes into conflict with the principles of initial assessment enshrined in the rhetoric of nursing process, nursing models and policy.

One way in which this type of activity has been described via psychological theory is that of cognitive dissonance (Festinger 1957), which is claimed to arise when people behave in ways that are felt by them to be inconsistent with their personal schemas or models of self (Carr 2003). For example, nurses are instructed during basic/post-basic education from their stocks of interactional knowledge (SIKs) that a schema of nursing as caring for the individual patient and interacting with patients in a way that protects and promotes patients' individuality is what they should strive for, a viewpoint that underpins many nurses' idea of what distinguishes nurses from other health professionals (Bolton 2000, Bowers et al 2001).

This approach would be inconsistent with bureaucratic, routinised admission interviews of multiple patients during one morning shift (as was the case in this study), an inconsistency that might be described as likely to create a state of inner tension within the nurse. According to Carr (*ibid*) and Bacharach et al (1996) individuals would seek to reduce the dissonance and tension of behaving against one's principles, and dissonance reduction can take many forms including individuals distancing themselves from their actions by proclaiming a no-choice situation ('we've

got to ask these questions'), or downgrading their activities ('silly questions', 'a hundred and one questions').

Whether dissonance reduction or downgrading the activity of assessment is "actually" the nurses' cognitive intention or motivation is a question that is incompatible with the methodologies employed in this study and cannot be answered here. I am also aware of Antaki et al's (2003) warning to analysts of the shortcomings inherent in what they call 'the circular identification of discourses and mental constructs' (p.7). Circularity occurs where analysts interpret discourse as the expression of mental constructs or attitudes (such as cognitive dissonance), and that once this identification has been made the analyst merely accepts all such phrases at face value as if *they were* outer manifestations of inner thought processes. Antaki et al's point is that no analysis, or under-analysis, takes place when these constructs or attitudes are merely pointed out or identified by the researcher with no attempt to construct an understanding of what kinds of work such expressions perform and what kind of contingencies they handle.

Therefore, in order to avoid such circularity I have attempted in the analysis above, and in the following sections, to provide 'some extra elements' (Antaki et al 2003, p.7). For example, an attempt is made above to draw attention back to the details of the talk uttered by the nurses, and the analysis aims to show how these specific patterns of talk are mobilized to achieve a certain kind of work for nurses in the particular context of the assessment interview at that particular time.

Thus, rather than hypothesising about, or merely presenting an attempt at analysis of the inner psychological state of nurses what can be estimated is the effect of the nurses' choice of communication style on the performance and accomplishment of the initial assessment. Therefore the question to be taken from the analysis of the opening

sequences of the assessment, and which will be expanded upon in the next section, is what are the effects of the nurses' and patients' agreement to orientate towards the assessment interview as a question-answer based interaction?

6.2 Nursing within organizations - discourse identities, social identities and footing within nursing assessment interviews.

Registered nurses on hospital wards occupy simultaneously diverse healthcare roles and identities such as carers, managers and educational mentors. The potential multiplicity of the nurse's role raises important questions of how analysts of nurse-patient interaction can establish which, if any, of these identities are relevant to understanding their interactional conduct.

CA takes a distinctive view on this matter, emphasising that the researcher should restrict their focus to how participants themselves make identities relevant within their interaction, rather than importing extrinsic social categories into the analysis.

Greatbach & Dingwall's (1998) study of divorce mediation is typical of this type of CA inspired approach to institutional talk. This study demonstrated that individuals during mediation interviews often articulate discourse identities such as questioner-answerer which are intrinsic to the talk, as well as social identities such as parent and spouse which derive from wider social arrangements reaching beyond the talk itself. The identities which participants used in their talk could change even within a single turn at talk. Crucially the researchers show how the identities were used by the participants as both a constraint, and a resource, for the accomplishment of the activity of mediation in which they were engaged.

Greatbach and Dingwall's study as well as others (see Antaki and Widdicombe 1998 for a volume of such work) has led to the conclusion that participants in talk can be categorized in terms of numerous social and discourse

identities, as long as the analyst makes relevant the identity to the interactional business going on. The tentative position being taken on the strength of the previous section’s analysis is that nurse-patient talk in extracts 1-5 makes relevant the discourse identities of questioner (nurse) - answerer (patient), identities that are used by both participants as a resource to accomplish the assessment interview as a series of question-answer chains (discussed further in Chapter 7). The broader and extrinsic social identity of nurse and nursing are also invoked in extracts 1-5, but it is suggested that this identity is suppressed or suspended by nurses in an attempt to promote the business of “doing the assessment”.

A clear example of the nurse invoking the identity of questioner, whilst simultaneously suppressing the identity of nurse, has already been discussed in extract 2 where the nurse states:

→52	n	umh I’ll go through the nursing side of thing[s: with you] (.) later
53	p	[alright ok]
→54	n	after I’ve asked you the quest[ions]↑
55	p	[right]

The utterances on lines 52 and 54 clearly orientates the patient to the fact that for the time being question asking takes priority within the discourse, but when the task of completing the assessment is accomplished then the nurse will resume a discussion of the ‘nursing side of things’.

What is of interest in the next section is the effect that the alignment and re-alignment of the participants’ identities as questioner-answerer/nurse-patient has on the patient’s reciprocal understanding of just what sectors of one’s self and one’s social knowledge should be made relevant at certain points within the interaction (Zimmerman 1998). This is particularly important given the status of the assessment interview within literature and policy as an opportunity for nurses to discuss and collect information from patients regarding the patient’s views of their illness and

hospitalisation. With this in mind interaction during assessments will now be further considered with reference to the data extracts already used in this chapter and through the introduction of additional data.

6.2.1 Multiple identities during nursing assessment interviews.

Section 6.1 showed how nurses establish common ground with patients for the assessment interaction during their opening utterances through projecting to the patients a sense of “what is going on” by informing them that they are going to ask questions, a proposition to which the patient agrees. Extract 6 (below) demonstrates an extended period of talk which follows on from the opening sequences of an assessment, an extract which represents a typical version of talk in all of the assessments recorded¹³.

Extract 6 Sa2 – nurse and patient as questioner and answerer during the assessment interview.

110 p yeh yeh I eat what I can eat then I just stick to it you know
111 n its not causing you any problems though
112 (1.2)
113 p the eating-the diet no no::
114 (3 – nurse briefly looks at notes)
115 n have you any problems with passing water at all
116 p no
117 (25 – nurse writing in notes)
118 n uh any bowel problems
119 p ((shakes head no))
120 (20 – nurse writing in notes)
121 n do you smoke at all
122 p not now I used to
123 (5 – nurse writes in notes)
124 n how about drinking-do you drink much alcohol
125 p very little
126 (15 – writing and reading notes)
127 n do you speak Welsh
128 p °oh no no°
129 n do you suffer with any pain
130 p no uh-not pain discomfort like if I’ve got a blockage ((lots of eye contact here
131 compared to previous few questions)) ((p breaths in to demonstrate difficulty with
132 breathing in)) and I cant get it from there if I did (get?) some then it seems to (.) go
133 n °ok°

¹³ More detailed and fine-grained analysis of the design of talk during assessment interviews will be considered in the next chapter.

134 (12 secs nurse writing in notes)
135 ((v. short interaction here which is difficult to hear on tape))
136 n do you know who your consultant is

The point to note about this extract is that the participants design their talk with an orientation towards the discourse identity of questioner-answerer, with the nurse asking a raft of largely unconnected questions which the patient duly answers. The patient appears to comply quite easily with the allocation of this discourse identity as projected by the nurse in the opening sequences of this interaction.

Sa 2 – opening sequence

1 n hi my name's Bethan just going to ask you a few questions ok
2 p ok

Silverman (2005 p.215) suggests that in qualitative research 'Comprehensive data treatment implies actively seeking out and addressing anomalies or deviant cases', and in so doing strengthening the validity of the research¹⁴. With this in mind, although for the most part the questioner-answerer discourse identity is common in the data there are occasional glimpses of the participants making visible larger social identities in their talk. Extract 7 (below) illustrates how, for example, the assessment interview occasionally strays from the persistent question-answer sequences to less restrictive forms of talk.

¹⁴ See methods chapter 4 for a fuller discussion of deviant case analysis.

Extract 7 Sa1 - a discussion of air travel triggered by the patient mentioning, in response to a question regarding any previous hospital admissions, that he was involved in a plane crash incurring a slight head injury some years previously.

136 n mm there we are (.) oh dear (.) have you flown since
137 p yes yeh
138 n have yeh
139 p I love it
140 n didn't bother y[eh]
141 p [no]
142 (5 secs - sn shuffles through papers)
143 n just a few more questions [now] ok love
144 p [right]
145 n are you a smoker
146 p packed it in a after my first ((nods towards paper work)) a few weeks ago
147 n how long ago was that
148 p seven weeks
149 n so you've stopped smoking for seven weeks
150 p yeh ((nods head))
151 (18 secs nurse writing in the notes)

Lines 136-141 in extract 7 see the nurse and the patient discuss whether the patient has flown, or not, since surviving an air crash that saw several passengers perish¹⁵.

Although this particular section of the interaction was triggered by the nurse questioning the patient about past medical problems, the nurse's talk on line 136, 138 and 140 show the interaction temporarily deviating from the typical talk format seen in the data when nurses assess patients. Even though the nurse continues to question the patient during these turns, the identities of the participants appear not to be that of questioner-answerer in the same sense as the earlier extracts, but appear to be consistent with "broader" social identities of story teller/air crash survivor and interested listener, which sees the discourse identities of questioner-answerer temporarily suspended

What makes this extract worthy of note is its difference to the usual question-answer format seen to dominate most of the data, and that the nurse on this occasion unusually asks a couple of follow-up questions (line 136 - have you flown since / line

¹⁵ The conversation regarding the specifics of the air crash extends further back than the data extract suggests, but for reasons of patient confidentiality there are restrictions on being able to use this data fully.

140 - didn't bother yeh) which have little relevance to the task of assessing the patient's needs. The fact that no mention is made of the minor head injury or the air crash in the nursing records, or the handover report at the end of the shift, particularly highlights that the air crash sequence of talk had little relevance within the patient's assessment.

Examining the different, or deviant, nature of this extract helps to establish therefore that the regular pattern of interaction during assessment corresponds to a high degree of formality, as participants throughout this data-set routinely avoid this type of interaction sequence commonplace in ordinary conversation (Atkinson 1992).

Atypical divergences, such as that provided by the air crash story, also demonstrate the extent to which participants share a stable understanding of the general goal of the interaction during assessment. This is seen when, although the assessment interview strays for a few moments into a topic (i.e. flying) which is not directly connected to the patient's nursing care assessment, the nurse resumes the assessment interview's customary question-answer format fairly briskly and both participants' discourse identities of questioner-answerer are restored. Confirmation of this is offered by the nurse's turn in line 143, which alerts the patient that the talk has to resume within a more bureaucratic discourse framework, compared to the previous few turns, when she informs the patient 'just a few more question now love'. The nurse's turn on line 143 functions to:

- a) terminate the talk about air crashes and flying,
- b) re-orientate both participants back to the task of completing the assessment interview
- c) simultaneously re-orientate the participants to the discourse identities questioner-answer
- d) which in turn clears the ground on line 145 for the unconnected question 'are you a smoker'.

A momentary switch from assessment interview to more general social identities can also be seen in the following extract, on this occasion the nurse abandons the question-answerer identity format and diverges to an “information giving” speech format.

Extract 8 Ma2 – the nurse has just completed asking the patient’s name and address before confirming that the patient knew the operation was scheduled for that day.

53 n: all right have you got any questions about it
54 (1.0)
55 p: don’t think so dear=
56 n: no no concerns the doctor will come and explain [if y]ou give consent
57 p: [yes]
58 n: but just so that you’ve got an idea of what’ll happen [bec]ause it can all
59 p: [yes]
60 n: be a bit alarming otherwise=
61 p: yes
62 n: all right and that will be some time this afternoon I don’t know what time there’s
63 three of you to go from here (.) so I don’t know the order of (.)
64 p: no=
65 n: who’s going where
66 (1.6)
67 n: all right
68 ((6.2 seconds nurse looks through previous notes that came with the patient on transfer))
69 n: let’s get through all this paperwork now then. So when did you come in to hospital
(.) this time was it on the twelfth
71 (1.0)
72 p: do-y-know I’m trying to think wh[at day it is now I came in on the Sunday I think]
73 n: [what is the day now (.) its Tuesday today]
74 n: sunday=

During extract 8 the nurse offers the patient an opportunity to ask questions about the operation (line 53), before informing the patient that the doctor will be seeking the patient’s consent for the treatment, and that the patient will be going to theatre during that afternoon at an unspecified time. It can be seen that this section of the assessment interview is largely concerned with information giving. This sees the patient inform the nurse that they have no questions (line 55 – ‘don’t think so dear’), and the nurse informing the patient of the pre-operative procedure of gaining consent (line 56), and that there are two other patients going to theatre which makes it difficult to predict the order of the surgical list (lines 62 and 63) or, as the nurse puts it, ‘who’s going where’ (line 65).

The nurse's invitation to the patient to ask a question, and the information giving sequence of talk which follows, acknowledges and attempts to alleviate any anxiety the patient may have (specifically lines 58-60 sees the nurse explain 'it can all be a bit alarming otherwise'). Alleviating pre-operative patient anxiety has consistently been identified as a nursing role of considerable importance (Hayward 1975, Faulkner 1996), especially as is the case here when the patient is within a few hours of attending theatre. This sequence of talk could therefore be classed as demonstrating evidence of the broader social identity of nurse-patient within assessment talk, as opposed to the narrower questioner-answerer discourse identities which dominates the data.

A clear example of the re-emergence of the by now characteristic and narrower discourse identity of questioner-answerer is mobilised by the nurse in line 68 with 'Let's get through all this paperwork now then' immediately followed by the question ('so when did you come in to hospital' – line 69) corresponding to a box ("date of admission") which is on the front sheet of the admission form which the nurse has just been reading (see line 68). The remaining discussion during the assessment interview follows on as a series of question-answer turns.

What is seen in the data considered in this section is the consistent orientation by participants to the questioner-answerer discourse identities as a means of accomplishing the assessment interview. There are occasional examples of participants briefly orientating to different modes of identities, as stimulated by an unusual patient story in extract 7, or by the need to accomplish a nursing role of information giving and anxiety control as seen in extract 8. What is interesting to note in these deviant cases is that it is the nurses who both initiate the switch from

questioner-answerer identities as well as directing the switch back to questioning which terminates the deviation.

The groundwork for establishing questioner-answerer discourse identities appears to be linked to descriptive choices made by the nurse during the earliest stages of the assessment interviews where nurses select terms such as ‘a hundred and one questions’, ‘asking some questions’, ‘doing the paperwork’ to describe the activity that is about to be embarked upon. Heritage (2004) states there are always alternative ways of saying something from which speakers unavoidably make a selection which invites speculation over the nurses’ choice for describing the assessment interaction in the way they did.

However, whilst it is tempting to speculate regarding the motives of individuals the reality remains that such speculation based on the transcription of this data, would amount to no more than merely second-guessing the participants’ intentions. A more rigorous approach is offered through looking at the descriptions used by speakers themselves for what they do. Particularly helpful has been the CA insights into lexical selections or lexical choices, which are seen as significant ways through which speakers evoke and orient to the institutional context of their talk (Drew and Heritage 1992). The following section explores the lexical choices made by nurses during assessment interviews in an attempt to further clarify how aspects of nurses’ talk articulate with the performance of the organizational task of admitting a patient.

6.2.2 Lexical selections, footing and neutrality in accomplishing initial assessment interviews.

Considering lexical choices of speakers can provide significant analytical insights into ways through which speakers evoke and orient to identities within their talk.

Numerous studies have documented the incidence of “lay” and “technical” vocabularies in such areas as law and medicine, and it is clear that the use of such vocabularies can embody institutional identities. The example often used in CA textbooks derives from Sacks and Schegloff (1979) who stated that while someone might use “cop” in ordinary conversation, when giving evidence in court they are likely to select “police officer” instead. The fact that this can involve selection is evident when speakers – as in Jefferson’s (1974) data – cut off the beginning of “cop” (“kuh”) in favour of the word “police”.

Jefferson’s data demonstrate the context sensitivity of descriptions, showing how speakers select descriptive terms which are fitted to the institutional setting, or their role within it. A further illustration of context sensitivity within talk is that when speaking as a member of an organization, persons sometimes choose to lexically refer to themselves as *we*, rather than *I* (Drew and Heritage 1992).

Examples of this phenomenon are also widespread within the data in this study. The following extracts are cases where nurses refer to themselves during the assessment interview as *we* (occasionally switching between *we* and *I* in the same sentence). This leads into a discussion of how these forms of lexical selections can shape whole sequences, and with them, the overall pattern of interaction during assessment interviews. For example (the examples that follow are all two party interactions).

Extract 9 - Ma3

66 p: and my doctor-when I went to have a check up he said your allergic to
67 penicillin so if anybody ever offer you penicillin don't ever use it
68 n: lovely (.) now then you had heart attack two years ago (.)
69 p: yes:
→70 n: have you got any other past history that we should know about medical
71 history↑
72 p: no I I ad the eart attack in uhm nineteen (.) eighty thre[e↑ and then one] in
73 n: [three years ago]
74 p: ninety seven=
75 n: >>alright <<
76 p: and uhm (.) I ave angina
77 n: how long ave you suffered from angina

Extract 10 - Sa 6 nurse walks up to the patient with medical and nursing notes and the BP measuring machine.

1 p what's this for now↑
→2 n we're just going to admit you ((shuffles the forms and bangs them on
3 the desk))
4 (1.5)
5 p [you shouldn't have to]
6 n [you remem-member]
7 n mmh=
8 p shouldnt have to readmit me ther-the (Dr ?) came to clerk me this morning
9 n °ahh°
10 (2) ((patient clears throat))
11 n has to be done though love
12 (10) ((reading through notes and organising the paper work))
13 n °right° can I have your telephone number
14 p two three seven (.) five three three
15 n oh two-

In instances such as this, speakers use the self-referring *we* to invoke an institutional over a personal identity, thereby indicating that they are speaking as representatives, or on behalf, of an organisation. The use of both personal (*I*) and institutional (*we*) identities by the same nurse can be seen within the space of a few turns in the following data.

Extract 11 – Sa8

7 n and your GP is a=
8 p Dr x
9 n (something about the name of the village/town the patient is
10 from) ((laughs))
11 p Llanxxxx ((both laugh))
→12 n I have to apologise for not being able to pronounce it ((laughs))
13 (5) ((turns a page in the notes))
14 n and you're going to theatre tomorrow for an oesophagectomy (.)
yeh↑

Extract 12 - Sa8

40 n ok did you have an occupation or still have
41 p well no I was re::ally a domestic you can say I worked for the same family
42 for years I worked in a guest house °and°
→43 n have you got any past medical history that we need to know about in the
→44 hospital
45 p I don't think so uh:: >>let me che<< (what do you mean?? I've been to)
46 hospital (.) three times in my life once I had my tonsils out when I was
47 sixteen uh once when I cut my finger ((laugh in voice)) and I had to have a
48 operation on that a::nd the last:: November I had to go to xray I had ()
49 which turned out to be a virus °uh:: °
50 n °ok°

The nurse in extract 11 apologises for her lack of proficiency in Welsh place name pronunciation, indicating that this is a personal ('I' - line 12) rather than an institutional short-coming. Interestingly this occurs a few turns before the same nurse evokes 'we' during the talk (extract 12 line 43), identifying in this utterance through use of a particular lexical choice (*we* instead of *I*) the question as an institutional question, specifically a question to do with 'hospital' (line 44) business. As discussed by Drew and Heritage (1992), this illustrates that the incumbency of an institutional role may not preclude the use of a self-referring *I*, which may be used to invoke a stance or identity that is somewhat less "institutionally" weighted. In institutional contexts, the choice between a self referring *I* or *we* is not therefore "determined" by the setting; rather, both formulations are available to the institutional incumbent, who can achieve a variety of communication actions and outcomes by selecting between them.

Extracts 13 and 14 are also interesting as they demonstrate a similar realignment of identities as discussed above, but this time with the realignment occurring within the same turn.

Extract 13 - Mb3 – the use of *I* and *we* within the same turn

107 p >>we've got an ensuite and we've got a bathroom<<
 108 n OH righ-up-upstairs they are though are they=
 109 p yes but the shower room downstairs isn't quite complete yet ((laughs))
 110 n oh right (.) in the process is it= ((laughs))
 111 p yes
 112 (11 nurse writing in the notes)
 →113 n this is just uhm (.) I ask uh (.) we ask everybody these questions because hh
 114 >>sometimes we<< get some people in and-then when uh-that the (.) they
 115 might need you know (.) when they go home:: like if there's already a
 116 shower or toilet downstairs the facilities are there for them if they can't use
 117 the stairs and what ave you
 118 p mmhuh
 119 n now this is like actually being (.) in the process of being built is it
 120 p huhhh ((breathes out - patient nods yes))

Extract 14 - Mb4 – the use of *I* and *we* within the same turn,

→13 n I'm just going to ask you a few questions really (.) regarding you know uh
 →14 your next of kin your GP any occupation just some sort of basic details we
 15 need for our a nursing assessment (.) uhm (.) and then doctors then will
 16 come around and uh clerk you and ask you a few more questions and a bit of
 17 an examination (.) and we'll go from there then (.) d-you know what your in
 18 for Claire
 19 p uhm stress tests
 20 n whats your (symptoms)
 21 p uhm (.) dizziness and uhm (.) blackouts
 22 n and blackouts is it
 23 p and a (stroke) it was four years ago now

The switch in both cases from *I* to *we* is interesting as the nurses in both extracts are presenting the patient with an account for why there is a need to ask 'these questions' (extract 13 - line 113) and a 'few questions' (extract 14 – line 13). Extract 13 demonstrates a switch of alignment from *I* to *we* in very close proximity to each other, with a slight pause and an 'uh' ('I ask uh' line 113) immediately followed by the repair 'we ask everybody these questions' (line 113).

The main concern in this section is the significance of the repair in extract 13 (line113), and the realignment in extract 14 (lines 13 to 14) from *I* to *we* - particular

consideration being given to the communicational outcomes achieved by the nurses selecting these formulations. As noted previously, speakers use the self-referring *we* as opposed to *I* to invoke an institutional over a personal identity, thereby indicating that they are speaking as representatives, or on behalf, of an organisation (Slilverman 1987, Drew and Heritage 1992, Clayman 1992).

The lexical choices made by the nurses during assessment interviews between *I* and *we* can be understood as part of a general issue of alignment; that is, alternating the nurse alternating between *I* and *we* signifies the extent to which the assessment interview is presented as part of a personalised nurse-patient relationship, or resisting this alignment and producing the interview as institutional business with little of the personal or therapeutic obligations expected during “nursing” discourse with patients.

Before expanding further on this point a brief methodological interlude is required to introduce Goffman’s (1981) work on the topic of footing, which assists in understanding more fully the work done by the nurses in presenting their own and the patient’s role within assessment interviews. For Goffman participation in interaction is not a simple either/or affair in which one party speaks and another listens. Instead there are varying forms and degrees of participation and involvement during interaction, with the results that the speaking and hearing roles within interaction can be broken down analytically into more specific interactional “footings”. As Clayman (1992) states speakers may take up various footings in relation to their own remarks, conveying distinctions between

- a) principal – whose position the talk is meant to represent
- b) author – who does the scripting
- c) animator – who actually says the words.

It is not uncommon for a single speaker to embody all three of these identities simultaneously, alternatively interactants may act primarily as animators when they

speaking, deflecting the other identities away from themselves and commonly onto some other party. Potter (1996) illustrates the different roles within interactional footing through an imaginary situation where a shy boy wants to ask a girl out:

‘He may get a friend to think of some phrase that he can use to represent his feelings, and possibly another friend to pass them to the girl. The hopeful boy in love would be the principal, the friend who composed what to say the author, and the other friend who passed it on the animator’ (ibid p 143).

A further important point made by Potter involves the implications for accountability between these distinctive roles – the girl, for example, is not expected to respond to the animator’s amorous advances as his, but as those of the principal. In more prosaic terms there are differences between making a description or factual claim yourself signified by the use of *I*, and reporting that of someone else, signified by *they* or *we*, given that the speaker is not generally accountable for factual claims that are merely reported second-hand.

To return to the data, a line of evidence that footing is actively managed by nurses within nursing assessment interviews comes from the detail of the nurses’ repair briefly discussed earlier in extract 13 and 14. In extract 13, for example, the nurse starts the sentence with a personal assertion regarding the reasons for asking questions, but breaks off and changes footing.

→113 n this is just uhm (.) I ask uh (.) we ask everybody these questions because hh
→114 >>sometimes we<< get some people in and-then when uh-that the (.) they
115 might need you know (.) when they go home:: like if there’s already a
116 shower or a toilet downstairs the facilities are there for them if they cant use
117 the stairs and what ave you

The claim made here is that, in relation to the reasons for asking the questions during the assessment, the change from *I* to *we* conveys a change in interactional footing within the talk, from the nurse as principal (whose position the talk is meant to

directly represent) to animator (the nurse only repeats the words of others, best encapsulated in the term “don’t shoot the messenger”).

The distinction between principal and animator does interesting work in terms of accountability for the nurses actions during the assessment event since, as Potter (1996) stipulates, animators should be treated as having low levels of accountability or “just passing something on” on behalf of the principal, which in this case is the hospital. Through their lexical shifting nurses distance themselves from the reasons why the assessment questions are needed, presenting the interview as not a personal choice or indeed a nursing choice, but as discourse on an institutional footing which they cannot be held to account for, and in which they have little personal stake.

Earlier in the chapter we saw nurses’ introducing the assessment questions to patients as a problematic discourse framework which was a potential source of difficulty within the broader nurse-patient relationship. In this section the nurses’ lexical choices reflect a discourse style which situates the talk as institutional rather than personal. Collectively extracts 1-13 construct an impression that nurses see patient assessments as a problematic activity which they perform on behalf of the institution, a situation which requires distancing both from “nursing” activities and the fact that assessing patients through asking questions could be seen in any way as the nurses’ personal choice for completing the assessment interview.

Interestingly, it has been previously noted that footing shifts appear when more delicate or contentious topics are discussed within talk (Pomerantz 1984, Clayman 1992, Potter 1996), a detail that further supports the claim that nurses experience difficulty with the format employed to assess patients. Extracts 15 and 16 (both of which are discussed earlier) illustrate this point well:

Extract 15 – Mb5

111 n semi detached
112 p yeh-uh yeh yeh ((puzzled look towards nurse))
→113 n what it is you see the reason I-why we ask these questions because
114 there could be some elderly people with (interesting?) lives

Extract 16 Sa6 – nurse walks up to the patient’s bed with assessment paperwork and BP recording machine.

1 p what’s this for now^
→2 n we’re just going to admit you
3 ((nurse shuffles the forms and bangs them on the desk))
4 ((1.5 seconds nurse reading the notes))
5 p [you shouldn’t have to]
6 n [you remem-member]
7 n mmh=
8 p shouldnt have to readmit me ther-the (Dr ?) came to clerk me this morning
9 n °ahh°
10 ((2 seconds - patient clears throat))
11 n has to be done though love
12 ((10 seconds reading through notes and organising the paper work))

The above extracts demonstrate that the difficulty which nurses have with the format employed to assess patients becomes visible in part through the fact that nurses shift footing at particular points within the talk. In both instances the nurses when confronted with the “delicate” situation of patients questioning the relevance of their actions (the puzzled look in line 112 extract 15; the patient’s question on line 1 extract 16), present the assessment interview as being associated with a third party, in this case the hospital by referring in their talk to the institutionally weighted ‘we’. It is particularly noticeable in extract 16 that the nurse takes care to create distance between the assessment interview and their own personal action by presenting their footing as a mere animator of the talk through the use of ‘we’ and through invoking a sense of the perfunctory “I’m only following orders” nature of initial assessments with line 11 ‘it has to be done though love’.

It is as though the nurses in this chapter fashioned the following utterances:

113we ask everybody these questions (extract 13)

13.....just some sort of basic details we need for our nursing assessment (extract 14)

114.....what it is you see the reason why we ask these questions because there could be.....(extract 15)

11.....it has to be done though love (extract 16)

to head off any imputation of personal stake or control in the interaction, encouraging the patient to treat the assessment as a fact of institutional necessity rather than personal choice. The implication being that institutional necessity is too strong a force to overcome.

6.3 Summary and Conclusion.

The question of the existence of an understanding between participants within interaction has long been considered in CA (Sacks 1974). Sacks states that conversation participants, have to some extent a shared or common purpose and that participants have, or assume that they have, some degree of shared knowledge, or common ground, in order to assist in the accomplishment of that purpose. Labov and Fanshel (1977), agreeing with Sacks, add that interaction between participants is also an important site for establishing and adding to common ground understanding of “what is going on”. A similar point is made regarding the importance of interaction during initial assessments in introductory nursing textbooks such as Potter and Perry (1997), which depict the assessment interview as an important stage in developing common ground understanding with the patient regarding the very nature of nursing, one chapter stating that:

'The nursing interview achieves several objectives. First, the nurse-client relationship is initiated. A nurse-client relationship is the association between the nurse and the client that has a mutual concern, the client's well being. The relationship builds a professional interpersonal closeness that develops and aids in the investigation and discussion of the client's responses to health and illness. This relationship encourages the sharing of information, ideas, and emotions, and enables the nurse to express a level of caring for the patient.... While conducting the interview, the nurse remains aware that the client is forming an impression about nursing' (Potter 1997 pgs 113-115).

Clearly, Potter states, amongst other things, that the assessment interview should be thought of as an important forum for impression management by nurses, highlighting in the final sentence the fact that the 'client' uses the interview to form an understanding not only of the nurse, but 'about nursing'. The data explored in this chapter provides a rather different view of the assessment interview to that provided in the above quote and within nursing's SIKs as a profoundly important interaction central to the development of a therapeutic nurse-patient relationship. Recent nursing policy demonstrates that the rhetoric of nursing assessments as a holistic undertaking is not restricted to the textbooks¹⁶, as the Department of Health (2000a) states that all RNs should:

'Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities'.

The disparity becomes particularly evident when considering that nurses in the data explained initial assessments to patients as a low status, onerous, institutionally mediated task, merely concerned with asking questions. Paralleling the conclusions reached at the end of the last chapter, nursing in this chapter is presented as appearing ambivalent about initial assessments; on the one hand it is described as an important

¹⁶ See also the quote on the opening page of this chapter from the former United Kingdom Central Council for Nurses which states that '*Nursing and midwifery are no longer routinised, task orientated roles; they are patient and client centred, based on holistic, partnership approaches to care*' (UKCC 1999, para 2.28).

and essential part of nursing work, but on the other it is performed in practice as nothing more than a bureaucratic paper exercise. The ambivalence is particularly acute when considering the literature reviewed in chapter 3 found that nurses since the late 1980s have attempted to embrace holistic care practices by shifting emphasis towards seeing the patient as an individual and away from seeing the patient as a series of tasks to be performed (Lawler 1991a).

Furthermore, the literature review also revealed that the introduction of professional values in nursing through the promotion of the nursing process, nursing models, primary nursing etc. have attempted to theorise nursing practice in an attempt to bring the ideology of holistic care and the reality of work closer together. However, the data here appears to support recent studies such as Brown (1995), Staden (1998), Waterworth (2003), Liaschenko and Peter (2004) which state that the actual work of nurses is prescribed by agendas of routine and patient management which lie outside these professional values.

Nurses' utterances, such as the use of the institutional *we*, which look quite innocuous and seem sympathetic, in fact lead to a discourse consistent with that which characterises a situation closer to "nursing meeting the needs of the organisation" as opposed to "nursing the individual". Nursing seen in this way seems to exist in a duality within two conflicting frames, both as a philosophy and an institutional body - on the one hand as a sub-discipline of the institution with associated institutional tasks where nurses have to collect information in a neutral disengaged way, and on the other hand nurses have to deal with being nurses within its moral framework.

The detailed analysis in this chapter therefore finds that a contradictory and dissonant structure emerges in the nurses' interaction and lexical choices during the completion of initial assessments. A significant effect of this is that assessments are

projected and completed as a routine bureaucratic task which largely focuses on formal “interview like” talk, with little digression into patterns of talk associated with everyday conversation. This is interesting as studies of interviews in nursing and medical interaction suggest that casual conversation provides an “ideal” model solution for conducting the initial assessment interview, and that the better we understand the rules of conversation, the better we understand interview behaviour (Frankel 1990, Brown 1995).

In the next chapter questions regarding the type of interaction imposed by a question-answer format within assessment interviews will be considered, where the contrast of conversations and interviews provides an interesting start point before commencing on a finer detailed analysis of the speech exchanges adopted by nurses and patients.

Chapter 7 – The nurse as interviewer and the patient as respondent.

‘The completeness of the nursing history depends on the effectiveness of communication. It sets up a special working relationship between the nurse or nursing student and the patient. . . . From the nurse’s point of view it is an opportunity to really get to know the new patient who has recently come into her (*sic*) care’ (Chapman 1983, p90).

‘Interviewing and assessment form the foundations of all our conscious and unconscious interactions with others. We make conscious decisions on the information we glean from effective interviewing, for example, determining the needs of the patient or client. . . . Assessment is the first stage of the nursing process and forms the foundation of all the care to follow. It is important that you engage the others in the interview in order to develop a partnership with them in the process and their co-operation (Sully and Dallas 2005, p.74).

The previous chapter established that nurses organised the assessment interaction, with a certain sense of reluctance, as a series of question-answer sequences. By focussing on turn-taking during interaction the analysis presented in this chapter progresses the discussion regarding interaction during initial assessments into the finer structures of how the participants accomplish the task in hand, and considers the effect, if any, of the speech exchange systems used by nurses on the quality of the information provided by the patient. Analysis such as this is important within nursing research as, contrary to the weight of writing and policy on this matter, there is little detailed empirical evidence concerning the assessment interview.

The tape recorded and observational data collected during the assessment interaction offers an opportunity to study how the nurses and patients, charged with completing the assessment form, design their talk when, notionally at least, they have the latitude to choose a variety of speech-exchange systems.

7.1 Nurse-patient interaction as a speech exchange system.

The origins of CA research were inspired by the realization that ordinary conversation as a speech exchange system is the predominant medium of interaction in society, providing a ‘kind of benchmark against which other forms of more formal

or “institutional” types of interaction are recognized and experienced’ (Drew and Heritage 1992, p19). It has long been recognised therefore that several speech exchange systems co-exist in society (Sacks et al 1974), with conversation being the most basic form of interaction familiar to individuals, whilst other more specialised speech exchange systems such as doctor-patient interaction, nurse-patient interaction, classroom and courtroom interaction alert participants to the fact that a different form of interaction to the usual is occurring (Heritage 1984, Woofit 2001).

7.2 Assessment interaction and ordinary conversations.

The juxtaposing of ordinary conversations and nursing assessment interaction within this section provides a useful analytic channel for two reasons. Firstly nursing assessment is characterised in many texts as a conversation which acts to build rapport (Jolley and Brykczynska 1992, Schober 1993, Brown 1995, Potter 1997, Graham 2000) or a ‘special working relationship’ (see Chapman 1983 p.90, opening quote of this chapter) between a nurse and a patient, with the goal of collecting relevant information regarding the patient’s need for nursing care during their hospital treatment (Crow 1979, Savage 1991, Hurst 1993, Ash 1997). For example, Jolley and Brykczynska (1992) acknowledge the importance of information gathering during patient assessments whilst also affirming the need to conduct assessments in such a way as to form a meaningful relationship with the patient:

assessment of patients becomes more than gathering information and recording it on a nursing history sheet. Instead, assessment is about forming a relationship with a person, getting to know him (*sic*) as a person and allowing him (*sic*) to get to know the nurse. (...) Through the relationship, meaningful information is then obtained (p.94).

Secondly, the juxtaposition of ordinary conversation and assessment interaction is a useful analytically as CA research has demonstrated that many kinds of institutional

interaction use the same turn-taking organization as ordinary conversation (Heritage 1997). However, other institutional interaction involves very specific changes to ordinary conversational turn-taking procedures, and it is these departures from the recurrent practices seen in ordinary conversation that makes institutional talk distinctive. In this comparative sense, ordinary conversation is seen as having a foundational or “bedrock” status with respect to talk in work settings (Woofit 2001). In light of this, any analysis of nursing assessment interaction from a CA perspective should demonstrate the degree to which assessment interaction is conversational by exploring the extent to which participants are oriented towards conversational practices.

In the course of this chapter it will be suggested that the speech exchange system used during nursing assessments is unlike free-ranging ordinary conversation, in part because of the interactional restrictions placed upon *both* speakers by the type of turn organizational formats used by the nurses. The following section will attempt to develop these thoughts further by exploring conversation analytic insights into the fundamental structure of ordinary conversation.

7.3 The structural organisation of talk - turn taking organization and turn construction in assessment interviews.

The basic analytical unit in conversational analysis is a turn; this can be a full sentence, a set of sentences or a single word or utterance (e.g. What?, Mmm).

Analysis of turns during conversations has revealed that the effective management of turn taking contributes greatly to helping participants in a variety of conversations in ‘doing what they are doing and getting it done’ (Schegloff 1992, xviii) – be it answering a telephone call, accepting an invitation to dinner or conducting a television interview (Drew and Heritage 1992) .

Sacks et al (1974) proposed a model (figure 6) of how ordinary or “mundane” conversation is constructed through a series of turns, demonstrating for example, ways in which any number of participants organise their turns of talk so that only one person talks at a time. The model proposed by Sacks et al demonstrates that the structures of ordinary conversations are far from messy; in fact they are highly structured and ‘incredibly orderly’ (Potter 1996 p58).

Figure 6. The essential features of conversational turn taking developed by Sacks et al (1974)

1. one speaker speaks at a time
2. number and order of speakers vary freely
3. turn sizes vary
4. turns are not allocated in advance but also vary
5. turn transition is frequent and quick
6. there are few gaps and few overlaps in turn transition.

Evidently, during ordinary conversations the order in which parties speak, how long for and the content of the speech all vary and are not specified in advance. Heritage (1997, p. 164) recommends ‘a first thing to consider’ during a CA study of institutional interaction is how far the talk deviates from ordinary conversation and ‘whether the interaction you are looking at involves the use of a special turn-taking organization’. A review of previous studies of institutional conversations reveal the existence of a variety of special turn taking systems which serve to restrict participants’ talk in terms of, for example, a wide variety of length and content of turns within the interaction. Such is the regularity of the patterns that emerge within these studies of institutional talk that three turn taking systems have been identified.

At one extreme all turns are pre-allocated e.g. seen in cross-examination in a court of law where some or all of the turns are pre-allocated to the incumbents of particular roles such as judges and defendants (Atkinson & Drew 1979), in the middle there is a

mix of pre-allocated and local-allocated turns e.g. seen in business meetings (Boden 1994), where the chairperson commences the meeting through a series of pre-allocated turns leading to a more locally designed turn structure as the meeting progresses . At the other extreme, a purely local turn allocation would preserve one-turn-at-a-time with no pre-allocation of turns e.g. seen in some aspects of counselling sessions (Peräkylä & Silverman 1991). It is noticeable that these turn taking systems each appear to have particular functions, usually related to the accomplishment of institutional business.

With this in mind, data fragments are presented below which illustrate typical sequences of interaction between nurses and patients during initial assessment interaction.

Extract 17 Mb1

157 n: Do you know your weight and your height?
 158 p: Uh:
 159 (1.1)
 160 p: Jus' over eight stone °I am ° (.) five one and a half (.) °should be°
 161 (3.6 nurse writing in the notes)
 162 n: Ok u::m any difficulties with your hearing or do you wear a
 163 hearing aid=
 164 p: no:
 165 n: No problems with hear[ing] then
 166 p: [no]
 167 (4.5 nurse writing in the notes)
 168 n: Any visual problems::
 169 p: U::hm I've gorra wear glasses for reading=
 170 n: for reading any double vision or (.)
 171 p: No::
 172 n: No- (.) jus' glasses for reading=
 173 p: yeh
 174 n: Do you wear dentures or your own (.) own teeth
 175 p: [no]

Extract 18 Sa5

117 n how much do you weigh
118 (1) ((patient turns away to think – hand to brow))
119 n any idea
120 p nine and a quarter I think
121 (2 nurse writing in the notes)
122 n suffer with any disabilities or weaknesses
123 p no (.) no
124 n arthritis or anything
125 p (a bit of) arthritis
126 (6 nurse writing in the notes)
127 n does that cause you a lot of problems
128 p well yeh my leg do
129 (12 nurse writing in the notes)
130 n speaking in uh English=
131 p English ((laughs))
132 n ((laughs)) any Welsh
133 p no you're joking ((p laughs))
134 n are you in any pain or anything at the moment
135 p no only from my ((cough?))
136 (5 seconds nurse writing in notes)
137 n you don't walk with a stick or anything like that now
138 p no

Extract 19 Ma2

335 n You don't take sleeping tablets
336 p: No
337 n: Right ok
338 (20.5) ((reads previous notes and writes in the nursing notes))
339 n: Do you speak Welsh as well as English
340 p: No
341 n: Just °English °
342 (4.1 writing in notes)
343 n: No problems with your hearing
344 p: No
345 (5.8 writing in notes)

It is possible to see that some of the conversational rules listed in figure 6 apply to these sequences, but that the majority do not. For example, the imperative for orderly conversation of one speaker at a time is upheld by both participants with the exception of minimal overlaps (e.g. lines 167 and 176 in extract 17). However unlike the essential features of conversational turn taking the number and order of speakers appears very orderly (n-p-n-p), invariably with nurses' questions followed by patients' answers, turn sizes do not vary and are mostly brief. A further feature of the

talk is the many gaps between turns where the nurse writes the information produced by the turns into the notes¹⁷.

CA's focus on the structure of turns usefully demonstrates therefore that the participants in extracts 17-19 constructively manipulate the everyday rules of conversation as a resource for "doing the job" of admitting a patient to hospital. Each of the extracts demonstrates a joint orientation, or co-construction, by participants to the task to be achieved, with the effect that the basic structure of the assessment in the hospital setting is a very simple chain of questions and answers, with the participants often producing long sequences where the nurse acts exclusively as questioner and patients as answerers.

Up to this point in the thesis the term "interview" has been discussed in a rather slack way, relying (much as the nursing literature does when discussing assessment interviews) on the readers' common-sense understanding of the word. What the data in extracts 17-19 demonstrates is that the type of speech system employed by nurses and patients during assessments can indeed be classed an interview, which is characterised by a speech event dominated by question-answer sequences (ten Have 2004) in which one person A, extracts information from another person, B, which was contained in B's biography (Labov and Fanshel 1977). Extracts 17-19 closely resemble a particular type of interview organization labelled by Mazeland (1992) as turn-by-turn interviews (TBT interviews), which mainly consist of an alternation of relatively short speaking turns, such as questions, answers and acknowledgment tokens.

That the process of information collection proceeds smoothly suggests that, on the surface at least, the production of assessment interaction appears very

¹⁷ A fuller analysis of writing activity in the gaps between turns will be presented in Chapter 8.

unproblematic. It is also worth noting here Peräkylä and Silverman's (1991) point that question-answer chains do not determine the actions of the participants as both parties are free to proceed as they feel within the interaction, the patient for example is either free to stop answering or free to ask a question. In response to this position however, it is widely regarded that within institutional talk the interview format tends to be based on an asymmetrical distribution of interactional jobs which impose restrictions on participants' possible actions (Heritage 2004, ten Have 2004) and generally that questions cannot be viewed as neutral invitations to speak, rather they shape how the respondents should speak (Baker 2004).

Such fixed relationships therefore, where questioning is the major on-going activity of one speaker and answering the activity of another, typifies a speech exchange system in which one party (a questioner), recurrently imposes upon another party (an answerer), a set of sequential obligations. The net effect for patients of this "obligation to respond", according to Frankel (1990), is that it creates a sequential deference structure insofar as the patient's speaking opportunities is constrained to responding to, rather than leading the talk.

Upon comparison with previous CA studies therefore, extracts 17-19 appear as "institutional" as any other studies of work place talk, especially in the sense of the interaction being task focussed (Boden 1994, Greatbach and Dingwall 1998, ten Have 1999) and operating within a similar sequential deference structure as discussed above. Seen in this way it would appear that initial nursing assessments follow a much more institutionalised or bureaucratic model of interaction compared to casual conversation.

Overall, the direction of the interaction appears to be both locally designed by the participants on a turn-by-turn basis as well as being pre-organized in so far as

what the participants say and do is largely orchestrated by the need to complete the paperwork¹⁸. There are firm grounds, therefore, to proclaim that the type of turn taking structure seen in extracts 17-19 constitutes the fundamental structure of the assessment interview within the areas from which the sample was derived, especially when considering that, although interactional formats within institutions can vary considerably, there is very little variation within the data-set collected here.

7.4 Asymmetries within initial assessment interviews.

The identification of recurring question-answer sequences within the data raises a number of intriguing questions about its interactional implications, how it works, and whether or not it has any bearing on the practical accomplishment of the assessment interview. These questions will be discussed in the subsequent sections, however the recurring asymmetrical distribution of question-answer turns, where the nurse is seen to ask most if not all of the questions during the assessment will be considered here.

Asymmetries within professional-patient interaction have been discussed in the medical social science literature for quite a time (Parsons 1951, Maynard 1991, Barton 2000), although this is a concept rarely mentioned or researched in the nursing literature (an exception being Jarrett and Payne 2000). Traditionally the asymmetry in doctor-patient interaction had been viewed as an expression of the doctors' inherent power, based in part on the differences in expertise and dominance between professionals providing services, and patients seeking them. Recently, this view has been challenged by findings that asymmetries in interaction are willingly "co-constructed" by both participants (ten Have 1991, Maynard 1991, Jarrett and Payne 2000), rather than existing as some sort of "given" within the professional-

¹⁸ The effects of documentation on topic selection during the assessment is discussed further in Chapter 8.

patient interaction. These authors forward a strong case which presents asymmetry in healthcare encounters not as a static and institutionally imposed aspect of the context, but rather as an aspect of interaction that emerges in the participants' talk in response to the interests of both parties.

On the surface the data in chapter 6 did hint that the assessment interview was a co-constructed 'negotiated order' (Strauss et al 1973, p.41) accomplished through interaction between nurses and patients. It could be viewed that the asymmetrical structure of interaction during assessment interview was negotiated and worked at by nurses and patients, particularly seen when patients "agreed" to the nurses asking questions and then both parties dutifully orientated to the task of asking/answering them¹⁹. In this way the meaning of assessment interviews could be presented as being actively built up and constituted through interaction.

However, a detailed analysis of the data suggests a more institutionally imposed asymmetry than an asymmetry which is co-constructed by participants. Firstly it has been noted in the analysis presented to date that the assessment interview is introduced to the patient in a way that enables the nurse to decide on the attribution and distribution of turns, as well as the introduction and control over the topics which are brought up. This is problematic for the patient's conduct during the assessment interview. The problem arises because an effect of the asymmetries is that the dialogue that a patient produces at any given moment takes its place in a pre-existing discursive space created by the nurse. Therefore, the patients' contribution to the interaction mostly consists of answers that are thoroughly grounded in the way in which the interview is organised and prioritised by the nurse.

¹⁹ See section 6.1

Asymmetry also exists in the participants' differential states of knowledge regarding the purpose and function of the nursing assessment interview. This asymmetry of knowledge is especially seen in the data presented regarding the opening sequences of interaction, where there is no mention made by the nurse that the questions that are to be asked are in any way related to an assessment of the patient's needs. Additionally, during the assessment interview patients are not given access to a copy of the assessment form that nurses constantly consult during interaction and which acts as a template for the style and shape of the interaction²⁰.

Seen in this way nurses enter an assessment interview armed with three sets of information: technical medical/nursing knowledge, knowledge of the nursing assessment interview structure, and interactional knowledge of mundane conversation. Patients (in this data set) only had knowledge of the latter of these sets of information, and a small number who had recent hospital stays had some experiential knowledge of the structure of nursing assessment interview, however the vast majority did not.

Thus, the data demonstrates that asymmetries of 'know how' (Cowley et al 2004, p.10) exist in the participants' differential states of knowledge, in addition to asymmetries between participants' capacity to control the initiation and shaping of topics within the interaction which combine to present a "nurse in control" picture of initial nursing assessment.

This is a different picture therefore from the more recent works originating from medical and nursing research (Maynard 1991, ten Have 1991, Barton 2000, Jarrett and Payne 2000), which argue that the structure of the professional-patient encounter is determined by both participants during the course of the interaction. The

²⁰ To be discussed more fully in chapter 8.

interactions are seen by these authors as not automatically and altogether asymmetrical and they clearly demonstrate through their data how asymmetries can emerge as an interactional response to contextual problems (Jarret and Payne 2000), and more specifically, to the discovery of patients' non-compliance with treatment (Maynard 1991, ten Have 1991, Barton 2000).

It is not my wish to portray asymmetries of interaction as “automatically” occurring within nursing assessments merely due to the institutional status of the talk. However, the data presented in chapters 6 and 7 strongly suggests that nurse-patient interaction during assessment interviews exists within an asymmetrical interactional space pre-defined by the projections heard in the nurses opening sequences of talk as and the asymmetries of know-how already discussed. Thus, rather than emerging out of specific contextual problems within the talk, asymmetries of interaction and knowledge during nursing assessment interviews seem to partly pre-exist. Nevertheless, as already mentioned the intention here is not to present assessment interviews as a distinct inert entity which command the behaviour of the interactants, but the intent is to acknowledge the pre-existence of the organization and culture, a pre-existence which is not presumed within this research but is seen to have implications for the very way in which assessments are talked into being. Further consideration of the ways in which assessment interviews are talked into being will be discussed in the following section which will consist of the exploration of two conversational rules revealed in the early work of Sacks et al (1974). Throughout attention will be paid to the question of the extent to which the chosen interactional style affects the type of patient information produced and affects opportunities for

patient involvement during the initial assessment interview, in line with the suggestions made in the nursing SIKs such as Sully and Dallas (2005)²¹.

7.5 Sequential organization of the interaction – adjacency pairs, preference structure and the influence of the third turn.

A significant feature of the analysis to this point has concentrated on how nurses' utterances' have implications for the kinds of utterances a patient produces. Put another way, it appears that patients have to design their talk to "fit" the prior talk of the nurse, and in this way the patients' talk is seen to be restricted to the terms and themes which the nurse introduces. Furthermore, as nurses principally ask questions during the assessment this influences the patient's next action because, until the patient has provided an answer, the nurse cannot proceed with the rest of the assessment. This may seem to be an overly complex account of an everyday event in nursing, but the point that will be expanded upon in this section is not that questions are followed by answers, but that through chaining together question-answer sequences nurses and patients choose to follow a specific pattern of interaction which gives a particular form to the discourse of nursing assessments.

For example, question-answer (q-a) sequences, such as those used by nurses in the course of assessing patients (extracts 17-19 in the previous section for example), are known in CA as "adjacency pairs". Adjacency pairs have the status of being a feature of all conversation and illustrate the *normative* character of paired actions, i.e. the social "norm" dictates that given that the first part of an adjacency pair has been uttered, the second part is immediately relevant and expected (Sacks et al 1974). This is not to imply that the second phase will *always* follow the first; indeed the response to a failure to comply with the expected response has itself been the focus of attention

²¹ An example from Sully and Dallas (2005) is used in the opening quotes of this chapter.

in CA studies. Adjacency pairs are therefore social norms which are largely invisible but widely influential in shaping behaviour from a very young age, and demonstrated most clearly when a norm is broken. This can be seen in the following extract between a mother (A) and child (B), where the norm being revealed is that a question requires an answer, or an account for why an answer is not forthcoming:

A: Is there something bothering you or not
(1.0)
A: Yes or no
(1.5)
A: eh?
B: No
(Atkinson & Drew 1979 p.52)

The normative character of the above sequence is demonstrated by A pursuing the second part of the interaction as an expectation that following A's first part, B should produce the relevant second part. The second part of this pair (the answer) is therefore made 'accountably due' (Heritage 1984 p.247) by the production of the first part (the question).

The concept of adjacency pairs is very informative in terms of the analysis in this study as it encourages the researcher to see the nurses' action of asking a patient "some questions" as something more than a neutral act. The data in this study further confirms the stability of the concept of adjacency pairs, as no instances were found of a nurse's question being followed by an utterance other than an answer, or an account for why an immediate answer was not provided. Thus in nurse-patient data, as in other instances of institutional talk, question asking carries with it a whole set of rules and expectations. Many of the data extracts used in the previous chapter and extracts 17-19 in this chapter clearly illustrate that when nurses ask a question the patients conform to the normative expectation of answering, or as extracts 20 and 21 now demonstrate the patient will offer an account for why an answer is not immediately forthcoming.

Extract 20 Sb2

127	n	how much do you weigh
128	(0.4)	
129	p	Oh (.)So::rry I'm not su::re (.) my scales are broken ((short laugh))=
130	n	that's ok:: we'll pop you on ours later

Extract 21 Mb3

183	n	which ward were you on last time
184	p	uh:: (.) gosh-cant remember you know I was on a couple

Extracts 20 and 21 illustrate the normative adjacency pair rule that where an answer cannot be provided by a patient following a nurse's question, the patient will offer an account for this (extract 20 – 'scales are broken', extract 21 – 'I was on a couple').

The apologetic accounts given in both extracts demonstrate that the patient is sensitive to the sequential context of their utterance (that an answer is due and expected), and to the questioner-answerer identities being orientated to in the interaction. Considered alongside the previous chapter's discussion of discourse and social identities the appearance of adjacency pairs in the data offers another insight into the fact that the "identity work" in this study is in the 'hands of the participants' (Antaki and Widdicombe 1998 p.4) rather than the analyst.

A closely related organisational principle to adjacency pairs known as preference structure is also apparent in extracts 20 and 21. The concept of preference structure has been described as the idea that the second parts of adjacency pairs can be ranked into responses which are preferred and responses which are dispreferred. Important here is the insight from Potter & Wetherell (1987) that the preferred response to questions is an 'expected answer while the dispreferred response is a non-answer or an unexpected answer' (p83). It is also important to stress that the term "preference" refers to features of the discourse action themselves, not the psychological desires or motives of the speakers.

Extract 22 below demonstrates the production of a preferred sequence within an adjacency pair, seen where the patient agrees to an invitation to participate in the assessment interview. This is followed by extract 23 which demonstrates the same patient/nurse entering a period of dispreferred responses during the interview.

From an initial glance it becomes clear that the action seen in a preferred response is different to the dispreferred response, the typical characteristics of which are featured below each extract for comparison.

Extract 22 Ma1 – Example of a preferred response

48 n: Righty ho (0.3) umh if it's ok with you I'll go through the nursing side
 49 of thing[s: with you] later↑ (looks at patient)
 50 p: [alright ok] ((nods head))
 51 n: after I've asked you the quest[ions]
 52 p: [right]
 53 n: and um if you want to ask me anything you'll be able to do so (.)
 54 al::right
 55 p: ye::s

Characteristics of preferred responses adapted from Potter and Wetherell (1987).

- Response is produced with a minimum of delay, occasionally in overlap (line 49 and 51).
- It is a brief response with the answer component of the turn delivered straight away (line 51 and 53).
- There is no hedging of the answer – the answer is clear cut (line 53).

Extract 23 Ma1 – Example of a dispreferred response

247 n: How-how long do you sleep (.) for↑
 248 (3.2)
 249 p: ° Uh:: I wake quite early uhm:: °
 250 n: How many hours do you sleep at night
 251 p: Well I try and get 8 hours but its not- its not always 11 o'clock umh
 252 (0.6)
 253 n: Broken sleep is it↑
 254 p: I sleep til seven probably yeh yeh
 255 (0.5)
 256 n: How many hours a night rough::ly↑
 257 p: (0.5) Say seven um I think
 258 (7.8) [n writes in notes – sleeps seven hours a night]
 259 n: Righty ho you're a retired gentlem:n

Characteristics of dispreferred response adapted from Potter and Wetherell (1987).

- There is a delay component (line 247 delay of 3 seconds).
- There is normally a preface such as uhm/well. This both marks the dispreferred status of the response and increases the delay before the disagreement is broached (lines 248 & 251).
- When disagreement is formulated it is done so weakly (line 251).
- Dispreferred second turns almost always include an account – providing some justification for not providing the preferred response (line 248 & 251).

The first part of the interaction in both extracts 22 and 23 is a question, which as discussed above, is normatively followed by an answer related closely to the possibilities raised in the question. In extract 22 the newly arrived patient communicates broad agreement with the nurse’s expressed intention that she is going to ask some questions (line 50) – for the patient to answer alright/yes is both relevant and expected in this context. The patient’s reply is both clear and concise throughout (lines 49, 51, 53) which are further features of preferred responses.

However extract 23 from the same assessment interview presents an interesting contrast. Previous CA research (Davidson 1984, Pomerantz 1984) reveals that silence occurring immediately after questions followed by utterances, known as prefaces (such as Oh, Uh, Well), are linguistic devices which respondents employ to mark their uncertainty with the previous talk. The 3 second silence in extract 23 (line 248), followed by the preface in line 249 (° Uh::) both serve to delay the main body of the answer and can be viewed as a display of some sort of trouble, reluctance or disagreement that the patient is having with the question and in producing a relevant answer.

247 n: How-how long do you sleep (.) for↑
248 (3.2)
→249 p: ° Uh:: I wake quite early uhm:: °

The concept of preferred and dispreferred responses therefore shows that the silence and preface not only reflect the patient’s difficulty in producing a relevant answer to the nurse’s question, in this case a clear quantity of sleep, but also demonstrates the patient’s awareness that not producing an answer has a “dispreferred” status within the assessment interview. The implications of this will be discussed in the following section which continues to analyse the same sequence of data.

7.6 Beyond adjacency pairs - the manipulation and control of the third turn slot in initial assessment interviews.

To this point the analysis has demonstrated that the assessment interview is primarily designed using a two-part question-answer structure. However, continuing with extract 23, the utterance in line 250 is analytically interesting as it clearly demonstrates that an adjacency pair may be followed by a third turn.

247	n:	How-how long do you sleep (.) for
248		(3.2)
249	p:	° Uh:: I wake quite early umh:: °
→250	n:	How many hours do you sleep at night
251	p:	Well I try and get 8 hours but its not- its not always 11 o'clock umh

Previous CA research of institutional talk has shown that the third turn following an adjacency pair is reserved for the producer of the first turn and ‘provides the first speaker with the possibility of displaying his (*sic*) reception of the response to the first turn’ (Houtkoop-Steenstra 2000 p.24). The nurse’s third turn in line 250 is an example of this, as the nurse clearly displays through a repair of the original question that the first response by the patient needs further work. Thus, if the patient’s answer in the second turn does not correspond to what the nurse expects, then the third turn becomes available to the nurse to correct or repair any

misunderstanding in the patient's turn. Repairs in the third turn can adopt various forms including repeating the turn that caused the trouble more clearly (line 250), reformulating the troubled turn so that the same is said in different words (line 256) or the speaker introduces candidate answers (line 253) for consideration (Houtkoop-Steenstra 2000) – each of which are present in extract 23 and suggests that the patient's answers did not correspond with the nurse's expectation of what constituted the "right" answer.

The central analytical idea that needs consideration is that nurses have a privileged access to the first position within the assessment interview. Occupying the first position especially through asking the initial question has long been acknowledged in doctor-patient interaction as representing an act of control (Mishler 1984, Frankel 1990), as this gives the first speaker an edge in that they are more likely to control the beginning of the second cycle of the conversation than the second speaker.

The same tendency is detected throughout the data collected for this study, where nurses occupying the first position have a tendency to control what can be said in the second position, a conversational strategy which also makes available a further third position turn if the answer does not match the institutional requirement. If the answer is acceptable the nurse resumes the assessment with another question. This is demonstrated as extract 23 unfolds, where it is possible to further explore the effect of the nurse's first and third turns on the patient's interaction.

250 n: How many hours do you sleep at night
 251 p: Well (.) I try and get 8 hours but its not- its not always 11 o'clock umh
 252 (0.6)
 253 n: Broken sleep is it↑
 254 p: I sleep til seven probably yeh yeh
 255 (0.5)
 256 n: How many hours a night rough::ly↑
 257 p: (0.5) Say seven um I think
 258 (7.8) [n writes in notes – sleeps seven hours a night]
 259 n: Righty ho you're a retired gentlem:n

The patient's adjacent turn (line 251) to the repair on line 250 once more displays characteristics of a dispreferred response with the use of the preface 'Well' which buys more time, followed by another indicator of a dispreferred turn, namely an account of why this request for an exact period of sleep is problematic:

251 ...I try and get 8 hours but its not always eleven o'clock'.

In this case the patient invokes information about his variable bedtime as to why it might not be possible to answer the question with an exact quantity of sleep. A factor noted by Potter (1996) is that dispreferred turns will sometimes produce accounts that invoke privileged or personalised knowledge, such as that seen in line 251, as means of mitigation for not producing the "desired" answer.

Also noteworthy is that the patient offers the quantity of eight hours as an expectation for a night's sleep before stating that his bed-time is not constant, making it impossible to identify an exact period of time as requested by the nurse. What appears to be the root of the trouble is not that the patient does not understand the question; it is that the question does not allow for possible variances of sleep.

The nurse's next turn is grounded in the patient's prior talk and offers a slight diversion from the previous questioning about how many hours the patient sleeps for:

253 Broken [sleep is it]↑

This type of turn during institutional talk is known as a reformulation (Beach & Dixson 2001), where an attempt is made by the nurse to describe and summarise the previous tract of conversations with the intention of demonstrating understanding.

The reformulation on line 253 sees the nurse offering the patient a candidate understanding of what the patient has just said, whilst also demonstrating to the patient that she is working closely with the patient's prior talk, an act described in

studies of doctor-patient interaction as displaying that she is 'on-board' (Beach & Dixson 2001 p.29) with the patient's experience of sleep.

The reformulation could therefore be seen on the surface as breaking the usual q-a sequence, with the utterance instead displaying the nurse attempting to empathise with the patient regarding his sleep pattern. However, closer scrutiny of the reformulation on line 253 shows that it performs as a further q-a sequence within the interaction. Firstly, the utterance ends with an upwards intonation in the voice of the questioner, indicating that "Broken sleep is it↑" is designed as a question to be answered rather than a statement of fact or empathy (Quirk et al 1985, Heritage 2002). That the utterance is a declarative question rather than a statement of empathy is also interpretable from the actions of the patient that follow it, namely that he continues to attempt to answer the question regarding the length of sleep. The patient's response to the reformulation makes no reference to broken sleep and carries no immediate confirmation that the reformulation by the nurse was acceptable, instead the patient continues to talk about how long he 'probably' sleeps for.

254 p I sleep til seven probably yeh yeh

The candidate understanding offered by the nurse therefore maintains rather than breaks the pattern of interaction built up by the participants to this point, constituting as it does the first part of a further adjacency pair (candidate understanding - confirmation/disconfirmation). That conversational control is maintained by the nurse is evident in that, following a gap of half a second, a further redesign of the original question is delivered, this time including the term 'roughly'.

256 n: How many hours a night rough::ly↑
 257 p: (0.5) Say seven um I think
 258 (7.8) [n writes in notes – sleeps seven hours a night]
 259 n: Righty ho you're a retired gentlema:n

The above extract of lines 256-259 provides an opportunity for a brief but interesting aside from the focus on adjacency pairs and third turns, an aside which further contributes to meeting the study's aim of understanding how nursing assessments and admissions are "worked at" and are "performed" in practice.

Previous CA studies have discussed the differences seen within institutional talk between what is an appropriate descriptive term in everyday conversation, on the one hand, and an institutional context on the other (Schegloff 1972, Mishler 1984, Drew and Heritage 1992). In particular these authors identified how temporal references and description can be used to formulate different contexts within talk, what Drew and Heritage (1992) term the 'pragmatic formulations of time' (p.31). An example of the pragmatic formulation of time in the assessment interview is seen in extract 23 when the patient produces four versions of how long he sleeps for, the first three versions which the patient produces refer to biographical or "personal" time and are akin to descriptions used within everyday conversations, the final version being a description which uses the more pragmatic and bureaucratic "clock" time (Adam 1995, Jones 2001).

Table 3 – temporal shifts in the patients description of the amount of sleep time per night.

Patient’s description drawing upon personal/biographical time.	Patient’s description drawing upon “clock time”.
<p>Line 249 - I wake up quite early</p> <p>Line 251 - Well I try and get 8 hours but its not- its not always 11 o’clock</p> <p>Line 254 - I sleep til seven probably</p>	<p>Line 257 - Say seven um I think (“seven hours” written in notes)</p>

Table 3 (above) demonstrates that three descriptions in the left column offer insights into the personal meaning of sleep for the patient, containing references to waking early, a target of 8 hours sleep a night and variable bed time, before finally the fact that the patient probably sleeps until seven. The final description of sleep produced by the patient in the right hand column sees the quantity of seven hours offered as a reply to the question ‘How many hours a night roughly’.

The nurse’s attempts at reformulating the question treats the patient’s personalised answer as inappropriate within the assessment interview format, however when the patient’s final answer corresponds to the format expected during assessment interview the nurse is seen to accept this answer (indicated by the nurse writing in the notes on line 258) and moves on to the next area of assessment (with line 259 ‘Righty ho you’re a retired gentleman’), which signals that the topic of sleep is closed and that the next topic in the assessment is beginning .

Therefore, while the patient looks to answer the question based on statements of personal experience and circumstances, the nurse declines these elaborations,

aiming instead for a more formal and objective quantification of time. Previous nursing research exploring temporal aspects of nursing care by this author may be pertinent when considering this data as it reveals that the conflict between “conversational” and “institutional” formulations of time may be indicative of the participants’ different agendas for, or comprehension of an encounter (Jones 2001).

7.7 Nurses’ neutrality and footing in the third turn.

Although extract 23 demonstrates the third turn as a potential interactional resource for the nurse to reformulate or pursue a different answer to that first offered by the patients, not all third turns are used in this way by nurses. Indeed in the majority of cases the patients’ answers during assessment interviews are accepted by the nurse and the third turn slot becomes a place for nurses to demonstrate this, either through the use of silence and writing in the notes or the immediate next question on a different topic (which becomes the first part of the next adjacency turn). Therefore, in assessment interviews a nurse is seen to receipt the patient’s answer in one of the three ways detailed in figure 7 below. Each of the three receipts seen in figure 6 performs different interactional work in the third turn slot during assessment interactions, certain features of which will be considered further at this point.

Figure 7. Receipting the answer – the 3 turn structure within assessment interviews.

Turn 1 – nurse asks question

Turn 2 – patients response

Turn 3 – receipt of response by nurse leads to:

- Reformulation by nurse – patient’s response needs more work
- Silence/writing in the notes followed by question– patient’s response is accepted
- Immediate next question – patient’s response is accepted.

One particular feature of the third slot during assessment interviews is how unlike the third turns seen in ordinary conversations they appear where, in ordinary conversation for example, the third turn is used as a slot to empathise, share an opinion or express surprise. For example:

Sarah: I've got a terrible headache
John : that sounds nasty
Sarah : yeh (.) its really getting me down

Julie: that's five pounds this week I've lost
Mary: you're joking (.) NO way
Julie: oh yes I've been behaving myself

In initial assessment interviews a contrary situation is discovered when patients reveal details which would, in ordinary conversation, elicit an affiliative or an evaluative response as seen in the above examples. In the assessment interview, rather than a response based on the content of the previous turns, nurses react with a display of neutrality to the patient's revelations, just as judges or journalists have been found to do in other varieties of institutional talk (Atkinson and Drew 1979, Heritage 1985, Clayman 1992).

Extracts 24 and 25 below (see also chapter 8 for neutral non verbal responses) demonstrate that neutrality in the third turn slot is displayed by nurses both through the use of silence accompanied by writing in the notes, and through the use of the immediate next question aimed at eliciting further information or to reiterate, develop and elucidate the information that has already been collected (seen in extracts 28 – 30).

Extract 24 Sb1 –third turn neutrality demonstrated through the use of silence and writing in the notes.

25 n any problems with your bowe[ls or w]aterworks
26 p [no-no]
27 (6 seconds – nurse writing in notes, patient watching)
28 n and you manage to wash and dress yourself
29 p yeh yeh
30 (8 seconds - nurse writing in notes, patient looking through window)
31 n and you're walking about ok [you] don't get short of breath [walki]ng
32 p [yeh] [no-no]
33 n walking around or anything
34 (7 seconds – nurse writing in notes, patient watching)
35 n °you're married° () sleeping what you're like with your
36 sleeping
37 p well you know its off and on you know not good not bad ((short sort of
38 laugh)) you know we both sleep for about three to four hours and then
39 we're awake you know so
40 (2 seconds – nurse writing in notes, patient watching)
41 n (do you do anything?) with religion or anything

Extract 25 Mb 3 – third turn neutrality demonstrated through the use of silence and writing in the notes.

304 n up to a couple of hours and that's all that they need (.) but you don't
305 have any problems sleeping [at] all
306 p [no]
307 (1.5 nurse writing in notes)
308 n °right° (.)°bowels°↓
309 p uhm yes I've got lots of problems with that
310 constipat[ion]
311 n [con]::stipat[ion]
312 p [mm]huh
313 (8 nurse writing in notes, patient watching)
314 n do you take anything
315 p ye::s I take senokot occasionally
316 n °senokot° ((writes))
317 (5 nurse writing in notes)
318 n what about
319 (0.6)
320 n urine
321 p that's [fine]
322 n [are y]ou regular
323 p mhuh
324 (5 nurse writing in notes)

Extract 26 Sa 7 – third turn neutrality demonstrated through the use of immediate next question

179 n you're not on any special diets at all Andrew
180 p nah
181 n and have you lost any weight over the last three months
182 p no °not that I know of no°
183 n good appetite
184 p yes

Extract 27 Sa 8 – third turn neutrality demonstrated through the use of immediate next question

111 n is English your only language
112 p yes °yeh°
113 n and have you got any hearing problems at all
114 p ((shakes head no))
115 n no (.) and you wear glasses all the time yeh
116 p yes:::

Extract 28 Ma4 – third turn neutrality demonstrated through the use of immediate next question

35 n no (.) sickness or anything like that
36 p no
37 n ok do you take anything for the pain-has the doctor give[n] you anything
38 p [no]
39 p the hospital give me stuff:: (.) I don know what it wa::s
40 n under your tongue or (.)
41 p the doctor give me some of that yeh
42 n that help
43 p no
44 n ok (.) anything in the family do you have any heart disease in the
45 family
46 p no

The identification of recurring displays of nurse neutrality within the data raises a number of intriguing questions, for example, about its interactional implications, how it works, and whether or not it has any bearing on the practical accomplishment of the assessment interview. One implication is that the production of such minimal or non-elaborative third turn receipts by nurses helps to maintain forward momentum towards the completion of the interview, but at the cost of a more personalised interaction with patients. An example of this is demonstrated in extract 28, when the patient's answer to a question regarding pain relief reveals that medication tried to date had been unsuccessful in alleviating chest pain.

37 n ok do you take anything for the pain-has the doctor give[n] you anything
38 p [no]
39 p the hospital give me stuff:: (.) I don know what it wa::s
40 n under your tongue or (.)
41 p the doctor give me some of that yeh
42 n that help
43 p no
44 n ok (.) anything in the family do you have any heart disease in the
45 family
46 p no

There are several possible ways which the nurse could respond when given this type of news by the patient. The nurse could attempt to clarify the patient's uncertainty in line 39 regarding 'the stuff' which the previous hospital had given him, although the nurse's 'under your tongue' on line 40 establishes the patient received this type of medication it remains unclear if this was the same "stuff" as the patient was referring to. At line 43 the patient unequivocally states ('no') that analgesic medication to date has not helped; again the nurse at this juncture could offer a range of responses such as sympathy and/or a possible reason for the medication not working, but she accepts the answer with 'ok' (line 44), before moving on with a question about the history of heart disease in the family.

What is clearly missing here is any affiliative response on behalf of the nurse that might be found at similar positions in a conversation, a response such as "I'm sorry to hear that" or "that must be awful". In similar tracts of data (e.g. extract 24 and the discussion of sleep line 37 onwards, and the discussion of constipation in extract 25 lines 308 onwards) found throughout the data set, not a single instance was found of nurses displaying their appreciation and understanding of patient's troubles or problems i.e. by selecting a hearably relevant empathic turn. Very similar neutral use of the third turn is seen in other types of institutional talk, with neutral displays during, for example, patient-doctor interaction (ten Have 1991) and telephone market research interviews (Houtkoop-Steenstra 2000) being discussed at length as a conversational strategy towards completion of the task being undertaken.

Of interest is that following on from the previous chapter's analysis of nurses footing as merely the animators or "passers-on" of the talk on behalf of a third party (the institution), both ten Have (ibid.) and Houtkoop-Steenstra (ibid.) make a similar claim for the end achieved by neutrality within their studies of interaction. Both

authors discuss the ways that neutrality displays an interviewer's position as a person who collects information on behalf of someone else with little or no personal stake in the actual interaction.

The thrust of my analysis at this point is therefore to explore the correlation between third turn displays of neutrality and institutional footing of nurses. What has been shown so far in this study is that both institutional footing and third-turn neutrality serve to institutionalise the assessment talk, giving the assessment interview a business-like rather than a personalised/conversational gloss. In turn, the business-like orientation of the talk leads to the timely and efficient completion of the assessment interview and associated paperwork, but with the cost of reducing the assessment interview to neutral question-answer sequences which only cover the areas required to fill in the assessment paperwork.

Moreover the position taken here is that the relative ease with which nurses produce neutrality in an assessment interview which is traditionally characterised in the literature as an opportunity to 'really get to know the new patient' (Chapman 1983 p.90) and 'which forms the foundation of all the care to follow' (Sully and Dallas 2005, p.74) is traceable to the opening sequences of interaction discussed in the previous chapter, in that neutrality is more easily performed during assessment interviews *after* the nurses have clearly established during the opening sequences their footing in the interview as mere animators of talk, asking a 'few' or a 'hundred and one questions'. This close relationship between footing and its effects on nurse-patient talk is explained in table 4, which contrasts the position taken by nurses during the assessment interviews, and a hypothetical situation occurring *without* the shift of footing to that of serving the institution's business.

Table 4 – the co-relationship between footing and neutrality.

Nurses' utterance	Footing	Consequences	Third turn display of neutrality
<p><i>From the data.</i></p> <p>The nurse as “we” during assessment interviews.</p> <p>Downgrading of the assessment interview – “hundred and one questions”, “Just going to ask some questions” etc.</p>	<p>Animator of the talk - institutional footing.</p>	<ol style="list-style-type: none"> 1. The nurse speaks on behalf of the organisation. 2. The institution not the individual has a stake in the interaction. 3. Nurse has a low degree of accountability the interaction and the information produced. 	<p>Enables the display of neutrality in the third turn as a resource which is in keeping with the institutional discourse framework produced by the utterances and the footing exhibited in the talk.</p>
<p><i>Hypothetical situation.</i></p> <p>The nurse as “I” during assessment interviews.</p> <p>Presents assessment interview as opportunity to get to know the patient, discuss their needs.</p>	<p>Principal of the talk – personalised footing.</p>	<ol style="list-style-type: none"> 1. The talk represents the nurses' personal position. 2. Personalised stake in the production of the interaction. 3. Nurse has a high degree of accountability for the interaction and the information produced. 	<p>The display of neutrality in the third turn would be at odds and untenable within a discourse framework produced by this footing.</p>

Table 4 is presented here following Atkinson's (1992) recommendation for qualitative researchers that it is sometimes analytically useful to consider what other things a speaker might have done at a particular point in the interaction. I also acknowledge that it is also preferable, wherever possible, to look at examples of different options actually being implemented, rather than to rely on intuitive reflections about theoretical or hypothetical possibilities.

However in this study there are no examples of nurses taking a different option to the completion of the assessment other than to present the interaction to the patient as an interview based on “questions that need to be asked”. The hypothetical position presented in table 4 is thus largely informed through the statements made in

the nursing literature and policy regarding the desired model of interaction during hospital admissions and through exploring the writing on footing (Potter 1997) and its effects on the accountability of the speaker for what is said.

What is hypothesised in table 4 is that an alternative to institutionalised footing adopted by nurses in the data would see each nurse position themselves as personally accountable for their actions within the interview by presenting themselves as the authors or principals of the talk. Potter's (1997) writing suggests that this would lead, in turn, to an increase in their personal stake within the interaction as nurses would no longer dissociate themselves from an action delegated by the institution.

As table 4 suggests, such an increase in personal stake within an interaction would make untenable the position of neutrality taken by nurses, in other words they would have to respond within the third turn in a different way to what is seen within the present data. Thus, the various displays of neutrality within the third turn demonstrated in the data, are made possible through the nurses placing the assessment interview beyond their immediate personal accountability and within the institutional realm of collecting information for a third party.

In this way nurses' neutrality in the third turn can be seen as a way of successfully completing the assessment interview whilst avoiding a range of alternative and more affiliative responses. For example, both the use of silence and the immediate next question by nurses serve to terminate the patient's prior talk, confirmed by the fact that once the topic has been left behind in this way there are no instances in the data set where patients return to a prior question, or offer supplementary information. This also clarifies that the patient is sensitive to the significance of the kind of action undertaken in the third turn by the nurse, in as much as the patient's actions indicate an understanding that silence or the immediate next

question signify a completion of that particular topic and an indication that the nurse evaluates the answer as sufficient for the purposes of assessment.

Therefore, absent or neutral responses by the nurse in the third turn facilitate the speedy onset of the next sequence of questions, thus they are not only constitutive of the sequence but they also display the nurses' and patients' understanding of the turn-by-turn progression of the assessment interview.

To summarise, the absence of "appreciations" by nurses to the patients' revelations is seen in other types of institutional talk and has been discussed as displaying an interviewer's position in the interaction as persons who collect information on behalf of someone else (ten Have 1991, Houtkoop Steenstra 2000). This insight resonates with the data for this study as nurses appear not to speak for themselves but as neutral channels of information between the patient and the nursing team, rarely displaying to the patient any sign of understanding, shared knowledge or empathy both of which are important notions within the writing on humanistic communication between nurse and patient (May 1992, Antrobus 1997, Barker et al 1997, Chant et al 2002).

7.8 Nurses' question construction in search of a "no problem answer" from patients.

This section adds further insights into the ways in which nurses phrase and construct their questions during assessment interviews. Question construction and phrasing is a topic which attracts considerable coverage within nursing literature, the emphasis consistently articulated being that nurses should be looking for expansive descriptions from patients during assessment interviews and that this is best achieved through the use of open questions. Typical examples include Crawford and Brown (2004, p.13) stating that 'open questions allow greater exploration of ideas and

exchange of information' or Betts (2002 p.275) who suggests that 'a timely open question indicates more skill in communication than does asking a large number of closed questions'. Support for the use of open questions within nursing interactions with patients seems to stem largely from the desire in nursing to address people as human beings first and patients with problems second (Barker et al 1997).

On reviewing the data collected in this study one aspect of communication that consistently appeared was the nurses use of closed questions during assessment interviews, demonstrations of which are displayed below in extracts 29 and 30.

Extract 29 - Mb 6 – closed questions

156 n do you smoke
157 p no
158 n and there's no problem with your breathing
159 p no
160 n and your walking ok yeh
161 p ((nods yes))
162 n right (.) you haven't been falling over at home have you
163 p nope-
164 (5 writing in notes)
164 n I just need to check your weight and blood pressure

Extract 30 - Sb3 – closed questions

110 n you're eating and drinking fine
111 p ye::s
112 n and your weight has been stable recently
113 p I think so (.) yes
114 n we'll weigh you later (.) d-do you know your weight
115 p twelve and a half I think
116 n Great (.) that fine
117 (3 writing in notes)
118 n no problem with passing water or going to the toilet
119 p none no

Whilst closed questions are very useful when needing to complete long questionnaires or surveys, they are also considered to be restrictive in the way they lead respondents to answer questions in a limited manner (Houtkoop-Steenstra 2000, Bryman 2001). Drawing inspiration from Houtkoop-Steenstra's work on standardised interviews in a range of (non-medical) settings there is evidence within the data that as a result of

nurses repeatedly using closed questions and similar documentation that nurses ostensibly used a comparable set of standardised closed questions and third-turn strategies in order to complete the patient's assessment to that used by, for example, market researchers during telephone interviews with members of the public (also see extracts 31 and 32 below).

The nurses in extracts 29-30 can also be seen to ask the patients questions that can be considered leading in a number of ways. In the first instance the questions are asked by the nurses in a yes-no format. Although not forcing the patients to say either "yes" or "no", it may be easier for them to choose one of these answers than to present a broader or even an equivocal reply, if they wanted to. Secondly, the questions in extracts 29 and 30 are designed as "no-problem questions" - which according to Heritage's (2002) work on doctor-patient interaction are questions that incorporate preferences that are biased towards best-case or "no problem answers". Added to extracts 29 and 30 the following data provide further clear examples of the use of closed, leading, no problem questions in the data below.

Extract 31 - Sa5

→137 n you don't walk with a stick or anything like that now
 138 p no
 139 ((n drops pen on floor))
 140 (20 secs nurse writing in the notes)
 →141 n you haven't lost some weight in the last couple of months
 142 p yeh I have
 →143 n but not a-not a great deal
 144 p no maybe half a stone or something maybe a bit more
 145 (4 secs nurse writes in notes)
 →146 n got a good appetite^ generally
 147 p uhm (.) depends on what food (.) I am very fussy though
 148 n are you ((laughs a bit))
 149 p I couldn't eat (anything?)
 150 n do you say (.) how would you say your appetite is then do you eat well or do
 151 you eat small amounts
 152 (1.5 nurse writing in the notes)
 153 p well I eat small amounts
 154 n mmhuh
 155 (9 nurse writing in the notes)
 156 n do you suffer with any diarrhoea or vomiting or constipation or anything
 157 like that

Extract 32 - Sa6

→ 131 n no disabilities at all you haven't had any CVAs or anything like
132 that
133 p >>no<<
134 (8 secs – writing in the notes)
135 n any pain
136 p no=
137 n no
138 (5 secs – writing in the notes)
→ 139 n and you haven't got a history of falls::
140 p no
141 (60 secs writing in the notes)
142 n has your weight been relatively stable over the last few months
143 p pardon
144 n has your weight been stable over the last few months
145 p up and down
→ 146 n has it (.) but there's been no (.) dramati::c weight loss
147 p no
148 n how's your appetite^

Extracts 29 to 31 therefore provide clear examples of the nurses' use of yes-no orientated declarative questions such as 'and your walking ok yeh' (line 160, extract 29) and 'you don't walk with a stick or anything like that now' (line 137, extract 31) .

Although the questions vary in terms of the yes-no polarity preferred each is constructed in search of a no-problem response. Furthermore, questions such as these which display a declarative rather than an interrogative syntax are not neutral, as the "default" response is a confirmation of the declaration (Houtkoop-Steenstra 2000, Heritage 2002).

Seen in this way there is little doubt that questions asked during nursing assessments can be considered to be leading questions. Added to this, it is overwhelmingly the case within the data that when a question is formatted so that it exhibits a preference for a certain answer, the patients will tend to pick that choice. However the following turns from extract 31 demonstrate a deviant case where the patient goes against this general rule:

→141 n you haven't lost some weight in the last couple of months
 142 p yeh I have
 →143 n but not a-not a great deal
 144 p no maybe half a stone or something maybe a bit more
 145 (4 secs nurse writes in notes)
 →146 n got a good appetite generally

The nurse in line 141 starts with a no-problem question in the form of a declaration to the patient that they haven't lost weight in the last couple of months, with the 'you haven't' at the beginning of this utterance transforming the question into a declarative statement, as opposed to, for example, the alternative interrogative of 'have you'. As already discussed these type of formulations are designed to occasion an agreeing response, in this case a "no" – but the patient in this instance deviates from the usual and generally expected response (as suggested both by the majority of the data here and in Houtkoop-Steenstra and Antaki 1997, Houtkoop-Steenstra 2000), by strikingly presenting the nurse with a 'yeh I have'.

The next turn in line 143 is very interesting not least because it provides a further demonstration of the potency of the third turn, this time used by the nurse as a resource for accomplishing agreement from the patient to an optimistically orientated query regarding bodyweight. Therefore, following the nurse's third turn reformulation 'but not a-not a great deal' the patient answers in the "no problem" manner anticipated by the first declarative question:

144 p no maybe half a stone or something maybe a bit more

The nurse demonstrates through writing in the notes that the patient's answer has been accepted, and does not offer any further comment on the weight loss of half a stone or a 'bit more'. It is difficult to see, on reviewing the field notes and the nursing notes what the nurse wrote at this time. There is no mention of the recent weight loss to be seen anywhere on the documentation, the phrase "small appetite" is entered under the

“Eating & Drinking” section of the assessment pro-forma²². A possibility exists that it was during this relatively short period of time that the nurse circled the “No” option adjacent to the section on the form “Referred Dietician Yes/No (Date)”.

Similarly, extract 32 (below) also provides a series of examples of the general “no problem” phenomenon that is under discussion in this section. Here we see the nurse present the patient with a positively orientated declarative statement, on line 139 regarding ‘a history of falls’ where the projected “no problem answer” is delivered by the patient on line 140. Line 142 sees the question of weight loss presented as more of an interrogative rather than a declarative statement, but still the option given to the patient is to disagree with the statement that their weight has ‘been relatively stable over the last few months’, repaired with the absence of ‘relatively’ on line 144 to ‘has your weight been stable over the last few months’.

→139	n	and you haven't got a history of falls::
140	p	no
141		(60 secs)
→142	n	has your weight been relatively stable over the last few months
143	p	pardon
→144	n	has your weight been stable over the last few months
145	p	up and down
→146	n	has it (.) but there's been no (.) dramatic weight loss
147	p	no
148	n	how's your appetite^

However the repair on line 144 is met by a disagreement of sorts when the patient answers ‘up and down’ – which, on the face of it, is the opposite of the stable situation presented by the nurse. In the same way as seen in extract 31, when the patient does not respond with a “no problem answer”, the nurse uses the third turn to revise the question on line 146 to ‘but there’s been no dramatic weight loss’ which leads to the patient’s immediate agreement in line 147 with the positively orientated statement – ‘no’.

²² A in-depth discussion of nurses reducing patient information and experiences is provided in Chapter 8.3.

Again there is no recording of the exact details of this interaction such as the oscillating weight in the nursing notes – the words “no problem” are entered in the “Eating & Drinking” section of the records and there is no referral to the dietician indicated. We can only hypothesise that a worst-case or “problem” answer would have been recorded differently within the notes.

To summarise there are interesting things to note about the revision of the questions seen in extracts 31 and 32. Firstly as illustrated in stages a and b in table 5 (below), in response to a patient’s answer which fails to conform to the positively orientated question regarding the patients’ weight the nurse reformulates the question rather than using the alternative actions such as writing in the notes or presentation of the next question. This action indicates to the patient that the answer given is not suitable.

Table 5. The management and emergence of a no problem answer in extract 31 and 32:

- a) Nurse presents a positively orientated interrogative e.g. you haven’t lost some weight in the last couple of months (extract 31) / has your weight been relatively stable over the last few months (extract 30)
- b) Patient responds with a “problem” answer – yeh I have (extract 31) / up and down (extract 32)
- c) Nurses revise question to a positive declarative statement – but not a great deal (extract 31)/ but there’s been no dramatic weight loss (extract 32)
- d) Patients acquiesce to the revised statement – no maybe half a stone (extract 31)/no (extract 32).

Secondly as illustrated in stages c and d in table 5, the nurse in reformulating the question abandons the interrogative syntax seen in the preceding lines and uses a more direct declarative syntax incorporating a positive stance (e.g. ‘no dramatic weight loss’). When designing third-turn reformulations in this way the questioner expects the respondent’s confirmation of the “positive” statement – such as in extract

32 'but there's been no dramatic weight loss' - which is indeed confirmed with a 'no' (line 148) from the patient.

It is evident, therefore, that there is a strong tendency in the data presented for nurses to present positive declarative descriptions such as 'but not a great deal' and 'no dramatic weight loss' to patients whose original answers do not correspond to the best case "no problem" scenario. Considering the stated importance of the initial assessment interview in gathering a patient-centred view of their health needs the possible reasons for the occurrence of such antithetical interaction during assessment interviews requires more thought.

As previously alluded to CA research of institutional talk has demonstrated similar interaction during a range of survey interviews. Houtkoop-Steenstra (2000), for example, found that telephone interviewers often re-phrased questions to project no-problem answers when there was potential embarrassment to the respondent, for example this was seen when questions were asked which left the respondent having to admit to literacy and numeracy difficulties. Houtkoop-Steenstra discusses the interviewer's "no-problem reformulations" as doing the same interactional work as Goffman's (1956) "face-saving practices", where the speaker designs a question in such a way to provide the respondent with a means of answering that ensures a lack of embarrassment on their part.

The interviewers were thus seen to employ "positive politeness", that is 'they orient toward the positive self-image that the respondents may want to claim for themselves' (Houtkoop-Steenstra 2000 p 152). Interestingly both extracts 31 and 32 (as, in fact, do extracts 29 and 30) demonstrate the face-threatening character of some of the questions asked by nurses during assessment interviews. Both extracts demonstrate nurses discussing body weight with the patients, an area of discussion

which has an increasingly moral and potentially intimidating aspect within contemporary healthcare. However, rather than nurses' reformulations regarding body weight being designed for face-saving, "positive politeness" reasons, what is seen in these extracts is the nurses strongly suggesting, through the design of their declarative statements, that the patient's weight has not dramatically *reduced* in recent times.

A similar orientation to no-problem answers is also seen in Heritage's (2002) study of the interaction between Health Visitors (HV) and first time mothers. The HV's questions were seen to be 'uniformly constructed so as to favor optimised no-problem responses' (p. 322). This tendency is explained by Heritage as embodying the benign order of everyday life, or put more simply the 'more general tendency in ordinary conversation for good news to be favored over bad news' (p.324). Adopting this style of questioning from ordinary conversation, with its potential for biasing the answer of the respondent, is seen by Heritage as a trade-off in HV-patient interaction between the desired objectivity of information collecting and the effort to build human bonds with the other.

Whilst a similarity is seen in that the tendency for nurses is for good news rather than bad news regarding the patient's body weight in extracts 31 and 32, the difference in context between ordinary conversation and nurse-patient assessment requires a more thoughtful consideration than the fact that the nurse may simply be building a bond with the patient.

So why is it that nurse reformulations strongly orientate the patient towards no problem answers that suggest no weight loss or a stable body weight? One consideration might be that, in contrast to Houtkoop-Steenstra's findings, nurses in these examples through their pursuit of no problems answers do not attempt positive politeness or face saving practices with the patients; rather they seem to be more

concerned with assessing a “stable” patient. That nurses reformulate patient answers to protect the patient from “losing face” can be ruled out when consideration is given to the fact that weight-stability may not be a positive body-image for the patient (the patient may well be obese/under-weight and have a stable body-weight). However, stable body-weight is definitely more positive for the nurses if the opposite situation is considered to be ‘a great deal’ (extract 31) or recent ‘dramatic weight loss’ (extract 32). In particular, acute and dramatic weight loss in nursing implies a more negative situation, where the patient’s general physical status has possibly deteriorated suddenly over the previous few weeks.

Thus, nurses do not appear to be pursuing “no problem” answers as face-saving utterances or positive politeness in the same way as telephone interviewers in Houkoop-Steenstra’s study, instead the evidence suggests that when confronted with “problem” answers nurses revise the original question to a more positive declarative statement which results in patients agreeing to information which presents them as more “stable cases” than in reality. This view is particularly re-inforced when the accompanying entries, or more accurately the non-entries, regarding weight loss/gain in the nursing notes are considered. Presenting patients as “stable” avoids any extra interactional work for the nurse during the assessment interview brought about by having to explore the “problem” which may itself have increased the emotion work which nurses would have to do with patients.

Discussion and conclusion.

Nursing literature and policy leaves little doubt that nursing assessment of patients, allied to good nurse-patient communication, is a crucial foundation for the satisfactory delivery of clinical care. However the interaction of nurses and patients during assessments has rarely been studied in detail within the practice setting. Not

withstanding the lack of research, the nursing literature describes nursing assessment as a primarily cognitive activity involving information processing and a problem-solving process which leads to the discovery of important clinical information (Fonteyn and Cooper 1994, Roper et al 1996). This approach to nursing assessment has been criticised for being mechanistic and instrumental (Hiraki 1992, Latimer 1995) and a device which regulates nursing practice through imposing a practice discipline (Rose and Miller 1992). It also compels nurses to attend to those aspects of patient care which are reducible to a problem, anything else a patient may have to communicate 'gets forgotten, excluded, remains private, ad hoc, a matter of luck' (Latimer 2000 p129).

More recent responses to the cognitive interpretation of nursing assessment have suggested that nurses are doing more than simply identifying problems during assessment, they are in fact establishing a long-lasting and far-reaching therapeutic relationship with the patient which, in turn, helps to form a more valid assessment of the patient's situation (Benner and Wrubel 1989, Barker et al 1997, McCance et al 1999).

Correspondingly emphasis in a range of recent healthcare policy initiatives over the last two decades, such as the NHS plan (Department of Health 2000b), has been geared towards encouraging patients to view themselves within healthcare interactions as active consumers (rather than passive recipients) of health services with associated individual rather than homogenised health needs. As a result nurses have been instructed to enter into conversations when assessing patients where, in the rhetoric of nursing policy and literature at least, it will result in holistic assessment and ensure that the patient is not interrogated through a set of mutually exclusive either/or questions, but rather in terms of more inclusive questions (May 1992).

Regardless of the differences in the approaches to understanding and describing initial nursing assessments a harmony emerges in the literature as authors concur that initial nursing assessment of patients is a process which sees the re-distribution of knowledge and information from the patient to the nurse. Researching the assessment interview therefore makes it possible to gain an insight into how the patient becomes “known” to nurses on the ward.

What this study shows is that nurses assess and get to know the patients’ history via a work based strategy which sees nurses reduce the problems of the patient to a set of physiological and behavioural categories, such as sleep, “bowels” and mobility. These sets of categories appear on the documentation which nurses need to be complete, with the effect that the information collected from patients appears to be much more closely associated to the bureaucratic or administrative needs of the nurse rather than get to “know” the personal meaning of the patient’s health needs. Moreover throughout this process of admitting and assessing, patients have no access to the documentation and they are largely only told that “questions” are going to be asked²³, a situation which is presented here as a major contributory factor in the production of an “asymmetry of knowledge” between the patient and the nurse. As a result of the asymmetry patients had no opportunity to indicate their own view of their assessment needs, instead the assessment remained, exclusively and covertly, in the domain of the nurse. In addition the nurses’ displays of neutrality in the interaction gave little feedback to the patient concerning the information they were giving in response to the questions, further compounding the lack of knowledge available to the patient.

²³ The lack of patient access to the documentation being completed will be discussed further in Chapter 8.

Therefore, throughout the data patients appear to have only a vague awareness of the professional objectives being pursued by the nurses and there is clear evidence within the data that patients struggle to understand the purposes lying behind particular questions, contributing to a sense of confusion with the result that patients are unlikely to communicate their assessment needs accurately.

CA insists that meanings are not predetermined by existing words of theorists or contexts, but are jointly constructed by the patient and the nurse themselves during and through interaction. The sequential analysis of the interaction attempted in this chapter demonstrated that the question-answer sequences, as a species of adjacency pair organisation, was the main interactional resource used during the assessment interview. However, the fine grained analysis in this chapter also suggests that there has to be some doubt about the type and quality of the information generated by this type of assessment interview, namely as the analysis shows an asymmetry of participation within the interaction which permits nurses to secure the initiative during assessments which determines:

- a) when an assessment topic is satisfactorily concluded,
- b) what the next topic will be, and
- c) through the design of the question how that topic will be shaped.

Similar concerns regarding the structure of interaction and the quality of information generated during healthcare interviews have been widely observed in other contexts, all of which report on the restrictions imposed by interviewers on the communicative freedom of the respondents (ten Have 1991, Brown 1995, Tapsell 2000). Similarly, over twenty years ago there was a realisation in nursing that 'The process of being admitted into hospital has often been a mechanical, frustrating and frightening experience for the person subjected to it' (Chapman 1983 p.87) and that 'the routine

procedures carried out by most hospitals may seem to be depersonalising in themselves' (ibid p.88).

In the same vein, Brown (1995) critiques the 'traditional provider question-client answer style' (p.340) of initial assessment interviewing as being restrictive of the patient's voice within assessment, going on to advocate instead a conversational approach to produce 'an accurate shared understanding of the client's health status' (p.340). The NHS plan (Dept of Health 2000b p.88), although not referring specifically to nursing assessments, expresses similar concerns stating that 'Too many patients feel talked at, rather than listened to. This has to change. NHS care has to be shaped around the convenience and concerns of patients'.

In spite of the criticisms of the "traditional" assessment interview and the promotion of patient centred talk, none of the authors cite empirical data in their discussions or put forward reasons for how and why the practice of talking to patients, and more specifically assessing patients, has evolved in this way. As a result the writing of academic papers and health policy neglects to place the practice of nursing within the complex world of work within which it exists. What this chapter, building on the work of chapters 5 and 6, has attempted to demonstrate is that the persistence of the traditional routinised interview format during initial assessments in the face of calls for change over the last 20 years reveals a survival instinct which seems to born out of the nurses wider organisational and institutional requirements.

As already mentioned several authors have written about the organisational requirements leading to the routinization of nursing work and the negative effects this has on patient care and the morale of nurses. In short, to deal with repetitive and routine work, organizations develop techniques such as clerical routines and standard operating procedures which ultimately aid in the processing and accomplishment of

work. Put simply, if a particular situation recurs often enough within an organization, a routine procedure will usually be worked out to simplify it (Simon 1960, Lipsky 1980). The fact that initial assessments are a recurring aspect of the nurse's daily work leads to a contemplation that the perfunctory, routinised interview style of interaction adopted by the nurses here is a reflection of how initial assessments are conceptualised on the wards used in this study.

Taking extract 23 as an example, the morning in question saw five initial assessments occurring on the ward, a typical number of admissions that would be repeated most days of the week and most weeks of the year. The nurse in extract 23 had previously assessed two patients that morning and my discussions with ward staff and observation periods on all of the wards reinforced that this was a routine occurrence on most week-days. For the patient however this was only the second visit to a hospital in 61 years, an unusual occurrence in itself and, because of this, a possibly stress provoking occasion.

As a response to the routine nature of assessment interviews nurses on the wards have developed interactional procedures for the management of multiple cases of assessments consisting of

1. minimising everyday conversational responses through occupying a neutral footing within the interaction
2. utilising the normative rules of conversation, such as those seen with adjacency pairs and preference structure as a resource for the completion of the assessment interview
3. using the third turn to shape patient responses to a format of information that corresponds to organizational requirement.

4. much of this is made possible as discussed in chapter 6 through presenting the assessment interview to patients in the opening sequences as an onerous institutional task, with the consequence also that this enables neutrality and minimal personal stake in the interview as discussed in chapter 7.

This chapter also examines that when the nurse asks a question, for example regarding sleep, what is routinely required is an answer that will fit the paper work designed for recording the patient's assessment, in this case a box of about 2 inches square, and not a conversation about the patient's variable sleep pattern or bedtime. This type of insight makes prominent an underlying conflict which runs through the patient's admission to hospital in that it is simultaneously a "workplace" for the nurses as well as a defining event in the life of the patients, with the patient simultaneously existing as an object of clinical and administrative work as well as a person with physical and emotional needs. This is further complicated because NHS ideology teaches citizens that they have a right to equal treatment and a responsive service. The ideology urges people to seek patient centred care and shared decision making as various NHS plans emphasise the need for patients to have more say in their own care and more influence over the way in which the NHS works (Department of Health 2000b, 2000c).

In reality it appears that the individual patient is pitted against the "we" of the institution during assessment interviews, a situation reflected in the nurses' lexical choices and general attitude during assessments ("nothing else can be done, we've got to ask these questions") which convey to patients what their expectations of the bureaucracy should be. Furthermore, the characterisation of assessment as routinised and institutionally centred raises doubts and questions about the nurses' use of nursing models, and the quality of information gathered about the patient. As the assessment

of patients is the first step of the nursing process, followed by planning, implementation and evaluation of the care (as discussed in chapter 3), the lack of patient centred information gathered during hospital assessment has obvious implications for the ensuing steps of the nursing process.

The following and concluding findings chapter further questions the extent to which nurses follow the ideals of nursing practice when assessing patients upon hospitalisation. Chapter 8 will again attempt to create a dialogue between nursing SIKs and the actual practices of nurses but this time through combining spoken data as well as an analysis of non-verbal communication, posture and the role taken by documentation during the initial nursing assessments of patients.

Chapter 8 – Writing, gaze and posture as ways of controlling the course of the assessment interview.

The first essence or element in nursing is the philosophical and moral recognition of nursing as a person-centred activity. With this acknowledgement comes a set of beliefs and values – whether they are overtly Christian, humanistic or existential is not important here – about the uniqueness of the individual, his or her own needs and how he or she should be treated also comes along a set of attitudes and behaviours required for the nurse to operate in a person centred way.

Techniques include paying attention to detail, uncovering meaning in everyday situations, being attentive and available, reliable and true to promises, understanding the importance of each person's own biography and how he or she is seeking to gain an understanding of what is happening to him or her (extract taken from 'The essence of nursing'; Kitson 1999 p.44).

What is increasingly becoming clear during this study is the extent to which the practices of ward based nurses during initial assessments deviates from the ideology of nursing presented in the literature and policy. The aim of this study is not to take a position regarding the usefulness of ideology or policy, but rather to contribute knowledge which serves to describe a detailed picture of the actual practices of nurses described within nursing ideology in order to develop a dialogue between the areas of ideology and practice.

A good example of nursing ideology is provided by the work of Kitson (1999) above, who views nursing as a person-centred activity demonstrable in the actions of nurses as they, amongst other things, understand 'each person's own biography and how he or she is seeking to gain an understanding of what is happening to him or her' (p.44). What is missing from this conception of nursing is the recognition that nursing exists within very different contexts and that, as the data in this study strongly suggests, nurses see the essence of nursing during the initial assessment interview to be that of gathering information about the patient which can be documented and processed according to institutional need. Whilst nurses in this study are 'attentive

and available', to quote Kitson, during assessment interviews their level of attention and availability is directly linked to the work that needs accomplishing at that time.

For example, a common appearance in the data, across all clinical areas, was the nurses' consistently attending to the need to collect patient information as well as attending to the nursing and medical records during the assessment interview. The nurses' behaviour included practices of reading and/or writing in the records, occasionally leafing aimlessly through the notes whilst at other times these readings seemed to occur more deliberately during periods of patients' talk and in the silences between turns.

Because of this association between nurses and the nursing record, initial assessment interviews cannot simply be looked at in terms of oral communication as assessments are also clearly embedded in the context and actions of producing a written document. The widespread acts of reading and writing behaviours during the assessment interview by the nurses (never by the patient), requires the researcher to consider the nursing records as dynamic rather than inert phenomena within the assessment interview.

This chapter therefore explores not only the contents of the nursing notes, but also the "active", constitutive manner which documents are used by nurses and integrated into the routine and "oral" activity of initial assessment interviewing. The breadth and depth of the record's mediating role in the production of the nurse-patient relationship, the shaping of the nurse-patient encounter and the general nature of the record's involvement in the production of the nursing assessment will also be considered.

These points will be considered in depth with the support of data in the form of transcripts, observation and excerpts from the nursing records themselves. This

analysis is presented in an attempt to balance the earlier chapters which looked at assessments as primarily an oral interaction. What emerges from this analysis is an understanding of the interactive and interdependent relationship within nursing assessment interviews between the spoken words of nurses and the written word of the assessment document, which culminate in the completed patient assessment form.

8.1 Nonverbal communication and the organization of gaze during initial assessment interviews.

Much of human communication is delivered through non-verbal channels or 'body language' and is not dependent on sound (Crawford and Brown 2004). Through their gestures, postures and facial expressions, people convey rich messages to others.

Attempts to study these phenomena have identified facial expressions, gestures and movements that when combined yield about 700,000 different possibilities, which may or may not be meaningful (Pei 1997). In their more complex form, nonverbal skills can involve abilities to initiate and maintain intimate relationships, abilities to deceive and detect deception, communicate empathy, and the establishment of interpersonal rapport and represent some of the critical elements for success in everyday social interaction (Feldman 1992).

In acknowledgement of the importance of nonverbal communication the ways in which talk and gaze are organised in interaction represents a topic that has recently gained the attention of researchers studying doctor-patient interaction (Heath 1986, Psathas 1990, Robinson 1998, Ruusuvuori 2001, Heath and Hindmarsh 2002). These studies of medical communication have captured details of the interrelationship which occurs between the doctor's gaze and bodily activities and the on-going and developing pattern of talk, an interrelationship considered as being very relevant to

the nature and production of doctor-patient interaction, especially in terms of the verbal contributions patients make to the interaction.

There is no evidence of any direct interest in this area within nursing research, although there is unequivocal acceptance of the importance of nonverbal communication in many aspects of the nurse-patient relationship. McQueen (2004) explains that 'emotional intelligence' (p.101) in nursing involves the use of nonverbal communication skills which:

'can be demonstrated in nursing when, for example, in the course of assessing patients and identifying their needs, nurses are sensitive to patients' emotions. The interpretation of emotional expression and intelligent response in the application of appropriate professional skills, such as emotional work, empathy and counselling skills, can result in patients' emotional states being modified and anxiety being ameliorated' (p.102).

Similarly the lack of research in this area has not daunted other authors from proclaiming relevant nonverbal communication from being important in conveying 'information about commitment' (Jones et al 1997, p.104) in the nurse-patient relationship as well as 'caring' (Fredriksson 1999, p.1172) and a 'trusting relationship' (McQueen 2000, p.728).

The aim of this section is to consider the production of the patient talk whilst considering the orientation of the nurses to the patient on one hand and the nursing records on the other. A trigger for this line of analysis was the common appearance in the data, across all clinical areas, of the nurses' consistently interacting with the nursing and medical records during the assessment interview. Alongside this, whilst examining the data extracts and field notes taken during the assessment interviews another interesting feature noted was the nurses' body position and gaze, and its influence on the patients' interaction.

In some of the most pioneering studies on conversational organization Goodwin (1980, 1981) drawing upon analyses of naturally occurring face-to-face

conversations showed that within the normative order of conversation, if a gazing recipient is not found, the speaker will engage in certain practices in order to secure the gaze of the intended recipient. These practices consist of discontinuities in speech, such as pausing in the middle of the utterance or restarting the utterance once started. Heath (1986) has suggested that similar practices may be used in medical consultations in order to encourage the non-gazing recipient to realign their gaze. In order to avoid pauses, discontinuities and restarts it can be seen that participants of a conversation coordinate their respective actions so as to create and sustain a situation in which successful conversation is possible (Goffman, 1981; Goodwin, 1981; Heath, 1986; Robinson, 1998). This kind of situation, in which both participants display mutual engagement in interaction with each other (i.e. one is speaking to the other, gazing at him/her, and the recipient demonstrates non-verbally that she/he is listening), is called an engagement framework (Goodwin, 1981; Robinson, 1998; Ruusuvuori 2001).

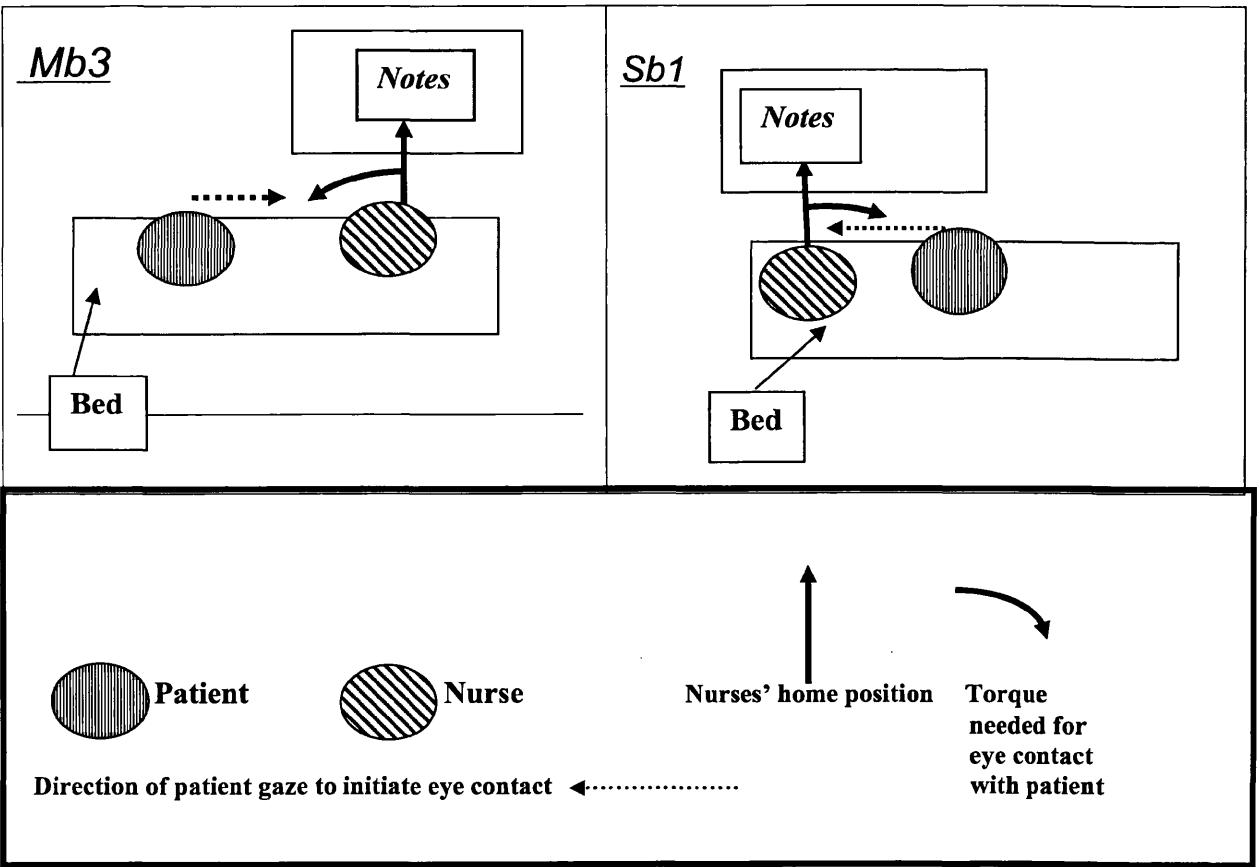
In addition to direction of gaze, the engagement framework may be created and sustained by shifts in body posture, such as turning towards the speaker to encourage continuity of talk. These postural shifts by listeners may be treated as displays of attention or disattention and can be analysed as shifts of “home position” of the body (Robinson, 1998; Ruusuvuori 2001).

The term “home position” is closely linked to the concept of body torque. The concept of body torque refers to the head’s position in relation to the body; when the head is in alignment with the lower body the position is known as the home position, but when the head is turned out of alignment with the body this position is known as torque or body torque (Ruusuvuori 2001). This is best explained with reference to figure 8 (below) which shows that the nurses’ are sitting square on to the table. The

nurses' home position therefore sees the nurses' head naturally pointing towards the table and away from the patient, which means that to talk to the patient the nurse has to torque or rotate her head towards the patient and away from the home position.

In addition to shifting the position of their heads in relation to the rest of their bodies, the participants of a conversation may display a shift in their postural orientation simply by engaging in another activity. Starting to read or to talk on the phone while the other participant is speaking signal to the speaker a major shift in orientation, thus, at least temporarily, breaking the engagement framework that had been established (Robinson 1998, Ruusuvuori 2001).

Figure 8. Diagrams of nurse/patient positions during assessment interviews and the direction of gaze and realignment needed to achieve eye contact during interviews Mb3 and Sb1.



Extract 33 Sb1

51 p _____ I had a hysterectomy
 52 n _____ when was that
 53 p hu::: twenny four years ago now twenny five
 54 n °oh alright° ok,,,
 55 n ,,,,,,____ (10 writing in notes) _____
 56 nany other medical problems _____
 57 p _____ uhm (.) yeh my () (on-going?) problems (swelling?)
 58 n _____ your ankles still swell do they
 59 p _____ yeh and my blood pressure is quite high my blood pressure
 60 n ,,,,,,,,,,,,,, (4 writing in notes) _____
 61 n is it high blood pressure you suffer with
 62 p _____ yeh
 63 n ,,,,,,,,,,,,,,(3 writing in notes) _____
 64 nhave you got medication you normally taking with you↑ _____
 65 p _____ yes I ()

As already indicated the nurse’s home position is directed towards the nursing and medical notes which are placed on a table in front of the nurse. Extract 33 shows that the nurse who had initiated eye contact with the patient during questioning subsequently had to turn their head to the home position to write in, or read the nursing notes. As already mentioned in a number of places in this study the nurses frequently end question-answer sequences with periods of writing in the nursing notes, and occasionally reading the medical notes. We find in extract 33 the nurse and patient discussing the patient’s previous medical history (lines 51-54), and at the end of the nurse’s utterance on line 54 her gaze moves towards the notes placed on the table in front of her. As the nurse begins the next question on line 56 the nurse’s head rotates towards the patient, and her gaze moves towards the patient’s face. The nurse’s gaze is maintained on the patient’s face throughout the patient’s answer and throughout the nurse’s follow-up question (line 58), however by the end of the patient’s turn the nurse’s gaze returns to the nursing notes where she writes, the patient remains silent, and the sequence is repeated.

Extract 33 represents most of the data collected in this study and is chosen to illustrate that patients' conduct during assessment interviews are sensitive to the nurses' actions, be it the nurse reading the notes or looking directly at the patient²⁴. This is of particular importance for the interaction during assessments as very rarely does the patient attempt to interact with the nurse during the silences accompanying the episodes of writing (see extract 35 below for a discussion of a rare exception). The act of writing in the notes also appears to signify the completion of different phases within the interview, as neither the patient or nurse return to the topic area, during the assessment interview at least, once the information is written in the notes in this way.

The terminating effects on interaction of the nurse's lack of orientation towards the patient when reading and writing the nursing/medical records confirm several findings from previous CA research of medical communication. Previous studies demonstrate that patients during consultations with doctors constantly monitor the doctor and the unfolding speech in order to be able to perform the relevant next action when the doctor finishes a turn of talk (Heath 1992, Robinson 1998, Heath and Hindmarsh 2002).

A clear example of this was discussed by Ruusuvuori (2001) who described how the doctor's breaking of eye contact by returning to the home position is interpreted by the patient as a display of disengagement with the effect of altering or terminating the patient's verbal interaction. Equally turning to gaze at the patient from their home position e.g. turning from their desk/computer screen to speak to the patient, the doctor non-verbally displayed that their main focus is in interaction with the patient, not for example in reading the medical records/computer screen .

²⁴ Extracts 6,7,13, for example, demonstrate the same phenomenon which adds credence to this claim.

Similarities are evident in the data here as the nurses' writing in the notes is organised sequentially in such a way that by following most answers and preceding the next question, the patient (and therefore we, as observers) can interpret it as having relevance for the interview. The relevance, once established, may then be drawn upon as a resource by the nurse in the management of the assessment interview, other aspects of the interview.

Therefore, the direction of the nurse's gaze is of utmost consequence for the continuation or discontinuation of patients' talk during assessment interviews as gazing at the patient constitutes a display of attention by the nurse. The nurses' behaviour in completing and reading the records is therefore seen as an integral part of the participant's activities, both in ways in which the conduct is produced and how the patients make sense of the nurses' actions.

However, it is vital during analysis that, rather than treating the medical and nursing notes as having an overarching influence on the field of conduct and assuming their significance remains *stable* throughout the interaction, it is advisable to examine the ways in which artefacts, such as nursing records, 'come to gain their particular significance at specific moments within courses of action' (Heath & Hindmarsh 2002, p.118). This type of analysis is particularly recommended when it is thought that material present in settings of interaction are invoked and referred to at particular moments and for particular purposes during interaction.

A couple of "particular moments" where nurses appear to be looking at the nursing records for "particular purposes" appear in the following extracts which show nurses confronted with a difficult or troubled period of talk.

Extract 34 Sa6

1 p _____ what's this for now↑ _____
 2 n _____ we're just going to admit you,,,,,,
 3 ((nurse shuffles the forms and bangs them on the desk))
 4 ((1.5 seconds nurse reading the notes))
 5 p _____ [you shouldn't have to] _____
 6 n[you remem-ber] _____
 7 n _____ mmh= _____
 8 p _____ shouldnt have to readmit me ther-the Dr came to clerk me this morning
 9 n _____ °ahh° _____
 10 ((2 seconds - patient clears throat))
 11 n _____ has to be done though love,,,,,,
 →12 --- ((10 seconds reading through notes and organising the paper work)) ---
 13 n --- °right° can I have your telephone number _____
 14 p _____ two three seven (.) five three three _____
 15 n --- oh two-

Extract 35 Sa4

47 n _____ did he get you to sign a consent form _____
 48 p _____ no= _____
 49 n _____ sorry about that _____
 50 p _____ not yet (.) so I think this is uh::m (.)°I can't° this is () cancer in
 51 the uh colon I had removed a tumour [remo]ved _____
 52 n _____ [mhuh] _____
 53 p _____ about uh >>twelve months ago<< by Mr Y and he's passed me on now
 54 to Mr X so I don't know whether its all related with the cancer in the uhm (.)
 55 oesopha::g _____
 56 n _____ oespophagus _____
 57 p _____ oesophagus yeh (.) so they're trying to burn it away now _____
 58 n _____ righty ho,,,,_ _ _
 →59 --- (10 nurse reading/looking at notes) ---
 60 p _____ I don't know whether I've got much to worry about at my age ((laughs
 61 a bit)) I think they're anxious for me to get a telegram from the Queen
 62 ((patient laughs))
 63 n ((laughs)) ,,,,_ _ _
 →64 --- (4 seconds nurse looking at notes).....
 65 n _____ so you've had a right hemicolectomy in the past didn you _____
 66 p _____ yes

The difficulties experienced by the nurses differs in each extract. In extract 34 (previously appeared as extract 10 in Chapter 6) the nurse is confronted by the patient regarding, according to the patient's talk, the dubious need to complete the assessment

interview, whilst extract 35 sees the student confronted by the patient's frank discussion regarding cancer and possible life expectancy.

What is of particular interest here is that in both extracts the nurses engage the notes in such a way that is influential within the interaction. In extract 34, following the aborted attempt on line 5 to challenge the nurse regarding the assessment, the patient's behaviour is seen as being sensitive to the removal of the nurse's gaze to read the notes (line 12) as any further patient initiated discussion of the need to hold the interview is withheld. The reading of the notes can also be seen to "buy" the nurse 10 seconds of silence, laying the ground for the opening questions of the assessment interview which immediately follows, a question which the patient immediately answers. The nurse's design of the opening question on line 13 is also interesting as it is prefaced with a quiet 'right', which is a further signal from the nurse of topic shift and closure (Beach & Dixon 2001) from the prior talk concerning the (disputed) need for an assessment interview. The assessment continues unchallenged by the patient from this point onwards.

Similarly, extract 35 demonstrates the nurse reading the medical/nursing notes at a potentially difficult time within the assessment interview.

50 p ____not yet (.) so I think this is uh::m (.)°I can't° this is () cancer in
 51 the uh colon I had removed a tumour [remo]ved ____
 52 n ____ [mhuh]____
 53 p ____about uh >>twelve months ago<< by Mr Y and he's passed me on now
 54 to Mr X so I don't know whether its all related with the cancer in the uhm (.)
 55 oesopha::g____
 56 n ____oesophagus____
 57 p ____oesophagus yeh (.) so they're trying to burn it away now____
 58 n ____righty ho,,,,_ _ _
 →59 _ _ _ (10 nurse reading/looking at notes))_ _ _
 60 p ____I don't know whether I've got much to worry about at my age ((laughs
 61 a bit)) I think they're anxious for me to get a telegram from the Queen
 62 ((patient laughs))
 63 n ((laughs 3 seconds)) ,,,,_ _ _
 →64 _ _ _ (4 seconds nurse looking at notes).....
 65 n ____so you've had a right hemicolectomy in the past didn you ____

The nurse’s first reading of the notes on line 59 follows an extended turn by the patient who describes a recent operation to remove a tumour from his colon, prompted by the nurse’s use of a continuer (line 52 mhuh – continuers are considered a good listening skill within the literature and a way of building rapport with the patient, Argyle 1972, Crawford and Brown 2004). The patient is also seen to be possibly “fishing” for more information towards the end of his substantive turn on line 53 with the turn ‘so I don’t know whether its all related with the cancer in the uhm (.) oesopha::g...’. The nurse at the end of this turn helps the patient with the correct pronouncement of the medical terminology (oesophagus), before the patient closes his turn with his description of the treatment he’s being admitted for ‘so they’re trying to burn it away now’ (line 57).

The nurse’s response at this point to the patient’s extended sequence of talk is ‘righty ho’ (line 58), an idiom associated with closing a sequence of interaction similar to the use of “right” in extract 34 (Beach and Dixson 2001), and the disengagement of eye contact as she reads the patient’s notes. The 10 seconds of silence during which the nurse reads the notes seems to be accompanied, after listening to the tape several times, by the nurse quietly humming a tune.

The difference between this extract and extract 34 is that the 10 seconds of (relative) silence is broken by the patient’s talk (line 60). As discussed earlier in this section, patient’s talking during the silence imposed by nurses’ reading or writing the notes are a rare occurrence in the data collected.

60	p	___ I don’t know whether I’ve got much to worry about at my age ((laughs
61		a bit)) I think they’re anxious for me to get a telegram from the Queen
62		((patient laughs))
63	n_____ ((laughs – 3 seconds)) ,,,_ _ _
→64		_ _ _ (4 seconds nurse looking at notes).....
65	n	_____ so you’ve had a right hemicolectomy in the past didn you _____

The patient's turn on line 60 seems to be an extension of the unrequited concerns expressed in line 53 and sees the patient once again "fishing" for information regarding his future with 'I don't know whether I've got much to worry about at my age ((laughs a bit)) I think they're anxious for me to get a telegram from the Queen ((patient laughs))'. As the patient laughs the nurse resumes eye contact and also laughs, the nurse's laugh overlapping and outlasting the patient's laugh. As the nurse's laughter tails off she turns back to the notes and disengages eye contact, this leads to a further 4 seconds of silence which is broken by the nurses next question on line 65 'so you've had a right hemicolectomy in the past didn you'.

The CA notation, as used in this study, is very useful in building a sense of the subtlety of talk and how talk-in-interaction is utilised as a resource by both participants during assessment interview. However in considering extract 35 there was a certain amount of benefit gained from stripping the talk to its bare minimum, below, to consider what was being discussed by the participants at the time.

Patient - describes removal of colon tumour,

Nurse – mhhuh

Patient - queries relationship between colon and oesophagus "cancer"

Nurse – offers correct pronunciation of oesophagus

Patient – describes current state of things going to "try to burn it away"

Nurse - righty ho – 10 seconds silence nurse looking at notes

Patient – unusual step of initiating a turn as he queries whether he's got much to worry about "at my age", laughs, jokes about life expectancies and telegram from the Queen, patient laughs again.

Nurse – joins patient in laughing, followed by 4 seconds of silence nurse looking at notes

Nurse - so you've had a right hemicolectomy in the past.

What is striking in considering the above is the extent to which the patient is "active" during this stretch of talk: he questions the nurse a couple of times, gives a summary of his current condition, initiates a turn after 10 seconds of silence, offers a "joke" about life expectancy. On the face of it, when merely looking at the "active" patient's contribution one could assume that he is participating in an assessment interview which corresponds pretty closely to the ideal models of patient-centred

communication and assessment interviews. Certainly the patient has “a voice” within this extract, and is not slow to ask questions, albeit in a slightly round-about-way, and has a good grasp of his current condition and treatment. However, whilst the patient could be said to be playing his part in terms of an idealistic patient-centred assessment interview, what is equally striking is the verbal passivity of the nurse, who offers a correct pronunciation of medical terminology, says righty ho, laughs in response to the patient’s wit, reads the notes a couple of times before progressing the interview with a question about the patient’s previous operation. Thus, the assumption that this is an exemplar of patient centred assessment interview is invalidated by the nurse’s passivity and ultimate lack of response to the patient initiated questions and concerns

In both doctor-patient and nurse-patient interaction literature, the patient is frequently portrayed as imprisoned within courses of action that are overwhelmingly undertaken at the doctors’ or nurses’ initiative (Byrne and Long 1984; Waitzkin 1991; Brown 1995; Hartrick 1997; Hewison 1999). This constraint is depicted as particularly marked in the context of history taking in medicine or assessment interviewing in nursing where, for example, the work of Mishler (1984) in medicine, and more recently Brown (1995) in nursing, have argued that the expression of patients’ lifeworld concerns may be discouraged by the design of the health professional’s questions. The prevalence of yes/no-questions, the selection of specifically medicalized topics of inquiry, and the provision of follow-up questions are commonly recognized to limit the exercise of patient initiative in the medical context (Mishler 1984; Roter and Hall 1992), although there has been little detailed research in nursing to date.

As demonstrated in previous chapters, it is clear that an activity such as initial assessment interviewing, organized through a sequence of question-answer adjacency

pairs, places substantial constraints on patients' next actions. As was also suggested in the previous chapters, by collaborating in these sequences through minimal answers, patients display an orientation to the assessment interview as a distinct activity within the nurse-patient relationship. Nonetheless, as data extract 34 and 35 suggests, patients' responses are not exclusively restricted to providing answers to nurses' questions, as in extract 35 especially and to a lesser extent extract 34, the patient provided more than the nurse asked for.

The additional material provided by the patient in extract 35, such as the discussion of the patient's fears and the graphic "lay" interpretation of his treatment summed up by the phrase 'they're trying to burn it away now' can be seen as 'narrative departure' (Stivers and Heritage 2001) within professional-lay interactions within healthcare. These departures by the patient in extract 35 can be used to accomplish a range of ancillary tasks; most significantly, they indicate features of the patient's lifeworld which are, for the patient, variously matters of significance, concern, or preoccupation.

For instance, in extract 35 as part of his response to a question about whether he had signed a consent form, the patient mentions a colon tumour he had removed 'about' twelve months previously.

47	n	_____did he get you to sign a consent form_____
48	p	_____no=_____
49	n	_____sorry about that_____
50	p	_____not yet (.) so I think this is uh::m (.)°I can't° this is () cancer in
51		the uh colon I had removed a tumour [remo]ved _____
52	n	_____ [mhuh] _____
53	p	_____about uh >>twelve months ago<< by Mr Y and he's passed me on now
54		to Mr X so I don't know whether its all related with the cancer in the uhm (.)
55		oesopha::g_____

Here, besides addressing the nurse's question, the patient volunteers an account of an experience which evidently remains significant to him. Similarly, during the patient's extended turn his concern whether the colon tumour and the oesophageal cancer are

'all related' is raised, followed up with a further concern veiled as a joke regarding his prognosis may be seen to display his preoccupation with this matter.

In the assessment interview context, these narrative expansions provide the patient with a resource for providing insights into their life circumstances. In the narrative expansions the patient actively initiates the offering of information that is neither part of answering the prior question, nor part of clarifying a provided response. Whilst the type of extended narrative expansion was rare in the data there are some similar examples where sometimes extra information is provided in the answer, for example the short data extract provided below.

Extract 36 Mb 13

89	n	do you suffer with arthritis
90	p	no touch wood ((laughs a bit))
91		(6 seconds nurse writing in notes)
92	n	are you in any other pain
93	p	uh (.) no::
94		(7 seconds nurse writing in notes)
95	n	do you need assistance with walking
96	p	no (.) not yet ((laughs))
97		(10 seconds nurse writes in notes)

Extract 36 demonstrates the patient answering the nurse's questions but also providing some expansion such as 'touch wood' (line 90), or 'not yet' (line 96), both supplementary to the otherwise adequate 'no', and both accompanied by short spells of patient laughter. A question is raised, therefore, regarding the purpose of such departures within the assessment interview.

Common to both extracts is the patient's attempt at humour. Humour as a conversational strategy within healthcare has previously been widely discussed in the literature (Jefferson 1984, Mallet & A'hern 1996; Griffiths 2002). Interestingly in the context of this study, Mallett and A'hern's study of talk between patients and nurses in a dialysis clinic, that patients often express anxieties with nurses through humorous

turns at talk as it is deemed more socially acceptable than the forthright discussion of troubles.

Looking again at the extra information provided by the patient's expansions in extract 36 it is seen that the patient introduces an element of humour into the talk when questions are asked regarding arthritis and mobility. When the patient's ongoing neurological symptoms are considered it becomes possible that the patient may well be expressing anxiety regarding the prospect of losing mobility and independence, or of contracting arthritis which would further deteriorate her condition. The nurse through the act of writing in the notes disengages eye contact and does not "pick up" on the patient's humour either on a simple level of acknowledging the turn with laughter, or on the "deeper" level that humour is possibly being used here as a cover for other troubles.

Interestingly the nurse in extract 35 does respond with laughter to the patient's introduction of humour (line 61) regarding the surgeon's being anxious for him to receive a telegram from the Queen. However, what is seen in line 63 of extract 35, is that the nurse's laugh outlasts that of the patients and may well be strategically deployed by the nurse to regain control of the interaction (Jefferson 1984). This claim of regaining control of the interaction is given credence within the data when it is considered that the nurse's laughter tails-off into a silence lasting 4 seconds (line 64), during which the nurse reads the notes before re-starting the interview with an unrelated question 'so you've had a right hemicolectomy' (line 65). The word 'so' can be heard as an effect of the nurse reading the notes, and has the immediate effect of orientating the interaction to what was just read (hemicolectomy) as an alternative to what was just discussed (cancer and prognosis) (see Beach & Dixon 2001 for a further discussion of the effects of 'so' formulations). Therefore the overlapping

laughter of the nurse followed by reading the notes effectively curtails any further discussion of cancer, treatment or possible prognosis, to the point that these important topics remain unvoiced over the remainder of the interview.

Similarly, Stivers and Heritage's (2001) U.S. study of history taking in doctor-patient primary care consultations sees a similar pattern of occasional narrative expansions by patients to what could be seen as otherwise straightforward yes/no questions. Although the data discussed were "non-humorous", Stivers and Heritage propose that narrative expansions have similar effects as they are attempts by patients to move away from the restrictive agenda of the physician's questioning as well as being an attempt by the patient to introduce their own agenda or providing an insight into what is 'on the patient's mind' (ibid p.165). This can also be seen in the extended narrative departure in extract 35, where even though an answer to the prior question is given, the patient's response is plainly focused on his own project i.e. the narrative about the previous operation, his current medical condition and the consequences for the future.

Therefore, a feature of the supplementary narrative departures offered by both patients in extract 35 and 36 seems designed to accomplish a different sort of action in contrast to merely answering the question with a "yes" or "no". These sorts of patient initiated narrative departures create different interactional possibilities for the nurse, for example, in ordinary conversation virtually any expansion, whether a supplementary "add-on" to an answer or a more lengthy narrative, could serve as a springboard for more talk. Yet what is emerging is that initial assessment interviewing constitutes an environment in which the potential seen in everyday conversations to expand is most often curtailed by the nurse. A similar phenomenon was discussed in

Chapter 7²⁵ where nurses curtailed empathic responses to patients' revelations of pain or other bodily problems to a minimum through maintaining a neutral footing within the interview, and this was discussed as a means of progressing with the main business of the interaction rather than responding empathically to patients' stories.

Narrative expansions by patients have a similar "curtailing" effect on nurses responses, possibly as they seem to pose a dilemma for the nurse of potentially detracting both parties from the business of completing the assessment interview. Interestingly however, the nurse's failure to respond to the expanded answers which cover topics which are evidently significant for the patient is not seen to be sequentially problematic within the assessment interview as the nurse takes refuge after each expansion in the nursing notes, from which action the next unrelated question emerges. As a result, what was "on the patient's mind" (as Stivers and Heritage 2001 put it) be it life expectancy or potential mobility problems does not get aired in the assessment interview, which according to literature and policy at least, appears to be the ideal forum for such discussion.

8.2 Nursing records as the drivers of interaction.

The focus of this chapter is to consider the nurses' practice of reading, writing and producing documentation during the assessment interview, practices which are considered as particularly important in the production of systematic and orderly institutional business (Prior 2003, Atkinson and Coffey 2004, ten Have 2004) but which have been largely neglected in nursing research to date. Thus building on the analysis carried out in the previous section, the aims of the following section in particular is to take account, rather than to ignore, nurses conduct vis-à-vis documents during the practice of assessment.

²⁵ See section 7.7 – Nurses' neutrality and footing in the third turn.

Extracts 37 and 38 (below) demonstrate a typical stretch of interaction within the data where the question-answer exchange is punctuated by the nurses writing and reading the nursing records. Importantly within the context of this section of the study, the extracts also demonstrate the similarity in the topics being discussed with only a slight difference in the distribution of the topics. This is particularly noteworthy as the interaction occurs in two different hospitals and is initiated by different nurses with patients being admitted to hospital with vastly different illnesses and medical histories.

Extract 37 Sa2 – Nurses questions on diet, toileting, smoking and alcohol consumption - alternating with reading and writing in the notes.

110 p yeh yeh I eat what I can eat then I just stick to it you know
 111 n its not causing you any problems though
 112 (1.2)
 113 p the eating-the diet no no:::
 114 (3 – nurse briefly looks at notes)
 115 n have you any problems with passing water at all
 116 p no
 117 (25 – nurse writing in notes)
 118 n uh any bowel problems
 119 p ((shakes head no))
 120 (20 – nurse writing in notes)
 121 n do you smoke at all
 122 p not now I used to
 123 (5 – nurse writes in notes)
 124 n how about drinking-do you drink much alcohol
 125 p very little
 126 (15 – writing and reading notes)

Extract 38 Ma1 - Nurses questions on diet, alcohol consumption and toileting, - alternating with reading and writing in the notes.

189 n Right your die::t (.) norma::l (.)
 190 (0.5)
 191 p Well (.) hu::h
 192 (0.8)
 193 n no fat?=
 194 p yes actually I've cut out fat just about altogether yeh
 195 (3.8 nurse writing in notes)
 196 p there's no special diet only um (0.8) cutting down fat really
 197 n Right
 198 (0.9 looks at notes)
 199 n Um do you drink any alcohol [at all]
 200 p [occas]ionally very little=
 201 n how much would you say Mike
 202 p (.) A glass (.) 2 uh 2 glasses of wine a week that's all
 203 n Right
 204 (8.9 writing in notes)

135 n Are your waterworks and your bowels all right
136 p Yeh yeh I get constipation sometimes just through taking all these tablets really you
137 know
138 n °Allright (.) ok °
139 (5.8 writing in notes)

The similarity and lack of variation in the topics of nurses' questions suggests that although nurses do not rely on explicitly fixed and predetermined sets of questions there is certainly uniformity in the questions within these interactions, a surprising amount when the enormous variation in circumstances and individuals is taken into account. The questions are also very similar with respect to the kind of answering information that is elicited by them, in that they provide for short answers in which factual information is given.

It appears when reviewing the transcripts and tapes that, over and above the circulation of information and the accomplishment of the practical goal of completing an admission, that the nurse-patient exchange is constructed within a prefigured, or even predictable discursive space/framework. This has the effect of positioning the patient within the interaction as a discreet object about which certain things need to be known, rather than an active respondent who arrives with the nurse at an understanding of their needs and how they are to be met. An interesting finding from this data is therefore the extent to which patients quickly adapt within the assessment interview to treating themselves as if they were categorical entities.

The processing of people into patients, assigning their everyday lives into categories for treatment by nurses and doctors, and treating them in terms of those categories appears to be a social process deeply engrained within the assessment interview which was tentatively identified during the observation period and briefly discussed in chapter 5. As discussed in the chapter 6, nurses always arrived at the bedside with the notes prominently to hand and often introduced the assessment interview to patients as a bureaucratic and onerous procedure. Furthermore, as

discussed in chapter 7, nurses continually read the nursing and medical notes throughout the interview.

It became noticeable therefore on reviewing the field notes, transcripts and tapes that the nursing record plays a far from auxiliary role within the performance of the nursing assessment interview, indeed it appears to be a very active element, or tool, within this social process. The active nature of the nursing record within nurse-patient interaction is particularly emphasised when the trajectory of the nurse-patient conversation is mapped against the lay out of the assessment documentation, as demonstrated in table 6 (below).

Table 6. Sequence of nurse initiated discussion compared to layout of document (Sb1).

The sequence of the conversation.

Front side of nursing record

- Nurse introduces herself as named nurse for the patient
- Asks for address, postcode
- Asks time and whether patient is "arranged"
- name of consultant
-next of kin and address
-telephone number
-name of GP
-Social services involvement
-type of accommodation
-reason for admission

Reverse side of nursing record – sequence of topic areas discussed, numbers correspond to boxes that are filled in on the form (right).

- 1 Language spoken
- 2 Any problems with diet?
- 2 Drinking fluids well?
- 2 Weight loss?
- 3 Any problems with bowels or waterworks?
- 4 Manage to wash and dress yourself
- 5 Walking about ok, no short of breath walking?
- 6 Your married – confirmatory statement
- 7 What are you like sleeping?
- 8 Do you do anything with religion?
- 9 Any hobbies?
- 10 You've come in with chest pain?
- 11 Do you smoke at all?
- 11 Alcohol?
- "There we are" – interview completed.

Copy of the assessment form of the nursing record (the reverse side).

**ROPER'S MODEL OF NURSING
For Assessment of Patient on Admission**

WARD.....

NAME.....

Maintaining safe environment	Communicating	Breathing
	1	
Eating & drinking	Eliminating	Personal cleansing and dressing
2	3	4
Controlling body temperature	Mobilising	Working and playing
	5	9
Expressing sexuality	Sleeping	Dying
6	7	8
Pain	Health promotion	Named Nurse
10	11	

Table 6 is an attempt to graphically represent the degree to which the requirement to fill both sides of the nursing assessment form influences and directs the content of the nurse-patient speech. In the left hand column of table 6 the topics discussed during assessment interviews are mapped in the very sequence that they arose. The nurse is seen to complete the front of the assessment form first, before moving on to questions that complete the reverse side of the form. The right hand column of the table displays

the actual layout of the reverse side of the assessment form and the numbers from 1-11 illustrate the sequence in which the topic boxes were filled.

The sequence of conversation during the assessment interview in Sb1 is typical of the overall data set as it is structured following the sequence of topics on the pre-printed nursing record (see appendix 3 for full version), with the nurse controlling via the ways discussed in chapters 6 and 7 the direction and the areas covered during the interview. As shown in table 6, following the nurse introducing herself as the patient's named nurse the first set of questions in the left hand column covers the patient's demographic details, GP or social service involvement, details regarding next of kin and the time and reason for admission. All of these questions correspond to headings in the empty information boxes that need filling on the front sheet of the nursing assessment document. The front sheet of the nursing record is structured into four columns, with the nurse progressively filling the column in a top to bottom, left to right sequence.

The next set of questions seen in the left hand column of table 6 are designed to seek information to complete the reverse side of the nursing record. The right column of table 6 demonstrates how, to a large extent, the sequence of questioning closely corresponds to the nurse reading and filling the boxes on the form in a top to bottom, left to right direction. The boxes that require filling are colloquially referred to on all of the wards as "Activities of Daily Living" (or ADLs), activities which form pivotal concepts in Roper et al's (1992) model of nursing (Roper et al refer to these as Activities of Living or ALs, with no mention of "daily"). In each of the data collection areas patients' problems are assessed via the ADL model on admission to hospital, which according to Roper et al (1992) should help nurses define, alleviate, solve or cope with problems (actual or potential) related to the Activities of Living.

The “Roper’s Model of Nursing”²⁶ shapes the talk during assessment, acting as a form of semi-structured questionnaire or interview schedule. The model can also be seen as constituting a ‘hidden agenda’ (Grossen and Orvig 1998 p.149) in as much as at no time did the nurses give an explanation to the patient that the “questions that had to be asked” were in any way connected to an assessment framework that needed completing and that to simplify its completion a chain of largely unconnected questions regarding the patient’s body and bodily habits would ensue.

The above discussion would certainly suggest that it would be a mistake to conceptualise the nursing record produced during assessment as a mere neutral copy of the patient’s concerns. The nurse’s use of the assessment form based on the activities set out in Roper et al’s model of nursing is also clearly seen to transform patients’ concerns into a series of nursing/medical problems by functioning as a structured framework for the collection of information. The nursing record appears therefore to be actively involved in shaping the very events it attempts to ‘represent’ (Berg 1996 p.519).

It is worth re-capping briefly at this point that writers such as Heath (1998), which were discussed in Chapter 3’s review of the literature alongside a discussion of stocks of interactional knowledge or SIKs in nursing, comment that nursing models and the nursing process provide a decision making framework whereby patients are seen ‘as individual psycho-social beings rather than homogenous groups with disease based medical needs’ (Heath 1998 p.290). However, this study demonstrates that the nurses’ use of the ADLs framework as a form of questionnaire, which is actively read and written-up during the assessment interview, has detrimental consequences for the

²⁶ As it is referred to on the form used on this particular ward – as shown in table 6, the title of the form states:

ROPER’S MODEL OF NURSING
For Assessment of Patient on Admission

view of patients as individuals. Unfortunately rather than liberating the individuality of each patient, the ADLs framework is used largely as an instrument of conversational control by nurses.

“Conversational control” is used a gloss in CA and other types of discourse analysis to describe various practices that get played out in context which have to be displayed in the data by the analyst (Buttny 1996). For example conversational control is instigated through various interactional asymmetries between nurses and patients such as when nurses read and write documents during assessment interviews, and patients do not which, in turn, contributes to the production and mutual recognition of the situation as an expert-nurse interacting with a lay-patient, and of the asymmetrical distribution of duties and rights which come with that (Silverman 1987).

There is also no apparent logic to the sequencing of the questions during assessment interviews, with the topical flow of the conversation reflecting nothing more than the order of the “ADLs” on the assessment sheet. Similar routine organizational contingencies, which are taken for granted by health professionals and used to shape interaction, but are unknown to the patients, have elsewhere been found to be the source of confusion or irrelevance to patients (Whalen 1995).

Initial assessments cannot then be simply looked at in terms of purely oral communication as they are embedded in the context of a written document and the actions this text assigns. What is made explicit in the analysis in this section is that the nursing record has been pre-structured and written to convey the nurse’s view of the patient’s experiences rather than arriving at a combined view with the patient. Further examples of this will be discussed in the next section.

8.3 Reducing patient descriptions in documentation.

Latimer (2000) in an ethnographic study of nursing care remarks that nurses conduct admission assessments as if looking at the patient 'according to a grid of perceptions and then noting according to a code' (p.91). Parallels between Latimer's study and the present study are seen in that, as already noted, the nursing assessment record as used by the nurses in this study plays an important role within the assessment interaction as nurses *reduce* aspects of the patients' experiences to traits and parts which correspond to the pre-printed section of the documentation that requires completion, and that effectively the record composes "a code" by which the nurses' and patients' contributions are profiled.

In both this and Latimer's study the patient's "actual history" is therefore seen to be selectively re-written to produce a streamlined and decontextualised image of a "nursing history". If we keep in mind that nursing assessments and the processes of documenting or "coding" patients are founded upon the use of spoken and written words and constructed through interaction, Latimer's otherwise admirable study is restricted somewhat as there is little detail of how nurses and patients interact in practice and thus only limited insight is generated into the very ways in which "looking at a patient according to a grid of perceptions" has an effect on the written and spoken words of both participants.

Therefore it is the aim of this section to understand the dynamics of the transformation of the patients' utterances into written nursing "data" through a comparison of the entries written on the record to the talk-in-interaction or the 'raw material' (Hak 1992 p.145) used to produce the record. The starting point for the analysis of this section will be to explore a previously considered data extract from Chapter 7.5. This data extract was first used to demonstrate how the third turn

position following a question-answer sequence was used as a resource by the nurse to reformulate a patient's answer using a personalised/biographical framework of time to a more objectively institutionalised "clock orientated" answer concerning the amount of sleep the patient had each night.

Extract 39 - Ma1

233 n Will you be requiring a sleeping table:t?
 234 (2.2)
 235 p Uh:: (.) no I've brought my own tablets with me really (.)
 236 p u[m] I take Timopra[_{min}]
 237 n [right]
 238 p yeah
 239 (0.5)
 240 p Whi[ch is]
 241 n [No d]o you need a sleeping tablet to help you s[leep at night]
 242 p [They do hel]p me to sleep yes
 243 n So you'd like one=
 244 p Yes
 245 n Right (.) 'cos its not on your lis::t=
 246 (4.6 – nurse writing in notes – requests sleeping tablets)
 247 n: How-how long do you sleep (.) for↑
 248 (3.2)
 249 p: ° Uh:: I wake quite early uhm:: °
 250 n: How many hours do you sleep at night?
 251 p: Well I try and get 8 hours but its not- its not always 11 o'clock umh
 252 (0.6)
 253 n: Broken sleep is it↑
 254 p: I sleep til seven probably yeh yeh
 255 (0.5)
 256 n: How many hours a night rough::ly↑
 257 p: (0.5) Say seven um I think
 258 (7.8) [n writes in notes – sleeps seven hours a night]

What is of interest in this section is that the nurse condenses the information discussed in the above extract into a box headed "Anxieties/Feelings/ Relaxation" on the admission assessment sheet, as demonstrated below.

<p>ANXIETIES/FEELINGS/RELAXATION</p> <p>NIGHT SEDATION Y/N NORMAL SLEEPING PATTERN <i>Requests sleeping tablet</i> <i>Sleeps 7hrs a night.</i></p>

The information in the box (reproduced above) records that the patient takes night sedation (the nurse circled Y for yes – a nominal Yes/No choice, interestingly there is no option for choosing “sometimes” for occasional use of sedation) and in the subsection “normal sleeping pattern” the nurse writes “Requests sleeping tablet. Sleeps 7hrs a night”.

The varied interaction in extract 39 is therefore transformed by the nurse into a concise statement which does not altogether tally with the patient’s description of how he sees the current situation with his sleep/sedation. The considerable extent of the transformation is made evident when the contents of the patient’s actual utterances in extract 39 are considered. What the patient says is:

- ◆ that he doesn’t require a sleeping tablet (line 235) but that they do help in sleep (line 242),
- ◆ that he wakes up quite early (line 249)
- ◆ that he tries to get 8 hours of sleep but he goes to bed at different times (line 251)
- ◆ that he sleeps until seven (line 254)
- ◆ that he sleeps for seven hours, he thinks (line 258).

As discussed in Chapter 7.5 it is evident that the patient has difficulty comprehending the particular line of questioning undertaken by the nurse, although the nurse fails to pick up on some of the cues which suggest that the patient is experiencing difficulty such as the long gaps between the nurses question and the patient’s answer in lines 234 and 248. Regardless of the patient’s difficulty he still manages to give a fairly detailed description of his variable sleep pattern is but in the act of “writing up” the notes the patient’s utterances are transformed by the nurse into a “normal” sleep pattern of 7 hours a night. Writing down one-line summaries (“sleeps 7hrs a night”) transforms the patient’s less than “normal” early waking sleep pattern and variable length of sleep into a more normalised and manageable state.

Nurses therefore do more than simply reproduce in their notes the patients' terms, accountings and assessments of the problems. Instead the nurse reformulates the patients' problems into different terms – to a discourse consistent with the nurse perspective, creating a sense that once patients present their problems nurses transform them to suit their needs rather than to represent the patient's. Barrett's (1988) detailed study of patients' admission assessments in an Australian psychiatric hospital similarly noted the process by which lengthy or detailed verbal accounts given by patients were reduced to sparse entries in the written record. He noted that this process changed the patient's detailed description into a textbook view of the signs and symptoms of schizophrenia.

A comparable sense of patient histories being reduced is noted in Berg's (1996) study of doctor-patient consultation in a Dutch oncology clinic. Berg noted that writing down one line summaries of the patient's complex medical and social situation reduced the complexity of the tasks on hand, producing a particular rendering of patients' histories that appeared more manageable on paper than when communicated verbally by the patient. Berg also notes, as was noted in Chapter 7.5 and seen above in extract 39, that the brevity and conciseness required for the record to work at the same time necessitates continuous repair work by both parties.

8.4 Delaying patient descriptions to fit the nursing record.

It has already been demonstrated that during the process of assessment patients' are asked a series of largely unrelated questions which reflect a reductionistic rather than holistic view of human beings. The unrelated and illogical nature of the questions has also been demonstrated to be an outcome of the nurses choosing to follow the layout of the form rather than adopting a more logical and expansive conversational approach to the assessment.

The view of initial assessments as reductionistic and illogical is further added to by the analysis presented in the following section. Data will be forwarded here that clearly shows nurses actively discouraging patients presenting their symptoms and experiences in any other sequence and order other than the order and sequence which appears on the documentation. Accomplishing this is reflected in the data by nurses delaying or co-ordinating the patient descriptions of particular symptoms – such as pain or sleep disturbance until the occasion where the relevant areas of documentation that most closely correspond to that symptom is reached.

The problem with assessing patients' health needs and experiences as a series of largely unconnected topics is that human beings, of course, rarely suffer symptoms of illnesses either singly or sequentially and in an easily labelled fashion. What is more likely is that patients, such as those in this study, suffer several symptoms of their illnesses at the same time. It is possible therefore that tension may arise between the largely systematic and reductionistic approaches nurses use to assess patients and how the patient's view and describe their problems.

The degree of influence imposed by the assessment form on the timing and nature of the patients' contribution to the interaction is evident in the following extracts which typify this phenomenon within the data set.

Extract 40 Mb2 - Delayed discussion of headaches

176 n YOU DO a lot round the house then to help is it-
177 p well (.) mu::muck in- with the daughters come in=
178 n do they oh ok
179 p wu since April I can't (.) bloody do much cos I (.)=
180 n alright=
181 p because these headaches come straight away-
182 n °right °
183 (0.8)
184 n what type of accommodation do you live in↑
185 p we've gorra council house

2 minutes later

208 n right reason for admission
209 (1.6)
210 p he[adaches]
211 n [wha does] (.) headaches right how long have you been having these
212 headaches?
213 p uhm since last April
214 n an what type of headache is it does it l[AST]all day
215 p [[oh its] its like continuous
216 n continuous-then is there any particular part of the head
217 p I was just telling the doctor that it moves about you know ((points to
218 left side of head)) lately now its staying here and this eye is terrible ((points
219 to left eye))

In extract 40 the nurse is seen to be asking the patient a question regarding his home circumstances e.g. domestic arrangements and type of accommodation, information which is entered on the form under the sub-heading “Social factors”. In the course of describing his social factors the patient mentions ‘because the headaches come straight away’ (line 181) as a contributory factor to his current situation of needing assistance with the house work.

However, the nurse chooses not respond to the patient’s description of his headaches, instead pushing on with questions relevant to the “social factors” section of the record being filled at the time – ‘what type of accommodation do you live in’ (line 184). The quiet ‘right’ and the 0.8 second pause on lines 182-183 does the work of closing down the subject of headaches for further discussion at this point, enabling the nurse to continue with a question more closely related to the area of

documentation that is currently being worked upon with ‘what type of accommodation do you live in[↑]’. The use of ‘right’ in line 182 works in a directly opposite way to utterances such as “yes”, “uh huh” which simultaneously signals the continued attention of the listener whilst encouraging the speaker to continue with the current topic of conversation (Atkinson & Heritage 1984; Houtkoop-Steenstra 2000).

The patient again introduces the subject of headaches into the assessment two minutes later this time in response to the nurse’s question ‘right reason for admission’ (line 208). As investigation into recurring “headaches” is indeed the reason for admission and the opportunity is now given for the patient to describe the type and location of headache. The nurse demonstrates the relevance at this point in time, as opposed to the earlier point in time, of discussing this topic through actively prompting the patient to come up with more information through the use of supplementary questions.

Interestingly, the extensive pause of 1.6 seconds (line 209), 0.8 to 1.2 seconds being the conversational norm (Jefferson 1985), which precedes the patient’s turn indicates that the patient has some sort of difficulty with this question, perhaps as he feels that he has already made it clear in the previously blocked interaction that ‘these headaches’ (line 181) are a major concern and consequently the reason why he’s being admitted to hospital. The 1.6 second pause may be a demonstration that the patient expects the nurse to take into account what he told her beforehand, a basic expectation within ordinary conversation summarised by Sacks (1992 p.438) as ‘if you’ve already told something to someone then you shouldn’t tell it to them again’²⁷. Therefore, looking at the 1.6 second pause in this manner indicates that the question has somewhat confused the patient.

²⁷ Sacks (1992) calls this “recipient design”, a concept that refers to the fact that participants in ordinary conversation design their talk for its specific recipients.

The outcome of the analysis of this fragment of data is important as it shows that the nurse and patient may be working from different conversational rules, the nurse expects the patient to know that the assessment interview is not an ordinary conversation but a form filling exercise, demonstrated through the suspension of normal expectancies such as recipient design, whereas the patient is unaware of this and his expectations of recipient design seen in ordinary conversation remains intact.

Further proof of the influence of documentation and that the patient does not expect to say things he has already said is seen in extract 41, which demonstrates a similar occurrence within the same interview only moments later.

Extract 41 Mb2 Delayed discussion of sleep

227 n are you able to sleep with it
 228 p oh:::ho I'm opeless sleeping I was just telling some of the boys here
 229 now he was up at six he said I'll be up at two
 230 n °gosh ° you haven't been taking anything to help you sleep no↑
 231 p whe-when I was in x hospital uh:m (.) they wouldn't give me sleeping
 232 tablets because of my chest =
 233 n oh you've got a bad chest have you-right so you've come in for
 234 investigation into headaches yeah
 235 (12.3) ((nurse writing in notes))
 236 n right you haven't got any breaks in your skin at all:?

6 minutes later

511 p I'm not sure what happened you know ((sniffs)) whether they were
 512 penicillin
 513 (3.1- nurse reading notes)
 514 n °o:k ° your not sleeping too well now you say (.) yeah (.) your not sleeping
 515 very well at the moment with your headaches↑
 516 (2.1)
 517 p Ah-I'll go to sleep three or four times a day (.) for an hour you know=
 518 n yeah
 519 p when it gets too bad I'll have a lay down=
 520 n mmhuh↑

Whilst still discussing headaches as the reason for admission the nurse asks whether, due to the pain, the patient finds sleeping difficult – 'are you able to sleep with it' (line 227) . The patient proceeds to explain that sleeping is indeed problematic ('I'm opeless sleeping' – line 228), and to a further question from the nurse ('you haven't

been taking anything to help you sleep no' – line 230) that his sleeping tablets have been discontinued due to 'my chest' (line 232). Inexplicably the discussion of sleep (and the chest problems) is terminated by the nurse's following turn, as the interview shifts back to the reason for admission which is the area of the paperwork currently being completed ('right so you've come in for investigations into headaches yeah' - line 233-234).

Effective topic management during the assessment interview through the termination of the patient's descriptions is demonstrated by the nurse in abundance in this turn, as both 'right' and 'so' are used as signifiers of topic termination, as well as the nurse withdrawing eye contact through turning and writing in the notes, all of which are discussed at length elsewhere in this study. Six minutes later however the interview arrives at the area of paperwork reserved for assessing sleep and the topic of sleep is re-introduced into the interview (line 514).

514	n	°o:k ° your not sleeping too well now you say (.) yeah (.) your not sleeping
515		very well at the moment with your headaches↑
516		(2.1)
517	p	Ah-I'll go to sleep three or four times a day (.) for an hour you know=

The nurse goes some way to acknowledge that this topic has already been discussed by the use of 'you say' ('you're not sleeping too well now *you say*' - line 514) before questioning (the upwards intonation suggests that this is a question rather than a statement of fact) if this is related to the headaches, something which the patient had previously confirmed earlier the discussion (line 228 – 'I'm opeless sleeping').

Once again a delay component, this time of 2.1 seconds is produced by the patient, a long pause between turns which again signifies the patient's difficulty with the non-conversational style of discourse being employed to complete the assessment interview. The difficulty with nurses questioning style illustrated in extracts 39-41

demonstrate that patients may not know or understand the purposes lying behind particular questions especially regarding unconnected topic areas or the revisiting of previously discussed areas. The interactional effects of nurses adopting a non-conversational style within the assessment interview are therefore clear to see, but how this situation affects patients psychologically or following completion of the assessment interview is less clear. However, according to Heritage (1997) the gap between ordinary conversation style and institutional talk, allied to the institutional know-how of health professionals compared to the patient's singular experiences of healthcare, can result in the patients' experience of such encounters being extraordinarily stressful.

Discussion/Conclusion

Standardised assessment formats for the routine collection of patient information appear to have evolved within a variety of healthcare occupational groups (dietitians Tapsell 2000, psychiatrists Hak 1992, medicine Frankel 1990, emergency services Zimmerman 1992). Similarly, as a response to the routine nature of patient assessment interviews nurses in this study have developed procedures for the management of multiple cases of assessments by assigning information gathered about patients into pre-specified categories on the nursing record, which roughly corresponds to Roper et al's activities of living model of nursing (Roper et al 1996).

Roper et al's model of nursing is used as a template for the collection and organisation of patient information during the admission interviews, and has been demonstrated to have a clear influence on the trajectory and content of nurse-patient talk during interviews. Prior (2003) states that it is possible to *see* a "world view" and image of reality within a document. I would certainly agree with this point whilst adding that it has also been possible during this study to *hear* as well as *see* an image

of the reality of nursing work on busy wards through nurses' design and use of assessment documentation. The "world view" or image of patients that is presented both by the nursing documentation and the ways in which nurses verbalise the documentation is that of patients as individuals who have such potentially complex histories that the assessment documentation and interaction needs to be reduced to a series of categories and questions to simplify and expedite the assessment process.

This chapter has also demonstrated how the patient's narrative during assessment interview is compromised somewhat by the nurses' need to divide their attention between the patient who is producing the information, and the nursing record which provides information to the nurse regarding topic areas that "need" to be covered during the assessment. In itself this may not be a major problem, however, rather than using the nursing record as an *aide memoire* during the assessment interview the nursing record functions more as a script for nurses to follow, with the areas discussed during assessment closely following the layout of the record.

The patient's narrative has been shown to lose out to the nurses desire to follow the layout of the nursing record, and the situation has been described in this chapter where the nurse pursues a non-conversational approach to aid in the completion of the assessment interview in this way. This is particularly seen when certain topics of discussion are prematurely closed down or delayed by the nurse only to be revisited further-on during the assessment interview with little or no acknowledgement of the prior talk by the nurse. This delaying approach was seen to cause interactional difficulties for the patient, but an approach which the nurse seemed content to pursue as it aided the completion of the assessment documentation in a particular order. It could be argued that in pursuing this aim the information produced within the interview is of a low quality as the patient's personalised and

expert account of their lives are re-written in the nursing record in terms of the nurses' professional knowledge and reductionistic frame of reference i.e. the nursing model.

Doubts about the quality of the assessment information are also raised when findings from previous CA research are considered. According to Goodwin (1981) it is possible that disengagements (such as not maintaining eye contact, scribbling with a pen) at crucial moments of talk signal clearly to the speaker that the recipient has little enthusiasm for what they are saying, and result in the speaker initiating a topic change. The nurses engaging in similar practices of reading, writing or rearranging the documents appeared throughout the data, and examples were discussed where this appeared to coincide with moments when patients were discussing emotive matters. Although nurses reading the nursing record may be regarded as a relevant activity at some point during the assessment interview, it may be considered as inappropriate during such crucial times of the interview, such as the examples here of the patient recounting their recent medical histories and explaining their concerns regarding their illnesses. The finding that nurses "block" patients' expansive or narrative disclosures regarding cancer and prognosis is similar to the findings discussed in the literature review (Wilkinson 1991, Booth et al 1999).

Whereas it could be argued that the nurses' lack of engagement may be of minor importance within the broader context of the patients hospitalisation it could also be argued that, considering the stated importance of the assessment interview in establishing the nurse-patient relationship, disengagements in gaze and posture such as these at times when the patient is sharing personal information may well undermine further attempts by the patient to communicate such thoughts. Whilst constant gazing at the patient during assessment interviews is neither desirable, or possible, displaying attention to the patient's story is considered as one constituent of patient-centred

communication (Ruusuvaori 2001), a concept that has been widely used as a yardstick in both nursing policy and literature as a yardstick of “good” and “bad” interaction with patients.

Accurate information during initial assessment is vital, if nothing else, as it constitutes the first step in the nursing process culminating in the care plan which subsequent patient care is based on. As Mason (1999 p.380) explains a nursing care plan is a written, structured plan of action for patient care based on a holistic assessment of patient need and structured by the model of nursing upon which it is based. However the clinical application of the nursing process has been described by some as a ‘professional mirage’ (O’Connell 1998, p.31) and Mason’s (ibid) own interviews with nurses saw some of the sample describe care plans based on ADLs as ‘a load of rubbish’, ‘a waste of time’ and ‘a joke’ (p.384). These sentiments are also shared by patients interviewed by Allen (1998) who had read their care plans

Overall the evidence suggests that nursing assessments and care plans appear to have no positive influence on nursing practice which was driven by other factors and information. The systematic reviews discussed earlier in this chapter by Moloney and Maggs (1999) and Currell and Urquhart (2004) can be added to by Allen (1998), Griffiths (1998), Latimer (2000) and Payne et al (2000) to name a few, who all provide evidence from UK hospitals that nursing records are inadequate in their descriptions of patient needs and are scarcely used to plan and deliver nursing care. An example is seen in Latimer (2000, p.145) who states that a ‘patient’s “problems” were very rarely made explicit in the nursing records’ and that nurses did not often use care plans’. Allen (1998) and Payne et al (2000) suggest that were it not for the legal requirement that nurses keep records of patient assessments and care the written nursing record would be in an even worse state than the research suggests.

Evidence from this chapter indicates that the ambivalence felt by nurses towards the nursing process and the nursing record within which the process is documented leaks into their performance of the assessment interview. This has the effect that nurses unthinkingly follow the layout of the paperwork, rather than engaging in an open ended conversation with patients. As a result patient descriptions are minimised or delayed to fit the trajectory of the documentation rather than of their lived experiences, and emotive talk by patients is ignored.

The lack of acknowledgment by the nurses of the patient's personal identity facilitates the depiction of patients in terms of bodily dysfunction. The predominant construction of patients throughout the assessment interview and within the nursing records remains within a biomedical discourse with the implication that patients were largely constructed as bodies to be processed in relation to the nomenclatures derived from nursing models. Prior (2003) argues that how the authors of documents function is the question that matters rather than who he or she "is". This chapter therefore makes uncomfortable reading for those within nursing who promote the registered nurses as holistic carers, and for policy makers in Wales who state that 'A patient centred NHS must not be just a slogan' (NAW 2001, p.35).

Chapter 9 – conclusion.

Throughout this thesis I have discussed the relationship between conversation analysis as a research method and the texts which represent the theoretical body of knowledge relevant to nursing. I have described the claims made throughout this literature that nursing assessment is a key feature of nursing work and the ways in which it is represented as the foundation of a nurse/patient relationship. I have also described the remarkable lack of research on the practice of nursing assessment as a naturally occurring activity. This thesis addresses that lack and has allowed me to achieve a number of objectives.

Combining conversation analysis with observation of the activity of nurses as they go about their work on an everyday basis, this study has examined, and made visible how nurses and patients interact with each other during initial assessments on a diversity of wards. Observational data presented in chapter 5 showed how the assessment interview is a routine and everyday part of hospital nurses' work, whilst analysis of nurse-patient talk and non verbal activities during the interview (chapters 6, 7, 8) shows how nurses observably achieve the completion of the assessment as a routine, bureaucratic, form-filling event which reduces patients' life experiences to a set of bio-medical categories which have everything to do with the needs of the organisation to complete a form entitled 'nursing assessment' but very little to do with nurses and patients building a relationship.

Chapter 6 discusses the ways in which nurses make clear from the very beginning of their talk that the assessment interview is a bureaucratic interaction and that no alternative is available other than to interact in this way. The person admitted to the bed is therefore immediately denied the opportunity of presenting themselves as a social and personal being and is remade as a patient. "Patients" as entities for

organisational purposes as opposed to persons are what the nurses' interaction is aimed at, and this is further perpetuated and extended through forms of writing in the nursing documentation as discussed in chapter 8. Much of the work of nursing during the assessment seems to be about the categorisation rather than the understanding of patients' experiences.

However, neither bureaucratic form-filling nor restricting the patients' voice within the assessment (as described in chapter 7) are satisfactory approaches to assessment from the point of view of nursing theories and literature, or in terms of the broader ethics of nursing practice both of which advocate an individualised, patient-centred and humanistic approach to nurse-patient interaction in general and initial assessment interviews in particular. Some of the analysis in chapters 7 and 8 also showed the ways in which patients themselves found the bureaucratic interview, and their role within it, a rather difficult role to grasp. This raises questions regarding the disparity between ideology and practice.

It seems relevant at this point to consider the observations made by early workplace studies (e.g., Dalton, 1950, 1959; Dubin, 1957) that while political and policy shifts may lead to the acceptance of new policies and practices at the institutional or higher management level (in this case patient-centred or individualised nursing assessments), core workers on the "shop-floor" are likely, at least in the short-run, to cling to old attitudes and behaviours inconsistent with the institution's new ideas but consistent with the institution's established environment, pressures, constraints and practices (in this case continuing nursing behaviours such as task-focussed, institutionalised interactions as discussed in Chapter 2.5). Over time, it is claimed by some that these inconsistencies are likely to be resolved in favour of the new policies and practices, resulting in stable, consonant states within the workplace.

The conclusion that could be drawn at this point is that this time is yet to arrive with respect to new policies and practices influencing the style of initial assessment interviews. However there is little evidence within my data that the current style of assessment interviewing shows any signs of change and that on the whole the assessment process corresponds pretty closely to the anecdotal opinions expressed over 20 years of it often being a routine and depersonalising interaction between nurse and patient (Chapman 1983²⁸). Thus rather than accepting the views of early workplace theorists that short term resistance to policy change will eventually be replaced by acceptance in the long term, the careful analysis of assessment interviews in their naturally occurring context shows how nursing practices are resistant to change and how policies actually work or fail to work. The analysis undertaken here therefore leads to an alternative point of view, one which suggests that changes in nurses' assessment style, which the data demonstrates to be so deeply embedded in nursing practices across a range of acute hospital wards, towards a more desirable style of patient assessment will only occur alongside changes in the environment within which nurses work. The resistance to change demonstrated by nurses continuing to practice an assessment style which has been roundly criticised for over 20 years signifies that changes to the nurses' interaction style will not simply occur through nurses getting used to new ideas.

This brings to mind the work of Lipsky (1980), first mentioned in chapter 5.4, who aimed to view policy from the perspective of welfare state professionals involved in the delivery of policy at the "street-level" e.g. professionals like nurses, teachers, people working in benefits offices, police etc. Lipsky argued that when viewed from this point, the real face of policy emerges:

²⁸ See chapter 7.8 for full quote from Chapman (1983).

“public policy is not best understood as made in legislatures or top-floor suites of high ranking administrators, because in important ways it is actually made in the crowded offices and daily encounters of street level workers... In practice, they must deal with clients on a mass basis, since work requirements prohibit individualised service...At best, street-level bureaucrats invent benign modes of mass processing that more or less permit them to deal with the public fairly, appropriately, and successfully. At worst, they give in to favouritism, stereotyping, and routinising - all of which serve private or agency purposes’ (Lipsky, 1980 p.xii).

Lipsky’s work offers nursing a means of evaluating the adoption (or adaptation) of new policy in practice, and that the research approach taken here of combining CA and observational analysis, enables additional insights into the play between policy and the existing conditions and orientations of the actors involved.

The disparity between the theory and practice of assessment interviews may also explain why nurses present the interview to patients as a source of difficulty (chapter 6.1). The difficulty is particularly noticeable in the rather apologetic and remorseful ways in which the assessment is framed by nurses and which portrays the assessment interview as introducing an alien set of relevancies into the nurse-patient relationship. It is as though the nurse is apologising to the patient for the dissonance created by choosing to assess the patient in a way that is clearly at odds with the written values of nursing and health practice more generally. However, this study does not claim to show what people are thinking. Heeding the advice of Silverman (2005), I cannot, and do not aim to make claims about what patients and nurses think as CA studies do not focus on people’s perceptions of events, but on their actual conduct. Thus, when discussing cognitive dissonance in chapter 6, the claim is not that nurses were “feeling” or “thinking” dissonance but that elements which could be described as representative of dissonance, and dissonance reduction, were observable in and through examples of their spoken conduct.

This study takes a new and more rigorous approach compared with previous nursing research in this area. This is particularly evident as this research is undertaken

from a position which is able to make nursing ideologies and rhetoric part of its topic rather than trying to carry out research from within these ideologies or rhetoric, and for that reason it has discovered different things. In particular as nursing ideologies are used as a point of comparison with actual nursing practice, rather than being accepted as pre-existing in nursing practice or an integral part of the research design, a critical evaluation of the dynamics between ideology and practice has been made possible.

The pioneering CA work of Peräkylä and Vehviläinen (2003) was especially encouraging in promoting dialogue between CA findings and professional theories and stocks of knowledge related to an occupational group. They describe the 'normative models, theories or quasi-theories concerning professional-client interaction' (p.727). of occupational groups which are contained within the theoretical body of knowledge (referred to as 'stocks of interactional knowledge or SIKs) which can be found in textbooks, policy documents and taught to students in the context of professional training. In common with the approach taken in this thesis they have described a range of possible relationships which are possible between these theoretical bodies of knowledge and the results generated by research methods which analyse and make visible the actual practices through which people carry out their daily work.

Although their work has been based in different institutional settings (medical and counselling interaction) it has clear relevance to work which explores the relationship between CA and nursing. They propose four possible relationships between CA findings and the theoretical knowledge, or SIKs, of occupational groups, namely that CA findings can:

- (i) falsify or correct assumptions that are part of an SIK; it may
- (ii) provide a more detailed picture of practices that are described in an SIK.
- (iii) CA may also add a new dimension to the understanding of practices described by an SIK, or
- (iv) provide the description of practices, not provided by a very abstract or general SIK.

Aspects of all 4 of the above points are evident in this study and have helped considerably in clarifying the often complicated relationship which exists between theory, policy and research on the one hand and their implementation in nursing practice on the other (Le May et al 1998, Rolfe 1998, Foundation for Nursing Studies 2001). Specifically, my work has shown that this approach to CA can assist in clarifying the complex relationship between nursing research and practice and that it can also help to reconcile the differences between nursing's theoretical knowledge and practice. In particular, whereas the business of nursing's theoretical knowledge, to date, has been to provide a normative framework which explains, legitimises (or opposes) existing practices with little reference to research findings, this study has offered a way of describing actual occurrences of interaction and creating a much needed dialogue between the previously disparate areas of theory and practice.

By embracing the 'challenge' (Peräkylä and Vehviläinen 2003 p.728) of addressing the theories or concepts that are held by the practitioners as valid and consequential I have shown the usefulness of CA in pointing out the simplified or empirically unsustainable assumptions located in one area of nursing's theoretical knowledge. However, this study has also achieved a complementary task of providing both detailed and concrete descriptions of known practices and showing new practices or functions during the assessment interview. This illustrates how CA can assist nursing to move more easily between the worlds of research, theory and practice and by so doing offers the possibility of responding to calls for more thorough evaluation

of nurse-patient interaction as a central concern of nursing knowledge and practice (Shattell 2004, Watson 2005,).

This approach therefore appears to have the potential to make possible something that previous CA research has struggled to achieve i.e. that health professionals can see the relevance of conversation analytical work/findings to their practice.

Conference presentations (Jones 2000, Jones 2003a, Bugge and Jones 2004) and publications (Jones 2003b), all of which were well received, suggest that the “applied” CA approach in this study does now appear to be seen as having relevance to practitioners.

A further challenge which the study presents both to nursing and future researchers is to explore and understand these findings in a way which allows for nursing practice and the practices of policy making to be changed. For example, a question that has been raised in this study is whether nursing and healthcare policy makers actually learn from, or repeat, past mistakes. The key point I wish to underscore here is that, under the traditional order, policy design is often a research-free zone, or as the case was made in Chapter 3.2, policy is sometimes based on flawed nursing research. In response to this, Government has sought to modernise the approach to policy making encouraging all involved towards the ‘better use of evidence and research in policy making and better focus on policies that will deliver long term goals’ (Cabinet Office 2001, para. 6).

The case for using such an evidence based approach to policy rests on a stunningly obvious point about the timing of research *vis-à-vis* policy – namely, that in order to inform policy, the research must come before the policy. Yet, curiously, this point does not correspond to the sequence employed in the development of healthcare policy. The view presented here is that CA has a part to play in the current

interest in evidence based policy, in particular that it offers an approach to policy research and development that can offer realistic information for deciding between contending policy/practice claims and move towards a progressive understanding of “what works” in nursing practice. Nursing leaders and policy makers must decide whether they want to acknowledge and investigate why practice is so different from ideology; CA can greatly assist policy makers if they actually want to look at the way organizational contexts and goals can conflict with values espoused in, for example, patient-centred nursing.

One way in which the relationship between policy and practice has been explored in other research areas is via policy ethnography (Bennett and Ferlie 1994, Flynn et al 1996, Griffiths 2003) which allows for the careful analysis of interactions at the level of service delivery to be related to the aims of policy makers and the organisational life which provides the context of such interactions. Policy ethnography can fill an important gap in nursing research as its commitment to the processual aspects of organisational life affords a perspective which can properly explore nursing and organisations in action. The emphasis on members’ interactions offers a framework which naturally builds on insights from conversation and observational analysis and other approaches to talk and communication which present talk and text as the tangible (and researchable) medium of social action (Griffiths 2003). The hugely varied but vitally important set of activities which constitute “nursing” in our society offer the same challenges and opportunities to researchers as any other area of work life. I believe that the case for further exploring this as a viable and effective approach to researching nursing practice is clearly made in this thesis.

Although the main focus of the thesis is not on the education of nurses the need for education to be clearly based in research evidence is as obvious as the

requirement that this applies to nursing/healthcare policy. Over the past two decades, UK nursing schools have implemented reforms to the nursing curriculum at all levels, with changes to course content and teaching methods reflecting the emerging changes in nursing ideologies and policies. However, as discussed in the literature review, evaluative research performed on the effects of communication training courses for student and registered nurses has shown a dubious level of effectiveness (Heaven and Maguire 1996, McLaughlin 1999, Wilkinson 1991, Wilkinson et al 1998) and it is questionable whether these results have been implemented into curricula and the educational literature as thoroughly as the policy reforms seem to have been (Freshwater and Stickley 2004). In view of this the traditional response in nursing to failures of this sort of calling for additional education and training (Bowman et al 1983, Allen 1998) appears to be of limited utility until educationalists ground their teaching more in research. At this time the image of nursing assessments being an area of nursing practice with a history of reform without any real evidence of change can also be applied to communication/interpersonal skills education and literature.

In line with all ethnomethodologically informed studies of interaction this research offers a contribution to the development of knowledge about activity in a particular sphere and location. It remains the case that further contributions which can build on and reframe the findings of this study are inevitably suggested by the conclusions which I have drawn here, this aspect of the study is also referred to throughout chapter 5 which discusses the limitations of the study.

This study has considered how nurses assess patients for care and has taken into account how nurses work in complex and sometimes chaotic environments which effect a technocratic approach to interactions, whilst also being increasingly urged to deliver a service based upon individual care. The use of transcripts and observations

of actual nurse-patient interaction, albeit from a limited sample, have hopefully contributed to a soundly-based evaluation of professional nursing practice. The challenge from here for those who are both nurses and researchers is to produce and bring together critical analyses of nursing work which can provide realistic bases for practicable changes in nursing practice. Changes which are practicable are those which are do-able, and their do-ability depends on their roots in careful, description, analysis and understanding of practice, rather than on politically motivated rhetoric around what should ideally be.

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Appendices

Appendix 1 – consent form and copies of patient and nurse information sheets

**University of Wales Swansea
School of Health Science**

RESEARCH CONSENT FORM

An exploration of the way nurses construct patient assessments.

**Please cross out as
appropriate**

Have you read the information sheet? Yes/No

Do you understand that you are free to withdraw from the study at any given time without giving reasons why? Yes/No

Do you agree to take part in this study? Yes/No

Name _____

Date _____

Appendix 1 – consent form and copies of patient and nurse information sheets

SCHOOL OF HEALTH SCIENCE UNIVERSITY OF WALES SWANSEA

Dear Patient

A study of patient's assessment by nurses

The aim of this study is to improve the understanding of how nurses assess patients when they are first admitted into hospital, and ultimately to improve the quality of patient care.

The study involves a trained nurse researcher observing nurses, and listening to nurses, as they collect and write information about patients when they are admitted. This is only done with the nurses' and your prior agreement. We are not interested in judging whether the assessment is good or not so good, but only in describing what happens when nurses admit patients.

If you agree to participate in this study it would involve allowing the researcher to sit with you and the nurse when the nurse does his/her paperwork on your first day on the ward. A tape-recording of the nurse talking to you and some written notes would also be taken.

All the information involved in this study is to be kept safe and confidential, and all names would be changed. This would make it impossible for anyone to be identified.

You are also entitled to withdraw yourself from this study at any time. Any decision you make will not affect your care in any way.

I hope you will be able to help with this research.

**Aled Jones
Lecturer
School of Health Science
University of Wales Swansea**

Appendix 1 – consent form and copies of patient and nurse information sheets

SCHOOL OF HEALTH SCIENCE UNIVERSITY OF WALES SWANSEA

A study of patient's assessment by nurses

Dear Colleague,

The aim of this study is to improve the understanding of how nurses assess patients when they are first admitted into hospital, and ultimately to improve the quality of patient care.

The study involves :

a trained nurse researcher observing and listening to nurses, as they collect and write information about patients when they are admitted.

A tape-recording of the nurse - patient interview and some written notes would also be taken.

A copy of the admission documents will also be taken, and the end of shift handover/report pertaining to the newly admitted patient will also be tape-recorded. This is will only be done with the patients' and your prior agreement.

My interest is in the resources nurses and patients draw upon in order to accomplish assessments and would seek to describe rather than evaluate these. I am not interested in judging whether the assessment is good or not so good, but only in describing what happens when nurses admit patients.

I realise that this would make demands upon both yourself and the patients, but would emphasise that the study does not require anything other than what you would normally do in the course of your work.

All the information involved in this study is to be kept safe and confidential, and all names would be changed. This would make it impossible for anyone to be identified. You are also entitled to withdraw yourself from this study at any time. The study has already gained ethical approval and been approved by the Senior Nurse in this Healthcare Trust.

I hope you will be able to help with this research.

**Aled Jones
Lecturer
School of Health Science
University of Wales Swansea**

Appendix 2 – orthography/transcription symbols adapted from Jefferson (1984).

Following the data collection the recording is transcribed using symbols, in this case based on the system developed by Jefferson (1984) that are an attempt to capture something of the variety of the sound of the talk as it was originally spoken.

(.)	the shortest hearable pause, less than about 0.2 seconds
<u>yes</u>	underlined fragments indicate speaker emphasis
°early°	degree signs indicate speech noticeably quieter than the surrounding talk
(30 secs)	examples of exactly timed pauses
((calls nurse))	a description enclosed in double bracket indicates a non-verbal activity or researcher's explanatory comments
()	empty parentheses indicate the presence of an unclear fragment on the tape
>>alright<<	indicate that the talk was produced noticeably quicker than the surrounding talk
uh:::	colons indicate a lengthening of the sound just preceding them, proportional to the number of colons
no=	equals' sign link material that runs on
appetite^	a circumflex accent indicates a marked pitch rise
[]	square brackets denote overlapping speech
↑↓	pointed arrows indicate a marked falling or rising intonational shift.

Appendix 3 examples of assessment/admission documentation.

PATIENT PROFILE

Occupation: [Redacted]
 DR [Redacted]
 73 yrs - church of England

Date of Admission: [Redacted]

Time of Admission: 11-00 AM

Type of Admission: Arranged.

2. Next of Kin: wife S/R.

Address: [Redacted]

Tel: [Redacted]

Person to contact (if different) Name: [Redacted]

Address: [Redacted]

Tel: [Redacted]

3. Community Care GP: Same as Above.

Address: [Redacted]

D.N.H.V. Social Worker: None.
 Social Services: None.
 Vol. Organisations: None.

Type of accommodation: Home.

5. Property Procedure: P.P.I.
 Disclaimer Form: explained and signed by patient
 Cash & Valuables: [Redacted]

6. Reason for Admission: Angina.
 Review Medication
 Medical Cert. Required: [Redacted]

7. Medication, prior to admission:
 Zocor 10mg night
 Nicorandil 10mg BD
 Aspirin SR 90mg BD
 Aspirin EC 75mg
 Glycine 75 Nitrate when required

8. General Appearance:

Condition of Skin:

Condition of Mouth:

Condition/Colour of Hair:

Mobility:

Abnormalities:

Weight:

Height:

9. Sensory:

Hearing Aids:

Vision Aid:

Dentures: Top/Bottom.

Loss of Sensation/Balance.

Speech/Language:

Other Prosthesis:

10. Additional Health Problems:

Disabilities:

Appendicitis 1958
 Raised cholesterol.

Allergies:

None known.

11. Sleep Pattern:

Sedation:

12. Elimination:

Bowel:

Aperient:

Urinary:

Urine Tests:

Refer to Roger Logan Tierney.

13. Menstrual Cycle:

14. Nutrition:

Appetite:

Special Diets:

Problems:


15. Name of Nurse completing form on admission.


Signature: [Redacted]

Date: [Redacted]

ROPER'S MODEL OF NURSING

For Assessment of Patient on Admission

WARD 

NAME 

RLT1	Maintaining Safe Environment	RLT2	Communicating	RLT3	Breathing
RLT4	Eating & Drinking No problem's diet Good fluids on diet	RLT5	Eliminating No problem's identified	RLT6	Personal Cleansing and Dressing Self coming to own hygiene needs.
RLT7	Controlling Body Temperature 37.2°c on admission	RLT8	Mobilising Mobile independently.	RLT9	Working and Playing Photography. D.ZY.
RLT10	Expressing Sexuality Married lives with wife.	RLT11	Sleeping poor sleeper insomniac.	RLT12	Dying CIE. Not diagnosed
RLT13	Pain Chest Pain Angiogram Showed blocked tubes.	RLT14	Health Promotion Non Smoker. Occasional alcohol.	RLT15	NAMED NURSE F. Thomas.

DATE TIME NEED No.

11:00 AM P1

NORTON RATING SCALE

4

NURSING REPORT AND EVALUATION

WUN 5661 IP2179

SIGNATURE

Patient arranged admission under care of Dr. [redacted] due to Angina and for review of Medication. On admission patient alert and oriented aware of reason for admission. Observations recorded Blood Pressure 141/68 mmHg, Pulse 83BPM, Temperature 37.2°C, Oxygen Saturations 98% on air. Auscultating Dr. [redacted] to dark patient.

SURNAME

FORENAMES

ADMITTED FOR

CONSULTANT

HOSPITAL No.

H. [Redacted]
Fu [Redacted]
Kt [Redacted]
Pe [Redacted]
MS
Female
MS

Mar: at State:

Religion: none age 64yrs.

Occupation:

Temporary Address:

Telephone:

Next of Kin/Relationship Husband Name: [Redacted]

Address: SJA.

Telephone: Informed Yes/No

Details of person(s) to be contacted in emergencies:

G.P.:

Address:

Telephone:

Temporary G.P.:

Address:

Telephone:

Date/Time/Type of Admission: [Redacted] 9.30am

Mental Health Act:

Relevant Medical History: Hypertension
Ankle oedema,
Hyperresponsive.

Medication (ongoing)

furosemide 40mg o.d.
co-trimoxazole 100/16.5mg o.d.
penicillin 2mg o.p.
Temozolamide 20mg o.d.

Allergies/Warning: none known.

Valuables/Property

DDI signed & explained.

DATE/TIME OF RE-ADMISSION

REASON

CHANGE OF DETAILS

NURSE RESPONSIBLE

[Redacted]

SURNAME

FIRST NAME(S)

CASE No.

BVULTUSING 09/12

PULSE 53

TEMP 36.1°C

WEIGHT (KG) 10.25 STONE HEIGHT (M)

WATERLOW SCORE Low 0

MANUAL HANDLING RISK (C)

NUTRITION RISK SCORE (U)

REFERRED DIETITIAN YES/NO (U) (DATE)

DIET

URINALYSIS

MSU?

SOCIAL CIRCUMSTANCES

SOCIAL WORK REFERRAL YES/NO (DATE)

SOCIAL WORKER

SPECIALIST NURSE REFERRAL (DATE)

BREATHING Smoke 15-20 a day.

MOBILITY Fully mobile & independent.

PHYSIO REFERRAL YES/NO (DATE)

ELIMINATION NO problems

EATING & DRINKING Small appetite.

WASHING & DRESSING Fully independent.

COMMUNICATION Good English.

PAIN - None experienced

PSYCHOLOGICAL no awareness experienced.

OTHER ADL'S

CONVALESCENCE YES/NO (U) (DATE)

BED BOOKED (DATE)

AMBULANCE YES/NO (DATE)

INVESTIGATIONS

CASE NO.

FIRST NAME(S)

SURNAME

CONSULTANT

Requires assistance from 2 or more staff with assistance and/or mechanical aids according to tasks.

Patient Details (Label)

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

DR [Redacted]

1	<7 St	<44.5 Kg
3	7-12 St	44.5-76.2 Kg
5	12-14 St	76.2-88.7 Kg
6	14-16 St	88.7-101.6 Kg
8	>16 St	>101.6 Kg

Disability / Weakness/Deformity

Arthritis in neck.

Patients Comprehension

Good English

Disability / Weakness etc.

0	Independent
3	Minimal assistance
5	Moderate assistance
8	Maximum assistance
10	Totally dependent/ comatose

Patients Comprehension

0	Fully co-operative
2	Comatose
3	Confused / unable to understand
4	Agitated
5	Aggressive

Handling Constraints

1	Pain
1	Skin lesions
1	Infusions etc.
3	Other

History of falls : Yes No

Equipment normally used by patient

none used.

Rating : 4

Body Shape

Tall	<input type="checkbox"/>	Medium Height	<input type="checkbox"/>	Obese	<input type="checkbox"/>
Short	<input checked="" type="checkbox"/>	Average Weight	<input type="checkbox"/>	Thin	<input type="checkbox"/>

Signature : [Redacted]

Grade : [Redacted]

Date : [Redacted]

Sa5

Sr 5

Admitted to ward as a routine admission for right mastectomy
↓ awaiting node clearance
Tammam
2 observation :- BP 100/70 Pulse 53 Temp 36.1°C.
1 nasogastric engorgement
environment



[Redacted] DR [Redacted] MS [Redacted]

CHINA

CHINA

PATIENT PROFILE

HOSPITAL NO:

Date of Admission: [Redacted]
 Time of Admission: AM.
 Type of Admission: Arranged.

2. Next of Kin: S/A.
 Address: [Redacted]
 Tel: [Redacted]
 Person to contact (if different) Name: [Redacted]
 Address: [Redacted]
 Tel: [Redacted]

3. Community Care
 GP [Redacted]
 Address: [Redacted] Surgery.
 D.N.H.V.
 Social Worker: } N/A.
 Social Services: }
 Vol. Organisations:

4. Occupation: (previous, if retired) Housewife.
 Marital Status: Married.
 Dependents (inc. pets): 1 daughter living at home.
 Lives alone: 1 son away.
 Type of accommodation: 3 seater bed room.
 Provides upstairs.

5. Property Procedure: Signed + explained
 Disclaimer Form:
 Cash & Valuables:
 6. Reason for Admission: Investigation for frequent prosthesis @ arm/leg.
 Medical Cert. Required: ? dentulining.

7. Medication, prior to admission:
 Atenolol 100mg OD.
 Pravastatin 40mg Nite
 Clopidogrel 75mg OD
 Bendofluazide 25mg OD
 Duloxetine 1200mg x2

8. General Appearance: Well kept.
 Condition of Skin: Egged on feet/hands.
 Condition of Mouth: Good, moist.
 Condition/Colour of Hair: Good, healthy.
 Mobility: Reduced due to seated weakness.
 Abnormalities:
 Weight: No weight loss.
 Height:

9. Sensory:
 Hearing Aids: None.
 Vision Aid: None.
 Dentures: Top/Bottom. Partial upper bottom.
 Loss of Sensation/Balage: 2/12 pruned, out of focus, blurry sight.
 Speech/Language: English.
 Other Prosthesis:

10. Additional Health Problems:
 Disabilities: Hypertension.
 CVA 1997. approx '93
 Appendicitis
 Allergies: Nil known

11. Sleep Pattern: GP advised on atonal at night
 Sedation: on atonal at night 50mg.

12. Elimination:
 Bowel: } No problems experienced.
 Aperiens:
 Urinary:
 Urine Tests:

13. Menstrual Cycle: 7 yrs Ago.

14. Nutrition:
 Appetite: Satisfactory
 Special Diets: None.
 Problems:
 15. Name of Nurse completing form on admission:
 Signature: [Redacted]
 Date: [Redacted]

NURSING REPORT AND EVALUATION

SIGNATURE

TIME

NEED

NORTON RATING SCALE

ALL

44 yr old lady admitted under the care of Dr [REDACTED].
 Poor medical history
 CVA 1997 affecting ~~the~~ ^{the} right side of ~~body~~ ^{body}
 Hypertension - often with high dose of beta-blocker.
 Hypercholesterolemia '93 ovarian cysts.
 Prostate gland symptoms.
 Postural hypotension in her right arm/hand also experiencing weakness
 in the proximal muscles of her right leg.
 MR Head June 2000 showed scattered lesions in both hemispheres.
 ischaemic. Reporting radiologist possibility of demyelinating disease.
 not specific diagnosis.
 On admission observations recorded BP 202/108 P 54.
 To be clerical this afternoon.
 Seen by Dr [REDACTED] on round. Amoxicillin 500mg

**MORRISTON HOSPITAL
CARDIAC CENTRE**

PATIENT DETAILS

MISSION DATE: [REDACTED]
NAME: [REDACTED]
KNOWN AS: [REDACTED]
ADDRESS: [REDACTED]
PHONE: [REDACTED]
P. Dr [REDACTED]
SURGERY: [REDACTED]

PRIMARY NURSE _____
TEAM _____

CARDIOLOGIST: [REDACTED]
HOSPITAL NO.: [REDACTED]
DOB: [REDACTED] AGE: [REDACTED]
MARITAL STATUS: [REDACTED]
OCCUPATION: _____
RELIGION: C of E
NEXT OF KIN: [REDACTED]
S/A

ADMISSION HISTORY

experienced chest/shoulder/back pain on Saturday - ECG suspicious of anterior MI but didn't present until Sunday CE on [REDACTED] 402. for angiogram today.

CURRENT MEDICATION: _____
Aspirin
bisoprolol
Atorvastatin
Nicotinic
GTh Spray
ALLERGIES: * PCWNS* - sickness

PAST MEDICAL HISTORY: _____
Inferior MI [REDACTED] - Strep.
lateral MI 20/06 - Rapilysin
↑ BP
↑ chol.
Diabetic diet controlled

DIAGNOSIS: _____

DATE - PROCEDURE / RESULTS: _____

HT M WEIGHT KG

ADMISSION ASSESSMENT

SIGNED

PAIN: INCLUDE

DESCRIPTION OF ANGINA PAIN AND ANALGESIA

3 admissions with chest/back/arm pain
A MI March/June
no pain day to day

RISK FACTORS: ASSOCIATED WITH

HEART DISEASE - FAMILY HISTORY ~~Y/N~~
HYPERTENSION ~~Y/N~~
CHOLESTEROL CHECKED Y/N Result
DIABETES - yes
OTHERS - ex. smoker.

RESPIRATORY:

SMOKER
NON-SMOKER
~~EX-SMOKER~~

gave up 50 years ago.

MOBILITY / EXERCISE

WATERLOW SCORE O/A
good usually.

DIET / FLUIDS

Diet controlled
Diabetic
monitored by G.P.

NUTRITION SCORE
DIET CONDITIONS DIFFICULTIES
ALCOHOL: none.

ELIMINATION:

regular -
no problems.

ANXIETIES / FEELINGS / RELAXATION

NIGHT SEDATION ~~Y/N~~

NORMAL SLEEPING PATTERN
sometimes sleeps well -
sometimes restless.

SOCIAL / CULTURAL / ECONOMIC

enjoys cycling.
lives with husband.

COMMUNICATION:

SPEECH English
SIGHT glasses
HEARING good.

EDUCATION / REHAB:

ASSESSED BY:



DATE

COMMUNICATION

SIGNED

SIB Dr [redacted] clerked and
consented for angiogram later
today

[redacted]

Transfers:

MRSA Swabs

Date:

Results:

Pre-Operative Patients:

MRSA Swabs - Date:

Referral to Surgeon Y/N

Consent Y/N

Ted Stockings Y/N

Pre-op Blood Y/N

CXR Y/N

Physio Referral Y/N