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The Culture of Community Nursing: An Ethnographic Study of Handover Reports

Denise Drew

Submitted to the University of Wales in fulfilment of the requirements for the Degree of Doctor in Nursing Science.

Swansea University

2008

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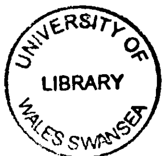
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Summary

This study explores the culture of community nurses exhibited during the time spent together in handover reports. As community nurses spend much of their shifts working alone in patients' houses, this is the time to meet up in clinics and health centres to share information about patient care. Culture is observed through group interactions, behaviour, language, ritual and the use of artefacts and so this handover time provides the opportunity to explore these matters.

The research question is: what cultural behaviour, cultural knowledge and cultural artefacts are exemplified during community nurses' handover reports?

Using an ethnographic approach, data collection was carried out using participant observation and semi-structured interviews. Two teams of nurses from one Primary Care Trust in the West Midlands participated in this study.

The resulting data was analysed using James Spradley's (1979) thematic cultural analysis and the findings are presented in four sections.

Findings include: sharing information and planning ahead, helping across teams and busyness, being in the team and how others see us. Issues of community nurses invisibility and the articulation of expertise are presented. Some of the findings were congruent with earlier studies (largely set in hospital or nursing homes) including teaching and learning and support for staff.

In addition, this study adds the following considerations to the body of knowledge relating to handover reports. Firstly, the importance of protecting reporting time for community nurses is suggested. In the current social and financial climate it is essential to make the case for continuity of care to be safeguarded. Secondly, the importance of professional identity for community nurses is stressed. The reporting time serves to enhance group identity, reduce anxieties and relieve isolation. Finally, report time crucially encourages the articulation of expertise between community nurses at a time when they are feeling professionally devalued.

Declaration in respect of the thesis:

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This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree

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This thesis is the result of my own investigation, except where otherwise stated. Other sources are acknowledged by explicit references. A bibliography is appended.

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Finally, thanks to the participants of this study who were willing to share their lives with me during this study.

Glossary of Terms used within this Document:

Auxiliary Nurse (AN)

Clinical Supervision (CS)

Community Services Manager (CMS)

Community Staff Nurse (CSN)

Department of Health (DOH)

District Nurse (DN)

English National Board (ENB)

General Practitioner (GP)

Health Care Assistant (HCA)

National Service Framework (NSF)

Nursing and Midwifery Council (NMC)

Primary Care Trust (PCT)

Queen's Nursing Institute (QNI)

Single Assessment Process (SAP)

"I'm so glad that this has taken me so long
cos it's the journey that made me so strong"

Snow Patrol (2006)

Chapter One

Introduction and Aims of the Study

This work aims to explore the culture of community nursing through the vehicle of the handover report. A key premise of this study is that to explore the culture of community nursing, it is necessary to observe interactions, knowledge, behaviour and the use of artefacts by the group members (Helman 2007). As community nurses spend, by the very nature of their work, much of the day working alone in patients' houses, the handover report is seen as a vehicle to access these considerations.

The research question for this project is "What cultural behaviour, cultural knowledge and cultural artefacts are exemplified during community nurses' handover reports?"

This introductory Chapter of the thesis aims to set the scene for this study, by presenting three key themes. These are the exploration of the culture of community nurses, the functions of handover reports and knowledge for community nursing practice.

To make clear my intentions, the rationale for this work will be offered in this Chapter. This will be followed by the background to the study including a brief history of community nursing and some discussion of the structure of community services. The functions of handover reports will then be introduced and, finally, some thoughts relating to knowledge for practice will be offered. This includes the notion of "invisibility" relating to community nursing practice.

The structure of this thesis will then be (briefly) presented for the reader and the research question will be stated.

Please note that for the purposes of this study, "community nurses" includes both District Nurses (DNs) who have completed post registration education in order to practice as Specialist Practitioners, and also Community Staff Nurses (CSNs) who work in teams with the DNs.

It is important also to note that essential information is routinely gathered from carers and family members, in addition to patients. To prevent much tedious repetition, please note that "patient" is intended throughout to be used as a short hand term for "patients, carers, family members and significant others".

Rationale for this Study – exploring Culture

Much of district nursing practice takes place in the homes of patients (Palsson et al 1996, Sweet and Ferguson 2000). Community nurses therefore spend much of their working lives in isolation from their professional colleagues. This has led to claims that much of their work is "invisible" (QNI and ENB 2002). Any attempt to explore the culture of community nursing needs to focus upon interactions between nurses and so is limited in terms of access to this group.

As someone with a background as a practising district nurse, I wanted to explore the above issues. I know (because of my prior experiences, from

reading the literature and from my discussions with community nurses) that community nurses tend to meet up for a "handover report" to discuss patient care and plan for the coming shifts. I propose here that this offers the opportunity to access the group interacting together and provides a vehicle for exploration of the group and its culture (Helman 2007).

The handover gives an opportunity to explore symbolic actions, patterns and ritualistic practices (Parker, Gardner and Wiltshire 1992, Strange 1996, Philpin 2002). The use of language is also of interest and may be symbolic (Wolf 1989, Holland 1993, Philpin 2006).

Culture manifests itself in terms of knowledge, behaviour and artefacts used. Therefore, an ethnographic approach was selected as being the most useful to explore these issues (Spradley 1979, 1980, Vidich and Lyman 2003). The Review of relevant literature (Chapter Two) suggests that ethnography would be a likely approach to use to explore the culture of community nursing.

The Background and Context of this Study

This section of Chapter One will explore the origins of, and outline the current position of, community nursing in the United Kingdom. The importance of sharing information about patient care with other nursing colleagues is then addressed, linking into the section about handover reports and their functions.

The currently prevailing uncertainty of future services due to the merging and reconfiguration of Primary Care Trusts (PCT) is then to be highlighted. The importance of effective information sharing in the provision of high quality care is recognised. The development of the Single Assessment Process (SAP) and the realignment of the health and social care system will further focus upon the need for optimum communication. This is the case within community nursing teams and also across professional disciplines.

The present Government's "Modernisation" programme continues to drive major reorganisation in shifting services from acute settings to the community. This seems unlikely to change in the near future.

This study explores the handover reporting practices of community nurses and their culture as exhibited during handover time. Both qualified district nurses and community staff nurses were involved in this study, which was carried out within a Primary Care Trust (PCT) within the West Midlands.

A brief history of community nursing

The frail and ill have been cared for in their homes since civilisation began. Families and social groups would tend to the sick in keeping with their knowledge and cultural norms. District nurses' predecessors included bible nurses and corpse washers (Sweet and Ferguson 2000). In literature, Dickens' Sarey Gamp and Betsy Prigg (outdoor relief district nurses in *Martin Chuzzlewit*) were presented as gin-swilling opportunists.

The “official” origins of district nursing are widely attributed (Sweet and Ferguson 2000) to the care given by Mrs Mary Robinson to the wife of wealthy William Rathbone in the 1850s. He was so impressed with the care he observed, that he established a training school attached to the Liverpool Royal Infirmary to found the Liverpool Queen Victoria District Nursing Association.

At the birth of the National Health Service (NHS), in 1946, the National Health Service Act refers to the “home nurse”. By the 1970s the term “district nurse” was widely understood by the general public as a nurse providing care in the homes of patients.

It is reported by Keywood (1977) that, in 1948, Miss E.J. Merry and Miss I.D. Irven wrote a textbook for home nurses. This would seem to be one of the earliest district nursing texts. Olive Keywood (1977, p 10) identifies the following attributes required for nursing in the community. “A district nurse fundamentally needs to be interested in people, rather than in elaborate equipment and techniques. The district nurse is involved in the joys and sorrows of a family to a much greater extent than she would in hospital”.

Thirty years on from this assertion, I would still give much credence to this statement. Certainly, district nurses often have the opportunity to nurse patients over a long period of time and develop close relationships with both patients and carers.

Although the technical aspects of nursing have developed a great deal and the role of nurses in both hospitals and community has evolved, the rise of medical science following two world wars resulted in a hospital focussed health service. This raised the profile of highly technical hospital interventions. Nurses who worked in areas such as Intensive Care Units (ICU) were held in high esteem and district nursing was devalued by technical rationality.

An influential study carried out in 1992 (DOH 1992), by the Value for Money Unit looked at the scope and range of tasks carried out by nurses. This report proposed that the number of qualified District Nurses be reduced and support from Community Staff Nurses increased. This was the trigger for the implementation of skill mix in primary care. The report was much criticised as being task focused and over simplifying the work of District Nurses. However, it has had an ongoing impact and the numbers of nurses being commissioned for the District Nurse qualification (currently at Specialist Practice level) has been reduced nationally in the past few years. Numbers of district nurses have, subsequently remained (at best) static over a period of tremendous growth in the complexity and scope of primary care.

It is estimated that 2.75 million people are patients of the district nursing service. Many of these are frail and elderly (Audit Commission 1999). The Commission's report found that 62% of the district nurses' caseload consisted of people over the age of sixty-five, many of whom are visited two or three times per week.

The needs of older people and their carers are often very complex and assessment of these requires a high level of knowledge and skill (Ryder 1997). The ways in which gathered information is shared is of great importance to the quality of care provision to this client group. Home visits with older people can involve in depth, sophisticated assessments (Audit Commission 1999, Department of Health (DOH) 2001, Stevenson 1999). Additionally, there are younger patients who may be visited either to be cared for following surgical interventions or with long term conditions.

The care of patients in community settings is documented in care plans, which are kept in the patients' homes and records stored within the health centre or clinic. These documents are to be considered within this study as ethnographic artefacts.

The current picture

Community nurses may work in a variety of organisational structures. For example, there may be a hierarchical system in which DNs report to a Community Services Manager (CSM), who, in turn, reports to a higher level of management. Traditionally, roles of community nurses have been very distinct (district nurses, health visitors, school nurses etc.). Increasingly, nurses are losing the rigid boundaries that separate roles and are working outside these constraints (DOH 2006).

Primary Care Trusts (PCTs) are currently merging and reconfiguring following recent publications (DOH 2005, DOH 2006). This is a time of anxiety for community nurses, who wait to discover the outcome of the plans to introduce a sustained re-alignment of the health and social care system in the United Kingdom.

However community nursing services are developed, working in teams is likely to remain a feature. Community nurses cannot and do not work totally alone (although they are often in patients' homes unaccompanied).

The NHS Plan (DOH 2000) offered both opportunities and challenges for community nursing. Nursing roles are expanding and developing to meet the changing demands of patients. There has been a shift of power to front line staff and, more controversially, to patients themselves (Drew et al, 2004). The involvement of patients in the development of services is a welcome one and the notion of the expert patient is a recurring theme in the policies and documents published by the Department of Health. The context of current policy is further explored in Chapter Two of this thesis.

Information sharing

The sharing of information about patients cared for by community nursing staff is considered necessary for continuity of care to take place (NMC 2004). Written documentation and oral handover reports provide the opportunity for

interaction between nursing team members and others involved in patient care.

Less formal communication is also used during daily discourse. Community care often involves input from many agencies, professional and informal, statutory and voluntary. Information sharing is, therefore, a complex but important process.

Information gathered by nurses during home visits leads to referrals to other specialties and agencies. Ineffective communication between nurses and other agencies has been cited as a major problem, resulting in incomplete or poor quality assessments of patients (Audit Commission 1999). Whatever shape develops for community nursing services, the sharing of information will remain crucial for high quality care for patients.

Handover Reports and their Functions

Currently, patients may be cared for by as many as six different nurses during a short period of time. Therefore, transferring and documenting information would seem to be a prerequisite for patient care. Handover report is viewed as a time when nurses come together, primarily to share information.

There exist a number of studies into handover reporting (Strange 1999, Lally 1999, Kerr 2002, Hopkinson 2002, Philpin 2006), but these tend to be focused upon secondary care settings. Data collection within this study was designed

to include multiple methods, again in keeping with an ethnographic study (Spradley 1979, 1980, Burgess 1984, Hammersley 1992).

Studies have demonstrated that meetings in which reports are transmitted serve many other valuable functions (Strange 1999, Lally 1999, Kerr 2002, Hopkinson 2002), including social support, teaching and group cohesion. These important issues will be explored within this study.

How information is shared, verbally, non-verbally and by the use of cultural artefacts, is a key focus for this research study. There have been many hospital-based studies exploring similar issues (Strange 1999, Lally 1999, Kerr 2002, Hopkinson 2002).

Community nursing has some similarities and differences compared to hospital based working. For example, community nurses' day to day routines and ways of working vary considerably throughout the United Kingdom (Audit Commission 1999). The timing of reporting sessions may be less fixed; the delivery may be less formal. Indeed, formal handover may not exist at all.

The term "handover" itself may be questioned. In acute hospital settings, the term relates to one shift of nurses preparing to come on duty and the previous shift handing over before departing. The patterns of working in the community setting are often very different. Staff may discuss patients that they are unlikely to see today (but may visit tomorrow). Each nurse describes their

visits in turn and may seek advice or confirmation of decisions taken during these visits.

Plans to introduce a single assessment process between health professionals and social services (soon to be managed together as care trusts) will also focus attention upon assessment and planning of care with patients. It is clear that effective communication and sharing of information will be of paramount importance. The Single Assessment Process (SAP) was being developed during the timeframe of this project, although there are still many debates around the most effective ways to maximise its effectiveness.

Collaboration and multi- agency working

Community nurses work together in teams, across nursing teams and also with many other professional agencies to provide care. There has also been an increase in the number of voluntary and informal agencies supporting patients in the community.

Care for patients in the community often involves a variety of professional staff. The interactions of all involved will affect the quality of that care. How community nurses interact with other nursing teams is also important. There is a tradition of community nursing teams helping out other teams when staffing problems arise. How information relating to patients is conveyed would seem to be a very important part of providing effective care to unfamiliar patients.

Working in collaboration is claimed to improve the range of skills and knowledge available to the patient and provide greater job satisfaction for

nurses. The development of commitment, respect and trust across professional barriers may be promoted by the use of a common language, shared learning and agreement of common goals (Newbury et al 1997, Dalley 1990, Hancock 1991, Hyde and Cotter 2001).

The importance of maintaining steady relationships with other professional groups was reported in a study by Goodman (2001). District nurses in her study often described their position as being caught “in the middle” of conflicting viewpoints of others. One General Practitioner interviewed spoke of the district nurses’ “tactful balancing act” between herself and community nursing managers.

However, the above is not easy to achieve and barriers to collaboration have also been explored widely. These include tribalism, professional rivalries, status conflicts and poor communication systems (Areskog 1994, Horder 1995, Engel 1994, Castledine 2000).

Knowledge for Community Nursing Practice

The final key theme to be presented in this introductory Chapter is that of knowledge for community nursing. It has been alleged (QNI and ENB 2002) that much of the skill and knowledge needed by community nurses is “invisible” to others. A brief exploration of the development of theory is

followed here by some useful staring points to explore community nursing practice.

It was widely believed in the 1980's that the development of nursing theory would of necessity improve patient care. This has, however, been contended (Walsh 1990). Community nursing is progressing and evolving in a number of directions – these include the adoption of evidence-based practice and acceptance of a bio-medical model. This enables community nurses to embrace the ten key roles presented by the then Chief Nursing Officer, Sarah Mulally in 2002. These include the ordering of diagnostic investigations, admitting and discharging patients, performing minor surgery, running out patient services and developing nurse led clinics.

This vision from the Department of Health could be interpreted as a move to transfer work no longer valued by doctors to nursing staff. These issues are revisited in Chapter Two of this work.

A paper produced by the Queens Nursing Institute and the English National Board (2002), found that the complexity of district nursing work is not always visible to decision makers. In light of the above, issues relating to how home visits are reported become pertinent.

A useful framework for nursing is offered by Joan Liachenko (1998). Her ideas have their origin in empirical work that sought to understand the ethical experiences of practising nurses. She describes nursing as a boundary

discipline sharing some scientific knowledge with medicine, but also embracing non-scientific knowledge. Liaschenko identifies four categories of knowledge, in which she aims to explain how nursing knowledge is used by nurses and how others respond to this. The categories are as follows:

1. Knowledge of therapeutic effectiveness. This includes an understanding of anatomy, physiology, disease processes, pharmacology and technical interventions.
2. Knowledge of how to get things done. Being aware of resources and ways of accessing these is a feature of this category.
3. Knowledge of patient experience. Community nurses are privileged to be in a position to witness the effects of ill health upon patients and carers.
4. Knowledge of the limits of medical science

Liaschenko (1998) states that nurses support medicine and are, to some degree, in collusion with the claims of medical science. However, nurses also have a perception of what is "real" to patients and carers and do not always see that medicine has the answers. I perceive the above to hold some recognisable value, in particular the implication that much of what nurses do is hidden, not recognised or classed as real work by others.

Liaschenko further expanded her ideas (Liaschenko and Fisher 1999) into a proposed classification of knowledge including case, patient and person and the interactions of these through social knowledge. I propose to set down this

classification here in order to revisit their ideas throughout the chapters later in this work in the presentation of its findings.

One of the things that I find appealing in Liaschenko and Fisher's work is that they aim to use words that practicing nurses are likely to use themselves. The articulation of knowledge is a key consideration of this work. They suggest that existing language from the "rich evolution of knowledge development within nursing over the years" (p30) is rarely used in clinical practice. They propose the following designation:

1. **Case knowledge**. This is termed biomedical knowledge by the authors and is concerned with the causation of disease and its treatment.
2. **Patient knowledge**. This is about how people become identified as patients, knowledge of the individuals' response to treatment, knowledge of how to get things done and knowledge of resources available.
3. **Person knowledge**. This is to do with knowing the individual as a self with a personal biography and who acts in accordance with his or her own desires.

Links between the three categories of knowledge involve social knowledge. Issues connected with the articulation of knowledge and expertise are a key consideration within this study of a group whose work is largely "invisible" (QNI and ENB 2002). The above work will be further explored later in this thesis (Chapters Five to Nine).

The Structure of this Thesis

This study is concerned with the sharing of information between community nurses during handover reports. This is viewed as an opportunity to explore the wider culture of community nursing. Therefore, exploration of some issues related to reporting will be augmented by other considerations arising from observation and interactions between the nurses within this study. There follows a brief outline of the content of this Thesis.

Chapter Two is a review of the literature of the current policy relating to community nursing, issues around assessment for community nurses, handover reports, rituals and nursing, clinical supervision and issues relating to handover and written documentation.

Chapter Three explores the history and development of ethnography. As an ethnographic study, issues of culture, ritual, reflexivity and rigour are viewed as crucial elements within this work and are explored here. Ethnographic studies within nursing are also examined here. Methodological and ethical considerations are offered in this section of the work.

Data analysis is presented and defended within Chapter Four. The use of a conceptual framework is explored here also.

The following five chapters are used to present the findings of this ethnographic study and to discuss these in relation to the literature reviewed in Chapter Two.

Finally, in Chapter Ten, following the presentation of the findings, I will critically evaluate the process of carrying out this work by examining its strengths and limitations. I will also explore issues of transferability and offer some recommendations arising from this study. In conclusion, proposals for future studies to further develop this work will be offered.

In Conclusion

Unlike their colleagues in hospitals and nursing homes, community nurses work alone for much of their time at work. Therefore, it would seem to be even more important to discuss the care that is being given with other team members than for nurses in institutionalised settings. Studies based in acute hospital wards and nursing homes indicate that much more is shared during handover reports than information relating to patients. There are other functions such as team-building and group cohesiveness that occur during the team interactions at the reporting time. Additionally, the handover provides time for shared support and opportunities to learn. The notion of "invisibility" will be explored within this ethnographic study into the culture of community nursing.

Chapter Two

Review of the Literature

Introduction to the literature review

> *"if you speak of nothing but what you have read, no one will read you"*
>
> Arthur Schopenhauer [1]

To assess the current knowledge relating to community nurses and handover reports, a review of relevant literature was carried out. The purpose of a review is to critically appraise and synthesise the state of current knowledge relating to the topic in question (Carnwell and Daly 2001).It became clear very early on within this process that studies connecting community nurses and handover reports were not to be found. A wider search for studies to inform this work was apparently needed. The handover report is a crucial part of my study, serving as a focus where community nurses meet and interact. The culture of community nursing was to be sought during these meetings. This Chapter of the thesis was revisited many times during the study. Search terms were repeatedly entered to ascertain whether more recent studies had been carried out in these areas.

Search strategy

The Bibliographic databases (CINAHL and MEDLINE) were used to identify the research reviewed for this study. In addition, on line resources of the Journal of Advanced Nursing, Journal of Community Nursing, the Royal

[1] Collins Dictionary of Quotations (2003)

College of Nursing (RCN) and the Department of Health databases were also searched. A manual search of the following subject related journals for the previous three years supplemented the above: Nursing Older People (formerly Elderly Care); Primary Health Care and Ageing and Society.

Key words included: assessment; community nursing; record keeping; shift handover; reporting; rituals; continuity of care and information sharing.

Papers available in the English language and published within the past ten years were included. Some older works were also deemed necessary for the review. For example, Le Lean's work "Ready for report Nurse?" was published in 1973, but contains valuable information for this study., for example, the time spent on handover reporting in hospital wards that was measured and could be compared with this study of reporting by community nurses.

It was accepted at the outset that this review would be developed and strengthened throughout the research project, as new studies became available. Also, insights developed during the study were found to require exploration through relevant literature. There are a number of ways to structure a literature review. I have selected a method in which literature is divided into content themes (Carnwell and Daly 2001).

This review of literature produced six main themes for analysis: the current policy context for community nursing; community nursing and assessment; handover reports; rituals, handover and nursing; clinical supervision (issues

relating to handover) and written documentation. Each of these will be presented in turn and summarised at the end of this Chapter.

Current Policy and community nursing: The Modernisation Programme

This study took place during a time of great change within the NHS, much of which was couched in terms of the Government's modernisation programme. These changes are greatly impacting upon community nursing services and the morale of community nurses. Baggott (2004, p245) states that primary care is: "a philosophy that emphasises the movement of health care out of large institutions into community based settings, bringing it closer to the people".

The Department of Health has produced a plethora of documents relating to the modernisation of the NHS and the development of nursing roles (DOH 1999, DOH 2000, DOH 2002, DOH 2005 and DOH 2006).

There has been a developing emphasis on the management of patients with long term conditions. Seventeen and a half million people are said to be living with a long term condition (DOH 2005b, p3) and the impact of this can be "discomfort and stress is an everyday reality". Long term conditions are chronic illnesses that need to be met by a range of skills and knowledge. Patients with chronic illness may have more than one medical condition. The Department of Health identified the National Public Services Agreement

(PSA) to improve the outcomes for people with long term conditions (LTC) by offering a personalised care plan for vulnerable people. In this document patients are stratified in order to "match care to different needs of patients" (2005b, p6). Three levels of patient care are presented in this document as follows:

Level 3

Case management is needed for the most vulnerable people with complex needs and long term conditions. The case manager anticipates co-ordinates and joins up health and social care.

Level 2

This is described as disease specific care management of patients with a complex need or multiple conditions. Multi-disciplinary teams work together here, using disease specific protocols and pathways (incorporating the National Service Frameworks) and Quality and Outcomes Framework to meet patient needs.

Level 1

This larger group of patients are categorised as being supported and self-caring. There should be collaboration across agencies and professions to help individuals and carers to develop the knowledge, skills and confidence to care for themselves

This publication announced the development of a new "Community Matron (CM)" role. Three thousand CMs were planned to be in post by March 2007. This had been announced publicly by the then Health Minister (John Reid) and, subsequently, needed to be evidenced in the Department of Health's strategies. The new CM was to gain twelve competencies in order to carry out this role in primary care. Many of the competencies identified in this document were traditionally the remit of district nurses – indeed the paper acknowledged that district nurses were the group of professionals who would be best placed to make this transition. Some of the competencies would involve a strengthening of physical assessment, diagnosing and prescribing knowledge and skills. However, the implementation of the Community Matron role was carried out in a variety of ways. In some cases, district nurses were indeed further developed into this position. In others, Advanced Nurse Practitioners were slotted into post. In many cases, the district nurses were left feeling disempowered by the introduction of this new practitioner who was to have caseloads of around 50-80 patients (2005b, p16) of the patients categorised at level 3 above.

One result of the above is considered in the specialist-generalist debate (Hurst 2006). Although there is evidence that patients with complex needs may benefit from shifting their care to a small number of highly qualified nursing staff (Johansson, Glielius and Sjoden 2003), this can cause problems. The remaining generalists are left to deal with more mundane work. I would concur with Hurst's observation that job satisfaction, recruitment and retention of staff may suffer as a result of this strategy.

Drennan *et al* (2006) explore the increasing demand for nurses to work in primary care. This paper reports on a Department of Health funded project to explore the modelling of primary care workforces, review the literature around recruitment and retention and provide a strategic model for planning for the recruitment and retention of primary care nurses.

In a supporting paper (2005c), the Department of Health expands upon the Community Matron role, stating that these people must be nurses. In a local PCT within the West Midlands region, this was not the starting point for the development of this role. This paper also makes the point that CMs should work collaboratively with District Nurses. There has been a mixed response to the development of the Community Matron role with some suggestions that it has not been implemented as intended.

There is a radical proposal to further develop primary care services. The White Paper "Our Health, Our Care, Our Say: a New Direction for Community Services" published in February 2006 outlines plans to shift 5% of the total budget from acute services to primary care. This includes decentralising many services currently offered in acute settings. Many out-patient services will be relocated and there will be pilot schemes to establish whether some specialisms (including ear nose and throat, gynaecology, urology and general surgery) would be better delivered nearer to patients' homes.

This Paper is based upon listening exercises carried out in the autumn of 2005. On page 1 there is a claim that this paper will help to move primary care into a new era "where service is designed around the patient rather than the needs of the patient being forced to fit around the services already provided". This is reminiscent of the 1993 "Community Care Act" in which the same claims were made. Unfortunately at this time health and social care were divided up. This was then viewed as the way forward, but I believe led to fragmentation of the services provide, particularly for those with complex needs. These changes could result in great upheaval and a real challenge to organise in the current financial climate. The role of community nurses will be affected by the radical reconfiguration.

It seems likely that this will mean that those admitted to hospital will be more acutely ill than at present. This will, in turn, put pressure upon the community nursing services. It is likely that there will be a shift of staff between settings. This could produce some training issues and will involve huge changes in primary care service delivery. It is in the context of this drive to modernise the NHS that this study is undertaken.

There has been an influx of new nursing roles with a confusing array of professional titles in recent years. Clinical Nurse Specialists (CNS) have developed in a fairly random way across the United Kingdom. I believe that the growth of the Community Matron has been at the cost of district nursing. It was announced by the Government in 2005 that 3000 Community Matrons would be recruited to post by the year 2007 (DOH 2005), taking a case

manager approach to keep people in their own homes and prevent hospital admissions. Criticism of this approach (imported from United States and adapted from the "Evercare" Model) has been around the lack of evidence of its effectiveness (Gravelle, Dusheiko and Sheaff 2007).

Currently there are questions around the future of primary care nursing and the roles, titles and developments to shape the service in order to meet the patients' needs. These debates are part of the context of this study.

Community nursing and assessment

The topic of assessment was included in this review as it was of particular pertinence to community nurses during the time that this study was carried out. This section of the literature review is included to contextualise community nurses work. Handover reports are ostensibly for sharing information about patients and their care. Assessment is viewed by this author as an ongoing process and a daily activity for all community nurses.

For community nurses, these are challenging times (Drew, Chilton, Clarridge and Melling 2004). There has been a shifting of emphasis away from caring for patients in acute hospital settings towards community care (DOH 1997, DOH 2001). Government policy has placed a much greater emphasis upon primary health care. Additionally, patients in the community can have a great variety of problems and needs to be addressed. For example, patients with palliative care needs, chronic disease management and postoperative care

are all features of the community nurse's caseload. Unfortunately, this increasing and diverse workload is developing at a time when the district nursing service is facing a staffing crisis.

The Audit Commission (1999) warned that a large proportion of the district nursing workforce would soon be approaching retirement. The numbers of qualified district nurses are reducing and Primary Care Trusts (PCT) in the United Kingdom are employing more community staff nurses and health care assistants. This is relevant to patient assessment as, traditionally, only those qualified District Nurses (who have successfully completed a Specialist Practice Course of study) would carry out new patient assessments. There has been a shift from this position towards Community Staff Nurses (CSN) being able to carry out some of the assessments. The role of the CSN is developing and will be further explored elsewhere in this chapter.

The assessment, organisation and delivery of care to support people being cared for at home are key elements of community nursing (Audit Commission 1999). At the heart of high quality community nursing must be the assessment of patients and families. Notably family members and carers are viewed as key people in caring for patients in their homes. As such they are an integral part of the assessment process. The views, health beliefs and abilities of carers need to be assessed, along with the patient's.

Within this section of the review, changing demographic and social changes, inequities of assessment, the single assessment process and the role of community staff nurses will be examined.

Community nursing is not a static phenomenon. Cook (2000) discusses the demographic and social changes which are impacting upon community nursing i.e. the increasing number of older people and the decreasing availability of informal carer support (due to changes in family configuration, employment patterns and expectations of client or carers). Assessment does not take place in a social vacuum and therefore these issues are important factors in the delivery of high quality nursing care.

The Audit Commission (1999) claimed that district nurses have an enormous and valuable reservoir of knowledge relating to the needs of the patients they serve. This is rarely recognised by those commissioning and shaping health care provision.

However, in its damning report in 1999, the Audit Commission criticised the inequity of the assessment process carried out by DNs. This work focussed particularly upon assessment of patients with leg ulcers and the promotion of continence. Measures suggested for improving the quality of assessment included the development of standardised forms and more effective communication between teams of nurses and other agencies. These suggestions were to be part of the review and collection of data within this study.

The single Assessment Process

Central to the National Service Framework (NSF) for older people (DOH 2001) is the notion of a single assessment process. This is intended to reduce the duplication of information gathering from a multiplicity of professional groups involved in caring for older people. Four types of assessment are to be implemented: contact; overview; specialist and comprehensive. The initial assessment may be undertaken by whichever service is first contacted by the person concerned: General Practitioner (G.P.), Hospital Trust or Social Services. The initial assessor is then required to use his/her professional judgement to determine whether further, more complex assessments are needed and the need for involvement of other agencies – subject to the informed consent of the older person.

This process was expected to be in operation throughout the U.K. by 2004 and is currently being implemented. The single assessment process alone will not improve the integration of care as there needs to be great commitment and development of collaborative working to move towards truly integrated care.

Goodman (2001) explored the reality of the relationships between community nurses and other professional groups, finding a sense of "balancing" from the community nurses involved. It would seem vital to consider the process in terms of partnership rather than a paper exercise.

The assessment of people's needs includes both tasks and process (Watson 2000). The task involves the gathering of assessment data to inform decision-making. The manner in which the information is gathered, and by whom, are important parts of the process.

Assessments should be clearly explained, acceptable and appropriate, focus upon the individual's perspective, identify strengths and abilities (not merely problems), encourage carer involvement, be non-judgemental and lead to agreement relating to future plans (Caldock 1994, Capstick 1996, Nolan and Caldock 1996). To achieve the above would seem to require great skill and ability. Community nursing teams perform a number of complex assessments on a daily basis.

There are many tools, which have been developed to facilitate this information collection in a standardised manner (Lloyd, Wise and Wyllie 2002; Royal College of Nursing 1997). Richardson (2001) assesses one of these ,"Easy Care", concluding that as Activities of Daily Living (ADLs) are both culturally and environmentally determined, one tool fits all may not be the best way to implement assessment. She does advocate a form of additional paperwork, which could be generated by each professional group, as appropriate. Other assessment tools include the Royal College of Nursing "Assessment Tool for Nursing Older People" (1997) and work by the Joseph Rowntree Foundation (1996) "Towards a National System for Continuing Assessment in Care Homes". These are aids to assist professional judgement and may be useful,

although as sections tend to be predetermined, it could be possible to miss something of great importance to the patient or care.

The content and use of assessment tools for older people are not explored within the scope of this study, which is more concerned with what happens to the information during handover reports. However, the views of nurses using these tools may be elicited.

The Assessors

Traditionally, nursing assessments have been carried out by qualified district nurses (who have undergone specialist post-registration education in preparation for managing a team of nurses in the community). As stated above, following the report of the "value for money" unit of the National Health Service Management Executive (NHSME 1992) there has been an increase in the numbers of community staff nurses (Audit Commission 1999) and a corresponding fall in the numbers of qualified district nurses in the U.K. Staff nurses now form between 20-60% of the workforce, with variations across Trusts.

Staff nurses have demonstrated dissatisfaction relating to the deskilling of registered nurses working in the community. Community staff nurses may carry out assessments, but they are currently seen to have little validity (Hallett and Pateman 2000) and patients are subsequently (re) assessed by a district nurse. This process is described as the "invisible assessment" by the researchers, who interviewed 16 staff nurses from two NHS trusts. It is

suggested from analysis of the data gathered in Hallett and Pateman's qualitative study that greater autonomy should be offered to community staff nurses within a supportive and educative environment.

Staff nurses may have considerable experience of assessment in acute settings and feel deskilled by the rigidity of the guidelines of many Primary Care Trusts (PCTS) that prevent role development. A personal view is that it is not possible to provide nursing care without assessing the patient. There is scope for further work within these areas and it is for these reasons that community staff nurses were to be included within this study. It is also acknowledged that there may be reluctance by the qualified district nurses to relinquish the role of the assessor and its associated power.

Continuity of care

It is my experience that when community nurse staffing levels are poor, there is a tradition of working across the nursing teams. This, along with the number of agencies potentially involved, has implications for continuity of care. This is particularly the case in complex situations and may be compounded by a lack of interdisciplinary collaboration. Of course, working with other agencies is not a new concept in community nursing, but there is increasing emphasis upon moving traditional boundaries and working "outside of the box". Liberating the Talents (DOH 2002) encourages the development of clinical roles and calls for greater freedom to practice in creative new ways. Assumptions relating to the roles of other professionals, therefore, need further clarification.

The development of integrated nursing teams in the community, consisting of district nurses, community staff nurses, health visitors and practice nurses emerged in the mid 1990s (Kesby 2002). The purpose of these includes intent to enable more effective inter-professional relationships and cross-agency practices. It is clear that community nurses do not work in a vacuum. At present it remains to be seen whether community nurses reject traditional professional demarcations in order to embrace the opportunities to develop true collaborative working.

Observing the information sharing practices of community nurses with other professionals and agencies may provide further insight into this crucial debate. It would also be interesting to gain insight into how community nurses perceive that other professionals view their role.

Handover reports

Handover reports may be seen as an important part of each nurse's shift, a time when the care of patients is discussed by the nursing staff on duty. Miller (1998) cites the earliest record of issues relating to reports in an American book dating back to 1885.

Following the early work by LeLean (1973), much of the recent work on handover reporting stems from the mid 80s to the present. Manias and Street (2000) highlight the importance of oral communication during handover,

contrasting this with the medical professions emphasis on written documentation.

This section of the literature review will explore some studies focussing upon handovers, the benefits of the handover report time, the use of language in district nursing, rituals relating to the handover, handover styles and some problems identified in the literature relating to handover reports.

In a study entitled “An investigation into the functions of nurses' communication at the inter-shift handover”, Lally (1999) explored handovers on one ward in a general hospital in the United Kingdom. He begins with statements about the importance of communication and says that continuity of care relies on patient information being passed between staff at inter- shift handovers. The study sets out to explore the functions of nurses' communications at the handovers. This study is based upon the ethnographic tradition, although this is not explored in any depth. There is an acceptance of naturalism by this author without further discussion. In the review of relevant literature, Lally refers to many studies identifying the transference of information and cites five studies identifying other functions such as teaching, team building, group cohesion and staff catharsis. No details of these studies are offered to the reader here and there is little evidence of critical commentary.

In the methods section of this paper, Lally usefully sets out underlying assumptions for the reader. Social reality is understood to be created,

negotiate and defined through interaction, for example. There is also acknowledgement that "language is the best medium for communicating shared understandings" (p, 30). There is a stated research question:
To what extent does the inter-shift handover involve social cohesion of the group/team? – I will return to this later in this discussion.

The data collection is said to be through an unstructured observational approach. As the focus of the work has been identified, I think that unstructured is probably too broad a term to use here, perhaps semi-structured would be better.
There is some confusion in the language used in this qualitative study, for example comments such as three handovers were observed at the beginning of the week and three at the end of the same week providing six data sets. These are considered by the author to be representative of the accessible population. The use of positivistic terminology may be inappropriate here as representiveness is not usually aimed for in qualitative work, where generalisation is not claimed.

Following the above there is a claim of data triangulation – again an example of realist thinking which may be incompatible with qualitative thinking (Schwandt 2001). Triangulation may be around multiple collection tools (often the case in ethnographic studies) or to do with "independent" researchers analysis of the data collected. This, I would suggest, is not in keeping with the notion of constructed realities.

The practical information around how many staff were involved is not presented in this article. Worryingly, important ethical issues, such as access, consent, ethical approval, and power relations are not considered in this paper. Participant information is likewise lacking. This makes it difficult for the reader to evaluate the quality of the design and implementation of the study.

The data is analysed by Lally by building and presenting data – this is not linked to any particular model or paradigm. However, the themes (sixteen of them) were presented to one member of the team who agreed them. We do not know how this person was selected or approached. Following this procedure an independent investigator was asked to thematically analyse one of the data sets. This person agreed that the sixteen themes were "true to the data collected". – This is possibly at odds with the notion of multiple realities and, indeed with Lally's own assertion that reality is created, negotiated and defined through interactions. Lally offers a useful diagram of the findings under five categories. Each of these is discussed in the article and linked back to the literature.

Category – "The Nursing Process"

Themes:
Name, age, diagnosis
Position on ward, information on empty bed
Problem solving
Discharge planning

Category – "Model in Action"

Themes:
Medication/ analgesia
Emotional status of patient
Retrospective nursing care
Activities of living
Observation/ obs

Category – "Them and Us"

Themes:
Multi-disciplinary approach
Reference to doctor

Category - "Learning the Ropes"

Themes:
Guiding junior staff
Eye contact with senior nurse
Looking for approval

Category – "Forward and Appendices"

Themes:
Off duty "chat"
Who's on and who's not.

Figure 1. Themes and Categories (Lally 1999)

These categories and themes will be revisited in the chapters of this thesis concerned with analysing data and presentation of the findings of this study.

In the discussion of the findings the notion of ritual is introduced and the value and benefits of ritual are briefly discussed. There is a rather short statement

here (p, 34) "the findings of the study answer the research question". This is perhaps a naïve claim and warrants further discussion.

Following this, a model of nurses' communication is presented to the reader. This model is interesting but implies that communication is only one way (from the senior nurse to the junior one). This has not been my experience of handover (in acute settings and community). If this was indeed the case in Lally's study, then the implications of this need to be unpacked.

The reader is then presented with three phases of the handover; two of these are more to do with team cohesion and one (the handover) with transferring of patient information. These are viewed as being of equal importance by the researcher. There is an unsupported claim that nurses perceive their role as carrying out the doctors instructions – this is not apparently emerging from the data offered in the article.

In general this paper was interesting and helped in the thinking around my research design. However it was a little confusing in terms of qualitative research ontology and epistemology. The use of triangulation, for example, is questionable, Schwandt (2001 p, 257): says that it (triangulation) is "questionable whether it is appropriate in qualitative research as it implies a realist position of the truth or meaning". There was, also, a noticeable gap on the very crucial issues of rigour and reflexivity in the study, which focussed more upon the findings of the study. This makes it difficult for the reader to evaluate the processes resulting in these findings.

Another useful study identified by this literature review was carried out by Hardey, Payne and Coleman (2000), which aimed to explore how nurses define and communicate information about patients and the delivery of care. This study used an ethnographic approach and the researchers observed a total of twenty three handovers. Additionally there was a total of 146 hours of observation of informal interactions between nurses. This was augmented further by 34 interviews of registered nurses, students and auxiliary nurses and an analysis of written records.

Data was collected from five acute elderly care wards in one hospital. It is stated that a grounded theory approach was used in data analysis to produce three main themes.

The literature review explores issues around the documentation and communication of information and identifies a gap in the failure to not recognise the importance of “scraps” of paper in studies to date. They refer to many studies undertaken by nurses in their review of the literature, which leads well into their presentation of the study.

The section on methodology refers to ethnographic, non-participant observation, tape-recorded handovers, semi-structured interviews and examination of formal and informal documents. The authors state that two research assistants observed the wards at differing times and completed field-notes. These were both registered nurses who had not practiced for some

time. This is briefly discussed as being useful in terms of not being over familiar with the research setting. There is no information presented here about whether and how the research assistants were prepared or briefed for this data collection.

Practical information could be improved by including a little more detail – for example over how long a period the 146 hours of observation took and how many staff were involved. It is not clear whether all staff were interviewed or a sample selected. If the latter, the reader is not privy to the details of inclusion or exclusion of participants. Ethical considerations were not made explicit in this article.

The interviews were carried out in private areas of the ward. The length of time for interviews is not apparent. It is not clear how these were negotiated with participants. The reader is informed; however, that the interviews focussed upon nurses' experiences and perceptions of handover along with information about individual's nursing careers. The tape recordings from handovers and interviews were transcribed.

The authors then present the notion of triangulation of data which (as above) is contentious in qualitative studies, but accepted here by the three authors. Data analysis is carried out to produce significant themes and (p, 210): "Two researchers examined the data independently to ensure the reliability of the analysis".

This statement may indicate some confusion in terminology as reliability is not the aim of some qualitative research approaches and is imported from more positivistic, realist and quantitative research paradigms. For example in ethnography it would be very unlikely to arrive at consensus across a number of researchers. It would not be useful to involve "independent" researchers to test out reliability. Concurrence of findings is not an aim of this approach to research.

The findings are presented with a statement that the wards had been allocated numbers to protect their identity. This is the only consideration of anonymity here.

Three themes are offered to the reader:

1. Construction and content of scraps.

This explores the use of scrap paper (or small note books) and also the choice of black and red pens. The red pen outlined what was needed to be done. Information was found to be added to the scraps during care-giving or after informal exchanges with other team members. Interesting findings about contentious issues were identified here. One auxiliary nurse was quoted as adding "pain in the ass" to her notes. Nurses were found to protect these jottings with the use of codes or shorthand.

2. The role and use of scraps

The use of scraps as a main source of information was found to be the norm in this study. Nurses claimed that their scraps were more up-to-date than more formal documents such as care plans and "Kardex" systems. The use of

scraps from uniform pockets provided readily available information to the nurses.

3. Confidentiality and disposal

The information stored on the scraps is viewed as private and individually tailored. Some nurses tear up the scraps after use – one individual took her pieces of paper home and kept them in a drawer for some time – this was linked with a protective function in that they may be useful one day to reconstruct the care given if asked.

A model is offered of communication and it seems a workable one with two way interactions and the position of the scraps explored in the processes of handover and care-giving.

Generally, this paper was found to be of great use and value in reviewing the literature for this study. The use of multiple data collection tools was found to be helpful. In this way triangulation may be valuable in terms of gathering information from across methods. One of the final comments made here was that the scraps are “one of the private places for a profession whose work is very public” (p, 214). A further statement about the articulation of holistic perspectives of nursing being confined to informal scraps was noteworthy and rang true to my held notion of hidden expertise.

One issue that I would have welcomed exploration of is that of the relationship between researchers and participants. Given the professional positions of the researchers (Sheila Payne was Director of Research, Michael Hardey a

Lecturer and Peter Coleman Professor of Gerontology – all at the same university), and in the absence of knowing who carried out the interviews, it would be helpful to understand how the nurses felt about the whole process. Issues of ethics and power could be usefully explored here. Reflexivity is not addressed within this paper. It is of course, accepted that articles can never tell the whole story and that word limitations have to be adhered to.

Benefits of the handover report

Within acute hospital settings, where patients are cared for throughout the 24 - hour day, a shift handover is usual to assist oncoming staff to give appropriate care. There have been a number of studies exploring the handover report in hospital and residential home settings (LeLean 1973, Lally 1999, Lamond 2000, Payne et al 2000, Manias and Street 2000, Kerr 2002 , O' Connell and Penney 2001).

Sherlock (1995) found handover to be an extremely important vehicle in providing information and guidance to nurses in preparation for giving care to patients. Parker et al (1992) states that handovers allow for containment and support required by nurses to deal with often disturbing or sad situations. This is supported by a number of other studies (Thurgood 1995, Strange 1996, Kerr 2002), which identify that handovers are a time for sharing and reducing stress and anxiety. In sharp contrast, Manias and Street (2000) found that handovers were the cause of anxiety and fear.

Some studies report that handovers offer a valuable opportunity for teaching and learning amongst nurses (Lally 1999 and O'Connell and Penney 2001). As nurses of differing experience and expertise usually attend handovers, this would seem likely.

There has been some recognition that there is considerable social interaction within handovers that does not directly relate to patient care. However, this may be viewed as a positive feature of the handover (Lally 1995; Strange 1996 and Kerr 2002) assisting with group cohesion and socialisation of nurses.

Appendix 2 briefly outlines some of the key studies (along with my comments) included in this review of the literature pertaining to handover reports.

The studies included in this review concur that, in addition to the sharing of information about patient care, shift handovers serve many other purposes (Strange 1996 O' Connell and Penney 200 and Kerr 2002).

A shared culture may be developed during the handover processes. Lally (1999) concluded that the handover report increased the opportunity to develop a shared value system amongst the nursing team. Other aspects of the reporting session were related to teaching and teambuilding activities (Lally 1999), social support (Kerr 2002; Lally 1999; Strange 1996) and group cohesion. Support mechanisms such as dealing with staff stress issues were also identified. In particular, newly qualified community staff may need this

period of time for support and confidence building. Additionally, Kerr (2002) asserts that the report should be viewed as a valuable nursing asset containing hidden expertise. This expertise, he suggests, should be uncovered and valued.

Hopkinson (2002) explored the views of 28 nurses in acute hospital settings and found support to be a key issue. Two important functions of the handover report were the opportunity to express feelings and emotions (particularly relating to caring for dying patients) and the provision of information. It was suggested that the handover report was useful in dealing with the emotional labour of nursing. Hopkinson warns that to view handovers as merely exchanges of information is to ignore the supportive opportunity and the forum to develop viewpoints and values. Again, thinking of these issues in terms of community nurses, they work alone for much of the day – if they were not to meet up and provide some time to discuss these issues, how would the emotional labour of caring for very ill and dying patients be addressed?

Nurses work together in teams to care for patients. This teamwork needs fostering to maintain relationships and group cohesiveness. Sharing a coffee and chatting are important social interactions that encourage a feeling of belonging to the team. This could be a very important issue when working in a community setting as much of the day is spent without the support of other team members.

Payne et al (2000) found that handover reports help to alleviate potential breakdowns in communication caused by "physical isolation" on poorly staffed wards. It seems very pertinent to investigate whether similar support is felt by community nurses, who are working over a wide geographical area, possibly in situations where bank staff are routinely employed and often work alone (Audit Commission 1999).

Within community nursing teams handover reports may occur more as a means of updating team members about the care of patients and their families. Reporting across shifts in a community setting may become more prevalent, however, as there is increasing pressure for community nurses to provide 24-hour care.

Manias and Street (2000) explored the handovers of nurses on a critical care unit using critical ethnography. This interesting study of six registered nurses looked at the practices involved in handover and identified five practices. These are: the global handover serving the needs of nurse coordinators; the examination; the tyranny of tidiness; the tyranny of busyness and the need to create a sense of finality. Although this study took place in a different setting than mine, I found some of the issues raised to be of particular importance, for example the power relationships amongst groups of nurses. These issues will be contrasted with the findings of this study.

In general, the studies included in this review are qualitative research projects, based upon multiple data collection tools and favouring an

ethnographic approach. The setting for them is either Hospital or Nursing Home. It seems very surprising that the community based handover report has not been subjected to the same scrutiny.

The use of language within handovers

Language is a powerful way of transmitting culture. The use of terminology can be symbolic (Helman 2007) and signify belonging to a particular group. Some of the verbal interaction within handovers is very informal and wide-ranging. For example, Allen (1998) found that oral handover reports took the form of narratives with anecdotes and information shared which could not be documented. In a later study of handovers in acute settings reports were criticised as being formulaic, cryptic, high-speed interactions (Payne, Hardey and Coleman 2000) that involved the use of abbreviations and jargon.

Parker, Gardner and Wiltshire (1992) found in their study of a large "Metropolitan Hospital" that the language employed during handovers varied from technical to lay and included judgemental, subjective and clinical expressions. They refer to the "construction of collaborative narrative" (1992, p33) and note illustrations of consensual decision making during which personal views are translated to group judgements or decisions. The use of the term "they" to refer to Doctors is also noted. This could indicate that the Doctors are viewed as others – outside of the team (us).

Wolf (1989) explored the functions of nursing jargon, particularly that exchanged during change of shift reports. Nurses' skill in using the language during report is said to reflect clinical ability. However, the report is claimed to expose the "performing" nurse's skills. Jargon is used to prevent lengthy explanations and clearly does serve a professional purpose. It may also serve as a way of excluding non-nurses from the discussions. Wolf (1989, p79) also stated: "Having an efficient sounding language enables nurses to justify time away from patients".

It should be illuminating to compare the above findings with the sharing of information between community nurses.

The use of metaphor in district nursing

Although not directly a study of handover reports, Goodman (2001) explored the priorities and definitions of district nursing through metaphor. This two-phase study involved semi-structured interviews and a three-month period of observation. She found that the work of district nurses was frequently described in terms of "balancing" and keeping relationships (with other professionals, patients and carers) steady.

Interestingly, also noted were a great number of references to sailing and sea travel – "not rocking the boat" and "not making waves", for example. Issues of powerlessness were contrasted in this study with the complex and skilled nature of district nursing practice. Issues of compromise were explored in

terms of fitting in the demands of patients with those of the caseload. Taking on inappropriate work was often preferred to spending time renegotiating with others – this time was viewed as time away from the patients.

In doing this, it may be deduced that any interaction with patients is deemed a more appropriate use of time than addressing issues such as poor (inappropriate) referrals. Not "making waves" may be a more acceptable term to use than problem solving or dealing with difficult issues. Metaphor could provide a way of "tidying away" uncomfortable situations by implying a decision or choice. Adopting phrases in this way could be seen to be a coping mechanism. If issues were spoken about more openly, maybe they would be more clearly seen to be problems that should be directly dealt with.

Handovers, Rituals and Nursing

Many of the papers reviewed for this literature critique used ethnographic principles and explored cultural issues in nursing. This led to a need to understand the developments in nursing relating to the position of rituals in nursing care and, particularly, handover reports. Helman states (2007. p224) that rituals have "important social, psychological and symbolic dimensions". In defining ritual he offers that ritual is a repetitive action with no direct technical effect. His example of cleaning one's teeth demonstrates that although this is a repeated behaviour there is a purpose to it (that of removing debris) that makes it a technical necessity. Therefore, he concludes that cleaning the teeth is not a ritual. However, if the cleaning of teeth were, for example

accompanied by added (unnecessary) elements such as chanting or being carried out with the burning of incense (my example) then it could contain ritualistic elements. He continues to explore the use of symbols that could be an integral part of ritualistic behaviours, including the use of particular words, artefacts or clothing.

The functions of ritual were defended in some of the papers reviewed within this section of the thesis. Authors (Strange 1996, Lally 1999 and Kerr 2002) suggested that ritual is a useful part of the culture of nursing. Nursing history has not always supported this viewpoint. In 1989 Walsh and Ford in their book "Nursing: Rituals, research and rational actions" portrayed the notion of ritual in very negative terms. In this publication, ritual was seen as the enemy of rational thinking

This point of view was, to a great extent, espoused in nursing literature for some time. However, latterly, (Holland 1993, Biley and Wright 1997, Philpin 2002) nursing authors have argued against such blanket condemnation and expressed the importance of further exploration into rituals in nursing and the functions that they may provide.

Holland (1993) explores what "ritual" is and sets out to determine its existence in nursing. She differentiates between the use of the term as "unsafe, outdated practices" and ritual in a cultural sense. Observing nurses at reporting time she notes that there exists an unwritten law that everyone must attend. She concludes that report is a ritual within the culture of the group

under study but that it also does serve a purpose. This would tie in with Helman's (2007) example above that actions may be purposeful and still contain symbolic and ritualistic elements. Sue Philpin (2007) takes this argument a step further in asserting that rituals and symbolism coexist with research based and technical elements of nursing care. Holland (1993, p1467) states the use of symbolic language "ensured exclusivity" from other groups in society.

A further useful example of ritualistic behaviour in this work is around the putting on of the uniform. This happens unseen by the rest of the group and is viewed by Holland (p 1468): as "putting on the inside clothes of the cultural group is a way of creating reality".

Biley and Wright (1997) criticise Walsh and Ford's dismissal of routine and ritual and suggest that they have approached the definition and interpretation of these in a rather limited way. They do, however, note a change of heart in Walsh and Ford's later work (1994) when they acknowledge that ritual could be of importance. Boyles and Andrews (1989) state that rituals are typically: "repetitive, stereotyped, formal, standardised and patterned" (p50).

Philpin (2002) critically explores the meanings of ritual across a number of contexts, arguing that earlier rejection of ritual was based on narrow interpretation of the concept. A robust search of literature is presented under two themes: Definition of ritual and purposes served by ritual. She asserts that definition of the term ritual is complex and difficult. An example of this is her

question relating to the labelling of an action as “trivial” – how and who can decide what is trivial?

Psychological definitions of ritual are then explored in this paper. Ritual is viewed here as a psychomotor action persistently repeated without technical reason (although the relief of anxiety is offered as a possible reason for repeated action). Anthropology and nursing works are found to have no consensus in definition of ritual.

Philpin tracks the pejorative use of “ritual” through nursing literature with interesting comments on the misinterpretation of Menzies (1960) earlier work. Many authors cite this as a key paper attributing the relief from anxiety as a central purpose for rituals in nursing. This is largely taken out of context as Menzies offers eight ways of reducing anxiety of which ritual is one. Ritual as a way of reducing anxiety is one possible purpose for repeated, patterned behaviour. Philpin gives examples of charms and incantations used by the Trobriand Islanders in Malinowsky’s (1954) study. These were used for protection in dangerous situations.

A second purpose of ritual, within this work, is suggested to be the maintenance of social order. In this way group members use ritual to express common values, particularly in situations of ambiguity. This paper (Philpin 2002, p 151) ends with a call for further exploration of ways that rituals are used by nurses in their work as they provide a “rich source of insight into the meanings attached to the accomplishment of nursing care”.

Strange (1996) sets out to explore whether handovers warranted the label "ritual" and also seeks to examine the functions of handover. As this is the stated purpose of his work, it merits a critical exploration within this section of the literature review. This paper was interesting to read and, as he uses an ethnographic approach in his study, was particularly useful to critique. The literature review section begins with a strong statement (p106) "very few authors bother to define what they mean by ritual". He supports the exploration of purposes and functions of ritual, such as celebration and an anxiety controlling mechanism being nurtured by the gathering of information (buying in to the widely held assumption of Menzies (1960) work discussed earlier). He also warns that rituals are both culturally and emotionally important.

In this study, Strange looks for hidden functions of handover. He refers to nursing publications and in this review of the literature concludes that rituals are generally negatively portrayed. I would agree with this statement and add that the trend of demonising rituals as being the enemy of evidence-based care could be an over-simplistic reaction. Rituals may be an invaluable way of dealing with uncertainty and challenging situations. Strange, however, does not access any of the nursing research carried out in this area. In this paper no research question is offered to the reader. One of the strengths of this paper is that Strange positions himself by contending "knowledge is not a fixed entity that exists independent of perceptions", (p107):

The sample for this study is one ward where the author had worked (intermittently) for eleven years and was "well known to the team" (p 108). As the occupation of the researcher is given as "Lecturer" the relationships between the researcher and participants would merit further exploration. There could be power issues at play during the data collection. He does acknowledge some possible problems in terms of exploitation of data or people and states that with these considerations and "confidentiality in mind, this study was designed to ensure that privacy and dignity of the people observed was protected". We do not know how this was carried out.

Issues of consent and the renegotiation of consent are not addressed by Strange in this paper. The data is collected by the use of participant observation. The possibility of behaviour changing whilst under observation is acknowledged here. The length of time to gather data is not made clear and observations were made when working as a team member. It is also an unanswered question whether the other team members were aware that data were being collected.

Strange offers an interesting description of handovers with observations on unwritten rules. For example it was tacitly agreed that handovers would not exceed 25 minutes in length and, also, that it was bad form to arrive too early (but acceptable to be late if busy).

In his discussion section, Strange notes the difficulties in separating out the technical and functional aspects of handover and so decides that to do so

would limit understanding. He presents three overlapping categories in his findings section of this paper as follows:

- Psychological functions.

He asserts that information is psychologically protective. Information also helps nurses prioritise patient need. He notes that information is shared in a safe place within the team. He states that ritual may help in controlling anxiety and that power; control and responsibility are moved from one shift to the next through the symbolic gesture of handing over the keys of the ward.

- Social functions.

These include group bonding and the establishment of trust. He discusses one “deviant” case (in which a nurse gives a very lengthy report) as revealing an unwritten rule – that handovers should be short in length.

- Protective functions.

Here patients who may be at risk are predicted through shared knowledge. This (p, 111) helps to maintain a “feeling of control”. Included here is the idea that novices are initiated into the values, culture and language of nursing during handovers. He links here to Carper’s (1978) four ways of knowing by giving brief examples with direct quotations. He concludes this paper by asserting that his work is not intended as a defence of ritualistic practice but an exploration of the functions of ritual.

Generally this paper is thin on practical detail. The reader does not know how many nurses were involved, how many handovers were observed and over what sort of time period. Issues of consent and confidentiality are not

explored. Although it would seem that ethnography is a suitable approach to explore the issues in question, there is no exploration of reflexivity offered here. For example, how did Strange's prior knowledge and experiences of nursing frame the findings expressed in this paper? The relationships between the researcher and researched would be of particular interest to the readers. Importantly, issues of rigour are also notably absent from this article. I did, however, find some of the ideas very thought provoking and useful in my planning for the design of my own research study into handovers.

However, O'Connell and Penney (2001) warn that handovers need to be seen as more than "just" a ritual. This would seem to be another case of the negative portrayal of rituals – perhaps a legacy of Walsh and Ford (1989).

The symbolism of handing over the ward keys along with the transference of responsibility and power is an interesting point raised within Strange's study (1996). This familiar handing over ceremony may not be replicated in a community setting in quite the same manner. For example, the significance of the key ceremony is likely to be lost as all of the team members need access to records and supplies and, therefore, keys are kept in a central place. The position of ritual is of particular interest in this study of the culture of community nursing.

In her study of the transmission of information between nurses in an intensive therapy unit, Philpin (2006) explores the meaning of ritual and symbolism. This paper presents a particular perspective from a much larger study. She

embraces the development of social groups' values and principles by ritual. Philpin suggests that symbolic action is central and is communicated "through symbols, such as language, gestures, clothing, spatial boundaries and documents, are accessible to the ethnographer and are a link to the underlying meanings of the ritual actions" (p, 87).

The exploration here of ritual, handovers and nursing provides me with a number of viewpoints to consider in the context of my own study. I am convinced of the cultural importance of rituals and would agree with authors supporting the need for further investigation in this aspect of nursing work (Holland 1993, Biley and Wright 1997, Philpin 2002, Philpin 2006).

Biley and Wright (1997, p 118) state that it is probably too late to reclaim many nursing rituals that have been abandoned as poor practice but end their paper with the need to: "explore the meaning and latent function of existing and new rituals before they are too hastily dismissed as irrelevant".

A high level of anxiety within community nursing staff has been reported (McDonald, Lanford and Boldero 1997; QNI and ENB 2002). The debates around the importance and functions of ritual will inform the findings of this study. Also, the notion that ritual and symbolism coexists with research based nursing, as expressed by Philpin (2007) will be explored.

Handover styles.

There are also many different ways of conducting handovers. Miller (1998) compares four styles, these are firstly, the recorded (taped) handover that is taped by the previous shift and played back by the on-coming nurses. Secondly, the walk around or bedside report, which was popular in the 1980s, but currently seems to be less so. This could relate to problems with patient confidentiality. Thirdly, Miller explores the written report, this includes care plans, the use of "white boards" and computer generated report sheets. Finally, the verbal report is explored.

All of the above are problematic and no one system is advocated. This was supported by the work of O'Connell and Penney (2001), who identified strengths and limitations of different methods of conducting handovers and concluded that there was no one style that was the best. Parker, Gardner and Wiltshire (1992) observed in their study within one hospital that bedside handovers obeyed different rules to those taking place away from the bedside. They noted that the patient could one minute be included in the discussion and the next be objectified by the nursing staff. There were also issues with negative terminology being used within patients hearing. This could lead to professional and ethical problems for the researchers. A limitation of this paper was that there was no recognition of the possible affect of the researchers upon patients or the nurses in the study. As one of the researchers is identified as a Professor of Nursing it would be valuable to

know whether the staff would know this fact and the potential impact of this on their behaviour.

More anecdotal views of the tape recording of handover reports (Burke 1999 and Ettinger 1999), suggest considerable time and cost effectiveness by replacing the verbal handover report. I am not aware of studies into tape recording reports for use by community nurses. Payne et al (2000) found that reading and compiling written reports could take as long to carry out as verbal ones, but were lacking interaction.

In conclusion to a study based in an acute setting, Kennedy (1999) suggested that carrying out a walking bedside handover report enabled nurses to put names to faces and involve patients in their own care planning. The problems of confidentiality were also acknowledged here as patients may be able to overhear information about each other. As someone who has been a patient in hospital on a number of occasions, I would personally hate this type of handover to be carried out around me and about me.

Manias and Street (2000) found a number of handover styles coexisting in their study of a critical care unit. There was a global handover that took place away from the bedside and served to mark the hierarchical position of the nurse coordinators within the team. A bedside handover also took place in which nurses perceived their care to be under scrutiny by others.

Some of these handover styles do not readily lend themselves to community nursing. For example the walk around report would be difficult to achieve!

Problems relating to handover reports

Timonsen and Sittronen (2000) explored the participation of patients during bedside handover reports and found marked differences in the views of nurses and patients. They distributed a questionnaire to 118 nurses and 74 patients to establish their attitudes using a Likert scale. Nurses reported a much higher level of interaction with patients than the patients themselves. For example, 91% of nurses felt that patients were encouraged to participate, but only half of the patients agreed. This is interesting, but does not translate into the community setting easily. It could be argued that concordance of care plans with patients is even more important in the home setting. Community nurses visit briefly and decisions about care are often implemented by carers or the patients themselves. For example, it is useless to write "must take fluids hourly" on a care plan if there is either no one to transport fluids to the patient of if the patient does not agree to drink them.

A study by Sexton et al (2004) compared the content of the nursing handover to the existing formal documentation on a General Medical ward. They discovered that 84.6% of the information shared during handovers could be located elsewhere in documentary sources. Only 5.9% of handover content included discussions about patient care or issues of management. The value of "traditional" handovers was questioned as the content, rather than being

essential to continuity of care, in fact produced confusion between the ward staff.

Sherlock (1995) reported that handovers may focus upon the care already given rather than in planning ahead. This may not be a problem if the benefits of handover are concerned with teaching and learning and socialisation of the team. Nurses carrying out handovers in an unprofessional manner were criticised by Wills (1994), who found some derogatory remarks made during reports.

Clinical supervision: as a function of the handover.

Many of the potential benefits of the handover, such as support, education and caseload management have previously been explored in the field of Clinical Supervision (C.S.) This was initiated in the early 1990s within the nursing profession and may be related to the tragic events surrounding the Allitt enquiry (DOH 1994).

The Department of Health in 1993 published *"A Vision for the Future: The Nursing, Midwifery and Health Visiting Contribution to Health and Health Care.* In this document, one of the five key areas was specifically related to research and Clinical Supervision. Within this paper , C.S. is defined as a formal process of professional support and learning which enables individual practitioners to develop knowledge and competencies, assume responsibility for their own practice and enhance consumer protection and safety in

complex situations. I intend to return to this definition later in this section of the literature review.

Although a standard feature of social work and psychotherapy practice (Winstanley and White 2003), the drive to introduce C.S. into nursing was the result of a “number of breaches of confidence” (Clouder and Sellars 2004. p264). Its implementation nationally has been gathering policy momentum (Department of Health 1993, UKCC 1996, UKCC 2001). Many models of clinical supervision have been developed (Faugier 1992, Hawkins and Shohet 1989 and Proctor1986).

Clouder And Sellars (2004) comment upon the top down introduction of Clinical Supervision and discuss issues of social control within the process. These authors do not necessarily view this as a bad thing. They note that surveillance of professionals is ubiquitous and should not cause concern in the attempt to improve quality care. This seems slightly at odds with a point made later in this paper that physiotherapists who did not feel threatened by C.S. or viewed it as a regulatory process could have a” degree of naivety” (2004, p267). However they then continue by suggesting that a positive view of C.S. could account for this standpoint. Although these two authors have a physiotherapy background, I was interested in their assertion that practitioners needed to value themselves and accept that surveillance was necessary in order to progress.

Morton-Cooper and Palmer (2004, p12) raise the issue of "narratives" as a defence against anxiety. This would seem to link back to the discussions above around rituals. The sharing of experiences is viewed here as a way of looking for shared meanings. These notions are of importance within this review of the literature, as they would, perhaps, be witnessed during the collection of data for this study.

Bowles and Young (1999) found a lack of empirical evidence relating to C.S, but identified some key "ingredients" (1999, p 959). These include a formal agreement or contract between participants. This formality indicates that there should be a dedication and purpose to Clinical Supervision (DOH 1993, Bishop 1998, Clough 2003). Handover reports are not formally a forum for this interaction, although it may occur in an informal way. Secondly, Bowles and Young state there should be a clear distinction between C.S. and performance appraisal.

It is accepted that reflective practice is a crucial component of Clinical Supervision (Morton-Cooper and Palmer 2000, Williams, French and Higgs 2005). The process intends to generate learning (Antrobus 1997).Again; it may be that there is informal reflection in and on action during report time for community nurses.

Finally, there is an aim in C.S. to develop practice by implementing what has been learned (Antrobus 1997, Hyrkas and Lehti 2003, Williams French and Higgs 2005).

The work of Proctor has been the most widely accepted in the United Kingdom. Her model describes clinical supervision as a "three-function interactive model of supervision".

The three functions are as follows:

Component	Explanation
Normative (managerial) component	Complying with policies, standards and audits. Adherence to local and national guidelines
Formative (educative) component	Developing skills and evidence based practice Relating theory to practice
Restorative (pastoral) component	Understanding and dealing with stress Listening, valuing and coping

Figure 2. Clinical supervision model – Proctor 1986

It is largely accepted that clinical supervision might involve guided reflection. Darley (2005) suggests that there should be three arenas for C.S. to take place. The first being regular one to one meetings with a senior practitioner, the second with a supervisor of the supervisee's choice and the third a group

supervision within the handover meeting. The third of these is described as being mainly “restorative” and “normative”. The normative here refers to the development and exploration of group norms.

The problems of CS are well documented. For example Supervision may be viewed as an aspect of social control (Clouder and Sellars 2004) in which practitioners may feel threatened. Palsonn et al (1996) found that CS had little impact upon burnout amongst nurses. In this study of Swedish district nurses a quasi-experimental design was employed to explore the relationships between burnout, empathy and a sense of coherence and personality traits. As part of a larger study, this work used a complex series of instruments to investigate whether Clinical Supervision would affect these factors. It did conclude that there existed a strong relationship between the personality traits measured and burnout, empathy and sense of coherence. An assertion made in this work that “Personal sources of support in the DN’s social network and personal problems in their private life were not examined. However, these social and individual factors are likely to be evenly distributed between the DNs in the groups” I found puzzling. I am unconvinced that support from social networks and personal problems are somehow evenly spread and I think would have a substantial impact upon the results, although I accept that this is a basic assumption of (quasi) experimental studies..

I would, however, concur with the final paragraph of this paper that states (1996, pp25): “As (Swedish) district nurses (my brackets) often work alone in patients’ homes and have to rely on their own resources in handling

demanding care situations, it seems important to give them opportunities to verbalise and reflect on problems with colleagues". This idea is central to my study.

The Audit Commission Report (1999) found that fewer than half of the district nurses in their survey had received Clinical Supervision within the last twelve months. Therefore, Clinical Supervision only partly explains the handover report experience. The issues raised above will be revisited in later chapters.

In view of the above, I would like to return to the Department of Health's 1993 Document here. The definition given above has some interesting notions of value for this project. Firstly, the "formal process" of C.S. may not be observed during the data collection of this study. It seems likely (from the review of handover literature above) however, that support and learning may be a feature of community nurses' handovers.

Issues of assuming responsibility may be interesting in the light of the consensus decision-making observed by Parker, Gardner and Wiltshire (1992) earlier in this chapter. Finally, the business of consumer protection and safety will be of interest during the gathering of data for this study. If community nurses are not embracing C.S, then may there be evidence of informal "surveillance" within the handover report?

The (then) UKCC (1996) stated that CS brings together practitioners and skilled supervisors to reflect upon practice. Within the context of this project

there was no identification of skilled supervision being a part of the interaction during handovers. It became apparent that expertise was shared between practitioners, but this was informally executed and unplanned. The principles of CS, as outlined above, were not seen to be implemented overtly during handovers during this study. Clinical Supervision was available to the Community Nurses within the project sample, but was not well taken up. The PCT are currently working to increase the uptake of CS by its staff. Therefore, it would be reasonable to assume that some of the requirements of supervision may have been met in an informal way during the handovers, but this was not a structured or planned event.

The notion of informal CS taking place during handover reports will be revisited later in this thesis.

Written documentation

A further theme to emerge from the review of literature involved the exploration of written records. Within this theme are relationships between nurse theorists and documentation, issues of reliability and validity, professional guidelines and finally, legal issues. As records are created as tools for community staff to use, they may be viewed as artefacts by the ethnographic researcher. A wide-ranging number of documentary artefacts exist for exploration. Some of these are commonly used and some locally devised.

There has been some exploration of written documentation (Moloney and Maggs 1999; Allen 1998 and Hardey et al. 2000). De la Cuesta (1983) found

that nursing theorists idealised the patient care plans, although the relationship for the nursing staff between patient care and documentation was not clear-cut. Dingwall et al (1988) suggested that patient records were attractive in terms of management, due to the sheer amount of documentation produced, and serve as a management tool.

In her classic study, LeLean (1973) found that written instructions in the kardex report seldom supported verbal instructions and, in some instances, contradicted them. Written handover reports are also problematic. Miller (1998) reports a lack of consistency with the format, although the benefits include their availability to be further reviewed during the shift. In this they are similar to tape recorded handovers.

Problems relating to reliability and validity when using health records in research were examined by Aaronson and Burman (1994). They note that errors and inaccuracies may occur during the original collection of information, when data is extracted and also during the interpretation of the data. The validity of such records is said to rely upon the writer knowing the truth and recording this truth. This is a somewhat positivist viewpoint that doesn't sit comfortably within this qualitative study. The existence of "one truth" is problematic and is discussed in some length in Chapter Three. However, issues of professional competence, patient concordance, care setting and type of data are usefully explored in this paper.

In 1998, the (then) UKCC published its "Guidelines for records and record keeping". This document claims that good record keeping promotes high quality patient care, continuity of care and improved communication between members of the inter-professional health care team. In addition, records are viewed as an accurate account of treatment and care planning. Finally, it is claimed that good record keeping aids the ability to detect problems and changes in the patients' condition.

Much of the above has been challenged. For example, the difficulties in ascertaining whether record keeping leads to measurable difference in patient outcomes are explored in a systematic review (Moloney and Maggs 1999). The review was hampered by the absence of abstracts robust enough for inclusion. From 10 years of research publications, not one study was found that would stand the rigorous tests used for the review. The researchers were unable to accept or reject the hypothesis that care planning and/ or record keeping has no measurable effect upon patient outcomes and recommend a large scale randomised control trial to further examine this issue. Anecdotally they state that record keeping is generally carried out retrospectively and away from the patient. In community settings, where care plans are kept in patients' homes, this should not be the case.

There are specific issues where care is to be planned, given and evaluated over long periods of time. Martin, Hinds and Felix (1999) researched the documentation practices of nurses with patients in a long-term institution. They found a need for clear, non-duplicating systems of records. This view is

supported by the Audit Commission report (1999). The Martin, Hinds and Felix study also noted gaps in their review of literature relating to nurses' use of documentation to improve practice and consistency of documentation. Patients may be visited in their homes over many months (or years). The development of recording procedures needs to address this.

Legal issues

Using ethnographic principles, Davina Allen (1998) examined nurses' views of nursing records in a hospital setting. She discovered an ambivalent attitude towards documentation. The importance of records was valued highly as a "symbol of professionalism", but nurses found there were problems in relating professionalism with the routine documentation in place.

These problems seemed to be compounded by Allen's experience of attending a study day on the subject of records as part of her data collection. The content of the study day depicted record keeping in terms of legal requirements and litigation rather than in terms of patient care, continuity or communication with others. Indeed, Annandale (1996) cites an uncertain climate of concern for the development of "excessive" record keeping. Allen (1998) fears that the claim that good record keeping is central to high quality patient care could, ultimately, distract nurses away from the giving of care and (particularly in time of pressure) nurses may focus upon recording in fear of litigation.

Hardey, Payne and Coleman (2000) found in their study of five acute elderly care wards, that "scraps" of paper were used as the main source of

information about patient care. This interesting paper found that nurses argued that their scraps were more reliably up-to-date than the Kardex records. The use of scraps meant that their records were easily accessible (as they were kept in their pockets).

The scraps were private and unique to each nurse. Some used codes and shorthand to note information that was perceived to be contentious. This, the authors state (2000, p 212), indicates "a recognition that the information that is noted down would not be in accordance with the priorities existing in handover and nursing records". This information is said to evolve from a tight, medically focussed handover reporting style. An interesting observation is that these unique and personal records are important to nurses and may offer a private space for the observations and thoughts of nurses.

It would seem that written records serve a variety of purposes. The ways in which written documentation is used by community nurses could impact upon the content and function of the handover report.

General issues relating to the Literature Review

The researchers in the majority of studies cited above approached their data collection from the Qualitative Paradigm. This is unsurprising as many of the projects sought to uncover cultural and social aspects of handover reports However, LeLean (1973) approached the analysis of the data, gathered by non-participant observation on six acute hospital wards, in a quantitative

manner. This produced information such as, the average length of time spent on group handover reports varied between 14 and 22 minutes. In another study, Lamond (2000) also examined the amount of time taken for reporting. It was found that the shorter reports took place between the night and early shift (mean 21 minutes) with other reports taking twice as long. This finding may be the result of expediency. The night shift, traditionally, work longer hours than day-time shift workers and could be reluctant to spend a long time in describing and discussing what has happened overnight. Alternatively, there could be a view that the night staff care-take the ward overnight and only report back on key issues. There could be an assumption that day time work is more valuable than what happens overnight. Or it could simply be that the day time staff have a comfortable period of overlap between shifts and this facilitates more discussion.

It is accepted that there are difficulties, within the word limitations of an article, to fully express ideas, ideologies and critically review relevant literature supporting studies. There was great variation of the amount of detail relating to the design of the reviewed studies. It would be useful to have a more detailed account of how some of the research projects were planned and conducted and to what extent other work has informed and guided the process of the research studies.

In a good example, Kerr (2002) states that semi-structured interviews were conducted around key issues. He usefully provides a table of issues and associated interview questions. He identifies the functions of the report and a

summary of each function's attributes. These include: social support, emotional support, stress relief and joking.

Interesting cultural observations are also included in the study by Kerr (2002). He divides his fieldwork into three phases. The pre-handover phase in which the off going shift update their documentation. This is followed the inter-shift meeting phase, where more experienced staff ask questions and give information. He notes that less experienced staff are relatively quiet during this period. Finally, the post-handover phase when the on coming staff are noted to give direct care very quickly after the handover, using notes. The findings of Manias and Street's study (2000) are of particular interest and will be compared and contrasted with the findings of this work in later chapters.

Issues of Rigour

Some of the studies cited above lack detail relating to research design and issues of rigour. Although most of the studies utilise the qualitative paradigm, reflexivity is not always apparent and rigour is poorly addressed in general. Within the qualitative studies, it is rarely possible, from the published articles, to extrapolate a decision trail (Sandelowski 1986). It is recognised that the limitations of publishing may constrain the authors from more in depth explanations. Most papers understandably focus upon the methods used and the findings.

It does seem appropriate, from the literature reviewed so far, to utilise a number of data collection tools. Issues of reporting can be very complex, involving cultural aspects of nursing and “usual” practices. The review of relevant studies would appear to support the use of an ethnographic approach to the design of this study.

Summary of the literature review

Having reviewed the literature, key themes emerging seem to be as follows. The complexity and diversity of community nursing would seem to indicate the necessity of good communication and sharing of information. This applies both within DN teams and inter-professionally. The quality of assessments carried out by community nurses may vary considerably. Effective communication could be an important contributing factor to improve assessment quality.

Linking back to the second of the three key themes presented in Chapter One, there may be many other functions of the handover report than the sharing of information. From the studies reviewed, these could include: teaching and learning; social support; dealing with stress; building group cohesion and the use of ritual. In this study I sought to explore these issues in the community setting.

The take up of Clinical Supervision (CS) is not widespread amongst community nurses. It would seem that there could be an unofficial element of

meeting the requirements of C.S. by team members during the handover period.

The position of community staff nurses is unclear and their role in assessment and dissemination of information needs further investigation. At the outset of the study, it was explained to the researcher that staff nurses were only to carry out a shortened form of assessment that was intended for use for six visits only. It may be that, in addition to the above issues, nurses may view written records with ambivalence.

Issues around handovers, rituals and nursing were explored within this project. The culture of community nursing is introduced as the first key theme of this work in Chapter One. The notion of whether handovers constitute a "ritual" is the first part of this important consideration. The use of language and its potential symbolism was of interest along with any exclusivity of terminology. The idea of ritual as a way of dealing with uncertainty is also of interest here. Issues relating to power relationships will be explored relating to the study by Manias and Street (2000).The existence of any unwritten rules is also investigated in this study. I would like to build upon the need for further exploration of rituals in nursing as identified by Biley and Wright (1997) and Philpin (2002).

The contribution of documentation to the planning and delivery of care will also be explored in the context of the development of cultural artefacts.

The above considerations arising from the literature review underpin this research study, which asks, "What cultural behaviour, cultural knowledge and cultural artefacts are exemplified during community nurses' handover reports?"

It is hoped that this study may add to the body of knowledge that already exists by exploring the culture of community nurses through handover report.

Chapter Three

Methodology

"One does not set out in search of new lands without being willing to be alone on an empty sea"

Andre Guide [2]

Following the review of relevant literature the research question for this study was formulated – "what cultural behaviour, cultural knowledge and cultural artefacts are exemplified during community nurses' handover reports?"

This study was designed to explore the cultural rules, social norms and patterns relating to the culture of community nurses. It seeks to explore culture encoded in language and behaviour of district nurses when meeting primarily to share information relating to home visits. The handover report time is viewed, therefore, as a vehicle to access issues of importance to the group. Artefacts and their uses will also be examined within this study.

The qualitative paradigm was judged to be the most useful approach to explore the above. Therefore, this Chapter aims to examine the ontological and epistemological assumptions supporting the design of the study. Issues relating to access, sampling and ethical issues will also be considered. Additionally, the important areas relating to quality and evaluation of the "goodness" of qualitative research will be discussed.

[2] Collins Dictionary of Quotations

Ethnography

This study adopted a qualitative approach using ethnographic principles. Ethnography is grounded in the concept of culture. Spradley (1980, p.6) defines culture as "the acquired knowledge people use to interpret experience and generate behaviour"

Culture has also been defined as a "pattern *for* behaviour and a pattern *of* behaviour" (de Laine 1997, p103). It is about learned patterns of behaviour, shared language and non-verbal communication

Ethnography has been described as a way of gathering, describing and analysing how people view their world (Aamodt 1991, p 40). Aamodt agrees with Spradley in that ethnography:

> "attempts to learn what knowledge people use to interpret experience and mold their behaviour within the context of their culturally constituted environment."

Researchers, therefore, use observation and questioning of action, interactions, experiences and feelings to build an ethnographic account.

Ethnography has been selected for this study because the process is focused upon learning from people (Spradley 1979, Burgess 1984, Hammersley and Atkinson 1995), which seems in keeping with an exploration of community nursing practices relating to reporting. The purpose of adopting this approach is to generate rich data based upon "seeing through the eyes of" community

nurses. However this stance is perceived to be a simplistic one – therefore the relationships between the researcher and the researched are further explored later in this chapter. Ethnography has been described as learning about people by learning from them (Roper and Shapiro 2000).

With its roots in sociology and anthropology, ethnography is concerned with understanding of the "other" (Vidich and Lyman 2003) and also is about the "self" with the observer at the centre of the research process.

It involves description of detail, contextualisation to the social setting, exploration of process and the avoidance of early use of theories (Silverman 2001). The latter point was interpreted here to mean that the researcher should not jump to conclusions in the early stages of the project, but be cautious in attaching meaning to events without careful consideration. This point is to be explored later in this chapter in the context of "insider" research.

The ethnographer needs to enter the cultural scene in an attempt to understand it and explore the language and thinking of the people involved.

A History of Ethnography

The roots of ethnography may be traced back to the 1920s when social anthropologist Malinowsky practiced field research on the Triobriand Islands 120

miles north of New Guinea (Burgess 1984). He explored such issues as social control, domestic organisation and systems of gardening as arranged by the inhabitants. Traditionally, ethnography is concerned with naturalistic inquiry and understanding of particular social groups by observing patterns of behaviour, customs and lifestyles.

In their introductory chapter Denzin and Lincoln (2003. p 19) refer to the "seven Moments of Qualitative Research". These are written as a history of research in North America, but describe the shifts and developments in thinking and practice very succinctly and so are reviewed here.

1. Traditional period

This is said to cover the time period between the early 1900s and World War 11 and is characterized by "*objective*" (their italics) accounts from a largely positivistic stance. In this period, ethnographers studied other (primitive) cultures.

Malinowsky sought to capture the natives' viewpoint by undertaking fieldtrips of one or two years in length. He called for ethnographers to go out into the world and explore cultures first hand. His fieldtrips involved being cut off from his European colleagues and learning the Islander's language (Hammersley 1989). His work contains the use of extensive photographic evidence (James 2001). Malinowsky focused upon the development of social rules in a society without

formal legal institutions (Burgess 1984).He is critical, however, of his own work, stating that he was aware of his own shortcomings and including an appendix in his 1935 study (Burgess 1984)evaluating his fieldwork errors. Denzin and Lincoln (2001, p20) write about Malinowsky in terms of loneliness, isolation and the frustration of the fieldworker- in quoting his words, however, they note that "on the one hand they disparage fieldwork, but on the other they speak of it within glorified language of science with laws and generalisations fashioned out of this self same experience".

In this period of time, Margaret Mead, a social anthropologist, was exploring childhood in New Guinea and is a key person in the formation of what became known as the culture and personality school of America. She observed the ways in which adults "trained" their children and set out to explore ways in which children take up the values of their society (James 2001). She refers to the geographical area under study as a type of laboratory, perhaps indicating a need to be accepted by the scientific fraternity.

The work of this period has since been criticised for its links with western power (Wax and Cassell 1979). The researcher in this instance may be viewed as a wealthy patron exploiting the group of interest as this was a time of colonial expansion. It is noteworthy that the notion of the "Lone ethnographer" (Rosaldo 1989) was demonstrated during this period by the production of classic accounts that were determined by four beliefs and commitments. These are said by

Rosaldo to be: a commitment to objectivity, complicity with imperialism, a belief in monumentalism and a belief in timelessness. All of these would be very much in question by contemporary ethnographers. The notion of objectivity is countered by reflexivity, accounts are not currently held to be set in stone, it is accepted that situations, history and society all have impact upon the cultural scene.

The Chicago School

The Chicago School of Sociologists in America developed in the 1920s and used observational methods to explore diverse groups such as the street gangs, homeless men and delinquents. The School moved the focus of anthropological research away from exotic locations towards home territory. This group has been very influential in the development of qualitative research thinking and warrants some attention here. The School has been generally recognized (Schwandt 2001) as underpinning and shaping more recent sociological fieldwork. Most of these researchers had little experience of the group under study (Vidich and Lyman 2000) and produced a set of ethnographic studies of subcultures within the city.

This work was the subject of an in depth review of qualitative research under the umbrella of the Chicago School by Martyn Hammersley (1989). This critique sets out to explore the methodological ideas underpinning the Chicago tradition of qualitative work, particularly the contribution of Herbert Blumer, who was linked to the school in the 1920s and 1930s. Blumer is known for inventing the term

"symbolic interactionism" with its roots in pragmatism (Schwandt 2001). This thinking was greatly influenced by the work of George Herbert Mead and together they created a standpoint based upon three premises. These could be described as:

1. Humans act towards people and situations based on meanings.
2. These meanings arise from social interaction between people.
3. Meanings are developed and adapted through interpretation.

The above would indicate that the inquirer must enter the world of those under study in order to understand meanings and interactions.

Hammersley (1989, p4), describes the big "dilemma" of Blumer's work as: "on the one hand, social phenomena cannot be understood without taking account of subjective as well as objective factors; yet, at present we have no way of capturing subjective factors that meet the requirements of science".

The following considerations of issues in this book include: notions of reality, the priority of epistemology and ontology, the position of science, abstract knowledge and hypothetico-deductive reasoning versus induction. The position of pragmatism is explored (Blumer's work was greatly influenced by Mead) and the notion that experience being the starting point and the end point of knowledge. Hammersley who, ultimately, concludes that here is no simple answer to

Blumer's dilemma but offer two possibilities for consideration also explores contributions by James, Peirce and Dewey. These suggestions being that either "science" or "symbolic interactionism" be redefined.

Hammersley (1989, p211) calls for a move away from hypothetico-deductive reasoning:

> "to treat participants' accounts as giving us direct knowledge of causal processes is to assume that participants themselves have privileged awareness of the factors that motivate them and also of the wider social conditions and historical developments that generate those motivations. In my view, that assumption is quite plainly false".

This would seem to support the view of Mead that the co-ordination of human activities is reliant on both language and gestures even when not consciously considered. Hammersley also questions the lack of consideration of motivation here. I intend to revisit these observations of Hammersley in Chapter Five, as they have been influential in the analysis and presentation of the findings of this study.

Through participant observation the ethnographer learns the ways in which people define things for themselves. However, although the Chicago School is often credited with the development of participant observation, they did not use the term to mean the same as is currently understood. The participant observers of the Chicago School were often people from the settings themselves and employed by the researcher to describe and develop accounts (Hammersley 1989). The belief that this group formed the basis for modern ethnographers is

felt by Hammersley to be misleading in that there is less emphasis now on documentary and already published works. Additionally, the Chicagoans were felt to neglect (Hammersley's word) methodological considerations in general.

In spite of the above, there is a rich legacy of studies including groups such as hobos, jack rollers (muggers), delinquents and homeless people.

2. Modernist phase

This "second moment" lasted from the second World War to the 1970s and is described here as a "moment of creative ferment" (Denzin & Lincoln 2003, p22) during which qualitative research developed and gave birth to many of the key approaches such as phenomenology, ethnomethodology and feminism. Much of the work of this period has its roots in left wing politics and a leaning towards romanticism.

In Britain, sociologists who were interested in studying deviance adopted the observational methods used by the Chicago School, which brought the second moment to its closure.

3. Blurred Genres

This "third stage", from 1970 to 1986 involved the development of many theories to underpin qualitative research activity. Denzin and Lincoln (2003) cite the work of Geertz in reframing the perspectives of qualitative work into pluralistic and interpretive viewpoints.

Burgess (1984) describes three models of field research. The first of these is described as the "going native" model. The researcher learns how to behave as a member of the group. An example of this could be Spradley and Mann's work with cocktail waitresses in 1975 when the researchers learned how to be both customers and waitresses. Secondly, Burgess offers the "undercover agent" model where the researcher is attempting to uncover hidden behaviour. This idea has been used in the study of "football hooligans" – where the identity of the researcher was covert to protect him from harm. Finally Burgess suggests an "advocate research" model where interventions are intended to improve the position of those researched. These ideas have been further developed in more recent times. The third stance could be a forerunner of critical ethnography (Manias and Street 2001). For this study, the covert model is not appropriate.

The notion of going native is tempered by the work of Gerrish (1997), as I am very much involved with community nursing from an educational perspective and have worked as a district nurse for a number of years prior to this. Therefore, I

have experiences and views of the cultural group under study here. The "advocate stance" is an attractive one. However, I can not claim that this study will improve the lives of the participants directly, although I would hope that the findings do offer some insight into their culture. Further features of this period are the sharing of ideas across disciplines and the embracing of the arts to illustrate research interpretations.

4. Crisis of Representation

The remaining tenets of traditional ethnography were finally relinquished here as researchers sought to explore issues of class, gender and race. There was focussed attention to the writing of ethnography and issues of power became central to the debates. Denzin and Lincoln (2003. p27) end this section of their critique:

> "There is, in the final analysis, no difference between writing and fieldwork. These two perspectives inform one another throughout every chapter (in these volumes). In these ways the crisis of representation moves qualitative research in new and critical directions."

5. A Triple Crisis

The triple crisis here is said to be that of "representation, legitimation and praxis" and challenges two fundamental assumptions of qualitative work. Firstly, that through representation the researcher is not actually illustrating the experiences

of participants directly. Secondly, that the terms used to measure the quality of such qualitative research (validity, reliability and generalisability) were no longer acceptable. The debate around these issues was taken up by Cutliffe and McKenna (1999) who proposed the development of qualitative evaluation processes. These considerations lead to the third crisis in terms of the ability of qualitative research actually impacting upon the world.

6. The Postmodern period

This included the struggle to address the above problems and is characterized by the rise of small scale theories relating to specific situations.

7. The Post-experimental moment

This runs into the seventh moment (the future) and is described by Denzin and Lincoln (2003, p29) as a movement in which: "writers seek to connect their writings to the needs of a free democratic society."

The authors of the above work conclude their history with recognition that things are not so clear cut or linear as their representation would seem. In fact there is a mixture of ideas, assumptions and practices operating at the present time. Manias and Street (2001) explore the notion of "critical" ethnography in which social and organizational issues are also considered. In later work

(2000, p 374) these authors state that critical ethnographers "are not only interested in interpreting situations and experiences, but also in collectively examining the power relations in social relationships". Again the researcher here does not seek to be an independent observer of the cultural scene but is interdependent in the processes. Current thinking exhorts the researcher to consider his/ her own biography and perspectives.

The seven moments illustrate shifts in ontological and epistemological considerations.

Ontology

Ontology is the questioning of the nature of reality (Denzin and Lincoln 2003a). The traditional ethnographic viewpoint of reality is based in positivistic thinking. The culture under study is "other" and there is a truth to be discovered by rigorously applying objective methods. This shifts into a "naturalistic" position. Gerrish (2003) explores the nature of this in terms of the researcher entering the field as "objectively" as is possible. She contrasts the contrasting philosophical stances of realism (in which the world has independent existence outside of the interests of researchers) and anti-realism. Anti-realism is said to underpin the perspectives of postmodern and post-structural social research. This takes the stance that there exist many socially constructed realities as exemplified by Guba & Lincoln (1994), who make the case for a constructivist ontology. These

constructed realities, they suggest, are then put together to create a truth of consensus.

Epistemology

This is concerned with the nature of knowledge and examines the relationship between the researcher and what is known (Denzin & Lincoln 2003a). An objective epistemology would hold that it is possible to exclude beliefs and values from the research process, contrary to Spradley's assertion above that culture is "only the thin surface of a deep lake"(1980, p.6) Beneath the surface of the lake lies cultural knowledge waiting to be discovered. Constructionists, who would refute that there is a "truth" to be uncovered by research, would not embrace this standpoint. Rather, they would assert that researcher and participants have their own realities in socially constructed forms (Guba and Lincoln 1989). Therefore the behaviour and artefacts observed would need to be explored in the context of the voice(s) of participants.

Knowledge is explored through a variety of paradigm positions by Denzin and Lincoln (2003b) including positivist, postpositivist, critical theorist and constructivist standpoint. In an earlier work Schwandt (1998, p236) states:

> "Constructivists are deeply committed to the (contrary) view that what we take to be objective knowledge and truth is the result of perspective. Knowledge and truth are created, not discovered by mind."

He continues with the assertion that reality is both pluralistic and plastic. Pluralistic in that reality can be expressed in a variety of ways and plastic in its ability to be stretched and molded.

Ethnography as Methodology

There are a number of qualitative approaches to research. These include phenomenology, grounded theory and ethnography (Roper and Shapiro 2000). Although there are similarities in overall intent, they do differ in their goals and focus. Ethnography is predominantly about the cultural context of the group under exploration.

Traditionally ethnography has been described as being based upon a naturalistic assumption in which the researcher would attempt to distance her/ his self from the participants of the study and there would be an attempt to block out preconceived ideas (Gerrish 2003). This practice would accept the notion of realism- that there is a truth out there to be discovered. The antithesis of this is anti-realism in which there exist a number of positions of "reality" including that of the researcher.

In consideration of the above discussions and debates, I would suggest that the following assumptions have guided my thinking throughout this work.

- Firstly, that it is not desirable or possible for researchers to put aside their own knowledge of the social world in an attempt at objectivity (Koch 1998).

- Secondly, that a naturalistic viewpoint is also untenable in its ontological position that reality exists outside of the researcher (Gerrish 2003).

- The constructivist epistemology of created and subjectivist findings (Denzin and Lincoln 2003b) seems to best address my standpoint throughout this study, as I accept the notion of interdependence and collaborative working to construct the data. By including the contextual and historical relations of the research setting, I also interweave some elements of critical ethnography in my study.

A shared consensus of "truth", whilst not excluding historical and political positioning (Koch 1998) would, in addition to the above, be my guiding principle.

Ethnography and Nursing Research

In the preface to her edited book, Janice Morse (1991) notes that qualitative research was beginning to be embraced by nurse researchers. She continues by outlining some problems that would need to be considered at the time of her writing. These include the inappropriate quantification of qualitative data

(converting findings into numbers for example) and the belief that the qualitative study was a preliminary venture. In this, she strongly asserts that good qualitative research constitutes a completed work and is not a precursor for quantitative research. Boyle (1991) explores the use of ethnography in nursing research and cites Byerly, who as long ago as 1969 described the use of participant observation in a nursing study.

Since this time there have been considerations of the contribution of ethnography to nursing research (Gerrish 1997, Koch and Harrington 1998, Manias and Street 2001, Philpin 2002, Allen 2004). Davina Allen (2004), in her exploration of the insider-outsider relationships of nursing ethnography, asserts that it (ethnography) is growing in popularity amongst nursing researchers. In tandem with the seven moments of Denzin and Lincoln (2003), nursing research has shifted its position.

Parker and Wiltshire (2003) explore the relationship and growth of narrative in research with the move away from positivism towards interpretation. They assert that research, including stories and narrative, is now a key contributor to nursing practice.

Murphy (2005) explores the notion of developing expertise as an ethnographic fieldworker. In her work she compares the work of Benner (1984) on the transition from novice to expert with the processes involved in developing

competence as fieldworker. She writes of her initial tendency to work more as a nurse than as a researcher and explores her apparent need to "revert to a nursing role in the early stages of the fieldwork". Issues of security and role ambiguity seem to be in evidence and the fact that the researcher has great expertise as a nurse could make it a useful stage to progress through before truly adopting the role of fieldworker.

Additionally, by reverting to the nursing role, Murphy asks whether this helped in terms of acceptance and building up trust with her participants (women who had experienced early miscarriages). This point was also made by Gerrish (2003) in her work with district nurses.

Culture

The intention within this study is to describe the culture of community nursing. It would seem appropriate here to consider what is meant by the term "culture". Keesing and Stathern (1981, pp.1-8) state that cultures are combinations of "systems of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that human beings live". Roper and Shapiro (2000) identify two main perspectives upon the term "culture". These are behavioural/materialist and cognitive. In the former, culture is observed through behaviour patterns and way of life. The second of these is more to do with ideas,

beliefs and knowledge. Together these concepts of culture enable ethnographers to explore what is known, believed and undertaken by the group under study.

In exploration of the concept of culture, Helman (2007) suggests that culture consists of guidelines that are inherited by being a member of a particular society. These guidelines affect how members view the world, emotionally respond to experiences, behave to other members and how to regard god and the environment. He describes (p2) how culture is transmitted: “by the use of symbols, language, art and ritual” and adds that without shared perceptions group cohesion and continuity would be not possible.

Helman describes divisions within culture as being crucial in that a number of categories are created. These include divisions into men and women, children and adults, beautiful and ugly, healthy or ill. He states that people are moved across categories for example from healthy to ill or vice versa. Further categorization could include rich or poor, members of religious groups and cults.

He suggests that professional *subcultures* (Author’s italics) also exist with his examples of medicine, nursing and military groupings. These share some of the attributes of a main culture (including concepts and values), but also have unique features of their own. Wider societal influences are inherent within the subcultures and are not fixed creating fluidity within culture. Cultural backgrounds

therefore affect many aspects of daily life such as values, behaviour, beliefs, dress, diet, rituals and language.

Schwandt (2001, p50) asserts that there is no consensus about the exact meaning of the term "culture" but offers the following useful general agreements.

> "culture (a) is not an objectified, self-enclosed, coherent thing or object and (b) is not something that is learned by observing and documenting but something that is inferred; culture is portrayed, written, or inscribed in the acts of representation of the inquirer"

This would support the notion of the construction of data and, also, identifies the complexity of representation. He continues by stating that culture may be "framed" in meaning, symbolism and language.

Spradley (1980) outlines three main areas for cultural enquiry. These are what people do, what people know, and the use of artefacts. The latter concerns things that are made and used by the group in question. It is fairly easy to observe behaviour and artifacts, however, it is accepted that "culture" itself cannot be observed, but exploration of the three areas enables the researcher to make inferences. These are based upon evidence and assumptions (Spradley 1980).These assumptions, however, need to be explored reflexively in terms of the issues explored above as culture is not static. It has been described (Schwandt 2001, p49) as: "shifting, contested, conflictual site of the meanings, values, norms, beliefs, actions and so on that make up the stuff of everyday life for some social group".

It is accepted that people move from one cultural scene to another and employ a range of cultural rules. Community nurses, therefore, may behave in particular ways and use particular language when engaging with other community nurses. They may display values, beliefs and perceptions in their daily lives with other members of their subculture.

Ethnographic approaches require extensive periods of time “in the field” (Maggs - Rapport 2001, Burgess 1984) and becoming immersed in the informant’s situation. Emerson (1987) warns of compromising fieldwork by not spending sufficient time in the field to carry out data collection effectively. Within this study, six months were allocated for observation visits. This is not very long in terms of an ethnographic study but a longer time period in the field would have been problematical in terms of managing the project.

Although there are a number of ways to refer to the people from whom the researcher is learning, the term usually used in ethnography is that of “informant” (Spradley 1979, Burgess, 1984, Holloway and Wheeler 1996). However, in agreement with Morse (1991) to choose a term that “fits”, the use of the term “participant” has been selected for this study, as there could be overtones of policing or “grassing-up” with the use of “informant”.

Participant Observation

Burgess (1984) considers participant observation to be the principal method used in field research, whereas Spradley (1980) refers to participant observation as either a tool or a strategy for both listening to people and watching them in natural settings. It is a way of finding out from the people and communities being studied how they see the world from their points of view. Traditionally the ethnographer would attempt to take an objective stance by being removed from those under scrutiny. Boyle (1991) examines participant observation and asserts that it enables researchers to take a slice of behaviour, interpret it and then put it into context.

Hammersley and Atkinson (1983, p37) state that the ethnographer:

> "participates overtly or covertly in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions, in fact collecting whatever data are available to shed light on the issues that he or she is concerned"

Participant observation is now considered to be more of a dialogue between the researcher and participants (Field 1991). At this point in time, the ethnographer's own interactions, relationships and emotions are now an integral part of the whole research experience. A more collaborative approach is more in keeping with current thinking. Moore and Savage (2002) maintain that there is a reciprocal relationship between participation and observation with each

influencing the other. They assert that a key premise of participant observation is that the researcher gains the trust of the participants by sharing their daily lives and the development of rapport. Gerrish (1997) explores the complex relationships which develop during fieldwork and which require day-to-day consideration.

In later work (2003, p83), Gerrish asserts:

> "It may be difficult both for nurse researchers and for research participants to differentiate clearly between the two aspects of the role, and relationships may be built and disclosures made on the basis of being perceived as a nurse rather than a researcher"

I would agree with the above after my experiences of fieldwork during this study. This position of being in the margins has also been termed "inhabiting the borderlines" (Cudmore 2007) and has been found to be a difficult place to maintain (Gerrish 2003, p83).

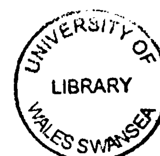
Within this study I take the stance of the "Marginal Native" (Gerrish 1997) and (as Gerrish did) participated in the activities of the participants by making the drinks, washing up and generally socializing. One of the dilemmas of this position is to be trusted and accepted whilst still having sufficient distance to "make sense of my observations" (Gerrish 1997, p 26). I would accept the assertion of Jan Savage (2003) that there cannot be an assumption that the worlds of the researcher (internally and responses to events) are separated by a clear boundary.

The extent to which the ethnographer is a participant observer was explored by Spradley (1980). He formulated a number of positions (see figure below).

Degree of involvement	Type of participation
High	Complete
↓	Active
↓	Moderate
Low	Passive
No involvement	Non- participation

Figure 3: Types of participation (Spradley 1980)

Non- participation is described as being the lowest degree of involvement. Spradley gives an example of this as watching television and making observation. The next level is “passive participation” in which the ethnographer is present in the scene, but does not interact with other people to any extent – this level of involvement may include “loitering”. “Moderate participation” comes next in the table. This involves the observer seeking to maintain a balance between being an insider and an outsider. There is some evidence of doing some of the things observed within the cultural scene, but being removed.



Spradley's next level is that of "Active participation" in which the person seeks to do what other people are doing. The ethnographer tries to learn cultural roles for behaviour. This can involve living in that culture and participating in daily life. Finally, there is "complete participation", which could be exploring the culture of a group that the ethnographer is already a member of.

I would put myself in this table at the level of Moderate participation. This poses the potential tension between insider and outsider – an issue that I will address later in this chapter. As a former district nurse, I am an insider. As a researcher, I am an outsider. In the terms of Gerrish (1997) I am a marginal native. Despite the above standpoint it is important to consider Spradley's (1980 p22) assertion that: "participant observation represents a powerful tool for invading other people's way of life"

Burgess (1984) urges those participating in ethnography to explore their own role as a social researcher by examining how their own experiences and characteristics impact upon the research process. For example my past experiences as a district nurse will affect the way in which information is received. As a researcher in my early fifties, I could be either perceived as an experienced nurse or out of date by the younger participants in this study. All of the participants in this study were white and female. This reflects the demographic make up of community nurses (Audit Commission 1999).

Participant observation involves a narrowing down of the myriad of things seen and heard by the researcher. Therefore, data analysis will always be partial. Silverman (2001) does not feel that this is problematic and I would support the view that it is impossible to tell the whole story, rather to "celebrate the partiality" of the data presented.

However, the use of prior knowledge of district nursing practice is both beneficial and problematic: beneficial in that experience can aid understanding of what is being observed, but there is a risk of making assumptions based upon that knowledge (Gerrish 1997). This notion posed dilemmas both in how this position affected my view of what was happening and also perhaps also how the participants' viewed me in my dual role as nurse and researcher. However, Aamodt (1991) warns that it is a mistake in ethnographic work to assume that one is a native when carrying out research in one's own society. There may well be nuances of language for example that could be missed. If the field is assumed to be familiar then important data may not be gathered.

I found that honesty was the most useful way of dealing with these issues by making it clear that whilst I have considerable professional nursing experience, I have not been working in practice for many years. This enabled me to ask for clarification on clinical matters and place the participants into a teaching role in which they were helping me to understand the current issues in community nursing. The ambiguity of being both a researcher and a nurse remained a

constant feature of the process of this study. In her study, Estabrooks (cited in Morse 1991), reported three problems interfering with her ability to maintain the researcher role as a nurse. Firstly, it became very difficult to balance the roles of observer and participant. Secondly, familiarity with the setting caused problems when affecting a role change to observer. Patients were also observed during this study and she felt very frustrated when unable to intervene with care. Lastly, she found that she could not distance herself from feeling emotionally connected with the patients. In this study, patient care is not directly observed.

Issues within Participant Observation

Although the most commonly employed data collection tool within ethnological research, observation is not without its problems. Traditionally, the observer may adopt an overt or covert role (Gold 1958, Burgess 1984, Mays and Pope 1995, Clarke 1996, Silverman 2001). Accepting the effects of reflexivity leads the researcher in the proposed study to adopt an overt stance in which the participant is an observer. This also sits more comfortably with ethical issues of consent. It is accepted, however, that roles are rarely as polarised as stated above (Merrell and Williams 1994) and that there will always be some elements of secrecy in research claimed to be carried out in an overt manner.

The participant as observer approach is best suited to prolonged observation during which the researcher is involved in major events happening within the

social setting identified. As explained above, I felt that Spradley's (1979) "Moderate" participation best described the stance taken within this study.

Hammersley and Atkinson (1995) claim that the ethnographic researcher may not find participant observation an easy experience. It may be possible to switch from being a participant (and forgetting to observe) to a more detached role. The need to maintain a balance is suggested and is also termed "moderate participation" by these authors. Researching a familiar culture may be problematic as it is difficult to stand back from assumptions. It is accepted here in agreement with Pellatt (2003, p31) that fieldwork "involves the performance of social roles and relationships, which puts the self at the centre of the activity".

Reflexivity

The focus of this study was to be upon social processes (Burgess 1984). It is important to consider that, as the researcher, I have worked as a district nurse and am now a senior university lecturer teaching district nurses. This will have a great effect upon my approach to the project. I must bring my own social development and personal experiences to the study. Lipson (1989) examines the use of self in ethnographic research, proclaiming that the researcher is the primary tool for collecting data. It is clear that my previous experiences will affect what is selected from the complex social processes within community nursing

teams. Additionally, the role assumed during the data collection will also be determined by the researcher's background (Mulhall 1997).

Marcus (1998) described four styles of reflexivity in ethnographic work. Firstly he refers to the "baseline" form of reflexivity (p395) associated with self-critique and subjectivity. He cautions that

> "At most this opens the possibility for the so-called polyphonous text or the completely collaborative project, but often as not, it ends by reinforcing the perspective and voice of the lone, intro-spective field-worker without challenging the paradigm of ethnographic work at all- to the contrary".

His second style is commitment to sustain objectivity. Reflexivity is viewed as a research tool. The researcher opposes any identity between the observer and the observed (Marcus 1998, p 397).

The third of Marcus' styles is that of emphasis upon the "intertextual or diverse field of representation" (p398) and may be termed as "The politics of location". This notion incorporates the existing alternative representations. It loses the traditional view that there are unknown "other" worlds waiting to be discovered.

Finally, he writes of a feminist style of reflexivity, which, in common with style number three is the "practice of positioning" (p401). This stance assumes that all work is incomplete and benefits from responses from others in differing positions.

Concluding this chapter, Marcus states that thoughts around reflexivity are ongoing and none of the above provides a model to guide ethnographers.

There has been considerable debate around reflexivity and the awareness of the researcher of self, responses and reactions to situations and groups being studied (Roper & Shapiro 2000, p26).

> "reflexivity allows nurses to become aware of their roles as ethnographers and to identify biases and their potential influence on the data and the interpretation of the data"

Reflexivity, therefore, is needed throughout the whole process of ethnographic research. Coffey (1999) takes the stance that fieldwork should include a self-conscious consideration of relationships including emotional interactions. She describes reflexivity as "having an ongoing conversation about experience whilst simultaneously living in the moment" (1999, p 132). She also argues that the real involvement of the researcher within the setting under study is a particular strength of ethnographic research. Pellatt (2003, p28) explains how reflexivity helped her to explore "taken-for-granted values" and how they affect research.

I tried to maintain a reflexive approach during my study and I tried to honestly state my background to potential participants when inviting them to take part in the project. I would identify most with the third of Marcus' styles of reflexivity above in that interpretation is one of a number of representations. Along with my stated position as a constructivist, the truth of this work is co-produced by the researcher and researched. A reflective diary was kept throughout the project in

which I owned thoughts and related beliefs underpinning the contribution made to this project by the researcher. The identity of the researcher would shape what was seen, heard, recorded and felt during the research process (Holloway and Wheeler 1996, Denzin and Lincoln 2003b).

It was considered important to aim for a reciprocal relationship in which the researcher gives something back to the participants and is not viewed by them as an exploitative outsider seeing to grab information for her own ends. Measures to increase the likelihood of this included me placing great importance on the sharing of the aims of the project with the participants, and agreeing to take the preliminary findings of data analysis back to the group for discussion (Manias and Street 2001). It was also agreed that the findings would be taken back to each team upon completion of the final report.

It has been suggested that all research reports may be viewed as cultural artefacts (Mulhall 1997) resulting from the interactions of researcher and researched. There needs to be an awareness of the ways in which the "Self" of the researcher affects the research. Therefore, there are two questions posed for exploration. Firstly, how did I affect the process and outcome of the research study? And, secondly, how has carrying out this study affected me?

To answer the former I need to explore what I brought to the study as an individual. This is to do with my prior experiences, values and beliefs. My

background as a district nurse and a lecturer leading the district nurse pathways at University will be a major contribution to the above. My experiences may enable me to understand more fully the way that I am seeing and hearing in the cultural scene of community nursing. The process of the study involves entering the field, observation, development of field-notes (including a reflective diary), interviewing, data analysis and dissemination of the findings.

Entering the field is a widely used ethnographic concept, which has been described as a continuous process of establishing and developing relationships (Schatzman and Strauss 1973). Within this study, a large proportion of the team members knew me already. I had taught one person and was known as a district nurse practitioner by another. Many of the participants had heard of me as the pathway leader for district nursing at a local university. This may have given me credibility in the eyes of some participants. The down side of this is that there may have been some trepidation on the part of some team members, who may have viewed me as part of a nursing hierarchy. Allen (2004) explores the literature in terms of how ethnographers accomplish group membership and manage identity during the process of study.

I sought to be accepted as someone trustworthy by getting to know the team members and sharing some of my experiences as a district nurse. Giving information about myself may also have been helpful in establishing relationships between the team members and myself as a researcher. Davina Allen found that

telling "self-effacing stories" within a planned strategy of disclosure (2004, p21) helped to build trust with her research participants.

I noted my feelings and views in my diary and reflected after each observation visit and every interview. These observations were added as memos to the transcriptions for analysis. My role as researcher was also discussed with each team during the discussion of preliminary findings. It was considered important to carry out this feedback with each team to sound out their views of the findings so far and to give them the chance to add any comments. I wanted also to check that I had not carried out major misinterpretations of the interview transcripts. I stated many times to the nurses involved in this study that I had not been in practice for many years and that I would need to ask questions about current practice. This was truthful and also an attempt to build up trust with participants.

It soon became clear to me that, although I had tried to reflect the stories of the participants, it was of great importance that they recognised and felt that there was some significance in my interpretation of their situations. By being present during handover reports, I had an effect upon one of the participants in particular, who commented at the end of the observation visits that she had wondered: "*Should I have said that?*" when in the process of reporting.

To answer the second question introduced above of how the study has affected me, (Mulhall 1997), I need to explore my emotions throughout the research

process and examine what I have learned from researching this study. I believe that I have further developed my own ability to appraise/ critique myself during this process.

Reflexivity is about critical analysis and exploration of feelings of those involved in the experience, challenging any assumptions made, re-framing the event to consider a number of perspectives and applying relevant theory to it. My field-notes demonstrate a shift from the early days to those made in the latter stages of data collection. Initially, I began from a normative perspective. I found myself writing down what people said – trying to capture the content of the observed handover reports. As I progressed through the study, my field-notes were more focussed upon observing cultural knowledge, behaviour and the use of artefacts. This may demonstrate my development as a novice ethnographer.

A situation occurred during one of the early observation visits about my position as a researcher. I did not feel that the team was particularly at ease, although they were friendly and welcoming. I felt uncomfortable and was not sure why. It emerged that some of the participants, whilst knowing that I was a Senior Lecturer, had not realised that I ran the Pathways for district nursing at the University. I thought that I had made it clear, but somehow this was not the case.

Communication had not been effective. This was an early visit within the six

months of data collection. The team members were very quiet for a while and seemed surprised at my role. In my reflective notes on that day I have written that I was trying to downplay my day job so that they would regard me as a "researcher" .After I had spent some time thinking about this situation, I became upset that they would think that I had misled them. At the next visit there was considerable interest in how the courses ran and what I taught on them. This felt like a step forward. I think that the team members accepted this part of who I am.

The insider/outsider Experience

The meaning and coherence of participating in a social situation is derived from being inside that situation (Spradley 1979). That we are a part of it is a crucial element of experiencing the feelings and emotions of the group. However, in participant observation, the researcher may shift positions from insider to outsider when observing events, people and her/ himself as objects. My professional background and experiences as a nurse and a nurse educator contributed to my "insider" status and was helpful in accessing the participants (Gerrish 2003). Following much of the accepted nursing jargon, sharing personal information and making the tea also added to this.

However, I was not a team member, needed clarification about some of the issues clearly understood by the team members and was only present for the period of time in which the data was collected. These made me an "outsider" to

the two teams involved in this study. This is a common situation for the ethnographer, as Spradley (1980 p80) pointed out: "ethnographic fieldwork involves alternating between the insider and outsider experience and having both simultaneously"

There are many potential dilemmas associated with the above roles, which may have led to participant observation being under- utilised in nursing research (Merrell and Williams 1994). These impinge upon issues of both rigour and ethics and are more fully addressed below. Decisions need to be carefully considered and documented in the field notes (Sandelowski 1986) in order to provide an audit trail. For example, as identified by Gerrish (2003), it would be impossible to predict or gain informed consent from every person who visits the community nursing team in the health centres. In addition, the researcher cannot be fully aware of everything to be observed (Clarke 1996), which makes informed consent problematic.

One of the main issues involved in participant observation is that the behaviour of participants may well be altered by the presence of the researcher (Burgess 1984, Hammersley 1992, Holloway and Wheeler 1996). Field (1991) noted in her study of nurses and patients that the nurses seemed more aware of the researcher than the patients. As soon as the nurses engaged with the patients, then the researcher observing was ignored. A very pertinent comment is made

by Field (1991, p96): “being observed often carries with it the threat of evaluation or judgment of their nursing care”

This was certainly an issue at the beginning of the study and is reported in a section from my field-notes in the findings section of this thesis. It is hoped that gathering data over a prolonged period of time may minimise this effect, as the situation becomes more familiar and “normal”. However, I would agree with Gerrish (2003) that this is impossible to measure.

Data collection involved multiple, opportunistic methods, including participant observation, semi-structured interviews and a review of written documentation. A plan of the study may be found on page 145. As the customs and practices relating to the reporting of information to colleagues were to be the focus of this study, opportunities may present themselves without being predicted. Language is the primary means of “transmitting culture” (Spradley 1979, p9) and shared cultural knowledge enables people to interpret experiences. This leads to the development of social norms in terms of expression and behaviour.

People move from one cultural situation to another in complex societies. The district nurse is likely to adopt different language and behaviours when interacting with her family, for example. Hammersley and Atkinson (1995) stated that we are all too some extent participant observers in life, learning about the world whilst participating in it. This is a rather simplistic account of the participant observer,

but it is this sense of social inclusion that leads the researcher to the adoption of *participant* observer in this study. I felt that separation from the group would be artificial and unhelpful.

During the observation visits I was engaged in discussion about the issues raised by team members during the handover report. I tried to be included by making the coffee and talking about current events – relating to nursing and non nursing topics. I did not attempt to take on the work or role of the district nurse, but detachment was seen as undesirable and impossible (Koch and Harrington 1998). Taking part in the day-to-day interactions with the teams included in the study implies a degree of involvement.

Field research is characterised by flexibility (Burgess1984), the project and its methodology were refined and redefined throughout the process. This makes the production of a clear proposal at the outset problematic. Burgess further states that a tidy neat fieldwork proposal is: "dishonest, pretentious and contrived" (1984, p3)

He therefore proposes a middle course, with information relating to the intended objectives, location and methods to be used. I tried to be honest and up front with the participants from the outset of the project. In so far as is possible the methods to be employed were explored in the context of the research questions, as the above does not offer permission for poorly thought out strategies (Silverman 2001).

Ethical Issues

Consideration of ethical principles was an ongoing process throughout this study, namely, respect for autonomy, beneficence and justice (Beauchamp and Childress 2001). Autonomy is viewed as being involved with respect for individual's freedom and choice. It was very important not to coerce any team member into agreeing to take part in this study. It was also necessary to make clear that any member could withdraw from the project at any time if they so wished.

Beneficence is to do with the benefits that any participant may gain as a result of the study. These may include being listened to, gaining insight and improving personal practice (Miles and Huberman 1994). Non-maleficence involves protecting individuals from harm and promoting their welfare. Measures to protect individuals include coding, not naming any person in field-notes or in the final writing up of the study.

I am (as a nurse researcher) bound by the Nursing and Midwifery Council (2004) *Professional Code of Conduct.* This requires nurses to be accountable for practice (including research activities), respect for individuals and to obtain consent before carrying out any treatment. The latter easily translates into the research process.

In keeping with research governance, the research proposal was also forwarded to the Research Governance Committee for the Primary Care Trust participating in the research. The Department of Health's "Research Governance Framework for Health and Social Care" document (2001) seeks to promote high quality research and to prevent poor performance. It contains five identified "domains" for consideration. These domains are: ethics; science; information; health and safety; and finance and intellectual property.

Science in this context is taken to include social science. In keeping with the framework, the dignity and rights of participants are of paramount importance. The Human Rights Act (1998) was also to be adhered to. Guidance for consent is informed by the Department of Health – http://www.doh.gov.uk/consent. Although created with patients in mind, the General Medical Council offer useful principles relating to the audio-taping of data – http://gmc-org/standards/aud-vid.htm . Respect for individual's autonomy and privacy were considered paramount and confidentiality was addressed throughout.
It was also vital to obtain permission to access written documentation relevant to the study. Issues of confidentiality, for patients and participants, were of paramount importance.

Mason (1996) highlights two main ethical issues for the qualitative researcher. Firstly, the rich and detailed data is often the result of close engagement with the individuals concerned. This may present problems in reporting findings which

may be viewed by participants in a negative way. Secondly, as the design of qualitative research may develop, as areas of interest are uncovered, this may create ethical dilemmas in terms of access and informed consent. Being explicit in terms of the intentions of the researcher and considering the implications for all involved are accepted as useful in confronting the above problems. The first of Mason's dilemmas above became a real issue for me in the latter stages of data analysis. I realized that some of the findings of this study may be received negatively. The challenge here was to be truthful but mindful of this fact.

Access and Sampling issues

Approval was sought from the Primary Care Trust's Local Board of Ethics and principles of research governance adhered to. Permission for the study was negotiated with the Director of Nursing for the Trust (Appendix 1), prior to any contact with potential participants. Once ethical approval had been obtained, location of the sample could begin. Selection strategies and sampling may be described as *probability* or *non-probability* (Burgess 1984). Probability sampling means that every unit has the same chance of being involved. This type of sampling is often used in quantitative studies and aims for representativeness. Non-probability sampling is not aiming for this. There are many sampling strategies under the umbrella of non-probability. These include convenience, snowballing (in which possible participants are suggested by people earlier recruited to the study. In qualitative research the sampling strategy may be linked

to the methodology employed. In ethnography the group to be investigated is key as they have the specific knowledge and experiences of interest to the researcher (Roper and Shapiro 2000).

A purposive sample was employed for this study, consisting of community nurses from one Primary Care Trust (PCT). Purposive sampling is a common type of sampling strategy in ethnographic research (Roper & Shapiro 2000) in which people who are most likely to be able to contribute to and supply experience and expertise in the area of study are selected. Crookes and Davis (1998) state that purposive sampling is carried out with conscious selection by the researcher.

Participants in this sampling strategy are not selected for their representativeness (Schwandt 2001), but for their relevance to the research question. Sampling therefore adopts an anti-realist approach (Mays and Pope 2000) and does not seek statistical generalization as an aim. It is important to select the most appropriate potential participants for the study (Morse 1991b). For this study of community nurses it was necessary to sample from that professional group, but decisions needed to be made about which PCT, which teams and which individuals would be approached.

As ethnographic principles were the basis of this study, these people were identified by the use of a “key informant” (Spradley 1979). The role of the key informant is explained later in this Chapter.

The Trust needed, for practical reasons, to be within a reasonable geographical distance from the researcher and support for the project from the PCT Board was considered to be a useful requirement. There are, therefore, elements of convenience within the sampling strategy employed for this study. Informal discussion aided the identification of a likely PCT. Ethical approval was subsequently granted by the Local Research Ethical Committee (LREC).

Access was not viewed as a simple process, but one requiring consideration and planning. The Director of Nursing for the PCT was contacted and approval for the study obtained. Subsequently, teams were contacted. Waddington (1994) highlights the importance of the researcher in maintaining his/her identity, whilst projecting a non-threatening image towards gatekeepers. In this project, the researcher is a nurse, a senior university lecturer responsible for programmes leading to district nursing awards and known by managers and staff of the selected PCT. These issues are revisited later in this chapter in my exploration of reflexivity.

The characteristics of the potential participants (Silverman 2001) were clarified as follows: The teams selected were to consist of qualified district nurses, community staff nurses and health care assistants. As ethnographic research is based upon the notion of key “informants” (Burgess 1984, Spradley 1979), the teams who were the most able and willing to provide answers to the research

questions were sampled. The term “participants” was selected for this study, as discussed above. A mix of grades and experience within the team was considered valuable, as comparison across team members may prove enlightening.

Although Health Care Assistants (HCAs) were considered, initially, to be outside the scope of this study, it was recognised that they do contribute greatly to the gathering and sharing of information, therefore, inclusion in the latter stages of the project was not ruled out. It was noted that the PCT selected for the project refers to Auxiliary nurses rather than HCAs. Therefore, this terminology was adopted within this project. It became clear very early on in the study that the Auxiliary nurses were not routinely involved in the regular handover reports, which I found surprising.

Key Informant

Teams who demonstrated willingness to take part were sought. This was achieved by the use of a “key informant”. A well used strategy in Ethnographic research (Spradley 1979 Heyl 2001); the key informant was an experienced practice educator and district nurse. The purpose of working with a key informant is that they have insider knowledge and are able to suggest people who would be best placed to take part in the study. My informant had worked for the PCT for twelve years and is very familiar with the team structures and the geography of

the area served by the PCT. She identified a number of teams as being likely to want to be involved and able to share information with the researcher.

Contacting the teams.

I contacted the teams by telephone and two of the suggested teams were particularly interested, agreeing to an informal meeting during which I would further explain the purpose and design of the study. Although the time frame was slightly different (one team joined the project a few weeks after the first), the procedure followed was similar. The two meetings were arranged at a time to suit each team and took place in their clinic bases. After the researcher had presented information about the project and any questions were answered, each member of the team was given an information sheet (Appendix 3) and a consent form (Appendix 4). For each team, a two-day interval was given to allow time for members to discuss participation in the project. It was made clear by the researcher that *every* team member must be in agreement for inclusion in the project. After two days, each team was telephoned by the researcher to ask for their decisions. Both teams agreed and dates were arranged for data collection to commence.

It was considered crucial that participants were as informed as was possible (given the discussion below). The researcher hoped to spend a long period of time with the teams and it was better for all parties if potential participants at the

outset can show interest. It was difficult to ascertain, however, whether there was any internal persuasion between team members during the two-day "discussion time". The researcher was aware of this from the outset and aimed to be sensitive to any indications that any of the team members seemed unhappy.

The location of the two teams is not crucial in this study as representative or typical teams are not the goal (Schwandt 2001, Mays and Pope 2000). Additionally, ethnography is not concerned with numbers as it studies the whole culture of the selected group (Spradley1979, Fetterman 1998). Both were situated in areas of some deprivation within the same Primary Care Team.

Two teams of community nurses were recruited, both (coincidentally) with four members. Each team had an Auxiliary nurse working within. The number of participants within the sample was considered a suitable and manageable one for the purposes of in depth ethnographic research.

I was also mindful that students (who may be on placement within the team setting) also needed to be aware of the research. It was not part of the project's design that the researcher would visit homes or interview students within this study. I planned to explain to students about the project and ask their permission to carry out my observation visit in their presence, but not to include them as individuals in the final report or to interview them.

It would not have been practical to obtain informed consent from every visitor to the two teams over the period of data collection and so I took a similar position to Philpin (2006) in that consent had been obtained from the PCT Board and from the members of the community nursing team members. I carefully protected the anonymity of these people throughout this project.

Following the selection of the two teams, information was given in writing. This outlined the study's intentions and processes and made clear that informants have the right to withdraw from the project at any time (Appendix 3). Consent was requested at the beginning of the study (Appendix 4) and renegotiated throughout. For example, a new Staff Nurse joined one of the teams during the period of data collection. Following discussions with the team involved, it was decided that a few weeks to settle into her new role would be followed by inviting her to join the project. The Staff Nurse was approached as planned and was very happy to be interviewed along with her new colleagues. Of course issues of joining a new professional group and feeling a part of this new team may have been instrumental in her decision. I was very careful in the phrasing of the invitation to take part and the information sheet was given to the potential participant. A few days to consider her decision were also built into the project to allow for a cooling down option.

It was recognized at the outset that further consent may be needed as to how data is used (Silverman 2001). There are inherent difficulties in fully obtaining

informed consent in observational studies (Mulhall 2003). For example, there could be ambiguity surrounding whether consent covers conversation which takes place during coffee breaks or other discussions outside of the handover report. Spradley (1980) cautions that participant observation should be regarded as a powerful tool that involves the invasion of the way of life of other people. He claims that all informants must be given the opportunity to say things "off the record".

It is virtually impossible to anticipate all of the situations that could arise during prolonged data collection using observation. Participants were made aware that data would be kept safely locked away during the study and would be shredded/ destroyed at the end of the research. However, data needs to be kept for some time (five years) following analysis for research governance purposes. Additionally, with further consent from participants, secondary analysis of data may be carried out. If, however, a team member wished the tape to be destroyed, then her wishes would be paramount. Only the researcher accessed data and those directly associated with the study (the research supervisor).

Individuals should not be identifiable from the final report, as quotations have been anonymised. It is not possible, however, to claim anonymity throughout the project, as team members will know each other and will recognize their own contributions. This requires great sensitivity by the researcher whilst interpreting data and producing the text.

It was of the utmost importance (Merrell and Williams 1994) that the community nurses within the selected teams felt able to trust the researcher. In studies taking place over a number of months, relationships are very important. Participants may informally talk about the customs or cultural conduct of the group (Holloway and Wheeler 1996). The role of the researcher needs clarification throughout the project. In relation to the above, consent needed to be renegotiated throughout the study (Merrell and Williams 1994).

Finally, practical arrangements were to be considered. The use of a desk/ chair during prolonged periods of observation and handover reports were required. Issues such as identification badges, access to health centres and rooms needed to be discussed. The use of equipment, such as a tape recorder needed to be organised.

Data Collection

In keeping with ethnographic approaches, data was collected using multiple and opportunistic methods, including participant observation, field-notes and semi-structured interviews (which were audio-taped) and a review of written documentation as artefacts.

Field Notes

The development of field-notes is a characteristic facet of ethnographic research. These notes record events, day-to day activities and reflections upon the

cultural scene. Ideally they should be made contemporaneously, or as soon as is practically possible. It would not always be acceptable to cease from taking part in a situation in order to note it down.

Field-notes also may include maps and diagrams to illustrate the settings and processes of the group being researched. Reflexivity needs to be addressed (Koch and Harrington 1998) as the researcher is viewed as the main tool for the study. Field notes were kept throughout to note interactions, events and the observations and feelings of the researcher. The notes were written in the first person as the impossibility, and undesirability, of being "objective" is acknowledged. An excerpt from the field-notes is available in Appendix 8.

It is also of note that the novice ethnographer may have more problems knowing what to "leave out" of field notes (Silverman 2001) rather than what to include! The process of writing and developing the field- notes is revisited in chapter Four.

Characteristics of reflexive research include self critique (Koch and Harrington 1998) and effective signposting to enable the reader to follow decision making. Transparency of viewpoints and contextual issues such as location and position are intended to aid the readers in their judgments relating to credibility and plausibility of the project. These issues were to be discussed within the field notes. It is accepted that interpretation of what is observed, heard and written will be affected by the researcher's experience.

A useful framework for the construction and organisation of field-notes is offered by Mulhall (2003). A modified version of her work was used as a starting point for the collection of this data (Appendix 5). This was intended to minimise the potential problems during analysis and was open to refinement during the project. I did find that my initial idea to use Anne Mulhall's (2003) structure for categorising sections of field-notes soon became less distinct (Appendix 5). It was difficult to differentiate between the "everyday diary" and "daily activities", for example. Also the section on people, roles and participants threaded throughout the reflective accounts.

Manias and Street (2001) sought to involve the participants of their study by circulating field-notes and transcripts of interviews for them to alter or comment upon. However, although an admirable attempt to include their views further and develop the cooperative and collaborative nature of their critical ethnographic approach, the participants found the experience of reading the notes and transcripts an onerous one and made no suggestions for changes to the data. In view of this the researchers helped the participants to prepare preliminary analysis of issues and supported these with examples from texts. There is a useful exploration of power relationships here, including the centrality of the researcher within the process. The authors explore the notion of "messy texts" (Denzin 1997, p iv) and the tension between these and a linear research process.

Observation of handover reports.

During the first few weeks of the data collection period, it was necessary to determine if a pattern existed relating to the exchange of information about patients. If a pattern or strategy emerged, the researcher would plan data collection around visiting at the most appropriate time of day. In fact both teams of community nurses appeared to operate in a similar pattern. At 10.30 hrs, messages were collected from answering machines. Sometimes only one member of each team would be in the clinics at this time. At 15.00 hrs the team members met together for a more detailed discussion of the day's visits. Work for the following day was often allocated at this time also. Participant observation and field-notes were then kept (Spradley 1979, Burgess 1984, Silverman 2001) and provided the key issues to discuss in the subsequent semi-structured interviews.

The researcher varied the times of observation and the days on which data was collected to provide a rich picture of events. In keeping with Spradley (1979), the field–notes were carefully scrutinised to look for patterns and themes. In total there were twelve participant observation visits (six to each team). I have included here the visit to each team to feedback the preliminary findings as data was also collected at this point.

Key issues emerging from the field-notes included teamwork with colleagues, working across teams, morale and the use of humour, issues relating to referral

of patients, the rituals and routines of the handover reports and the views of other professionals – see Figure 4. These formed the basis of the subsequent interview schedule (Appendix 6).

Figure 4: Key areas and related issues from field-notes

Key areas	**Related issues from field-notes**
Working in this team	Partnership Morale humour
Working across teams	Across boundaries Helping each other Continuity of care
The handover report	Patterns Information sharing Social processes
Referrals	Who refers? Staff nurse assessment issues
Other people's views of community nursing	Doctors Social workers Other nurses/ health visitors

Semi-structured interviews.

It was intended that interviews would be scheduled to take place towards the closing month of data collection (six months). The participants (see sampling) were interviewed on a one-to-one basis. The interviews took place at a time and venue considered to be the most convenient by the participants, although rescheduling was needed for some interviews due to pressures of work upon the team members.

A semi-structured approach was selected, as open-ended interviews cannot be considered to be free from elements of social control (Hammersley and Atkinson 1983). A rigid interview schedule was also rejected, as it would be at odds with the selected paradigm and design of the study (Spradley 1979, Burgess 1984, Silverman 2001). Semi structured interviews should allow for the crucial balance between flexibility and consistency (Antle - May 1991).

In his seminal work, Spradley (1980) explores issues surrounding the ethnographic interview, dividing questions up into types. For example "descriptive questions" may be posed. These are to encourage participants to explain and illustrate situations in their own terms. These may be prefixed with "tell me about..." Secondly, "structural questions" may be employed. These are to ascertain how knowledge is organized. The interrelationships between one part of the cultural scene and another may be examined using these. Finally "contrast

questions" may be used. These encourage comparisons by the participants and information gathered is often repeated back for clarification.

Prior to the interview, consent was revisited and issues of confidentiality and anonymity reviewed. It was proposed that, in the event of an interviewee becoming upset during the process, the interview might be terminated. Before the launch of the scheduled issues, an introduction was given with a reminder of the purpose of the study. Permission to tape record interviews was also sought at this time (see appendix 4).

Questions were formulated around key areas arising from the provisional data analysis following participant observation and the field notes. Participants were encouraged to interpret and enlarge upon events and issues from their own perspective (Holloway and Wheeler 1996). See Appendix (6) for the interview schedule of key issues, which were discussed in a semi-structured way.

Sequencing of key issues may be flexible (Holloway and Wheeler 1996), but the areas to be covered were similar with each participant. Some people introduced topics that were not directly linked to key issues. These were considered to be of value and were also considered in the data analysis process.

Interviews were tape- recorded (with the permission of the interviewee – Appendix 4), transcribed verbatim and analysed. The basis of analysis was Spradley's assertion (1979 p92) that analysis involves: "the systematic

examination of something to determine its parts, the relationship among parts, and their relationships to the whole".

Field-note observations and points raised in the reflective diary were linked to the transcribed interviews in the form of memos. This enabled linkage of events to build up a richer picture of the cultural scene. In total eight interviews were carried out within this study.

Review of documentation.

Ethnography is concerned with cultural behaviour, cultural knowledge and the things that people make or use. The latter are known as artefacts. Documentation is a critical feature of nursing. Within this study, the creation of methods and ways of keeping records and exchanging messages were explored. Cultural artefacts identified included message books, card systems, diary sheets, telephones and personal folders.

Documentation is one of the traditional sources of information for the ethnographer (Burgess 1984, Hammersley and Atkinson 1995), although the latter authors are concerned that many formal documents are written by powerful people for other elitist groups. It was crucial to obtain consent to include documentary sources from the PCT involved in the research in addition to vital issues of confidentiality relating to individual patients.

Examination of documents and reports can provide additional insight into the customs, practices and values of those participants in the field. It is important to recognise the limitations of documentary evidence (Atkinson and Coffey 1997). The focus of this aspect of data collection altered during the process of the research study. The notion of documents as artefacts became of great interest and their usage took precedence over the content of such documents. Therefore, analysis of documentation became more an exploration of community nurses' artefacts and not a means to explore care planning or patient care issues. Sandelowski (2003, p 192) states:

> "Artefacts become what they are by virtue of what they are physically (which is itself determined by human beings, in addition to such factors as available materials, stylistic conventions and scientific knowledge), and by virtue of what human beings make them out to be"

Other issues here include the layout of offices and the development of record keeping systems.

Rigour

How to measure the quality of qualitative work is the subject of much debate. Although qualitative work is being increasingly valued for the insights gained, various positions are currently held in terms of its credibility. Proponents of a number of camps are well summarised by Cutliffe and McKenna (1999) as follows: firstly, the stance that qualitative studies should be evaluated against the

same criteria as quantitative work; secondly, that they cannot be judged in a meaningful way, and finally, that criteria should be created to specifically evaluate qualitative research

Problems exist with the first of these in that qualitative research is not for example concerned with reliability and would measure badly against quantitative criteria. This would undermine its contribution to the sum of human knowledge and greatly hamper development. More generally, many qualitative researchers believe that quantitative criteria are inappropriate. The second viewpoint is somewhat defeatist and could imply that qualitative research is a mystical process. This could be viewed as a rather oversimplified stance, although Rolfe (2004, 2005) explores the work of Jacques Derrida in that attempts to deconstruct are not analysis or critique and may have no perceived goal. He makes the case that although deconstruction may not be defined or presented as a rational argument, it is able to be demonstrated. The third position, adopted by this researcher, appears to be gaining ground with evaluative criteria being widely developed.

Burns and Grove (2001) discuss standards of descriptive vividness, analytical precision, theoretical connectedness and congruence. Criteria to measure rigour may focus upon truth, credibility and confirmability (Sandelowski 1986). Guba and Lincoln (1989) explore the “fourth generation“evaluation criteria. Beginning with parallel criteria, they identify ways in which qualitative research can be appraised. I have summarised the work in the figure below.

Conventional paradigm	4th generation term	Enhanced by the following
Rigour	Trustworthiness	
Internal validity Internal validity (cont.)	credibility	1. prolonged engagement in the field 2. persistent observation 3. peer debriefing 4. negative case analysis 5. progressive subjectivity 6. member checks
External validity	Transferability	The burden of proof moves here from the researcher to the receiver Main technique = thick description
Reliability	Dependability	Methodological changes may occur – these need to be tracked and presented
Objectivity	Confirmability	Data can be tracked to sources – raw data and processes of the work are transparent

Figure 5: Evaluation Criteria – (After Guba and Lincoln 1989)

The above are explored in some depth, then followed by a caution that they are all concerned with method and may not in themselves ensure that the stakeholders' perspective is represented.

It is my intention to focus upon the notions of credibility, confirmability and transferability within my research. The acceptance of co-constructing the data that forms the rich "thick" description leads to the need to demonstrate reflexivity in this thesis. The above will be reviewed in the light of my experiences during this study and may be found in chapter 10 of this thesis.

Audit trails

An audit trail approach is to be adopted (Sandelowski 1986, Guba and Lincoln 1989) documenting how and why decisions are made. This will be located within the field notes and analysed throughout the process of the study.

Recently, there has been some debate upon the use and value of audit trails. Cutliffe and McKenna (2004) propose that the expert researcher has little need for this tool as decisions are intuitive and would be difficult to write up in stages. They also claim that audit trails may not actually test the credibility of research findings. In response to these claims, Koch (2004) criticises the narrowness of their interpretation of what constitutes an audit trail. She asserts that all decisions, insights and emotions form a part of the process and advocates keeping a "reflexive diary" which subsequently is woven into the research text.

I would certainly not consider myself to be an expert ethnographic fieldworker with a vast range of experience to call upon. Additionally, I would support the views of Koch (2004) in relation to the value of a systematic approach in developing diary data into a meaningful part of the story. Therefore, despite the audit trail debate, I intend to offer my evidence relating to decision- making and leave the reader to decide its value. This information exists in the form of excerpts from field notes and my reflective diary throughout this thesis. It is intended that this will enable the reader to decide to what extent the project is believable and plausible (Koch and Harrington 1998).

Transferability

Transferability may be considered to parallel the notion of "generalisability" as offered by positivistic research (Guba and Lincoln 1989). Within this study it is viewed as the process of checking out the similarities between the sending out and receiving contexts. The burden of "proof" is felt to be with the receiver not the researcher. Thus, issues of transferability will be linked to how plausible the reader finds the work to be and how relevant it is to the reader's own setting. The case for reflexivity above places a responsibility upon this researcher to account for how (as the key tool of the study) I have affected the study and how the study has affected me.

In the figure above, transferability is enhanced by "thick" description. A definition of this term by Schwandt (2001, p255) is offered: "to thickly describe social action is actually to begin to interpret it by recording the circumstances, meanings, intentions, strategies, motivations and so on that characterize a particular episode". James (2001, p246) cites the widely recognized work of Clifford Geertz (1973). His essay included a definition of ethnography as being "an interpretive act of thick description". However, in a later Chapter of this book, Spencer (2001) critiques the work of Geertz. He states that "ethnography moreover should not be assessed by the amount of undigested information it contains but rather by the clarification it offers". This would seem to me to make sense. It is not by producing tons of raw data and presenting that to the reader in the hope of enhancing transferability. Rather the insights and inferences made by the ethnographer may resonate with others. The use of thick description of the setting for studies enables the reader to determine whether the setting is similar to their own.

Spencer criticizes Geertz in that he feels that the anthropologist ignores the fact that interpretation is socially situated. This, Spencer states (2001, p445), means "different forms of life vary in the kind and degree of interpretation they can or should receive". This implies that some data is less dependant on construction than others.

Difficulties of representation

Sandelowski and Barroso (2002, p216) explore the difficulties of representation (or misrepresentation) of data as findings. They caution that it is vital to be wary of letting the data "speak for itself". This can lead to a mass of description with little interpretation of data. They continue by asserting: "Inquiry entails the hard work of locating participants' views and lives in some intellectual, theoretical, or other disciplinary tradition, and the risk of committing oneself to an interpretation."

James (2001), suggests that in order to understand the significant constructions of others the ethnographer needs time. This is one of the reasons that researchers spend long periods of time in the field to immerse themselves in the culture under study. It is my intention to engage with the views and practices of the participants and enable them to articulate the issues and concerns that are significant to them. This will, hopefully allow for some measure of transferability. It is my intention to revisit the important topic of rigour in the concluding Chapter of this thesis. An evaluation of the processes outlined above will be carried out in this section of my work.

Limitations of the Study

There could be a problem of reactivity with overt observation (Abbott and Sapsford 1999). It is acknowledged that it will be difficult to know to what extent

the presence of the researcher will affect the interactions of the nurses involved (Gerrish 2003). However, it was acknowledged that the input of the researcher was a positive component of the research process (Coffey 1999). It was also important to explore power relationships as there could have been a perception that the researcher was in a position to influence developments for the district nurses.

Even though there was an open stance taken, with the researcher clearly identified as such, the understanding of nurses regarding what is to be used as data could cause problems ethically, for example, observations made outside of interviews and formal reporting sessions. A balance needed to be reached and consent renegotiated during the data collection experience. It is accepted that cultural knowledge is not a predictor of events but may anticipate the likelihood of what may occur.

Although generalisability is not the aim of this type of research project, it is hoped that some measure of transferability may be possible and that this work will be believable and plausible (Koch and Harrington 1998).

Writing an Ethnography.

To effectively convey the stories of the participants of this study requires effective writing skills. Gilgun (2005) explores the history of the ways in which qualitative

researchers write. Her arguments are convincing and have encouraged me to try to develop a style that is honest, clear and (hopefully) will “grab” the reader. The use of first person writing is adopted as being the least pretentious way to include myself in the study. Contemporary thinking amongst researchers accepts that the researcher shapes the writing. By this, I mean that the investigator determines what is asked, how the data is collected, how the data is analysed and, finally, how it is presented. Gilgun (2005) notes that social scientists observe, interact transform and are transformed by contact with human beings. In agreement with Charmaz and Mitchell (2001), I found that the analysis of data gathered begins during the collection period and extends into the writing of ethnography.I agree with Van Maanen (1988) in that writing is part of the process of knowledge construction. The act of writing can clarify thinking and help to generate new ideas. Spradley (1979) sees examples from the data as being crucial to break up “dense” writing and suggests a special reading to see if enough examples have been given. This was a useful consideration and I have attempted to do this.

The applications of the findings of this study are believed to have some degree of transferability. This is contextualized in the form of thick description (Hammersley 1992). The detail of and credibility of the examples given in the text is intended to strengthen transferability for readers of this thesis and it is hoped that this study will resonate with their own experiences.

It is hoped that by using a mixture of suggestions from Gilgun (2005) and Spradley (1979) along with some ideas of my own, that this work will prove to be readable to the audience.

A summary of this Study

This ethnographic study was undertaken from a constructivist perspective (Denzin and Lincoln 2003b). Participants were considered to be interdependent and collaborative partners in terms of constructing the data. Some elements of critical ethnography have been explored through the contextual and historical aspects of the research setting. In rejection of the notion that reality exists outside of the researcher (Gerrish 2003), a naturalistic viewpoint is not therefore considered tenable.

A purposive sample was employed within this study and participants were identified by the use of a "key informant" (Spradley 1979). Two teams of community nurses were recruited from one Primary Care Trust in the West Midlands.

The study employed a number of data collection methods. These being, participant observation, semi-structured interviews and examination of artefacts. Data collection took place over a six-month period (ten participant observation visits) and interviews were carried out at the end of that time. The interviews (eight in all) were transcribed and analysed using Spradley's thematic cultural analysis (Spradley 1979). Please refer to the plan of this study on page 145.

Conclusion to the Methodology Chapter

This study sets out to explore the culture of community nursing. The use of ethnography as methodology is defended within this Chapter.

I have attempted here to explain the decisions taken relating to the selected paradigm and design of my study. Important considerations relating to the access, sampling and ethical issues have been offered. Exploration of the evaluation of qualitative work is seen to be key in the planning of this study. Some of the assumptions guiding this work have been stated, namely that there is no attempt here to seek an "objective" stance as reality is not perceived to exist outside of the researcher. Rather that reality is constructed between the researcher and those researched. I view my position as a "marginal native" (Gerrish 1997) and as a moderate participator in events.

I have explored crucial issues around the quality of qualitative research , including reflexivity, the renegotiation of consent, the ongoing consideration of access and the co production of truth. These issues, along with notions of credibility, confirmability and transferability will be revisited in Chapter Ten. Although I am going alone onto the empty sea, I hope that these will help me find my way.

Plan and Timetable for study

Date		
2007 -2008	Viva examination and submission of thesis.	
December 2006	Complete thesis - draft	
December 2004 -to December 2005	Data analysis	Writing up
June 2004	Literature review	Fieldwork - interviews
December 2003- to July 2004	Literature review	Fieldwork Please refer to section below
November 2003	Literature review	Ethical approval Access/ setting up
August 2003	Literature review	Research design
May 2003	Literature review	Research design
March 2003	Literature review	Research design
November 2002	Literature review	Research Proposal completed

"fieldwork" includes:	field notes
Observation	semi-structured interviews
Documentation review	reports

Chapter Four

Data Analysis

Data Analysis: an Introduction

Within this Chapter, I intend to explain the process of analysing the data. This includes the analysis of the field-notes, the development of the interview schedule and the carrying out of the interviews. The analysis of the data collected during the semi- structured interviews will also be explored here and the position of documentary data.

Also within this section of my thesis, issues relating to interview transcription and the use of a software package to manage the data will be examined.

Thematic cultural analysis (Spradley 1979) formed the framework for data analysis. This comprises a series of seven steps, namely the organisation of the collected material, reading and re-reading data, dividing data into manageable sections, developing, comparing and contrasting categories, searching for relationships between categories and grouping these together, describing emerging themes and interpreting meanings. This analysis was to be applied to the field notes as an ongoing process. In keeping with Spradley's (1980 p22) assertion that "every ethnographic description is a translation", I tried to explore the significant constructions of the participants in this study.

It was deemed important to use "native" terms and their meanings as well as those of the ethnographer and the participants' own words are used verbatim where possible.

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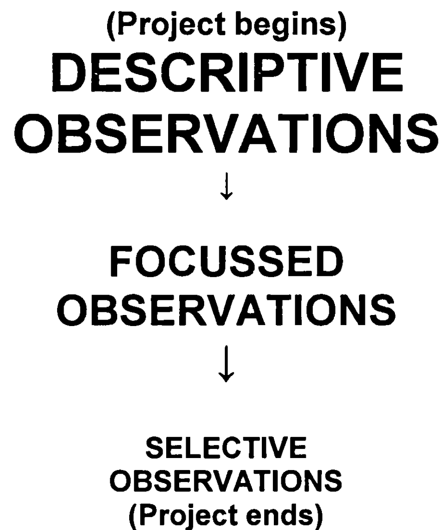
Analysis of Field-notes.

Spradley advocates that analysis be applied after each period of fieldwork (1980, p34). Observations begin with a wide angle viewpoint and descriptive observations becoming more focused and, in the latter stages of the study, selective.



Problems can occur as human beings are deemed to block out information that is not needed in everyday life in order to prevent overload. The researcher may need to overcome years of “selective inattention” (Spradley 1980). The analysis of ethnographic data has been described as a test of the ability to think and process information in a meaningful manner (Fetterman 1989). As an “insider” researcher there are also issues of partially

understanding and affiliating with the field under study. The "marginal native" (Gerrish 1997) position will affect both the data collection and analysis. The processing of information includes analysis of data from field-notes, reflective accounts and takes place in the context of the researcher's own beliefs, experiences and values.

Spradley's (1979) seven steps of analysis were applied to the field-notes. Field-notes were initially made in small notebooks. I began with a colour coded system – red notebooks for the field-notes and blue ones for my reflective diary. Following Mulhall's (2003) work (please see appendix 5), I began with my field-notes (red) in four sections:

A – Structural features

Including diagrams and descriptions of the environment

B – People

This includes roles of participants and descriptions of professional experience

C- Daily Activities

This section included meetings and patterns of daily work

E- Everyday Diary

To record events as they occur.

My first red notebook was divided up into these sections. However, it soon became apparent that information was not received in such a neat fashion. There is considerable overlap and the maintenance of the four categories soon became unworkable! Additionally, the merging of the information allows for a richer description of events. At the beginning of the data collection, the diagrams of layout were a useful focus. The interactions between the community nurses, however, changed from visit to visit. This was a fundamental part of observing culture via the handover report. Although, obviously the bricks and mortar were fairly fixed, the other considerations weren't. Things didn't always go to "plan". For example:

Excerpt from my field-notes 3/02/04:

- I have made a mistake. I arranged to visit today at 10.30hrs, but put 2.30 in my diary- I apologised to the team, who said they were happy for me to stay. A quiet afternoon- I feel a bit in the way today- probably because they weren't expecting me this afternoon.

I probably felt a bit awkward, additionally, for getting it wrong. I was also hampered by the ongoing staffing problems, which led me to ask when visits would be possible.

The structured field-notes soon became a more mixed system of noting observations, feelings and ideas! The field- notes were reviewed and typed up after each observation visit. As the study progressed, they included diagrams of the office layout in which the two teams operated, drawings of filing cabinet contents and notes of the categories of visits (as stated by the PCT).

Interestingly, I found that, although the typed up versions were useful, it remained valuable to refer back regularly to the red and blue notebooks. I could remember more about the experience of being present in the clinics by reading the notes written at the time and the typed up versions seemed to be a step removed. This could be due to my status as a novice ethnographer or may be connected to the immediacy of the handwritten notes, reminding me of the situation in a more holistic way.

By organising the collected materials, reading and re-reading data, dividing data into manageable sections, developing, comparing and contrasting categories and searching for relationships between them, key issues were identified. The typed field-notes were coded using different coloured highlighter pens.

Initial categories were as follows:

- Sections relating to "Rituals" were highlighted purple

- "Working in the team" was allocated yellow.

- "Working across teams" highlighted in green.

- "Functions of report" in orange.

- "Staff Nurse roles and referrals" in blue.

Figure 6: Key issues identified for the semi-structured interview schedule

Key areas	Related issues from field-notes
Working in this team	Partnership Morale Humour For example, working together seems to be highly valued by participants. Partnership and teamwork with colleagues.
Working across teams	Across boundaries Helping each other Continuity of care In times of short staffing or being particularly busy – this is almost constant! Helping each other across boundaries is a feature of community nursing
The functions of the handover report This included the data categorised as rituals.	Patterns and rituals Information sharing Social processes During the handover, there were many examples of teaching and learning and peer support noted

	Related Issues
Referrals	Who refers? Staff nurse assessment issues Noted that quality of referrals varied. Issues relating to the staff nurses' role in assessment of new patients involves a number of issues for the teams – also who refers?
Other people's views of community nursing	Doctors Social workers Other nurses/ health visitors Field-notes contain evidence of tensions across some professional boundaries – involves G.Ps, social workers and other nurses

This study aimed to explore the culture of community nursing through the observation of handover reports. The above emerged from the field- notes as issues of great importance to the members of the two teams involved. These categories and themes were used to indicate some of the areas for further exploration in terms of the culture of community nursing and formed the basis of the subsequent interview schedule (Appendix 6).

Analysis of Interview data

Tape-recorded interviews were transcribed verbatim for this process to be applied. It was recognised that the analysis of multiple data would be both complex and time-consuming. Certainly, the transcribing of tape- recordings was a long repetitive process, involving playing the tapes over and over, noting each word and marking emphases and pauses featuring in the interviews. However, it was recognized that this time was valuable in really getting to know the data and formed the beginning of the analysis process.

The use of software to analyse qualitative data

A software package (MAXqda) was used to help to manage the vast amount of data generated from the multiple collection methods presented above. This package was selected as being an effective tool for qualitative data analysis and user friendly. Weitzmann (2000) explores what qualitative software is able to achieve (and what it can not) beginning with the statement that software cannot do the analysis for you. This would not be a real advantage for the qualitative researcher. If it is accepted that the researcher is the researcher tool, then it makes sense for the researcher to analyse the data and interact with it. However software packages are useful in storage, editing, searching and retrieving and memoing. Although MAXqda is classed as a code based theory building programme, my experience of using it is that it does not in fact build theory, but does have an effective search and retrieve

function. In agreement with Weitzman (2000) the main advantages of the use of software in qualitative data analysis are consistency and speed.

Although it took time to learn how to use the software, it did repay in terms of time. For example, new insights led me to change codes and reallocate sections of the raw data. This can be done very quickly using the above package.

The transcribed interviews were imported into the software package in the section entitled "the document system" and each line of the data was numbered. A code system was developed after sectioning chunks of the data into manageable portions

Coding

Coding may be viewed in qualitative research as the first step in the analysis of the data. However it is important to recognize that this is a part of the process, but does not constitute analysis by itself (Coffey and Atkinson 1996, Sandelowski and Barroso 2002). Coding links segments of data together relating to a concept or theme. A number of approaches to the coding process are suggested by Coffey and Atkinson (1996, p28). Firstly, coding may be a form of data simplification. In this, the researcher uses a method of indexing to code and retrieve data. Secondly, they explore the role of coding in data complication. In this way coding may be used to expand and reconceptualise data. The third stance is a mixture of the two approaches. This would seem to

fit with my comments above. Attaching codes to the data using the software package did not analyse data per se, rather it offered a way of managing and retrieving chunks of data for consideration and analysis.

The analysis of qualitative data is a creative process. Miles and Huberman (1994, p56) suggest that coding enables the researcher to "differentiate and combine the data you have retrieved and the reflections you make about this information". Charmaz and Michell (2001) assert that coding can be used to make comparisons between ideas, people and events. They continue by making the following statement: "Codes grow beyond mere means for sorting data and become processes to explore. Treating codes analytically transforms them into theoretical categories" (p, 167).

Coding, therefore, makes the researcher consider the meaning of blocks of text (Ryan and Bernard 2000). It is not a mechanistic activity and decisions are taken throughout. Building upon the work of Tesch (1990), Coffey and Atkinson (1996, p 31) suggest that "concepts are identified or constructed from prior material, theoretical frameworks, research questions, or the data themselves". This is an important consideration that I will return to when presenting my development of a framework within this study.
Initially, manageable sections the raw data were related to the questions asked in the interviews. This was a starting point. As I became immersed in the data, further insights were discovered. There were patterns emerging from the transcripts and the challenge was to capture these. Coding involved

attaching key words and memos to sections of the text. Figure 7 displays the coding system that emerged from the data in the early stages of analysis.

Figure 7: The sub-categories constructed during data analysis of interview transcripts.

Help across teams	**Functions of handover reports**	**morale**	**Views of others**	**Assessments**
Continuity of care	Rituals	Getting to know peers	Patients and carers	Referrals
Staffing levels	Value judgments	Job satisfaction	Practice nurses	Staff nurses
Standards of care	Planning ahead	Laughter	General practitioners	New roles
	Information sharing	Confidence	Hospital staff	
	Teaching and learning	Isolation	Social workers	
	Support from peers	frustration		
	Problems when not having reports			

Following this, categories were developed, compared and contrasted within the data. The next stage of data analysis involved searching for relationships between categories and grouping these together, describing emerging themes and interpreting meanings.

Feedback of Preliminary Analysis

I arranged to take back my first thoughts to the two teams who participated in the research project. There were many reasons for doing this. Firstly, I was conscious of the dangers of "smash and grab" research in which the researcher takes the information and is not seen again. I wanted those involved to see where the analysis was going and have a chance to comment upon the process and findings. "Member checking" can be viewed in a positivistic, objective way (Schwandt 2001) as a method of "triangulation". I accept here that taking the data back to the participants is a form of triangulation. I feel that it is of value in that the participants have a further opportunity to contribute to the findings of the work and to comment upon the progress of analysis so far. Therefore I do not see difficulties with my previous discussion, earlier in this thesis, where I reject some notions of triangulation as being at odds with the epistemological and ontological position proffered in Chapter Three.

The following is a write up of my field-notes and thoughts during these discussions.

Team B

2.45p.m – I am in my car. I have arranged to meet up with Team B at 3p.m. I want to ask for their views of analysis so far. Feeling very apprehensive – what if they don't agree!!! This was a real concern.

There were three of the team members present. They were expecting me and were keen to hear what I had found.

I began by outlining the process of transcribing and loading up the data on to the software package and subsequent printing off of coded data for today's discussion. Excerpts from transcripts were passed around the group for comments. There was a new team leader who stated that little had changed from the comments made in the summer.

I asked about the Auxiliary Nurse (AN) as there was not a lot of information about the role within the data. She has now retired! There was one AN who visited patients from all of the teams in this sector. She used to visit on Friday morning at the clinic to "sort out care plans" and fold up plastic aprons for the team. She only had one patient from this team (for a leg wash). It is planned that she will be replaced by a Health Care Assistant in reorganisation of community nursing planned in the new- year.

During data analysis, I was surprised at the responses to my question in the interview schedule relating to how the participants felt that other professionals viewed their service. This was one area that I wanted particularly to check out with the nurses. This is in keeping with the testing of findings with participants (Emden and Sandelowski 1998), but is seen as a constructionist vehicle to further develop understanding.

I passed around a number of quotations (from participants of both teams) and we discussed these. It was agreed that the picture of others having little

insight into community nurses work was a fair one. Comments from the three included:

"I agree with the viewpoints"

"it is sad that people don't know how busy we are"

"they don't know how hard we work" and then (the patients) say "how hard the nurses work in the hospital and we work as hard – they just don't see it…and it comes from other nurses as well".

Generally – they said that comments seem to be a true picture, although individuals stated that they could not remember exactly what they said at the time of the interviews. This is an interesting point in the light of the practice of "member checking" – taking back transcripts for verification. It would support the debate that offers some merit in taking findings back for ethical reasons rather than to confirm the data.

In response to positive comments about G.P.s and Practice Nurses, one participant said :

"*that's obviously not our team"* – it wasn't!

In answer to my general question: "How did you feel being part of the research study?

"it was O.K."

"Yeah – fine"

However, just as I was about to leave the clinic, one of the nurses said with great emphasis

"I think that if we didn't come in here and get it off our chests, we wouldn't cope –we need to meet up"

This comment had, subsequently, a profound effect upon the rest of the data analysis process.

I promised to feedback the completed report findings and recommendations when available. After this meeting I wrote:

15.45 –I am back in the car. My initial feeling is that it went very well. Participants seemed to feel well represented and appeared to be pleased when recognising their viewpoints and perspectives as their own.

Team A

Before the meeting:

- Here I am on Christmas Eve! 10.20a.m – I am in café in a garden centre on the way to feedback my preliminary findings to the group. I have just rung to check I am still expected. This date was suggested by the team-leader but cannot assume that they have sufficient staff to accommodate me today!

When I got to the clinic, I was expected. Those present were three of the participants in this study and a new member of staff "R" who was on loan from another clinic. I checked with team members that it would be O.K. to feedback

in front of her as there was not another room to go to and, also, checked that the new S/N was O.K. about it all.

Again, I was interested in the views of other professionals of the service. When I said that this was something for us to discuss, one of the team immediately said:

"have you come to bath me?"

Everyone laughed.

Generally, participants feel that the summary of views is right. It is rather a negative one and so checked again that this was representative.

I asked about the role of the Auxiliary nurse – she works between two clinics and I was told:

"she doesn't like to come here for some reason". She "works from another clinic – not really a part of this team".

However they do meet up with her for a "double-up" at the moment and so do see her at a patient's house. I asked, following a circulation of the transcripts, if they felt that I had misinterpreted anything. The participants made the following responses.

"none"

"it seems fine to me".

The team were still happy for R to be involved in these discussions – I checked this at frequent intervals during this meeting.

Following the comment made at the previous preliminary feedback session, I asked the group whether they felt that the handover reports were needed. They all agreed that meeting together served their needs.
I then asked "how did you feel being a part of this study?"
Responses included:

"interesting – very interesting – daunting at first, but came to trust you"

"what will she write about me?"

"should I have said that?".

Then the team-leader asked me how I felt as the researcher. I shared my own feelings of anxiety with the team and said that I was feeling very daunted at the beginning of the research.

This question pleased me, I felt that the participants trusted me and cared about my feelings. I felt rather sad to think that my data collection period was over as I had enjoyed very much getting to know the nurses and felt that they had enjoyed being part of the project. I promised to bring the final report and findings back to the team upon completion. Back in the car, I noted that this session seemed to go very well.

Documentary Data

As stated earlier in this thesis, initially it was intended to analyse documents and patients' notes stored at the two clinics. This exploration could have been carried out in a number of ways. For example, content analysis could have been used to search for themes within documentation. However, as the study developed, the documents were considered more from an artefact perspective and the ways in which they were developed and used were focussed upon rather than the content of these. For example the development of a message book by Team A, to record information such as which patients had been admitted to hospital over the weekend. This was used by GPs and nurses to transfer information across disciplines.

In exploration of the concept of culture, Helman (2007) explores the guidelines affecting how members of cultural groups view the world. He describes (p2) how culture is transmitted: "by the use of symbols, language, art and ritual" and adds that without shared perceptions group cohesion and continuity would be not possible.

The development of artefacts offers a way of exploring symbolic actions and rituals. Documentary data in this study was viewed in this way and analysed in the context of handover reports.

Examples of artefacts observed within this study include message books, folders and cards containing information. These are presented within Chapter Six.

Cultural Themes

Spradley (1980, P141) defines a cultural theme as: “Any principle recurrent in a number of domains tacit or explicit”. He adds that themes have a high degree of generality.

Immersion in the cultural scene and intensive reviewing of field-notes are seen as necessary to begin a thematic analysis. This includes identification of organisational processes and stages of these. In this study that included the ways of organising work and allocating patients. It is suggested that examining text for conflict, cultural contradictions, informal methods of social control and problem solving strategies (Spradley 1979) is likely to produce cultural themes.

It seemed that handover reports occurred to meet a need or needs. This became apparent during the preliminary feedback of the findings to the participants. I arranged to visit each of the teams to discuss these. This was intended to assist with data analysis, however, I did gain further insights during these interactions and so these meetings could be also considered as data collection.

During the first of these meetings it was agreed that handovers were both important and necessary to the group. One participant stated:

> *" I think if we didn't come in here and get it off our chests we wouldn't cope".*

This view was endorsed by all present. At the second meeting to discuss the preliminary feedback I tested out the idea that handovers were seen as useful and needed by the team. They echoed the importance of the report time. Returning to the interview transcripts provided support for this notion. The following excerpts illustrate the value of handover reports for the participants:

"it's very important cos when you're on your own for most of the day you need to speak to somebody at the end of it"

"I look forward to the handover – I think it's really important".

"I think it's important to have handover – if you're taking on new patients or patients whose condition is changing".

"Apart from updating each other on what's happening with a particular patient I think you also gain insight into that person's knowledge and their capabilities within the team".

"We do find the handovers useful – very beneficial".

There are professional expectations in the process of handover reporting (NMC 2004). It is something that managers of the district nursing service would suppose would take place. However, emerging from the data is a clear notion that handovers serve to meet other needs within the teams of nursing staff.

The analysis of data was an ongoing process throughout the study. The categories presented above (Figure 7) are further developed and explored in Chapter Five of this thesis. By analysing the data from field-notes and interview transcripts, cultural knowledge, cultural behaviour and cultural artefacts are presented as exemplified by community nurses' handover reports. The time spent in the clinics by both teams offered a vehicle for the exploration of the wider culture of community nursing.

As discussed in Chapter Three of this work, I have worked as a district nurse and am now a senior university lecturer teaching district nurses. It is recognised that I bring my own social development and personal experiences to the study. Therefore, clearly, my previous experiences will affect what is selected from the complex social processes within community nursing teams. Additionally, the role assumed during the data collection will also be determined by the researcher's background (Mulhall 1997).

This background also affects the theoretical and professional perspectives brought to the field- work (Schwandt 2001). In the next chapter, I will explore the effects of this upon the analysis and presentation of the data.

Conclusions to this Chapter.

Within this Chapter I have outlined the process of data analysis. This included data from field-notes, interview transcripts and documentary data. I have referred to frameworks by Spradley (1979) and Mulhall (2003) and the impact of these upon the analysis of data within this study. The uses of coding data in ethnographic studies have been examined. The use of software to help with data management has also been explored. This Chapter ends with some thoughts around a framework for the findings and their presentation. I have presented the development of the process of data analysis and some of the decisions taken along the way. This forms a part of the audit trail (Koch 2004) within this work. The notion of need has emerged as a key component of the data analysis at this juncture and this debate will be further explored in Chapter Five of this thesis.

Chapter Five

Presentation of the Findings – an Introduction

Introduction to the Findings

The following five chapters of this thesis present the findings of this study. Within this Chapter I will introduce some of the key cultural elements of this study. An exploration of community nursing handovers and rituals will follow. The next section of this Chapter will offer a framework to present the findings of this study, which aimed to explore the cultural knowledge, cultural behaviour and cultural artefacts exemplified during community nurse handover reports.

Spradley (1979) asserts that there are levels of ethnographic writing. These move from universal statements to specific incident statements. In this introduction, I intend to focus upon his levels "3" and "4", namely "general statements about a society or cultural group" and "general statements about a specific cultural scene". I would agree with Coffey and Atkinson (1996, p108) that "we do not merely report what we find; we create accounts of social life and in doing so we construct versions of the social worlds and the social actors that we observe". This process of creation involves both the representation of the data and analysis.

The group to be studied within this project is community nurses. Community nurses tend to work from Health Centres, Surgeries or Clinics. They are usually formed into teams with a mix of experience and qualifications. Teams may be attached to GP practices or work in a designated geographical area. There are a variety of models for the organisation of community nursing in the

United Kingdom. As their roles develop in response to the current NHS reforms, community nurses are expanding their repertoire of skills and expertise (Drew et al 2004). Earlier discharges from hospital and increasingly complex packages of care are impacting upon community nurses. At a time of great change, community nurses are feeling under pressure in terms of role and direction (QNI 2006).

General Statements about the Community Nurses in one PCT in the West Midlands

Community nurses within the PCT setting of this study are linked to a number of GPs. They work in teams based in Health Centres – some of these are also the base for the linked GPs and some are not. The Health Centres (HC) house other professional groups such as Health Visitors and a number of clinics operate on the premises. These community nurses wear uniform (please see below). They work Monday to Friday and rotate to cover work at weekends. Therefore there is usually a team member having days off during the week. Ethnography (Holland 1993, p1461) has been described as: "the descriptive study of a culture where the ethnographer gains an understanding of cultural behaviour within a specific setting".

The setting for this study involved two teams of community nurses based in separate Health Centres within one PCT in the West Midlands.

It has been asserted (Spradley 1980) that there are three main elements to any social situation. These are described as: the place, the actors and the activities. I would like to introduce the reader to these elements as viewed within this project.

The place

This ethnographic study focussed upon two teams of community nurses, based in two Health Clinics within one Primary Care Trust in the West Midlands area.

One Clinic (team A) is a modern purpose built building with a high level of security measures. This building is in a built up area of some deprivation. Car parking is at a premium here. In order to access the building, there is a press button panel by the main entrance. Upon pressing the button, a receptionist enquires as to who you are here to see, before releasing the door. Once in the reception area, a code is needed to open the door leading to the offices upstairs. During my time here collecting data, I was not made aware of the code and so relied upon the staff to let me in. The offices upstairs are modern, small and full of furniture. The layout of the DN s office may be seen on page 182.

Excerpt from my field- notes 16/12/03:

3p.m

- arrived at clinic A for first observation visit. Could not park on Clinic car park – too busy. I approached the reception desk inside the purpose built, modern building. There is a lock on the connecting door to the corridor leading to the offices. The staff have the number to key in. The

receptionist operated the lock and let me into the corridor. The district nurses' office was upstairs. I knocked at the door and was asked to come in by a disembodied voice through the door.

The second Clinic (team B) is housed in an older building. The geographical area served by the staff here is also one of deprivation. This is a traditionally designed, one story health centre. Car parking is not a problem here, except on market days when the general public try to park on the clinic car park! Access to this building was very different. Walking into the main entrance, the rooms were off in different directions. Occasionally, someone would be in the office directly opposite the front door. I was never challenged or asked to identify myself, but would call out a greeting as I entered the building. Often, the building would be quiet with little apparently happening in the main room in the centre of the building. The DNs' office door tended to be closed. As there is a main waiting area outside the door, this is unsurprising.

In chapter Three, I outlined the procedure for selecting the two teams for this study. By the use of a "key informant" (Spradley 1980), teams were identified as being likely to take part in this ethnographic research project. The teams suggested by the "key informant" were approached and found to be willing to participate.

The Actors

Team A comprised four members with a variety of nursing experiences. Team B also contained four people. Other actors included a Staff Nurse who was new to community nursing and temporarily attached to one of the teams.

Both teams also had a Nurse Auxiliary member attached to them. These two individuals were never seen by the researcher. They were shared across a number of other community nurse teams and their roles were explored during the two visits to feedback the preliminary findings with each team. Additionally a pre-registration student on community placement was present during one of the observation visits. Both of these people were asked if they were O.K. with the data collection taking place. Both agreed to this.

As can be seen above, there is considerable movement of staff within the teams. For example, one SN left suddenly and was replaced by a newly qualified Staff Nurse. Fortunately, the new addition to the team was willing to take part in the study and supported the research project. It could have compromised the project if this had not been the case. The team-leader of team B left during the study and so was not involved in the interview process. Her replacement was, however, keen to be included.

Additionally, one member of one of the teams had a prolonged period of sickness and was not present for some of the data collection time. All of the community nurses involved in this study were female. As the workforce is predominantly made up of women (Audit Commission 1999), this is unsurprising. The age range of the participants also supported the Commission's findings. The average age of qualified DNs in this study was found to be 45.4, with 27% of the total aged 50 or over. One participant had entered nurse training as a (in her terms) very mature student.

To maintain confidentiality, participants were allocated a letter for identification. Please refer to Table 1 for information about how each member of the teams was "labelled" for this study.

Table 1 – Team Membership and allocated Code Letter

Team A			
Team-Leader - **Z**	Staff Nurse - **L**	Staff Nurse - **M**	Staff Nurse - **N**
Team B			
Team-Leader - **V**	Staff Nurse - **Y**	Staff Nurse - **W**	Enrolled Nurse - **X**

Please note that Staff Nurse P and Team-Leader Q were not interviewed (left their posts during the study) but were included in field-notes

As community nurses, all of the above wore uniforms issued by the PCT. Some chose to wear trousers and tunics, others dresses. The team leaders wore a navy coloured uniform. Staff nurses wore a lighter blue outfit. Both the F grade sister and the enrolled nurse wore white.

Additionally, everyone wore an identity badge displaying their names and positions. This helps patients and other professionals to know who is who. As a researcher, I attempted to blend in with the teams as much as was possible. I tended to wear trousers and tops in plain dark colours and flat shoes. I wanted to appear relaxed, but not draw too much attention to myself.

The putting on of uniform is viewed as a symbolic part of being a part of the cultural group (Holland 1993, Helman 2007). Symbolic action relating to clothing, language, documents and spatial boundaries are viewed, in

agreement with Philpin (2006), to be both expressive of ritual and also part of the creation of ritual.

In addition to the actors presented above, there is naturally a great number of other clinic staff, visitors to the centres and patients calling in for appointments. These were not included in the project's data collection, but their presence was an important part of the social scene of community nursing. At all times, I sought to protect their anonymity.

The activities

The focus of this study was handover reports and the opportunities to access the culture of community nursing through this event. I firstly had to establish whether there was a pattern to the working day for each team. During the initial meeting, this was discussed, in order to establish the most effective times to visit for data collection – it would not make sense to call when everyone was out carrying out their visits.

It became clear very early on that there were (for both teams) two times in the day when I would be likely to meet up with staff. In the mornings at about 10.30 a member of each team would call in to collect messages (from their respective answer-phones and on paper/ message books). Both teams aimed to meet at about 15.00 hrs in the afternoon for a handover report.

Community Nurses' Handovers and Ritual

One of the manifestations of the cultural behaviour of a given group is that of participation in rituals. Rituals are a feature of all human societies (Helman 2007) and aid with the maintenance, celebration and renewal of the world. They are prescribed behaviours and are formal, repetitive and patterned. As discussed in chapter two of this work, actions may have a defined technical purpose and yet still contain ritualistic elements within those actions.

The importance of ritual was examined in papers reviewed for this study. Strange (1996) felt that reports offered an anxiety controlling function. This is in keeping with nurse authors who cite Menzies (1960) as offering protection from stresses using ritual. This notion has been further explored by Philpin (2002), who questions the assumptions that were widely accepted from Menzies' work (she discusses a further seven anxiety controlling measures, but tends to be remembered for only the comments upon "ritual").

Certainly district nurses have been described as being frustrated and concerned about their role and its future (QNI and ENB 2002, QNI 2006, McDonald, Lanford and Boldero 1997). These issues of anxiety and stress will be revisited in Chapter nine of this work.

The term ritual may be defined as formal actions which are primarily symbolic. In nursing literature, "ritual" has mainly negative connotations. For example, Walsh (1991) sees ritual as the opposite to professional practice and being

based upon tradition. However, Philpin (2002) states that in nursing and anthropological literature, ritual may serve the purpose of protection from anxiety. Additionally, she cites the uses of ritual in maintaining social order. In her research into nursing culture, Holland (1993) concluded that the handover report is a ritual within the group studied in her work. She suggested that the handover encouraged group cohesion, maintenance of the social order and a way of ensuring that common values are sustained.

Additionally, Parker's study (1992) finds that handovers give the opportunity for nurses to demonstrate their competence and offer an opportunity for group validation. I think this is an important issue and intend to return to it. Philpin's study of nurses in an intensive therapy unit (2006) also found that the hand over reinforced and represented their care and concern for the patients under their care.

As stated earlier in this thesis, the ritual of the handover of keys (an important factor in ward based reports) does not exist in the same way in the community. However there does seem to be considerable evidence of ritual in the handover reports observed in this study.

Attendance at the handover

All of the team members on duty each day are expected to be at the handover meeting in keeping with Holland's (1993, p1467) work in which she found an "unwritten law" that all nurses on shift must attend handover. This did not,

however, include the auxiliary nurses, whom I never actually met. Their absence was explored during the feedback sessions following the preliminary analysis of data.

It seems that the auxiliary nurses were not specifically linked to a team, but work across a number of teams.

The Auxiliary Nurses did not seem to be viewed as full members of either team. When the other team were questioned about the role of the auxiliary nurse

Excerpt from my field – notes 24/12/04:

- "She's now retired –she was shared between all of the teams in this sector – she came in on Fridays and only had one patient from this team".

In retrospect, this is a missed opportunity and I feel that an exploration of how the auxiliary nurses view team membership would be a useful addition to this study. In the current climate of financial shortcomings, the role of the Auxiliary Nurse, along with all of the levels of community nurses, is being reviewed. The implementation of *Agenda for Change* has also focussed upon the roles and abilities of nursing staff in order to "band" them.

It was found that the working day had a clear pattern to it with set times of the day for team members to visit the clinics. Boyle and Andrews (1989, p50) write that rituals are typically "repetitive, stereotyped, formal, standardised and

patterned". Some aspects of the reporting practices of the two teams would fit into these categories. For example, the place and the time of the handover meetings are repetitive, formal and patterned. However, it could be argued that there is a clear purpose of the meeting that would not involve ritualistic behaviour (Helman 2007).

Where the handover takes place

For both teams, the handover report takes place in their communal office. There were no other staff based within these offices (I have been to many clinics where staff are not segregated into their own groups). Presence in the DN office confirms the spatial boundaries of being a member of this community (Philpin 2006). The community nurse handover, therefore, has similarities with the global handover of Manias and Street's study (2000) as it is located away from the patients.

During the participant observation visits, it became apparent that the interactions and non verbal communications differed greatly across the two teams. Team A gathered around a small table, ensuring that eye contact could be made. The layout of this office may be found on page 182.

There was always a considerable amount of encouraging body language within this team during handover reports. Individuals would nod at each other and smile when appropriate.

The other team (B), perhaps hampered by the office space and layout of furniture (please refer to layout on page183) within it, were, in general, less communicative. This indicates a difference in the patterns of non verbal communication between the teams (Manias and Street 2000).

When the teams were busy, it was evident that individuals were thinking about other issues during the handover or carrying out related tasks such as writing care plans. There was an urgency to get started:

"Shall we begin – I'll go first"

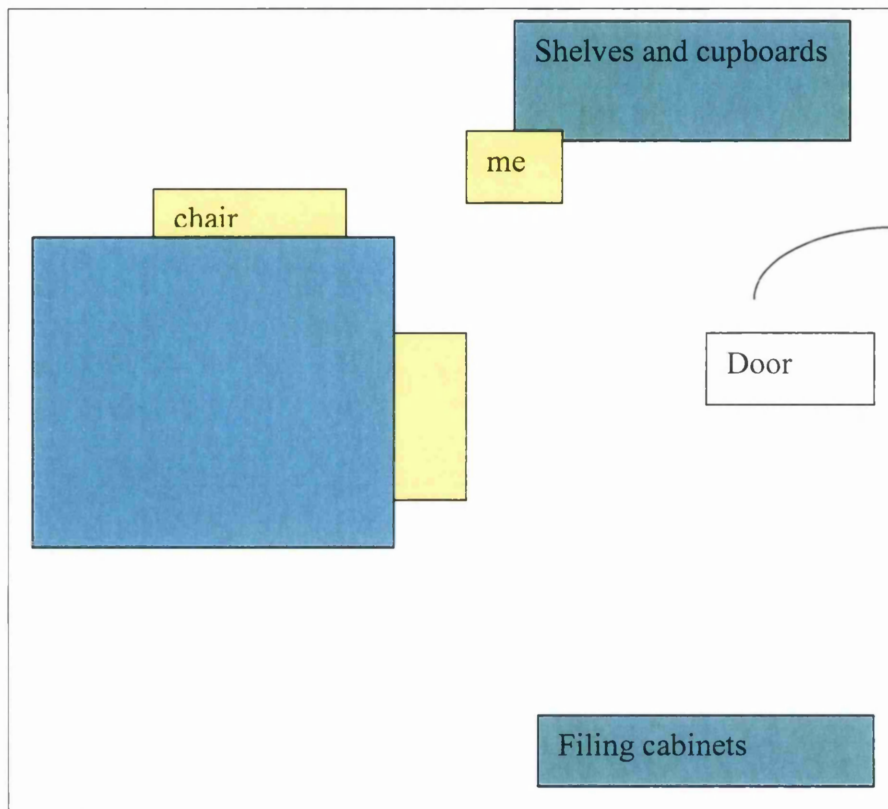
On these occasions, as soon as the last patient is discussed, the team immediately turn back to the notes and begin writing. This could affect concentration levels.

W- It's interesting to watch – sometimes people are very –hanging onto everybody's word, but when you're busy trying to write your care plans and things it's difficult?
(interview 7 paragraph 34)

Although individuals stress the importance of handover, there is a tension between the time that it can take and other commitments. To protect this period of time from other interruptions is not easy and sometimes not possible. On other occasions, the teams were very attentive with active listening in evidence and encouragement from team members to less experienced nurses. This did vary across the two teams.

The team members meet in clinics each afternoon to discuss the patients who have been visited that day and to plan for the next day. Each team had a different room layout.

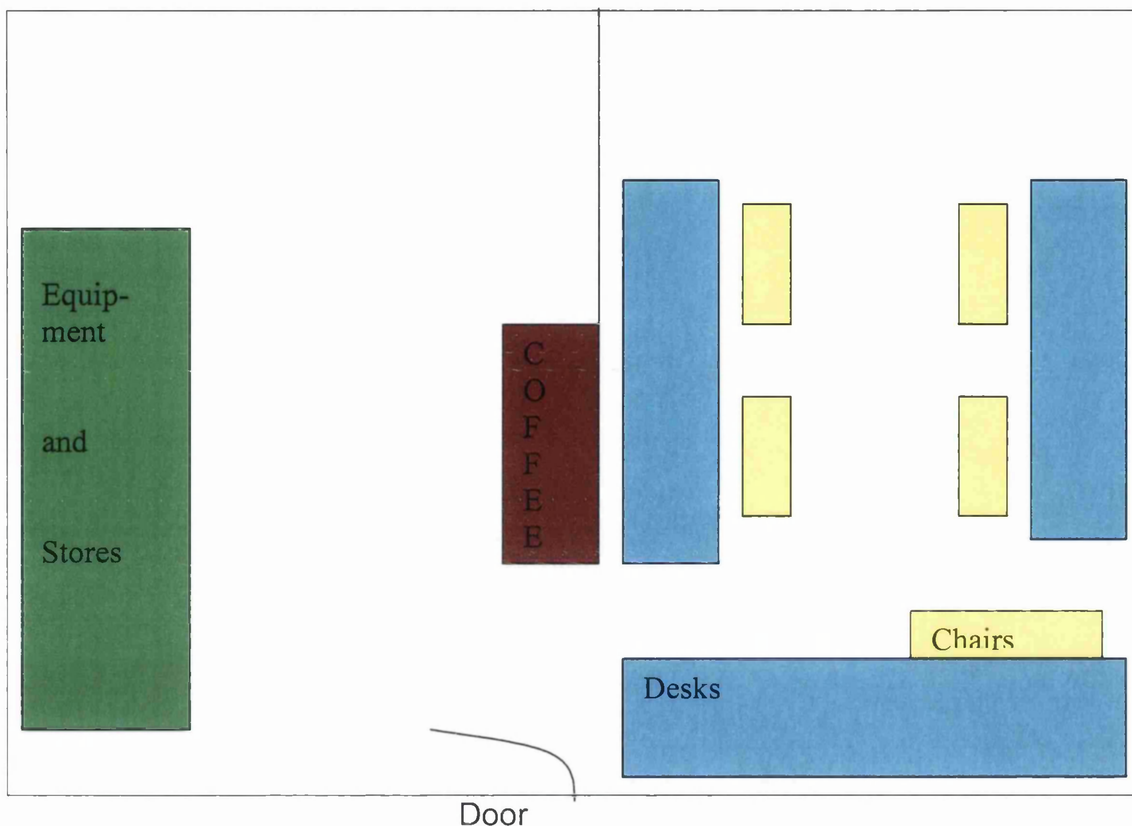
Figure 8 - **Plan of shared Office – Team A**



The above shows the layout of the room for team A, with preferred seating. Sometimes other chairs were brought in, depending upon who was present. The selected position for the chairs above demonstrated collaboration and promoted teamwork. There was good eye contact between the team members during their handovers.

In congruence with Philpin's (2006) study, this team communicated non-verbally with nods and encouraging gestures. There was movement around the chairs – individuals did not have a particular seat to call their own.

Figure 9 - Team B office layout



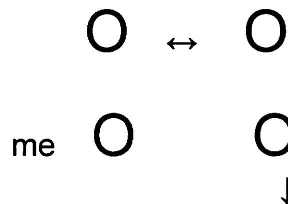
The above plan illustrates how the chairs and desks are placed in a way which maximises space. However, for much of their time in the team B office, nurses are facing away from each other. Their backs face outwards. This makes it easier to concentrate on what each person is doing away from the interaction of the team. It poses problems during report, as sometimes team members did not turn around to engage with the individual reporting back. This made communication limited as eye contact was not easily achieved. Eye contact is a fundamental part of communication and helps to build trust

between people (Ribbens and Thompson 2002). An example of how waitresses avoid eye contact when not free to serve illustrates how much is shared by eye contact (Spradley 1979). Once the waiter or waitress looks directly at the customer, he or she knows that it is their turn to be attended to. With backs to the room the flow of conversation may be difficult to regulate. Ribbens and Thompson write about studies showing that when we talk to others, we maintain eye contact with people for about 40% of the time. This increases to 75% of the time when others are talking to us. This is suggested to be partly about reassurance – gauging how honest and sincere the speaker seems to be.

It could be that this team were totally trusting of each other and did not feel the need to maintain eye contact during the handover. Or, more worryingly, that the handover was given in a more perfunctorily manner and the responses of others were not considered.

Excerpt from my field- notes 23/03/04 – 15.05hrs

- two of the nurses are facing each other and exchanging non verbal communication along with the verbal sharing of information. The third nurse has her back to the room and is facing into the corner of the room – eye direction is noted by arrows below.



For both teams, each nurse reports on the visits made in turn. This is believed to aid the continuity of care for patients on the caseload and this requirement is readily identified by the participants in this study:

W – "I think it's important to have handover cos if you – if you're taking on new patients or patients whose condition is changing- then it's the ideal situation. There's all the information across where you have been and what you've done"
(Interview 7 paragraph 33)

The members of this team always sat in the same seats. A folder with their name on it was prominently placed upon the table in front of each seat. This marked out their territory and clearly designated their place in the team.

Initiating the handover report

Lally (1999) described the time before the handover business began as "foreword". During this period, general chat would happen. In keeping with Lally's work, it was noted that the nurses would gather together and talk about issues relating to outside work. This chat at the beginning of proceedings also took place within this study of community nurses. Topics included purchases from a shopping channel to buying a house.

Kerr (2002) writes about handover reports in three phases. The first being the pre-handover phase during which the staff going off duty are busy updating documentation. Although handover in the community setting differs in that there is no shift change, the nurses in this study would also be busy updating patient records, cards and lists for planning purposes.

Team members tended to collect in the clinics at around the same time, but the reports began at differing times. It was interesting to observe the moment when someone would initiate the handover. There was no one way to indicate that the handover was to begin, rather a variety of signals.

Sometimes there will be a volunteer:

"Shall I start?"

"Shall I give you report?"

"Shall we begin then – shall I go first?"

Sometimes the team leader would prompt the team members:

"Would you like to begin?"

I noted that all of the above are posed in question form. It is as though there is a need to seek permission from the rest of the team to begin – this could be because of the great variety of tasks being carried out by the team members during their time in the clinic.

The use of language in handovers.

In chapter two of this work literature pertaining to the language used by nurses is explored. Allen (1998) found that nurses used narratives interspersed with anecdotes within reports. The narrative approach to reports was earlier explored by Parker, Gardner and Wiltshire (1992) who found collective decision making to be a feature of nurses' handover reports.

I noted that, given the general feeling of business within the teams, the visits were described in terms which minimise the visits:

"Shall I tell you about my little lot?"

"So – tell me your few then?"

"I haven't got much to say".

I found this interesting. It was as though it would be a cultural faux pas to make much of the day's visits. This would support the work of Lawler (1991), who explored what she termed "minifisms". In her study of nurses in an Australian Hospital, Lawler writes (p166) that minifisms "are techniques whereby the nurse deliberately and overtly understates the situation or minimises the extent of something". Primarily this technique is used with patients to reduce the extent of potentially alarming situations. For example if the patient has bled considerably the nurse would refer to a "little bleed". Minifisms are helpful in controlling situations that may become problematic. Lawler continues later in this work to say that (1991, p169) "nurses often use humour as an aspect of minifisms to help each other". This could be the case in my study in that making less of the day's work may give a better sense of control over the events. It could, however, be an indication of a general "dumbing-down" of the amount and complexity of the caseload and practice of district nursing. This problem was also identified by Lawler who warned that minifisms can add to the sense of care being invisible and could contribute to nursing care being undervalued. This is worrying in the light of some of the findings presented below. If community nurses assist in rendering their practices invisible and do not articulate their expertise (even to themselves) then this camouflages their skills and knowledge.

Jargon

Nursing has been found to employ its own language (Wolf 1989, Holland 1993, Helman 2007) which is largely developed during pre- registration education. This language is an observable indication of the culture of nursing and denoted membership of the profession.

The language employed during the handovers was symbolic and used phrases which would be difficult for an outsider to comprehend. Some of the terms were accepted abbreviations, such as:

"I did a BM"

"She's had a CVA previously"

Others were activities, understood by the members of this cultural group.

"when was her Doppler last done?"

"I was concerned about her pressure areas, but she only scores 12"

"is Mr X still in a three layer?"

As someone who considers herself to be a "marginal native" (Gerrish 1997), these terms meant something to me. This study would support the claims of Payne, Hardey and Coleman (2000) in that the handovers observed used abbreviations and jargon. However, shared vocabulary is seen to be learned, practised and developed during handover (Strange 1996, Wolf 1989, Holland 1993).

Strange (1996) classes the use of language as symbolic within the ritual of handover report. This was found to be the case within this study in that the nurses communicated through language and non-verbal means to create shared meanings (Schwandt 2001).

Ethnographic analysis of rituals can be helpful in identifying special functions, but is also a vehicle to increase understanding of what is considered to be valuable by this social group. Important issues within this study are the exploration of what is valued and what is transmitted at report time.

Sequencing of reporting

The order in which nurses reported back to their team members seemed random in team A. Different individuals offered to begin and there was no noted pattern as to how the others sequenced their reports. In this practice, in contrast to the findings of Manias and Street (2000), there was no attempt made to affirm status or control. Kerr (2002) refers to this part of the proceedings as the inter-shift meeting phase and is where the “business” of the handover is taking place.

In contrast, team B seemed to have a marked pattern. One team member always commenced the report (when she was on duty). Two other team members tended to go in second or third place. One person opted to discuss her patients last. This individual occasionally made a great use of drama – pronouncing that she would “go last”.

From my field-notes 22/01/04:

- At the beginning of the report P states that she will report back last. When it is her turn, she says Mrs X – "I will come back to her later" – this is said with a flourish. We are all wondering what is to come.

This observation was really the antithesis of minimising what was to come. In contrast with the comments discussed above, this nurse wanted everyone to wonder what was to come. There was a theatrical build up of anticipation amongst the team:

- At the end of the report about her other visits today, P dramatically says :"and now Mrs X – I got the G.P. in because she feels low. Her legs are shiny and red and very oedematous. Her toes are all inflamed. The G.P. rang back while I was there so I asked her to come first- she came an hour later. She (the G.P.) was horrified and has referred her back to the Consultant again"

All of the team members are engaged with this presentation of what happened. I felt that they enjoyed the performance. P. brightened up the handover report time for them. As there is no "official" technical reason for nurses to report back in a particular order, this could be ritualistic behaviour (Helman 2007). It is interesting to note that the Doctor was "horrified". There was some relish in reporting this back. I perceived a feeling here that it is the nursing staff who deal with the "horrific" events and that doctors would be shocked if they had to deal with these issues personally.

Ending the handover report

This also varied, sometimes the team members seemed to just turn away from each other at the end of the patient information. Sometimes there was a comment to indicate that the report was completed:

"So – that's it really"

"That's it of mine"

"And that's my list"

One team leader took the opportunity at the end of her report to sum up the situation in a positive light:

"Right, lovely – everyone's happy".

This individual was notably upbeat throughout the participant observations.

Following the end of official proceedings, Lally (1999) talked of "appendices" – these involved a change of conversation topics to more general talk and off duty activities. This was found to be the case within this study.

In contrast to Kerr (2002) this post-handover phase was notably different. In the ward setting, nurses were found to proceed to give care to patients very quickly at the end of report. As patients are, of course, scattered in the community this would not be the case. Conversation drifted into personal and wider considerations, for example one nurse was house hunting and would

give the team an update on her progress.

Hierarchy

A system of authority and power distribution exists, based upon the "Grade" and position of each team member. It is noteworthy that the Grade system is currently being dismantled with the introduction of the "Agenda for Change" strategy. This hierarchy is reflected in the titles given to community nurses within the teams.

Each team was headed up by a leader, who was identifiable by the colour of their uniforms. The views of the leader were generally approved by the team members – although I did observe a difference of opinion relating to the care of one patient. Significantly, this was voiced when the team leader was not present. This Team Leader did not encourage discussion or debate around issues raised at reporting time. By challenging the Leader's viewpoint in front of me, I feel that this may be an indication of the trust which was important to build up between the team members and the researcher.

Although all members of the team participated in the handovers, there was no evidence of the reaffirmation of control and status by the team leaders. This is in contrast with the Manias and Street (2000) study. It was, however, perceived (by me) as an unwritten rule that team B did not challenge their leader at handover.

In contrast, the leader of the other team encouraged the development of junior staff by encouraging them to see problems through.

The following is an excerpt from field-notes:

- Staff nurse: "I'm worried about her – I felt her dorsal pulse – she needs dopplering" Team leader replies – "have a word with her Doctor if you are concerned".

This implies a democratic leadership style (Marquis and Huston 2003), in which the leader directs through suggestion and guidance. Communication is a two way process in this style of leadership. This Team Leader was noted throughout the project for motivating and involving all of the team members in decision making .Team members identified that the above Leader had developed trust throughout the team and this was very much appreciated by them. During the participant observation visits, there was no evidence of the fear or defensive behaviour noted by Manias and Street (2000) in their study of critical care nurses. More junior nurses seemed to enjoy their telling of the care given to their colleagues.

Interestingly, the allocation of work for the following day was a job shared out between the nurses and not necessarily carried out by the "highest grade".

Within this study, I would support the view of Strange (1996) that handover reports warrant the label of "ritual". During my observation visits to the two teams, I could see how the conventions of community nurses' culture were recreated and accepted as the way things are by participants.

Hammersley and Blumer's Dilemma

In Chapter Three, I refer to Martyn Hammersley's critique of qualitative research and the work of Blumer and other Chicagoans. I would like to return here to the point that was raised in this work relating to the neglect of motivation. Hammersley (1989, p217) states that Blumer's social psychology is incomplete as although we get "the active character of human behaviour, we get little sense of the motives that generate it". He goes on to elaborate "what is missing, it seems to me, is the attempt to locate human motivation within the context of the study of animal behaviour generally, without reducing it to claims about instincts".

In his study of "the Vanity and Suffering of Life", Schopenhauer (1987, p101) compares the pain and suffering of human beings to that of wild animals. He postulates that "in proportion as knowledge attained to distinctness is enhanced, pain also increases and consequently reaches its highest degree in man; and all the more, the more distinctly he knows, and the more intelligent he is". He continues by stating that all of human willing is based on need, lack and pain.

Schopenhaur (1987, p 102) reinforces this viewpoint "man is concrete willing and needing through and through; he is a concretion of a thousand wants and needs". The above leads me to explore the relationship between motives and needs.

“Motive” may be defined as “what induces a person to act in a certain way. Concerned with movement” (The Hutchinson Encyclopaedic Dictionary 1998). The same source defines “need” as “circumstances requiring some course of action”. It could be here that human motivation and need are closely related.

Handy (1993) explores human motivation in relation to work. Under the heading of: “intrinisic theories”, he addresses Maslow’s categorisation of human needs, disagreeing with the belief that needs only act as motivators if unsatisfied. Handy suggests that needs become less powerful as they are satisfied (except at a very primitive level).

The Development of the Conceptual Framework

The need to share views and experiences with other team members is apparent within this study. The value of handover was demonstrated by the participants during the reporting time. There were many reasons for this. Some were to do with professional practice, expectations of the team members and their managers and for planning purposes. It became apparent in early stages of data collection that there were a number of other – less overt – reasons for valuing this time. It seemed that, in keeping with other studies (Strange 1996, Lally 1999, Payne et al. 2000, Philpin 2006) that there were many other needs being met during the report.

Notions of "Need"

The notion of handover "meeting needs" emerged as a key component of this study and the presentation of its findings. This occurred at the point when the preliminary findings were taken back to the two teams for their comments (Chapter Four). In order to explore the notion of need, a review of the concept of need was undertaken.

A "need" has been defined as circumstances requiring some course of action; a requirement or want at time of difficulty or crisis (Hutchinson Encyclopaedic Dictionary 1994). Certainly there appears to be a requirement to meet to share information about patients. Additionally, there seems to be a whole raft of other reasons for the team to meet.

Much of the literature around need is located in public health and health promotion studies. The work of Maslow in 1954 appears throughout health and social studies readings (Naidoo and Wills 1994). Maslow's hierarchy of need, depicted as a pyramid, begins with physiological needs at its base. It is purported that if basic needs (such as breathing, eating and sleeping) are not met then the human being can not progress up the pyramid to the next level involving safety needs. Safety includes security, freedom from fear and stability. If the person feels safe the need to belong (to a family or group or culture) becomes important. This need includes the need for love and affection. If this need is fulfilled then self esteem becomes necessary. The desire for positive self respect drives this level of need. Finally, at the apex of

the pyramid is the epitome of self-actualisation. What a person can be he or she must be. It is largely accepted that this higher level is not easily achievable. If one subscribes to Maslow's taxonomy then self- actualisation and health may be equated.

Although this work is of great interest it was considered to be more to do with individual growth than a way of exploring a cultural group. Therefore it was rejected as a conceptual framework for the analysis of the data. Some individual comments and observations will, however, be related back to the taxonomy of need as identified by Maslow.

Handy (1993) critiques McClelland's categories of need (or human motive) in his exploration of motivation relating to work. These are the need for affiliation, the need for power and the need for achievement. Later in this work he introduces the notion of the "psychological contract" between individuals and the organisation. He states that this contract meets some of our needs which, in return, we will use some of our energies to get results.

Nursing theory also lends consideration to the needs of patients. Meleis (1991, p252) outlines the work of needs theorists (Abdellah, Henderson and Orem). Henderson's theory is described as being conceived "to describe all nursing care in terms of the needs of patients." Although this early work remains strongly influenced by medical science, the notion of nursing being about helping to meet the needs of patients is compelling.

The work by Jonathan Bradshaw (1972) was then examined. He explored the concept of social need. He claimed that four definitions of need were commonly used by administrators and research workers. These are "normative need"; "felt need"; "expressed need" and "comparative need".

Normative need

This is need as defined by the professionals. There may be professional or legal requirements involved. This assessment of need may be quite different to the individual's perception of what is required. The normative assessor may frequently make value judgements about the people or situation under scrutiny (Lawton 2002).

The professional requirement to share patient information seems to me to sit comfortably within this definition of need. The planning function would also be comfortably classed as "Normative". Additionally, both teaching and learning feature within this "need".

Felt need

This is described as what people want. It is to do with needs arising from within individuals or groups. These needs are shaped by the individual's circumstances, experiences, knowledge and understanding.
Within this study a great number of felt needs were identified. These include confidence building, feelings of isolation, support from peers and the use of

humour in district nursing practice and are explored in depth in Chapter 7 of this thesis.

Expressed need

This is where the felt need is expressed in words or action. For example an individual asking for help or a community group demanding a service. Not all felt needs are translated into expressed need. Lawton (2002) states that there are potential barriers in expressing need including lack of motivation or lack of assertiveness. This proved to be an important feature within the findings of this study and will be addressed later. In addition, it is worthy of note, that barriers may be real or perceived.

Some needs within the teams of community nurses that are expressed include the development of shared values (which may be expressed through ritual). In addition to these, the perceived views of patients and carers are explored. The perceived views of other professionals proved to be problematic and the source of some conflict. Issues of assertiveness were initially explored within this definition of need. Finally, the morale of the participants in this study was to be explored here.

Comparative need

This need arises by comparing one group, individual or situation with another. It often includes the use of statistical data. Within this section is an exploration of what happens when (often because of poor staffing levels) handover reports don't take place. There were many conflicts around the helping of other teams and perceptions of how busy one team is compared to another. This also ties in with the staffing level issues.

Bradshaw's taxonomy is derived from sociological perspective and was published in New Society in 1972. Although very widely welcomed as a valuable tool by workers in the fields of health and social care, his work is not universally accepted.

In 1983, Clayton explored the use of Bradshaw's taxonomy in need assessment. Although this paper critiques the four classes of need in the context of its use in policy formation, some of the points raised are salient here. She argues that need is not about "simple objective facts" (p215) and considers practical application of the taxonomy. Clayton asserts that people in most need may have difficulties in expressing themselves and is sceptical about the validity of data based on questions around the need for services. Questions are raised around who decides that there is a need, for example in "normative" need a desirable standard is laid down and becomes "approved" need (her quotation marks). The assessors own needs are also a feature here as there may be a tendency to see what they (the assessors) are able to give

to the problem and turn that into "needs". Finally, there is a problem in that using this taxonomy, people are deemed to be "in need" or "not in need" – things are not so clear cut in reality.

Bradshaw himself offered a critique of his taxonomy (1994, p45) in which he reviewed his work from twenty five years earlier. He states that need has always been "too imprecise, too complex, too contentious to be a useful target for policy". He concludes that it would be better to target inequality than "need". This review provides useful insight and will be revisited in the chapters presenting the findings of this study.

Nursing has a history of importing theories developed by other disciplines (Meleis 1991). This has been equated with a professional barrier towards developing nursing knowledge. Meleis (1991, p58) talks of a phenomenon within nursing, in which that which is imported is viewed as *superior* (her italics). McKenna (1997) explores the importation of theories from other disciplines and suggests that reworking may be needed to "fit nursing's unique perspective" (p133). Other theorists disagree. Levine (1995) states that nurses owe a debt to other disciplines and would seem to accept this position. However, Adam (1992) warns that nursing needs to build a stronger nursing framework instead of borrowing from others. These are positions that I intend to return to later in this thesis.

Using existing literature is viewed here as a way of developing perspectives through which the data and its analysis may be represented (Coffey and

Atkinson 1996). As a nurse and a senior lecturer in nursing, I have had a keen interest in health and health promotion. The work of Bradshaw was already known to me through these activities.

Therefore, this decision to represent the findings of this study with reference to an "imported" framework was taken consciously as a vehicle to convey this account of social life to the reader. In Chapter Ten, I will revisit this decision.

Adaptation of the Framework

The use of an analytical framework for data analysis in this study is not intended to be reductionist but, it is hoped, that it will provide some suggestions through which to critically analyse the data. Spradley (1980) recommends the development of a schematic diagram of the cultural scene – a visual diagram of the themes.

Initially, the data were presented in the four categories as identified by Bradshaw. However, further critical analysis and expert feedback led to a later adaptation of this work. The process of developing an adapted framework will be explored in depth at the beginning of Chapter Nine.

The following figure (Figure 10) depicts the assignment of categories to the framework offered by Jonathan Bradshaw. The subsequent chapters concerned with the presentation of the findings will explore each of these and the relationships between them.

Figure 10: Bradshaw's analysis of the concept of need and related data

Normative need	Comparative need	Felt need	Expressed need (later revised)
Information sharing	Problems when not having report	Support from peers	Job satisfaction
Planning ahead	Helping other teams (busyness)	Confidence building	Views of others G.Ps/Practice Nurses/ Social workers/ Other nurses
Continuity of care	Staffing levels	Isolation	Rituals
Teaching and learning	Standards of care	Frustration	Morale
Referrals	Views of patients and carers	Laughter	
Staff nurse role in assessments		Getting to know peers	
		Value judgements Rituals	

Conclusions to this Chapter

The complex journey of analysing the data, which took me far longer than anticipated, finally led me to the use an adaptation of Bradshaw's taxonomy of need along with my own critical analysis to present the findings of this study. I have presented here some of the decisions that were made along the way.

I would like here to return to the work of Sandelowski and Barroso (2002, p216). I quote them earlier in asserting that participants' views should be located in some "intellectual, theoretical, or other disciplinary tradition". They also refer to the risk of committing to an interpretation. In the latter stages of writing this thesis, I very much understand that notion of "risk". All decisions taken in the use and development of a conceptual framework are contentious. I thought of alternative directions that this work could have taken and finally came to the position adopted here. It is hoped that the reader will gain a sense of the journey within this work.

In Chapter Ten, I offer some alternative positions that I could have taken. Although this (adapted) framework is not a neat fit to encompass all of the presented data, it feels to me to be a useful position to expand upon. Hopefully, the following Chapters will illustrate this to the reader. The adaptation of Bradshaw's work supports the view (Coffey and Atkinson 1996) that literature is not used to produce a ready made model but that it helps in the development of perspectives on our own data.

This brief introduction to the findings is intended to set the cultural scene for the reader. It includes exploration of ritualistic behaviours and the use of language. These link into the first of the key themes identified in Chapter One. The following four chapters present the findings of this study and discussion of these relating to the studies reviewed in Chapter Two of this work. Please note that where names are attached to field-notes, they have been altered to protect individuals from being identified.

Chapter Six

Findings 1 – Meeting Professional Needs: Sharing Information and Planning Ahead

> " 4.3. (As a registered nurse or midwife) you must communicate effectively and share your knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients"
>
> Nursing and Midwifery Council (NMC) 2004

This chapter focuses upon the normative needs which are met by the handover report, including information sharing, continuity of care, planning ahead, teaching and learning and the staff nurse role development. Exploration of Normative need in the community nursing handover focuses upon the cultural knowledge, behaviour and artefacts relating to the professional requirements of nurses. Bradshaw (1994) in his review of his earlier work accepts that there may be more than one view as to the professional judgement of normative need. Citing Clayton (1983), he points out that there often is more than one judgement to be considered.

Information Sharing and the Handover Report

There is a professional requirement to share information about patients with other colleagues who are involved in their care (NMC 2004). This is largely carried out during report and forms the basis of the decision to include these issues within this Chapter of the work. However, other important issues were found to be discussed by the participants in this study during their reporting time. These were considered to be a vehicle to explore the wider cultural scene of community nursing.

Prouse (1995) raised the issue of costs involved as the time spent during the handover takes nurses away from direct patient care. This issue of costs has resulted in a number of initiatives such as tape recorded reports and bedside handovers (Miller 1998). For practical reasons a bedside report is considered to be problematic in a community setting. The handovers observed during this study were all clinic based with each nurse reporting verbally upon her visits for that day.

Researchers of handovers in acute settings have identified that reports contain a mixture of information and anecdotes (Allen 1998). Additionally, Payne, Hardey and Coleman (2000) found them to be cryptic interactions carried out at high speed and including a high degree of jargon. None of the handover reports observed within this study appeared to be rushed, although they varied in nature. Issues around the quality of the handover report are addressed in Chapter Seven.

Discussion about the care given was a key element in the handover time. Questions from team members – for example "*when was she last dopplered?*" led to plans and alterations in the care.

M- (Sharing information)- "It's vital because you don't know if you're going to go into that patient next time and it could mean something extra when you go in – things might have changed things might have got better, worse - you don't know"
(Interview 2 paragraph 61)

Some jargon was noted with recognised abbreviations used (e.g. B.P for "Blood Pressure), although much of the information shared was about the

patients' social conditions. Language and the use of jargon are part of the culture of community nursing. Shared language is one of the ways in which culture is transmitted and observed (Spradley 1980, Wolf 1989, Philpin 2006, Helman 2007).

It soon became apparent to me during the participant observation visits that I am, generally, conversant with the terminology and could usually follow the interactions (despite being away from practice for some years). This supports the notion of the "marginal native" (Gerrish 1997) .There were, however, exceptions to this. For example, at the weekend the PCT would add a "floater" to the workforce. This didn't mean much to me. I asked for an explanation and was given the following information. The "floater" works across caseloads and mops up the patients who are considered to be in excess of individual nurses workload for the day. This was a new concept to me.

Strange (1996) wrote of the symbolism involved in the use of language during report time. During this event, junior nurses are socialised into the culture of the group (Wolf 1988; Holland 1993 and Lally1999) and learning to use "professional language" is integral in this process. The socialisation of newly qualified nurses has been the subject of many studies (Philpin 1999, Gerrish 2000, Mooney 2007). In her study of twelve newly qualified nurses, Mooney found that low self esteem was linked to the process of professional socialisation. Her participants were very keen to be seen to "fit in" with the practices of the wards in which the study was set. In cultural terms the use of language denotes acceptance within a group (Helman 2007).

On the subject of terminology and language, Spradley (1979 p 65) asserts that a central question for ethnographers relates to the question:

"What language shall be used in making an ethnographic record?"

As a "marginal native" I was a part of the shared language of community nursing. The use of language is an important one for the researcher. This insider status can enable the researcher to have esoteric knowledge and empathy for the participants (Coffey 1999).

My field-notes were written in everyday language, but with abbreviations and phrases identified as part of nursing terminology – the marginal native again!

Usually there was a purposeful atmosphere during report times. Interactions were often light hearted at the beginning, but it was apparent that this meeting was seen as an important part of the community nurses' working day. This reflected the professional "normative" need to share information across the team (NMC 2004).

Excerpt from my field-notes 16/12/03

- They (the team) discussed patients known to them both very well. Comments about treatment given was interspersed by practicalities – for example, when will the patient next receive a visit?

Both of these types of information, treatment and practicalities are needed to plan the care for each patient. Without sharing these important considerations, the patient care would be considerably fragmented. The treatment needs to be consistent and also the information shared between individual nurses, patients and carers. Knowing when the next visit will be is an important issue for patients and families.

This would, perhaps, be an example of Liaschenko's (1998, 1999) knowledge of resources and patient knowledge. It is not only the medical, disease orientated work that needs to be considered. If this is seen as "legitimate" work by community nurses, it is probably viewed as less important than the causes of disease or treatment knowledge required.

Continuity of care

One of the normative needs addressed by the handover report is that of continuity of care. By the sharing of information about care given and discussion of the patients' progress, it is intended that there will be an ongoing process of nursing care. This may be seen as the main purpose of the report (McMahon 1990, Thurgood 1995, Kerr 2002 and Philpin 2006) and is offered here as an important example of normative need for community nurses.

The following question was asked in relation to the passing of patients to other teams when busy.

D –I think that continuity of care must be a worry?

Z- It is a worry – I mean – we had a team meeting in the week and I do feel overall that it has been pretty horrendous – the last few months and I do feel that we have..

D.Yeah?

Z – Managed to keep the standards pretty high and that's down to the sheer hard work and motivation of the teams – to be honest and I'm very pleased that things haven't slipped and we are pretty up to date and that another thing as well – we do move our patients onto the weekends if it's our weekend so we do follow it up on the weekends and weekends are slightly quieter so we have managed to tick over.
(Interview 4 paragraph 23)

This participant was constantly working to keep up the morale within the team and could always see positive elements – even in very difficult circumstances. It is noteworthy that her concerns about continuity of care are followed by consideration of the hard work and motivation of her team. There could, perhaps, be a little of the researcher influencing the data here, though. If Z could reassure me that everything was being coped with then that would be OK.

Z -But it's not the best way that it could have been and this week, having all the staff in, makes a big difference – it's like a pressure has been lifted off you and you can actually do your job properly again – instead.
(interview 4 paragraph 25)

There is a sense of relief here and, also, acknowledgement that things have not been done as they should be. I think that there is evidence here that this participant felt able to trust me with this comment. Coffey (1999, 40) states that the onus is firmly on the researcher to develop “a working rapport and level of trust”. This is a real challenge for the ethnographer and crucial to the success of fieldwork, I believe.

For community nurses, it is a worry handing patients over to other teams, but it is also a problem for continuity of care when the nurse is visiting other teams' patients.

L- "yeah –we get to patients and find they've got no dressings because people have forgotten to call us to order them"
(interview 1 paragraph 21)

The above comment seemed to imply that the team would not expect the team handing over patients to ensure that provisions were ordered – the problem (as L saw it) was in not letting <u>her</u> team know that things were needed.

It is a complicated process to ensure that all relevant information is transmitted to the nurse, who will (probably) not know the patient. There is so much more to say than just what is needed that visit. Information sharing and continuity of care are the most readily accepted purposes of the handover report and this is in keeping with many of the studies reviewed in Chapter Two of this work (Sherlock 1995, Lally 1999 and Kerr 2000).

Again, the adoption of Liaschenko and Fisher's (1999) categories of knowledge would be a useful way of articulating some of the issues here. I would suggest that the recognition that the "patient" knowledge here, which is described by the authors as "the largest, most complex domain and is absolutely critical to the work of nursing" (p35), would gather together issues around individual responses to therapeutics, how to get things done and knowledge of other providers.

The Planning Function of Handovers

The delegation of work for the following day is an important part of the afternoon handover meeting. Lally (1999) states that the planning of patient care is a key function of the handover report. Work is allocated to the team depending upon their experience and time that each patient's care is expected to take. The methods of organising work and delegation involved the use of a number of artefacts. These are things made and used by the group (Spradley 1979). The cultural artefacts within this study were devised by each team and were varied.

Cultural Artefacts

Cultural artefacts are tools developed by the cultural group and their usage may be symbolic (Helman 2007). The teams developed their own ways of operating and communicating with each other. These artefacts were understood by members of each team and used in ways particular to the group.

One team (A) had a message book, kept in a locked cupboard, for team members to convey information. Each message was ticked off upon receipt. These messages could be very brief and to the point. An example of this included the instructions "wound assess – ankle op." Sometimes these brief messages would be very important – "Mrs X admitted to hospital". The action of ticking off signified to the rest of the team that that issue had been dealt

with (or at least taken on by a team member).This team also used a card system, organised in sections within a box a shown in Figure 11.

Figure 11: Card System for workload organisation – team A

Study and updates
Leg ulcer clinic
Hospital
Sort –(this section was empty)
Friday patients
Thursday patients (a very big section)
Wednesday (the biggest section)
Tuesday (big section)
Monday (big section)
Tuesday and Friday patients (big section)
Monday and Thursday patients (big section)
Monday/ Wednesday and Friday (empty)
Daily (empty)
Nurse X patients with tomorrows work included
Nurse Y patients with tomorrows work included
To put on for Saturday (contained a bundle of cards with post it notes attached)

The above shows a snapshot of the system taken on a particular day, it was rearranged regularly as new patients were taken on, patients discharged and conditions of some altered. Additionally, this team used a notebook entitled “Prescriptions” containing notes of what patients needed and crossed off when dealt with. So we have a ticking system for messages in one book and a “crossing off “system in a separate one. These practices were a part of the shared culture within this team.

Weekend work had its own folder in Team A. Whichever Sister for the area is working the weekend receives a small ring-binder containing cards of who needs visits. These are colour coded: pink cards for a Saturday visit and Blue for a Sunday. Some patients need two cards.

Team B

The second team kept records in a filing cabinet draw sectioned as shown in Figure 12:

Figure 12: Organisation of workload – Team B

Equipment loans
Hospital
Dopplers
Thursday 1 month/ 3 monthly
Wednesday 1 month/2 month/3 monthly
Tuesday 2 weekly/1 month/3 monthly

Monday monthly
Friday weekly
Thursdays
Wednesday weekly
Mondays
Tuesdays/Fridays
Mondays/ Thursdays
Monday/Wednesday/Fridays
Alternate days
Daily

Front of the drawer

This team worked from individually labelled folders in which the work for the day was placed. I did not notice until writing up this Chapter that I had not noted the amount of work in each section. This could be due to my developing skills as an ethnographer – it is difficult to know what to leave out when making field notes.

The card system (used by Team A) had not been adopted by this team. The team-leader was of the opinion that patients could be missed with this system. Although the artefacts devised by the teams differed it appeared that both systems worked well. Practices had developed in different ways across the teams.

A communication system used extensively by both teams was the telephone. Messages were left on the clinic telephones and dealt with during each day. In the mornings one member of staff would listen to the messages and decide on the action required. In addition to this, many of the staff had their own personal mobile phones. In particular, newly qualified staff felt reassured by their ability to summon help if needed throughout their working day.

Another artefact used by the community nurses is the "off duty rota". This is a tool for planning staffing levels and also a depiction of who is due to be on each shift. I find it interesting that this document is referred to as off duty – not on duty. This could indicate that actually this tool is more about when each nurse gets a break from work.

It is worth remembering here that "culture" itself can not be observed (Spradley 1979) but the ethnographer may make inferences from the observation of behaviour, knowledge and artefacts. These inferences include interpretation and construction. The behaviour of the participants and the rituals involved in the handover reports is further explored in Chapter Five.

Teaching and Learning during the Handover Report

Nurses are constantly learning from each other in practice. I have often witnessed more experienced nurses' share their knowledge with those more recently qualified. Increasingly, however, it seems to me that nurses may specialise in particular areas of practice – for example in tissue viability and

wound care. In these instances, the less experienced nurse is in a good position to educate those who have, perhaps, been working in the community for a much longer time.

The opportunities for teaching and learning during the handover were clearly identified by most of the participants, in keeping with studies reviewed in Chapter 2 (Lally 1999, O' Connell and Penney 2001, Kerr 2002). This was seen as a real benefit of the group meeting.

Excerpt from my field-notes – 16/12/03

- Nurse M says "A thinks she may have an allergy to aqueous cream" Nurse Z replies " I have just read an article about aqueous cream and it should not be used as an emollient – which we do"

The nurses in this team were able to criticise their own practices with each other. There was a sense of trust and acceptance which promoted this within their interactions – not least between the team and myself. As an insider/outsider, I was very conscious of the times when participants opened up in front of me and sought to develop trust and openness to encourage this (Coffey 1999).

D- I've noticed, as well, that you learn from each other during the report.
L - Yeah we do
(Interview 1 paragraph 34)

D- If someone's done something for the first time??

L- Yeah

There is a sharing of ideas and decision making during the handover relating to treatments and nursing interventions. All of the above are members of Team A. Members of Team B kept their thoughts more to themselves at handover time. This may have been because I was present – I have no way of knowing how things were when I was not present !

Z - And we'll talk about the picture in general the wider picture in general, but also discussion sort of errm try to get other ideas it might even come down to somebody might suggest a treatment and they would say to them "well why do you think that?" – so it's because of a sort of learning environment as well. (interview 4 paragraph 43)

It is also a time to ask questions and learn from colleagues. Practice is constantly developing and changing. Keeping up to date is a professional requirement (NMC 2004). As new treatments and approaches to care are developed, community nurses update each other by sharing their experience.

Excerpt from field-notes – 30/03/04

- There were only two members of staff on duty today (L and Z). Z says "we're fed up today – we're very short staffed. I went with the staff nurse to a patient with prostate cancer to see her give a Zoladex (injection) – I'm going to have a go next week – very scary". Z is clearly anxious about this procedure, but is happy to share her feelings and experiences with her colleague"

This willingness to share and learn from other team members was also

reflected in the interview transcripts. Again the above excerpt involves members of Team A, where the trust experienced within the team enables the nurse to share her anxiety. This is acceptable within this group.

Exchanges from Team B include:

Excerpt from my field-notes11/03/04:

- W says "it didn't stick so..unless I've done something wrong??"
- Y replies" no they do an adhesive one but we haven't ordered it!"

Teaching is more informal within this team. Remarks are more "throw away" and rather in passing. The nurses in this group are not so willing to challenge or question practices or decisions. It would seem to me that Team A has a more open interaction. Team A members identify the teaching and learning function of handovers more readily:

M - If you've got any questions – that's always the thing with handover – if you've gone into a patient and they've got some kind of new cream or something – you read about it obviously before you put it on , but – you know – you come back and errm you discuss it – you know if somebody's been in . If, say, a specialist nurse has been in and prescribed this the treatment that they want and errm – you carry it out err and then you come back and discuss that and see – you know what the benefits of that will be – it was like that with Promogram errm – and it took some time for people to learn to use it- you know properly.

(interview 2 paragraph 68)

As might be expected, the nurses participating in this project saw the handover meeting as an opportunity for both teaching and learning. The

absence of fear and defensive behaviour helped to create an atmosphere in which teaching and learning could take place. This was in contrast to the findings of Manias and Street (2000).

Referring back to Liaschenko's (1998) categories of work, the normative needs of community nurses could be said to include knowledge of therapeutic effectiveness. I would suggest though that addition of the later work (Liaschenko and Fisher 1999) to include consideration of patient and person knowledge would strengthen the articulation of community nursing work in a way that would more comprehensively encompass its complexity.

Staff Nurses' Roles

The issue of professional development and positioning of staff nurses is seen as very important at the time of the data collection, and through the vehicle of handover reports, aspects of this developing change to practice could be observed. The position of staff nurses within the cultural group is explored here in the context of the shift of skill mix and new roles in community nursing practice (NHSME 1992, DOH 2000, DOH 2005, DOH 2006).

This section is placed here as it is tied in with professional roles and responsibilities. Therefore it would seem to have some resonance with normative need. This is to do with what the professional expectations are and also the frustration (Hallett and Pateman 2000) of the "invisible" assessment alluded to in the review of the literature earlier in this work. This has been

documented as the repetition of assessment by more “qualified” staff after the staff nurse has visited.

The PCT involved in this study has begun to implement a staff nurse development programme to enable staff nurses to assess new patients. This had not been part of their role within this PCT prior to this time. It was identified during the participant observation visits as a key consideration in the allocation of patients. It was of great interest to me to find out how the impending staff nurse development programme was perceived by the participants.

One nurse saw clear advantages, from a workload perspective, of more staff being able to assess. I had considered before undertaking this study that qualified district nurses may be reluctant to relinquish the assessor’s role. This proved not to be the case. Short staffing over a long period of time, the increase in complex cases in the community and a perceived generalised increase in workload may have minimised the resistance of some district nurses. They welcomed the help offered by the changes in the staff nurse role.

The Queen’s Nursing Institute and the English National Board highlighted in their paper (2002) the great concern of district nurses relating to the quality of services provided and resource limitations. These issues could have an impact upon the role of staff nurses within this PCT. The QNI and ENB state (p18):

"This is a workforce which feels under resourced, overburdened and lacking in support"

More recently, the Queen's Nursing Institute (2006) reports enormous pressure on community nurses.

One nurse was quoted (p5) as stating: *"the patients emerge quicker and sicker so we have to work faster and slicker"*

The views of participants were solicited relating to the planned developments within the Trust. The development of the staff nurses' role in assessment was high on everyone's agenda. A member from Team B expressed the following:

Y - "mmm – obviously being in a more senior position now – it's – it is easier if the E grade staff can do some assessments"
(interview 5 paragraph 55)

D- "so do you view it (the development of staff nurses carrying out assessments) as a positive thing?"

Y – "a positive thing yes as well as for the E grade staff because otherwise you're deskilling them – you do forget how to do the assessment – for myself particularly it had been what – six or seven years before I'd done full assessments and it was..it was quite an anxious time"
(interview 5 paragraph59)

This last point frequently arose. Staff nurses felt deskilled by the prior practice of not allowing them to carry out assessments. They supported the proposition of Hallett and Pateman (2000) that it was necessary to develop their professional autonomy.

When one nurse was asked about the assessment of new referrals:

D- That's really good – thank you. That's wonderful. O.K. I'm going to move you on to talk about referrals now and I want you to tell me what your experience is of the assessment of new referrals –

She indicated that she was not yet in a position to assess new patients and spoke of her team members' experience and knowledge of assessment.

N - Errm which I think that's important because of their knowledge base – I don't think it would be acceptable for me to go in straight away., because the paperwork – it's a bit of a (laughs)…(Interview 3 paragraph)

D- Daunting??

It is interesting that the focus is placed upon the paperwork and not the assessment of the patient. The documentation surrounding the Single Assessment Process (SAP) is complicated and lengthy.

N - Daunting to say the least, isn't it? But we get the fair majority of different things from hospital – wards mainly the M hospital .Then we get the odd ones from doctors – for different things – for enemas to a new patient – those are I think, from the experience I've had, those are the main two referrals we get from.

D- Hospital and G.P.?

N – Hospital and G.P, really – yeah.

The paperwork involved in the assessment of new patients is something that staff nurses feels they need to learn more about. The completion of this paperwork has been identified as a training issue by the PCT in which this study is based. This is part of a structured series of development.

I wondered how one CSN felt about the impending programme to prepare Staff Nurses to carry out first assessments.

D- O.K. there are moves for staff nurses to assess – how do you feel about that?

N- I've heard something – I can't remember if I've heard it on the grapevine or whether I've read it I think it would be good. I don't think I'm quite ready at the moment, but it would be something to – perhaps simple referrals – if there is such a thing, but I think that would be good it would make you – although you're a valid member of a team, make you a bit more, you know, valued, perhaps. I'm not sure.

This is an interesting observation. She feels that being an assessor would make her more valued and validate her team membership. This could strengthen her position within the cultural group (Helman 2007).

Her comment about simple referrals – "if there is such a thing" shows her developing expertise. I would agree with this point of view. It is a common issue in district nursing (Audit Commission 1999) – what looks simple on paper can be very complex in reality.

D- It would stretch you a little bit further when you feel ready?

N- Yeah – I think it's just a matter of confidence really and getting a bit more experienced – I mean, you know, I think yeah it's more to do with confidence than experience really. Really the two together – I think there's then perhaps – I don't know whether there's workshops going to be in place or it would be useful just to go and see – definitely.

There are programmes in place to develop staff nurses into their assessment role. These were just about to begin at the time of interview and this participant had some awareness of the process. As the study progressed, the development programme was carried out. I noted in my field-notes that the job of allocating the patients for the following day was often carried out by the

staff nurses. This was rotated around the teams for experience and practice to be had in delegation.

Although assessment was always a part of what they did with patients (I do not think you can give care without some element of assessing), the formal acknowledgement of the staff nurse as the first assessor for some referrals was a real opportunity for development.

V- "they (staff nurses) have got the knowledge and the experience as well – errm they've got the ability to know when they come across the need for a more experienced member of staff to come and look at and assist them in the assessment process"
(Interview 8 paragraph 36)

This participant from Team B identified the need for the staff nurses to be supported in their new role.

D- "you see that as a good step forward?"

Z - "I do yes I do – I think that as trained nurses we are trained to assess and I think that with the right teaching and the right mentoring it will do good for the staff as well and also it will enable us to do reassessments and to follow up complex patients as well"
(interview 4 paragraph 53)

This made the point that staff nurses assessing new patients would free up the more senior nurses' time to devote to more challenging cases. The pressure of work was a factor in the responses offered:

V – "Yeah – I mean we've got three new assessments to do today – if we weren't able to share them out there's no way that one person would be able to do it with everything else that we've got on as well"
(interview 8 paragraph 39)

Although staff nurses participating in this study stated that they were well supported, they gave examples of other teams within the PCT where they perceived that things were not so well considered.

W -"yeah well it's not always done like that – some clinics they just throw you out and you're left to your own devices – just thrown out – here's your new patient, but seems to have been a bit more managed"
(interview 7 paragraph 49)

This was a worrying point of view raising concerns. We had some discussion about what staff nurses in such positions could do to improve their lot.

The new staff nurse development programme was also seen as a measure to remove some frustration relating to red tape. Some staff nurses felt held back by the restrictions in their practice. One very experienced community nurse observed:

X - "you feel stupid if the patient – somebody phones up and wants a referral for urgent clips that they've forgotten to refer to us – there's no one that can do it"

D – "and it's not that you don't know how to do it?"

X – "no no"
(interview 6 paragraph 48)

The staff nurse development programme was well underway when I took back my initial data analysis to the teams. Generally it is thought to be a successful move forward.

The above issues are grouped under the umbrella of "Normative need" within this Chapter of the findings of the study in which some of the normative requirements for handover are closely related to the culture of community

nursing. Culture may be referred to (Spradley 1980 p 86) as: "Patterns of behaviours, artefacts and knowledge that people have learned and created".

Handover reports are considered in this Chapter of the findings to be a professional requirement for community nurses. This time provides the opportunity to share information and plan ahead.

Summary of Key Issues

This chapter of the findings, that are categorised here as normative in nature, includes issues of professional requirement. Naidoo and Wills (1994, p204) define normative need in terms of "an objective need as defined by professionals" which may be measured against an occupational or legal requirement. The sharing of information is primarily the reason for the gathering of community nurses in the afternoons. The stated aim of sharing information is to assist with the continuity of care. Each nurse discusses the patients visited and outlines the care given, decisions taken and planning of future care with the team. These are professional requirements (NMC 2004) and there is an expectation that information be shared with the rest of the nursing team involved. It would seem to be part of this group's culture to meet to carry out these activities.

The planning functions of the handover report are then explored. This involves the team deciding upon the workloads for the next shift, planning for major events and scheduling meetings. Decisions are taken here relating to whether

the team will need help from elsewhere or is in a position to offer other teams help. Again this planning is a requirement to provide on-going care for the patients on the caseload. This could be evidence of Liaschenko's knowledge of how to get things done (1998). It also includes the "patient knowledge" and "person knowledge" of the later work (Liaschenko and Fisher 1999), in that deciding which patients to pass to other teams involves a complex calculation of these matters. This forms a part of the exploration of knowledge for community nursing and will be further explored in Chapter Seven.

There are many artefacts used by community nurses to aid the planning process – message books, off duty rotas and card systems are examples of these and are explored above. There are traditions of crossing off some information and ticking others. This crossing off and ticking symbolises work accepted and/or completed. These add to the exploration of the culture of community nursing.

In accordance with the second of the key themes identified in Chapter One of this work, teaching and learning were identified as being a valuable facet of the handover report. This is a good time for experienced staff to share their knowledge with more junior members. Additionally, there is an increasing opportunity for members of the community nursing team to develop expertise in specific areas – such as the promotion of continence. This enables teaching and learning in a less hierarchical manner with less experienced staff developing expertise in some subjects. Teaching and learning is viewed as a

professional requirement and features in many of the studies reviewed in Chapter Two.

Finally, in this Chapter the staff nurse role development is explored. This is considered to be a normative issue as it involves the professional boundaries and expectations of this group. There were a number of viewpoints expressed by the participants within this study. Generally, there was a feeling that it was a positive move to develop staff nurses' assessment roles. There were issues of feeling deskilled by the previous practice of not "allowing" staff nurses to assess. Providing the developments were to be well managed and staff well supported then this was endorsed by the participants.

Explicit cultural knowledge (Spradley 1980) is exchanged during the handover reports of community nurses. This is revealed through speech and is the primary means of transmitting culture from experienced nurses to more recently qualified staff. There are occasions, however, where the opposite is the case. Normative need denotes a pattern or standard requisite of handover reports within this study.

Chapter Seven

Findings 2 – No time for Handover Report: helping across Teams and Busyness

This chapter addresses the comparative needs of the community nurses within this study and looks at what happens when teams do not have report. Although there is a will to engage in handover reporting, it appeared that this does not always happen. In this section of the findings, I aim to explore why this may be the case and what the results of not having handover are.

Naidoo and Wills (1994,p206) state that " a person or group is said to be in need if their situation, when compared with that of a similar group or individual is found "wanting" or lacking with regard to services and resources". They go on to state that need is not objective and is relative, influenced by other attitudes, agendas and values.

In his own critique of the taxonomy of need, Bradshaw (1994, p46) talks of "comparative need, which I did not describe very well, has to do with equity".

This section includes issues relating to staffing levels, helping across teams when busy and standards of care. These issues were found to be of considerable importance to the community nurses within this study and both field-notes and interview data yielded many pertinent issues. Perceptions of busyness also feature here as (in agreement with the statement above) comparative need is affected by the values, attitudes and perceptions of the participants within this study.

The cultural knowledge, behaviour and artefacts presented during the handover report sessions relating to the above considerations are offered

here. They take the findings of this study beyond the focus of the handover itself. This is viewed as an opportunity to explore more widely the culture of community nursing.

Finally in this Chapter, patients' viewpoints relating to being cared for by those outside the team are explored through the perceptions of the participants.

Not having a Handover Report

Although participants all felt that handovers were an important part of their working day, they did not always have a formal handover session. It seemed to be something that staff were reticent to discuss. This is not surprising as it was clear from the outset that this study was to be focussed upon the handover report. The participants would, perhaps, feel reluctant to share with me that handovers were not always carried out. However, as the data was collected it became clear that it was not always possible to have a report every afternoon.

On these occasions, one participant clearly had a need to discuss her patients for the day and had developed her own strategy to deal with not having an official report session.

N - "I think it's really important. I really do – you know- there has been occasions when you don't get a report and I'm like – but I always make sure that throughout the period that I'm in the office, I mention all the patients – (laughs) I get it in – just for.."
(interview 3 paragraph 44)

This person related in a very open way that she needed to build up her confidence in community nursing. There seems to be a strong element of reassurance needed here. If this Staff Nurse talks about the care that she has given to each patient, then it is a check for her that she has done a good job.

If the ritual of handover provides some protection from anxiety (Menzies 1960, Biley and Wright 1997, Philpin 2002) then not having report could have detrimental effects. The Staff Nurse's strategy for mentioning each patient ensures that she gets (in some measure) reassurance.

Lally (1999) found that junior staff used the handover to seek approval from more experienced nurses. This may be verbal or from non verbal gestures, such as head nodding and eye contact. This approval is important in developing professional confidence. The two teams varied in this respect. Team A employed non verbal interactions throughout the handover time, whilst Team B were less supportive of each other in this manner.

In an attempt to find out about the practices across the PCT, I tried to ascertain if the afternoon handover was a feature across the teams.

D- Do you think every team meets like you do? To handover in the same sort of way? Probably an unfair question ? I'm just wondering.

X- In the teams that I've worked in –we did. Virtually every day discuss each patient – sometimes just to say – no problems – which is good (laughs)

D- But at least you've had that contact and you know that you're not waiting for someone to ring you or……O.K?

X- "that's it, but I find report very useful actually, because when you're too busy to have report you don't know what you're going into the next day or if a patient's on weekly or monthly even – you can lose track of what's going on" (interview 6 paragraph 33).

Although I must acknowledge the leading questions asked here, the inclusion of the word "virtually" gives the game away – it is not always possible to gather everyone together to report across the team members. I do note that my questioning was leading in this section of the interview and could be improved upon.

The loss of the handover report is seen as a failure of the team by one participant:

D- *"what sort of things go on during that time (handovers) – in your opinion?"*

V - "well – we have a lot of difficulty errm having set reports in the afternoon – we''ll start the week off being really dynamic and promising that we'll have a report and we might do it the first day and then it goes to pot"

(interview 8 paragraph 17)

D- "when it goes to pot – what happens?"

V – "well the phones are going – people are having to go to meetings or to see additional patients so you haven't got the whole team there that have worked the day- so what will remain is giving each other little titbits during the day- if you come in and you've had an experience – you'll speak about it at that time – usually when people are on the phones again and people are popping in and out to do photocopying".

D –" it's not ideal is it?"

V - "no- and we like get frustrated because you follow up with your next visit, realise that something hasn't been done that you wanted done and then it's either delaying treatment or it's just – because you want something to be a continuous process and it's just being hampered all the time."

(interview 8 paragraph 23)

This individual from team B wanted to improve the situation for her team. Sadly, there is an unfortunate knock on effect in terms of time management here. If because of staffing problems, the handover is omitted, then the staff feel less sure of what they are going in to patients for.

L – "Well – Yeah and when you're going in you're not quite sure what's going on and whether it's this patient that needs..and then you have to read all the care plans and .."
(Interview 1 paragraph 44)

It could be argued that it is good practice to always read the care plans in the homes prior to giving care. This will become even more of an issue with the single assessment process (DOH 2001, Richardson 2001) with a number of professionals adding to the combined paperwork. However, a discussion with the person who visited last can provide information above and beyond that which is written down.

Lack of support is also perceived when handovers do not take place. This participant noted:

V – eerm well – you haven't got that kind of support with each other – you can't have a debriefing - errm if you're having problems with a patient you're keeping all the problems to yourself and taking them home and becoming frustrated- patients are suffering"
(interview 8 paragraph 21).

This appears to become a vicious circle leading to increased frustration:

V – and we get frustrated because you follow up with your next visit, realise that something hasn't been done that you wanted done and then that's either delaying treatment or its just – because you want something to be a continuous process and it's just being hampered all the time.
(interview 8 paragraph 23)

The identified frustration may ultimately impact upon the morale of the team.

The Quality of the Handover Report

When it is busy in the office during handover report time it can be difficult to fit everything in that needs to be done. This is potentially damaging to the quality of the handover and was also explored within this study. This section is included here as being relevant to "wanting" in terms of resources. The comparison is between a full report and a (poorer quality) rushed report.

W - "It's interesting to watch – sometimes people are very –hanging onto everybody's word, but when you're busy trying to write your care plans and things it's difficult?"
(Interview 7 paragraph 34)

W – "Yeah – it is now especially now X (G grade) has gone we're finding it very hard to have the handover – and when we do it's like – OK I do this whilst your talking and we're on the phone and we're just carrying on".

I witnessed on a number of occasions, nurses talking about their patients' care whilst their colleagues made telephone calls or were carrying out other (necessary) tasks.

Excerpt from my field-notes 4/05/04

> - 15.05hrs. all writing, telephoning – not much chat – X says "shall I start?" she begins to go through her patients – X moves her chair to the centre of the room – she looks directly at Q – Q answers the phone and is there for 10 minutes – X is still talking – but who is listening?

It is interesting that the above entry was made when observing the team in which W is a member – it has been acknowledged that the nurses involved

are not actively listening to the content of the handover report, just "carrying on". It may be that even if there was no-one listening that the verbalisation of the days work was, in itself, of value to the nurse. I wondered if the report would have taken place had I not been present. Abbott and Sapsford (1999) discuss the bias that may occur by the researcher being in the field in that participants may behave in a way that they think the researcher would want them to. Maybe there was a perceived pressure to have a report, regardless of who was listening.

Helping across Teams

When teams are busy they tend to call on other teams for help. This, in turn, pressurises the "helpers". Comparison of workloads across teams is, therefore, another feature of handover reports. This would bring in Bradshaw's equity issues (1994).

The Audit Commission (1999) cited the year on year increases in the number and proportion of very elderly patients in the community. In addition to the faster rate of patient turn over and increases in acute cases nursed within primary care these trends seem to indicate an increase in the demands on district nursing services (QNI 2006).

It appears that within district nursing culture, teams help each other out during busy periods. The patients were usually allocated to other teams by telephone – this in itself being a very time consuming operation. A very interesting

picture of the perceptions relating to this helping out is illustrated by the participants in this study.

Firstly, there is a feeling that sometimes the team being helped are less busy than those doing the helping.

D- "O.K – What about when you're helping other teams or they're helping you – how does that work?"

W –" Well (sighs) – what we have been doing is well we've been getting everybody's patient hours in – getting the actual nursing hours - and if someone is short and we're able to help – help them out."
(interview 7 paragraph 10)

D- "You help them if you can ?"

W- "Yeah – errm some occasions we've had it where we're going out with more work than the team that we're helping are going out with."

The term "nursing hours" refers to the dependency ratings allocated to each patient. This is an attempt to quantify the number of hours likely to be spent giving care in each house or care home. This term is a part of the language of community nurses and culturally relevant (Helman 2007).

X - Well – we sort of tend to do more of the helping rather than getting help.
(interview 6 paragraph 15)

D- Right?

X-Cos I've been over to errm the south helping out there as well as doing patients here.

Although names were never mentioned (or specific teams identified), there seems to be a view that some individuals would not be particularly willing to help. It appears that it is not done to name colleagues when criticising aspects

of their practice. This would seem to be an "unwritten rule" of this cultural group. Unwritten rules have been identified in earlier studies of handovers. For example, Strange (1996) identified that, within his study, there was a maximum of twenty-five minutes allowed for report. Transgressing this would be noteworthy within the group.

D- Mm?

X- Errm it works quite well – it's difficult (laughs) – I don't know what to say really on that one….cos….

The above response related to being asked to describe what it is like when nurses help out across teams during busy times. After prompting it became clear that the participant was reluctant to say how she felt about some of her colleagues.

D- You know who will help you and you probably know who won't?

Y - That's true – yeah. We are good at helping other teams, but it's difficult when you're asked particularly to help a team that you know would never…..

(interview 5 paragraph 24)

D- It's about knowing who – who is in which team?

Y - So it makes it difficult.

It seems that it is known within the group that some teams have a reputation for not offering help. This was acknowledged by both of the teams participating within this study.

D- I think that's fairly common really, but as you say, everyone knows who the helpful people are…

L – But the day will come when they need the help..
(interview 1 paragraph 14)

D- Very true

L- And they won't get it (laughs)

The laugh here could be a way of signalling that the statement is meant as a joke – rather than a true comment upon the situation. However, it could be just to soften a statement perceived by the participant as a little harsh.

M - And that's why they've always had to ask for help- but now we've got another member of the team and she's coming along – when she's fully trained up this team will be brilliant, you know, absolutely the best and we won't have to ask for help – in fact they'll probably want us to help them and we'll probably have long memories!

(interview 2 paragraph 42)

again the "we'll probably have long memories" could be in jest – or not. Sometimes it seemed that the team was already too stretched to help others out.

Excerpt from my field- notes 17th February 2004

- it is half term and the team is short staffed. Y says "and we have to help out X clinic on Thursday – we're the furthest away as well!"

There was a real sense of frustration when, due to staffing problems, help

was needed on a fairly regular basis.

Z -Errm – to be honest – since I've come back from maternity leave, which is about 18 months now – it's been continuous, for some reason or another, that we've been having to have help and I think it's very frustrating – I mean the other teams are very co-operative and we do try to work, you know, together but you do get a feeling that you are – how you are seen by other teams and you get some of the team members from some of the teams can get quite short with you, you know, and they think, you know, X clinic are phoning again for help and it's also frustrating for us as a team because we can't follow our patients through and I spent a lot of hours on the phone trying to move patients and cancel patients and it's very frustrating and it's quite demoralising when it gets like that.
(interview 4 paragraph 17)

The subsequent effect upon morale is clearly stated here. The team leader in this situation was notably encouraging to the team. She adopted an optimistic approach and worked very hard to rally the team in difficult circumstances.

Busyness

The notion of busyness became an interesting point during this study. It was noted during the participant observation visits that comparisons were made about how busy each team might be. The two teams tended to perceive that other teams were less busy than their own and not all other community nurses were viewed as helpful. This relates again to issues of inequity across teams and is, therefore, included in this section of the findings of this study.

Excerpt from my field-notes 11/03/04

- 15.05hrs chatting – not into handover yet – P is sorting out the work for tomorrow – she says with a sigh "18 hours work and three of us on - the weekend's going to be dreadful. Six diabetics plus a tetraplegic patient who needs a manual (evacuation) – all for early visits at the weekend. A lot of new patients are diabetics"

W -" No and at the moment I'm having a problem cos I'm running a leg ulcer clinic errm on Tuesday I was having a right game trying to get somebody just to cover for 2 or 3 hours at the leg ulcer clinic and nobody wanted to help – the majority of patients were other teams and next week I've had to cancel it because no one's willing to help again, but they want the service to carry on running but they don't want to put any effort into it – it's unfair and it does sort of make us feel angry – because we're always helping other teams out and we're never getting anything back."
(interview 7 paragraph 17)

Busyness in this study differed from the "tyranny of busyness" stated by Manias and Street (2000). In their work, nurses were compelled to keep busy around the patients. In the community setting, busyness is perceived as being "out there". Busyness is not easily seen by others. The work of each team and each nurse is carried out independently and it is difficult to compare across workloads. Additionally, patients may have little insight into what happens outside their own home and ideas about busyness may be difficult to consider.

X -Well –everywhere really and we've sort of ended up helping more because errm – they seem to think that we've got more staff here than anywhere – but (laughs) – it has been hard this last few months.
(interview 6 paragraph 20)

Y - Errm – we've helped other areas recently because we were better staffed than they – up until Q leaving.
(interview 5 paragraph 19)

The following excerpt from an interview transcript demonstrates very powerfully how difficult it can be to have to cope with staffing problems. This participant (from team A) was new to community work.

D- And you've had to have help from other teams and I just wondered how that works from your point of view...?

N- Errm – in particular last week we were very short staffed – there was just myself so I liaised with x clinic – they were absolutely fantastic – Sister there and the team members – errm things like sorting the work – I've never done that before because of the staffing problems we've been experiencing. I haven't been able to do that, but as you can see I've been trying to – get to grips with it. They've been really really supportive. –errm.
(interview 3 paragraph 26)

D- It must have been quite daunting? Being left on your own?

X – Yes.

Some of the pressure resulting in not having a handover resulted from times when staffing levels were low due to illness.

The Audit Commission Report (1999) identified the time lost through sickness absence to be between 5 – 7% of nurses' contracted hours within the PCTs studied.

This is clearly a concern. There could be many reasons why the rate of sickness absence may be high. The result of this situation, however, can only add strain to an already busy service. Additionally, because of the closeness of the team members, being sick can create feelings of guilt.

M -I feel a bit guilty actually for being off ill – I'm still off ill really can only do 3 days a week, but I do feel guilty – because I know this team won't get the help that they need because the other teams – they don't want to do it. You know – they get fed up- and – I know it sounds very unprofessional – and they think – Oh you know – why should we – we don't get help off them – but we haven't been able to give them help because we're only a small team
(interview 2 paragraph 34)

This participant was clearly concerned about her colleagues and the help needed because of her reduced hours.

Z - Yes and also you start to feel that when you're asking for help maybe the help is there but because they're so fed up of you asking and they're having to cancel things that they need to do – that they've come to the end – people don't want to help – any more – so it's it can get quite nasty really – it can get quite, you know..
(interview 4 paragraph 27)

The phrase "it can get quite nasty" contrasts with the impression I got which was that helping across teams was the norm. I did not witness any incidents or hear anything in the observation visits that could be interpreted as nasty. This may have been partly to do with my presence in the room or I may just have not been there on these occasions.

Z - You don't want to – you get to the point where you don't really want to ask any more because you think they'll think "oh no not them again asking for help", but at the moment there's problems with other clinics and we're actually helping other clinics – that's a bit of a shock (laughs)
(interview 4 paragraph 29)

D- Yeah?

Z - So – it's swings and roundabouts but it has been particularly bad.

The problems of poor staffing levels have knock on effects for patient care. This clearly causes stress for the nurses in the team.

N - You know – especially in the last couple of weeks, I've noticed more perhaps things because of staffing problems that we've been having. We can't do things as we'd like to immediately – It's had to be delayed or put off onto another day and it's frustrating for us and I don't think that they think – you know ..are they bothered? (the community nurses).
(interview 3 paragraph 76)

The busy times were further strained by the loss of one of the team leaders. This individual relocated to another part of the country.

Y - Laughs – where do I start? Errm it's a very nice team, but errm as you know, there's been a lot of changes recently so it's unsettling with Q the G grade going it's more unsettling for me cos now I'm in charge for a short while.

(interview 5 paragraph 6).

The team was, understandably, unsettled by the team-leader moving on. At this point they did not know who would be replacing her or how long they would be short of staff as a result. The issue of illness was seen to impact on the busyness of the team. The knock-on effects result in conflicts across teams. Although I was not present to witness any of this, it was alluded to by Z in her interview. These issues were noted in field notes during the observation visits and explored further in the interviews.

Patients' Viewpoint

With patients being "given away" to other teams, it seemed reasonable to ask the participants to comment upon how patients tended to feel about the situation. Again the equity of sharing out patient care is an issue.

D- "O.K –what about from the patient's point of view when you're having help from other people?"

M - "We try not to give them patients that we feel – errm, you know, if they're having treatment that is complex. If we feel that the patient – it would unnerve them and make them feel, you know, unhappy – because some people don't want different people all of the time – they know the team and they don't want outsiders"
(interview 2 paragraph 47)

It would seem that the selection of who to pass to the helping team clearly required careful handling. This involves in depth knowledge of the patient. Liaschenko and Fisher (1999) identify the knowledge of the patient, the individual's response to therapeutics, knowledge of how to get things done and knowledge of other providers in their work. It would seem to me that all

four sections of this “patient knowledge” are needed by community nurses when passing over patients to other teams.

D – “does it affect continuity of care do you think when you’ve got teams helping each other out?”

Y - “obviously – yeah- for the team you’re helping out with the patients – you don’t always get the whole story so ..they end up with different nurses all of the time – it’s not nice for the patients”
(interview 5 – paragraph 31)

There is a perception that patients would prefer to see the same team of nurses rather than be passed over to helping teams of staff.

Excerpt from my field –notes 16/03/04

- the team were discussing difficulties from “giving away” the same patients to other teams when busy. There can be a lack of continuity. There is always a humorous side to the worries, however – A says of one patient “lets face it – she’s someone you would give away!” – much laughter!!

Patients and community nurses can form very close relationships over (sometimes) long periods of time. It can be unnerving (for patients and carers) for someone from outside the team to visit. There would also be a fair amount of information to hand over – for example about the access to the property. The above considerations were clearly of importance to the participants of this study.

Summary of Key Issues

The handover report promotes a feeling of control over day to day events. The ritual of handover may help to maintain the social order (Holland 1993, Philpin 2002). Comparing the effects of how people feel and what happens when handovers don't take place was a useful way of checking the perceived functions of handovers. Feelings of not knowing what is going on, frustration, lack of support and failure were found to be the result of not reporting back within this study. These issues are very important components of the culture of community nursing.

It would seem that not having report could lead to increased feelings of anxiety about what is going on. However, despite their best efforts there are times when handovers are omitted or of poor quality.

When staffing is not good or the team is particularly busy, then handover may be reduced to a general question such as "How are things?" or "How are you getting on"? This created its own tensions as participants within this study then feel that they are less sure of themselves when they visit patients.

The quality of the report is also an issue. Interruptions by telephones or visitors to the centres can lead to breaks in concentration or important information being skipped over. Linking back to Liaschenko's categories of nursing work (Liaschenko1998, Liaschenko and Fisher 1999), the shifting of work across teams and the giving and receiving of help in busy times could be

classed as knowledge of how to get things done. This organisation takes up considerable time but may not be perceived as real work by the nurses themselves. This links to the third stated theme of this work (Chapter One), around the articulation of expertise. If the knowledge of how to get things done is not recognised and valued by nurses then this aspect of their work will remain invisible to others.

Tracking patients' treatments and their progress is a feature of the reports. Both teams expressed concern about the perceived busyness of their colleagues in other teams. This chapter looks comparatively at what happens when either there is no report or the report is rushed.

The next section of this Chapter aimed to explore helping across teams. There was a perception amongst the participants that sometimes the team being helped out was actually less busy than their own. Some teams were felt to be less helpful than others. Without naming any of these – there appeared to be a consensus that there would come a time when they would ask for help and (maybe) not receive any. Illness was also raised as an issue. It seemed that when sick, nurses felt very guilty about the effect that their illness would have upon their colleagues. These are related to issues of inequity across teams. The invisibility of community nursing work makes comparisons of busyness difficult.

An important feature to be explored in the next chapter is that of morale. It is when the teams are really busy that they need support from each other and that is precisely when the handover report is likely to be omitted.

Chapter Eight

Findings 3 – Being in the Team

"The whole is more than the sum of its parts"[3]

Aristotle

This Chapter explores the felt needs of the participants in terms of support from team members and confidence building. Naidoo and Wills (1994) describe felt needs as what people really want. They may be classed as perceived needs (Armstrong 1982). Bradshaw (1994) refers to want, desire or subjective views in his description of "felt" need. In this Chapter, participants convey their feelings of job satisfaction and the importance of this for themselves.

Handover reports are seen here to be useful in dealing with the sense of isolation felt by community nurses. This issue was considered to be of paramount importance by the community nurses within this study. The use of humour proved to be a positive element of social interaction during handover reports and would seem to be helpful in dispelling feelings of isolation.

Cultural knowledge, behaviour and artefacts relating to felt need are offered here. The process of handover report was seen as a useful way of increasing social cohesion within the teams. Handovers were found to involve symbolic actions referring to the goals and values of this social group.

[3] Collins Dictionary of Quotations (2003)

Job Satisfaction in Community Nursing

Job satisfaction has been described (Pilkington and Wood 1986, Blegen and Mueller 1987) as representing the degree of positive affective orientation towards the job undertaken by the individual. In Blegen and Mueller's study of nurses a content analysis of a random sample of 130 nurses was taken from the results of a national survey. It was found that pressures were affecting the job satisfaction of those studied. These pressures were found to be related to the undertaking of new roles, worries about job security, lack of resources, a perceived lowering of standards of patient care and coping with increased paperwork. As the national survey looked at ward management, all of those involved were working in a hospital setting. I believe that many of these pressures translate into the community setting and tried to explore them with the members of the two teams.

Relating back to the considerations of motivation and need, this part of the Chapter on felt need would seem to me to equate to notions of intrinsic theories of motivation (Handy 1993).

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I began each of the interviews by asking participants about being a team member and received many positive replies.

L - It's very good – my role has particularly really blossomed since I've been in this team purely because they haven't got a G grade there all of the time which gave me more of a chance.
(interview 1 paragraph 5)

Role expansion and development is seen as an opportunity by this participant. In the absence of the team leader, she is able to grow.

Sometimes the answer was simple and straightforward:

X -It is – I like it here I'm settled.
(interview 6 paragraph 13)

The excerpt below illustrates one community nurse's frustrating experiences as a mature student. She expresses her current job satisfaction well, giving three facets of her job that evidently contribute to her feelings.

M - It is – I've had some terrible experiences – absolutely dreadful, but here, you know, I feel trusted, I feel respected and I feel that I'm treated as a professional and they are the three things that I really wanted out of nursing – because I came into nursing late – I was a mature student and errm I was 53 when I started and I'm sixty next year
(interview 2 paragraph 16)

D- You don't look it mate!! (laughs)

M -So – and it's my own colour hair (laughing)

D- I know

M - Much to X'S annoyance (laughing) –you know – we've got a great sense of humour

I have kept this humorous banter here (as opposed to moving into the section headed "humour" later in this Chapter) as I think that it demonstrates the tone of the interview effectively. She identifies trust, respect and being viewed as "professional" to be key attributes within this team of community nurses. These are felt needs for this participant. They are what she wants (Naidoo and Wills 1994).

Job satisfaction was expressed in global terms or by smaller examples of aspects of the work of community nurses in their daily practices.

L - For me – errm I do love helping people and I get so much job satisfaction from seeing wounds heal – I love it – sad- (laughs)
(interview 1 paragraph 71)

D- No it's not

L - I do – I really enjoy it – I dunno I think most of us have got a need to be needed in us – It's part of the job.

The above quote was the result of me asking (in the first interview) what "district nursing was about". Unfortunately, it was not explicit in the semi structured interview schedule and subsequently got lost from later encounters. This is a pity as I think that it may have produced interesting data. The need to be needed is probably important to many nurses. This participant made fun of herself – she felt that her satisfaction in seeing wound heal made her a "sad" case.

M - And that's not just sitting and listening to people and there's more about palliative care – it's not just cancer patients – it's other patients and I said it's being aware because I mean – like the other day – I went to see a patient and I looked at him and you just look and you know something – and you can't put your finger on it – he's in hospital with this pneumonia and then I went to another one and I thought Oh dear it's one of those days – I mean he was dehydrated, you know and he'd got this bossy daughter – you know cos you haven't just got the patient you've got the family and you are in their house. You're on their territory – you're an invader – so you've got to have tact, diplomacy, patience, but it's a wonderful job. I think it's the best job in the world. It's what I came into nursing for you know –this is what I thought nursing would be like in the hospital and it isn't – it's vile – I hated the hospital.
(interview 2 paragraph 100)

This quotation presents a number of very salient issues. She begins by raising some notions relating to intuition and decision-making. The role of family care

givers is then introduced – in a very honest fashion. We then are given some of the attributes needed by community nurses – tact and diplomacy. Finally, she ends on a real high, clearly expressing her job satisfaction and her preference for community work rather than acute hospital nursing.

The following participant commented upon working with a colleague when working in a different team.

M .-It's –err –it's a very close team – we seem to have gelled well and errm I think it's because – not just because, , but one of the things that I think helps is that I worked with X before
(interview 2 paragraph 8)

D- Right?

M - So I knew where I was coming, but X who's the team leader, her attitude really makes a difference – her management style is excellent.

D- What's good about her management style?

M - Trust- she's built trust in the team.

This participant contrasted her positive experiences of being in this team with previous teamwork in acute settings. It became clear that she preferred working in the community. Again "trust" is identified as an important component of the management style of this team leader.

Although pressures are recognised by the participants within this study, there are many positive aspects relating to being in the team – job satisfaction appears to be linked with team identity.

Isolation

Community nurses spend much of their working day without the support of colleagues. Unless there are clinical issues which necessitate "doubling up", visits are undertaken alone. The Report by the Audit Commission (1999) found that district nurses' clinical work is rarely overseen by peers or managers, as it takes place mainly in patients' homes. This isolates the community nurse in practice.

L- It is- It's very important cos when you're on your own for most of the day you need to speak to somebody at the end of it.
(interview 1 paragraph 33)

The social processes at work during the handover report are an important part of the cohesion of the group. Lally (1999) found in the study of six inter-shift handovers on one ward that the theme of team building was found to be stronger than that of transferring patient information. In the relatively isolated world of community nursing, the development of the team is an important issue. I suggest that handover goes some way to meeting the felt need of alleviating isolation.

N - Yes – definitely – you know. It's like last week, you know, we were having report- I was telling people about my patients, but they didn't know them anyway and I, again, you feel a bit isolated really, but no I think they're really important and also it's not only what I'm telling people – when people tell me about their patients it might jog my memory about something about that particular patient that I saw last visit and – you know – perhaps errm you think "Oh yes – it was like this and I wrote such and such in the notes ..and I do think that they're really important.
(interview 3 paragraph 46)

Even if those present do not know the patients being discussed, there is

reassurance in telling the tale and sharing what has happened during the day.

The relationships between team members were very much valued.

Colleagues were not viewed as merely co- workers.

Y - Errm.. apart from updating each other on what's happening with a particular patient I think you also gain insight into that person's knowledge and their capabilities within the team.
(interview 5 paragraph 37)

An assessment of team members' strengths is also a feature of the handover report. This may be demonstrated by the use of shared vocabulary and the demonstration of knowledge and skills valued by the group. The nurses in this study were not fearful about reporting to their team, unlike those in the study by Manias and Street (2000). This enabled a sense of development rather than criticism between the team members and was seen to be helpful by more junior nurses.

Additionally, there is a need for general chit-chat. Not all of the interactions are about patients or other work related subjects. This social role of handover is reported by other researchers (Strange 1996; Lally 1999 and Kerr 2002). This time together can act as a forum to meet more hidden needs.

Participants felt that being in the team provided very valuable peer support. This supports the findings of Hopkinson (2002), who suggests that handover reports assist with the management of emotional labour in nursing. Lally (1999) found that group cohesion was developed during handover report time. Expressing worries and looking for support helps to build cohesiveness

amongst team members. This helps to meet felt needs.

There is a real sense that being in the team is important to the participants within this study. The nurses could be described as meeting the third level of Maslow's hierarchy of needs (Naidoo and Wills 1994) the need for belonging by membership of their groups. Everyone appeared to feel that the team is a good place to be.

Confidence Building

Developing professional confidence is seen as something which is encouraged by being a member of the team, particularly by staff new to community work. This need to be accepted as a fellow professional nurse is viewed as a felt need here.

When I asked participants about handovers, they clearly valued this facet of their work. One viewed this time as essential and stated that she needed to let the other members of the team know about the care that she was giving. This sharing of her actions was closely related to her developing confidence in community nursing.

D- *O.k. – I'm just going to ..move us on now – I have sat in on quite a lot of handover reports – so I've got an idea of what goes on, but I'd like to know, from your point of view, what happens during the handover report?*

N - *Well – basically for me – I look forward to the handover – it's my way of – the patients I've seen during that day there might be just the slightest thing – I might think – Oh a bit concerned or even – we're running out of dressings – It's my time to say to the rest of the team, who've got more experienced members of the team, any problems, anxieties about the patients that I might*

have or anything relating to that patient and the part that I'd played in the care for that day – It's my way of letting off steam and saying ..errm..

So this time supports a vital function of sharing anxieties and concerns with other more experienced members of the team. Strange (1996) describes the functions of handover as being psychological, social and protective. Having information is a way of making the world more predictable. Also during the handover power, control and responsibility is said to be transferred from one shift to another. This would be the case in an acute setting such as a hospital ward. However, in community nursing, it may be that the staff nurse would be also making the next visit. Therefore, the psychological gain would be more to do with checking out her plans and evaluating her actions with other more experienced nurses. The motivation for this results from her felt need. In contrast to the study by Manias and Street (2000), junior staff were not anxious about participating in the handover. Rather, as above, they were anxious about <u>not</u> having one.

D- It's important?

N -- I think it's really important. I really do – you know- there has been occasions when you don't get a report and I'm like – but I always make sure that throughout the period that I'm in the office, I mention all the patients – (laughs) I get it in – just for..

This is clearly a support mechanism – N will make sure that she shares her care with others in the team, whether there is a formal handover report or not.

D - You feel better if you do ?

N- About, just little things – just a bit of reassurance for myself – and I'll get

my confidence a bit more.
(interview 3 paragraph 17)

N- Yeah – I think it's just a matter of confidence really and getting a bit more experienced – I mean, you know, I think Yeah it's more to do with confidence than experience really. Really the two together – I think there's then perhaps – I don't know whether there's workshops going to be in place or it would be useful just to go and see – definitely.
(interview 3 paragraph 56)

The workshops referred to by this participant relate to the Staff Nurses' Development Programme being introduced at the end of the data collection period.

Z - Yes – you say _why_ *do you think that or what do you think and I do hope that everyone's opinion is valued you know and everybody answers and they say things like you see that patient next time and then it sort of focuses upon patients that I should actually try to get out to see – so really it's more sort of like a learning environment.*
(interview 4 paragraph 45)

D- *It's a new thing, isn't it?(Staff Nurses assessments of new patients)*

W – It's a new thing for me – yes to take out
(interview 7 paragraph 40).

D- How do you feel about it?

W – Well when I first started – cos I started with just reassessing the patients – so that got my confidence up and rewriting care plans – so I got me confidence up.

D- That's good.

W – And actually learning what things to be put down now and then I started off with just simple things like removal of clips – errm – built my confidence up.

D- So you just gradually built it up?

W – Yeah.

This business of developing confidence is well illustrated by this participant.

Support for Community Nurses

It is important to feel welcomed by the team and fitting in, as a new member of the community nursing team this was a priority. Joining a new team is potentially an unsettling time. The felt need here is linked to the need for affiliation (Handy 1993).

N - I'm doing quite well with this team – whether it's because – I'm not quite sure, but errm – It's pleasant – very pleasant – errm I've never had a bad experience with wherever I've worked, but I think with this team in particular – I do feel as if I've just fitted in – there was a gap and I've just slipped in nicely. They made me welcome – the doctors – what bits I've seen of the doctors and the receptionists here – they've made me feel quite – errm – quite welcome really – I don't feel as if it's difficult to ask anything..
(interview 3 paragraph 4)

It was notable that the team members also welcomed transient nurses. For example, during one of the observation visits, there was a new Staff Nurse. She was with the team as part of her induction programme. This is a planned period of time during which the new member of staff gets to know people, procedures and is introduced to the ways of working within the PCT. The Staff Nurse was really made to feel a part of the team (even though everyone knew that she would move to another team once the induction programme was completed). Her opinions were sought and she was very much involved in the social interaction of the group. She was welcomed into the cultural group by its members.

I also observed that student nurses were fairly easily made a temporary team member. As I did not intend to involve student input in this study, my comments are made generally.

X – It's very good actually – it's a relaxed team though. There's new members at the moment – there are going to be changes.
(interview 6 paragraph)

There is a sense that being in the team is a positive experience for those participating in this study.

W - I enjoy working in the team because I feel quite lucky – because we work quite close with each other.
(interview 7 paragraph 3)

D- Yeah?

Z – Errrm It's a very happy environment – er very co-operative – we're very happy – errm sometimes it can be very stressful because of being a part-time sister – actual stress and strain.
(interview 4 paragraph 6)

Z -And I also think it puts a lot of stress on the other team members because, obviously, they need senior cover, but all in all- I think we compliment each other very well and it's very nice ..

D- Everybody says that in your team..

Z -Yeah? I mean, you know – obviously there are problems as in all teams, but on the whole we are quite a happy bunch.

This experienced Sister could see the effects of being part time from a number of perspectives.

Y - So –yeah – it's quite a nice team – I always like working here.
(interview 5 paragraph 11)

D- Quite an interesting time, perhaps?

Y -Yeah – because we're a small team as well – I think that's nicer.
D- O.K. We're just about to start – So, can I ask you what is it like working in this particular team?
M - Brilliant

D- That's good

M - It's really, really brilliant – in fact it's its the best experience I've had

(interview 2 paragraph 3)

D- Right

This participant went on to share her worst experiences, also. These were related to being a mature student nurse in Hospital settings. She clearly enjoyed a community role and felt it to be a setting where she could give more holistic care.

Social Support and Stress

Kerr (2002) reported that social support was a key component of the handover time and felt that this was important in dealing with the stress experienced by staff. I would suggest that this stress relief is a felt need by this group.

One participant in this study of the culture of community nurses, and who had been recently promoted, felt a distinct lack of support in her new role:

V -"Well I feel very privileged to have been placed in the team that I'm in because of how supportive they've been – being new to post and I'm tending to get that support rather than from the team than from management – but err I feel that I haven't had the kind of mentorship and induction and support that I should've had from peers or from management"
(interview 8 paragraph 2)

Again, I noted that she felt that it was good to be a member of this team. The team is providing her with some measure of support (Strange 1996; Lally 1999 and Kerr 2002). However, she does not think that managerial support is there for her.

V -" it is because you feel unsupported then and the frustrations increase because it only seems that you and the colleagues in the team that you're in understand how busy you are and how much you've actually got"
(interview 8 paragraph 47)

There is a tension here. It seems that there is a lack of appreciation relating to how busy the team is.

In 2005, a survey by the Healthcare Commission found that 36% of staff reported that they were suffering from work related stress. Change and uncertainty are asserted to be stressors. The NHS is constantly changing. As these findings are being written, primary care looks to be next on the agenda for major reform.

D- *"So it's your peers and colleagues in the team that keep you going"?*

V - Yeah – with the frustrations of not being able to have report, you errm start to feel like you have to blame each other for things that – messages that aren't picked up and care that's not being done – so – we leave messages in patient's notes for someone to follow up – you get frustrated".
(interview 8 paragraph 50)

I found this comment to be a really honest one. This participant readily acknowledges the support that she has been getting from her team. However, in times when the team is really busy, they make mistakes and blame each other. This seems to be a very sad state of affairs. Potentially, there could be real damage to the groups' cohesion if a blame culture continues to develop.

The above participant could, however, identify some success in her new role. The team members, rather than managers also acknowledge this.

V -"Yeah ,but the team themselves have acknowledged how little I've been able to accomplish because we've been so under pressure – but have made me feel that I've improved their working environment – so in that respect I feel I've achieved - I've been successful in some part – even though we haven't been able to turn things around as I wanted to"
(interview 8 paragraph 4)

The changes in the team's working environment provide some positive feedback for the intentions of the leader. This could be a valuable source of job satisfaction.

Stress can be anticipated by staff when staffing levels are particularly poor.

For example:

N– *Monday morning I was driving to work and I was thinking "Oh my goodness – how am I going to cope?"*
(Interview 3, paragraph 29)

The above is from an interview with a staff nurse and her initiation into community nursing. This focussed upon a "baptism of fire". This newly qualified staff nurse finds herself unsupported by colleagues due to sickness. She has only been in post for about three months (the first three weeks of this time was spent at a different clinic on an induction programme). She is new in post and really loved her community experiences as a pre-registration student. Although settling in well to the team – she is still finding her feet.

She tells me:

N – "if I'm at a patient's house I'm always on the phone to X (one of her team members) – X will tell you – three times you know in a morning sometimes"

I think that this illustrates how much she feels that the support of her colleagues is needed and valued. Being in the team is valued by this

participant. The use of the mobile telephone is a fairly recent introduction to community nursing. It seems evident that its availability provides a useful back up for staff that are learning about community working. This supports the notion of "learning the ropes" (Lally 1999), where new members to the team gain competent membership of the culture by learning the way things get done.

In response to my question about helping across teams, she replies that the previous week the team was very short of staff – in fact she was the only member of the team at work.

N - *The pressures were immense for me really and I was having, giving my patients away and getting – them feeding back, reporting back things to me, but some patients I didn't know them at all and I felt that was quite scary –I was writing all these notes down and well as liaising with the team-leader at x clinic – I was thinking "these patients-I don't know them at all", but what if something goes wrong – you know and I was quite stressed. I'll be quite honest with you – I was very stressed last week. It's just – a big sigh of relief…*
(interview 3 paragraph 31)

D - A bit of a baptism of fire by the sounds of it?

N - Yeah, but I think the occasional clinic and the occasional person would think I should, you know, know these patients and they were asking me things about them – can you get such and .. as they need this or they need that and I felt ..sometimes a bit honing in on me..

D - Cos there was only you?

N - Yeah – cos there was only me in this clinic and that's that's how I felt to be honest last week…I felt "do these people know I've only just started?"(laughs) and I think, you know, that people were aware – at the same time people have got their own jobs and responsibilities to do – they're giving me information about our patient at the same time I'm thinking "what should I do now then?" ..apart from that..

Other community nurses may not have known which of the patients were known by this nurse. She expresses very clearly her feelings of frustration about the amount of information, both requested and received, from colleagues based in other teams.

Although laughing at her situation, it was clearly a traumatic time for her – being a new member of staff and still finding her way around. She was looking at this period of time from a number of perspectives – she was very aware of other nurses' priorities and did not expect to be the focus of their working day. The telling of the story also benefited her. This is a situation in which it could be supposed that Clinical Supervision would be a useful tool to help her to reflect and develop learning from.

Being by herself was the result of sickness – it would never have been the planned rota for the week.

D - It must have been quite daunting? Being left on your own?

N - Oh it was terrible (laughs) – Monday morning I was driving to work and I was thinking – Oh my goodness – how am I going to cope? I didn't know how I was going to cope – by Wednesday Thursday Sister x said "you look a lot better today than what you did at the beginning of the week" – they realised that – you know- being a newly qualified as well.

This would imply that it was known outside of the team that she was under extreme pressure. The comment made half way through the week by a colleague could indicate that she is settling into her situation and perhaps just having survived the beginning of her ordeal has already had an effect upon her professional confidence. Additionally, once the week of working alone was

completed, she worked her very first weekend in the community setting as a Staff Nurse

D - But you survived it?

N - I survived it and I came back today after two days off (laughs) – of course it was my first weekend last weekend as well – so that was the wrong weekend to work, really – after the week I'd had.

There was a real sense of achievement in this telling of her story. She believed that she had passed the test. In relating her tale to me, she was careful to put a balanced view of the whole situation.

D - Weekends can be very stressful, can't they?

N - Yes – so I must admit it was quite nice – we had a nice sister on the weekend as well – so – that was good.

This positive attitude was demonstrated when I asked her about joining the team in the community. The perceived attribute of the sister in charge (being nice) was welcomed by the staff nurse.

D- First of all, N , could you tell me what it is like being a member of this team?

N- I'm doing quite well with this team – whether it's because – I'm not quite sure, It's pleasant – very pleasant – errm I've never had a bad experience with wherever I've worked, but I think with this team in particular – I do feel as if I've just fitted in – there was a gap and I've just slipped in nicely. They made me welcome – the doctors – what bits I've seen of the doctors and the receptionists here – they've made me feel quite – quite welcome really – I don't feel as if it's difficult to ask anything..

D - Yes?

N- If I'm not sure about anything - I've always been up front and asked people.

D - That's good

N - Errm – knowing my own limitations really.

This links into her professional obligations as stated in the NMC Code of Professional Conduct (2004). Her perception of slipping into a gap in the team helps her to feel a valued part of this group.

The use of Humour

The participants within this study made many references to humour and valued "having a laugh". This is offered here as a felt need and is viewed as a positive attribute of the cultural group.

D-" Yeah – and then you lose that contact and don't have time for a laugh, don't you? And you need it more when you're so busy?"

I think that this is a very salient point. It is when the pressure is on that the social contact is reduced or removed by having a limited report or none at all.

W - I enjoy working in the team because I feel quite lucky – because we work quite close with each other.
(interview 7 paragraph 3)

D- Yeah?

W- Although we get a lot of work in we all have a laugh together and that – we make sure that the work's equal whoever's taking it out that they're capable of doing it .

M- You know – I mean we can laugh and joke but we don't get carried away do you know what I mean?
(interview 2 paragraph 25)

D- You still respect each other?

M - Yes – very much

There was concern that I may think that professionalism could be lost by the use of humour. There were riders to the comments made. It was important to tell me that the laughter would not get in the way of behaving "properly". This gives an indication of the groups values (Helman 2007). It is culturally accepted that humour is a good thing. The conduct of the group (and the shared value of "respect"), however, takes precedence.

Z - Our personalities errm seem to get on very well – professionally but we also are I'd say – we're friends as well – not out of work, but you know- in the situation – yeah it's very nice.
(interview 4 paragraph 12)

The relationships between team members were very much valued. There were a number of "in" jokes For example the great age of one team member was an ongoing theme. Sometimes the humour between the teams bordered on cruelty!

Excerpt from my field-notes 16/03/06 14.55hrs:

- Ribbing about one of the team who is late for the handover – "at her age it's probably Alzheimer's – she's probably got lost!"

M - Well – we're usually exhausted (laughs) we sometimes make a cup of coffee and –and have a few minutes just generally chatting
(interview 2 paragraph 56)

The use of humour as a "minifism" was explored by Lawler (1991), who felt

that this was a way for nurses to help each other. Making light of the working day helps everyone to cope, but may be seen to reduce the emphasis of issues. It was rare for nurses to be late for the handover. By using humour this minimises the transgression of not being on time. Punctuality was a feature of the nurses in this study. This seems to reflect Philpin's (2004, p252) finding of "symbolism of punctuality and commitment to their work" in her ethnographic study of nurses in an intensive therapy unit.

D- I've been sitting in, as you know. For quite a number of your handover reports, but I'd like you to tell me from your point of view- what happens during the handover reports?
(interview 1 paragraph 30)

W - Right – well we have a gossip (laughs) – we let off steam having a laugh sometimes.
(interview 7 paragraph 28)

In fact "having a laugh" was often the first consideration during the interview process.

"Letting off steam" is also a valuable facet of this time. Frustrations may be building up during a busy time. Conflicts may be causing individuals to feel stressed – it would not be a good move to take these pressures out onto the roads whilst driving between visits or, even worse, into patients' homes. The existence of frustration and stress is seen as a part of the culture of the group. It is acceptable to feel these emotions and, also, to share them with each other. Additionally, it was acceptable to share them with me. This may indicate a trusting relationship with me as a "marginal native" (Gerrish 1997).

Good- natured banter about patients was also noted during the handover

report.

Excerpt from my field- notes 7/04/06 14.45hrs:

- Y says "I've pre-warned her that I'm going to do a Doppler on her – see what kind of mood she's in and I'm going to try and see her bottom as well – pushing my luck aren't I?

Judging by the shared laughter generated by the above remarks, the team felt that she probably was pushing it somewhat. This could also be an example of "patient knowledge" (Liaschenko and Fisher 1999).

D – Well OK- as you know, I've been hanging around whilst you've been having your handover reports – and taking a few notes, but what I want to know from your point of view is – what sort of things go on during the report ?

W – Well we have a laugh about things.

W- We have a moan about patients sometimes and we'll all have a laugh and a joke – if somebody who we've been going into year after year we'll say "them the same" – no change in em really – we do have a laugh during it..
(interview 7 paragraph 31)

I felt that it was a good sign of being accepted by the participants in the study that they could talk to me about "having a moan" about patients. This was probably not something that would have been shared with me early on in the data collection period and maybe resulted from a building of rapport and trust (Coffey 1999).

On one of the participant observation visits, I arrived a few minutes late. After knocking the door, I entered and said:

D – I bet you thought I wasn't coming today?"

The team leader responded with:

Q – "We were *<u>hoping</u>* *!"*

This comment resulted in general laughter. I noted in my field work afterwards that I really felt a part of the team and that including me in the banter had been a very positive sign of being, to some degree, accepted by this team. Some of the patients provided humorous material for the community nurses:

Excerpt from my field- notes11/03/04:

- This is said in a very amusing way and the rest of the team become animated and laugh. Then W says "Mrs X - she used to hide twenty pound notes between the layers of her bandages – she hid it from her daughter" – we all laughed and then thought about the consequences of this – where has the money received from banks and shops been before???! We all groaned!

In addition to the general use of humour, each of the teams had a "joker", who I identified as the member most likely to lighten the atmosphere. The following are examples from my field-notes 16/03/04 14.55hrs.

- This team is still one member short – there should be a new member starting soon. We discussed the problems experienced when "giving patients away" to other teams. One member of the team (M) injects humour into the conversation very effectively. For example:
- *M says - " let's face it –* *<u>she's</u>* *someone that you would give away" – (all laugh).*

Later on when M gives her report:

M– "So! – she, the patient says "I've been having that Z all week, but I'm glad

that you're back!!!"

This is said with obvious respect for Z – the team leader. The notion of competitiveness is apparent – the patient prefers M. Everyone in the team appreciated the humour used here.

One team within this study (A) were particularly notable in their optimism. Although they suffered ongoing shortness of staff and had, unfortunately, a member of staff on sick leave, I noted the following:

From my field-notes 16/03/04:

- Z "hopefully things will get better now" I note that it's always jam tomorrow in spite of the relentless understaffing. M lightens the atmosphere by theatrically waving her clip board in the air and announcing". I've discharged someone today – hurrah!!!"
  This report concludes with Z saying "right, lovely, everyone's happy".

During a participant observation visit with the other team (B), I noted the following in my field – notes 3/02/04: 14.50hrs:

- X is reading a nursing journal, Y is out of sight and W is putting care plans in order - I feel a bit "in the way" today – no one seems very chatty.

Cont.

- 14.55hrs X comes in from the waiting room carrying a singing stuffed monkey, which is massive! Everyone laughs and seems to relax a little – Y opens up about the new manager, whom she has not met- she comments that there are too many new members of staff.

By bringing in the toy from the waiting room, X lightened the mood of the team, who seemed to be involved in separate activities and not interacting with each other verbally on this day.

Summary of Key Issues

In this Chapter the experiences of the participants in terms of being in the team are presented. I suggest that this represents the felt needs of community nurses relating to the handover time. Job satisfaction demonstrates the participants' motivations for being community nurses. They feel a sense of being needed and of doing a good job. This is clearly very important within this cultural group. This has a positive effect upon the sense of support felt by the group.

Linking back to the second of the key themes (Chapter One) of the functions of handover, it can be seen that for community nurses there is a clear supporting role. Being in the team is a shared value of the participants of this study and assists with job satisfaction.

The isolation experienced by community nurses is, to some degree, offset by

the meetings to handover report to their colleagues.

Confidence building was an issue that featured highly within this study of community nurses. There was a strong feeling that the interactions with team members in the Clinic settings served as a vehicle to develop professional confidence.

The sense of peer support is viewed as being a very positive one. The daily work of the community nurses is complex and demanding. Feeling part of a team is a big help to individuals.

One participant, who had been recently promoted, cited a feeling of not being supported by managers. This participant was unique in sharing that she sought improvements to the team's position by asking for help from senior colleagues. She did, however, acknowledge the positive regard of the team members and valued this highly. A sad reflection from one of the interview transcripts revealed that when under extreme pressure, the team may make mistakes and then blame each other. This could lead to damage to the group's cohesion and, ultimately, destroy the supporting network.

Finally, in this Chapter, the use of humour by the team members was examined. Humour was very much valued by the participants within this study. It was viewed as a way of "letting off steam" and bonding. There were often on- going jokes within the teams. An example of this was that many references were made, within one team, about the great age of one nurse.

This was very affectionately employed and well received by that individual.

Each of the teams was found to have a “joker” in the pack. These could be relied upon to lighten the atmosphere. The felt needs of the participants in this study support the protective and group cohesion functions identified by Strange (1996). This Chapter provides some observations about the culture of community nursing and the shared values of the group. The opportunities for bonding and the development of trust are seen here as key components of the handover ritual. The handover may protect both physically and psychologically as information is exchanged with peers in a safe place.

Chapter Nine

Findings 4 – Suppressed Need: the Case for Assertiveness

This fourth and final chapter presenting the findings of the study initially set out to examine the expressed needs of the participants. The nurses in this study expressed some strong views during the reporting time that moved the focus of the study away from handovers per se. This would seem to support my premise that handovers would provide a vehicle for exploration of the culture of community nursing.

Expression or Suppression?

However, further consideration of the data and critical expert feedback led me to revise this section of the findings significantly from my earlier analysis. Consequently, from Bradshaw's "expressed" need (1972) there is now a major shift in this representation of the findings of the study.

Billings (2002) suggests that "expressed" need (in Bradshaw's taxonomy) to be felt needs that have progressed to a demand (p115). This understanding is shared by other authors (Naidoo and Wills 1994, Endacott 1997, Chilton 2004).

It appeared that, in fact, the issue here was that the community nurses in this study were not demanding action for some of the strongly held areas of contention held within the group. In fact they were feeling very aggrieved and unhappy, but not taking action to address these strongly expressed needs. In response to this, after much consideration, I have adapted Bradshaw's work to replace the "expressed" needs with "suppressed" needs.

This, I feel enables the voice of the participants to be more readily heard and understood. This has been a difficult choice for me as a nurse, a district nurse and as someone still very involved with the community nursing world. Reflexivity (Coffey 1999, p136) and representation are about the "reconstruction and reproduction of lives and experiences through critical engagement with our data". I would certainly agree with Coffey, having gone through this process that this is an emotional process.

When the ENB and QNI paper "The Invisible Workforce" (2002), was published, it outlined a service in jeopardy. The paper called for a clear role for district nurses, more effective leadership and pointed out a lack of identity within the profession. A somewhat pessimistic picture of district nurses emerged from this paper.

I remember feeling rather angry with the QNI/ ENB study of 2002 of district nurses, which coined the phrase "the Invisible Workforce" – I recall thinking that it could be undermining in its depiction of a group with whom I hold a strong affiliation. This, however, does not let me evade what I have found to be a feature of my study into the culture of community nursing. The above decision was not reached lightly and I am aware of the potential consequences of the use of the term "suppressed".

As a nurse researcher with a vested interest in community nursing, I accept that I hoped to find a stronger sense of identity and purpose within the group participating in this project. Although the group were comfortable in their own

group identity, this was not articulated outside the group. The sense of team support that assisted with the meeting of felt needs contained the strong feelings but did not translate into group action.

Within this Chapter, the perceived views of how other professionals see the district nursing service will be presented. This section of the findings was of particular interest to me and I found the participants' input here to be both thought provoking and worrying. Further cultural knowledge and behaviour observed through the participant observations and interview data relating to need are presented here. An exploration of the characteristics of oppressed groups is also considered.

This chapter also contains exploration of some indications of inter professional tensions. The use of disparaging terminology is then presented under the heading "the pop in service".

Finally, the morale of the participants of this study will then be explored in this fifth Chapter presenting the findings of this study.

Suppressed Need

In order to be clear about my understanding of this term, I offer some definitions and my thoughts around the meaning here of "suppressed need".

The Collins English Dictionary (2006) defines “suppress” in the following ways:

1. to put an end to something by physical or legal force.
2. to prevent the circulation or publication of (information or books).
3. to hold (an emotion or response) in check, restrain (he could barely suppress a yawn).
4. electronics – to reduce or eliminate (interference) in a circuit.

The Chambers Giant Dictionary (2007) states:

1. to hold back or restrain.
2. to put a stop to something.
3. to crush (a rebellion).
4. to prevent (information, news) from being broadcast, from circulating or from otherwise being known.

From the Latin “*supprimere*” – to restrain.

The third of Collins' definitions above would seem to describe the situation that I hope to present here. In holding back responses, instead of translating feelings into action, there is suppression of some of the needs of the community nurses. The Chambers definition (number one) would support this understanding of the term. Additionally there are, perhaps, some elements of preventing information from circulation, although there is, perhaps, not a conscious decision to withhold information.

Suppressed need here, therefore, describes the holding back or restraint of feelings and responses. These feelings and responses are not acted upon

and remain within the community nursing teams. This may have an effect upon the morale of the participants within this study.

The use of the term "suppression" in Freudian psychology also denotes a conscious restriction of feelings, wishes and thoughts (Malim and Birch 1998). Suppression here is a voluntary activity rather than "repression" which is an unconscious defence strategy. Defence mechanisms are the result of painful anxiety or guilt and, although helpful in the short term, may be dangerous in the long term (Malim and Birch 1998, p730).

In his own critique of his earlier work, Bradshaw (1994, p50) identified that need "is not an absolute state, not just an untreated condition..., but also an absence of well-being or quality of life". This suppressed need identified within this study, I link here to a deficit in "well-being". Later (p54) he continues by asserting that (it may be that) "the undermining of confidence, diminishing self-esteem and an increasing sense of worthlessness are sharper when inequalities are pronounced". These issues of confidence and self-esteem have relevance in this Chapter of the findings of this study.

Nursing has been largely invisible and devalued as an occupation (Lawler 1991).I suggest that this could be compounded by suppressing (holding back) feelings and needs.

Views of other Professionals

During the participant observation visits I noted that there were many

comments made relating to other professional groups. These seemed to signal issues of conflict. Social conflict is identified (Spradley 1980 p152) in a tentative list of universal themes. "Looking for conflicts among people is a useful strategy in studying any society".

The perceptions of the participants in relation to the perceived conflicts were, therefore, sought during the interviews.

In response to my question within the interview schedule:

D.- "how do you think that other professionals (such as G.Ps, practice nurses, social workers) view the district nursing service?"

Only <u>one</u> of those interviewed expressed a positive viewpoint:

Z - "I think that we're very lucky here with the GPs I do think that they appreciate the role that we've got and 9 times out of 10 we don't get inappropriate referrals".
(interview 4 paragraph 57)

D- That's good

Z -" I do know that there are some GPs that ask for errm for instance, a B.P. check or, you know, something that is inappropriate or patient could have gone somewhere else and you still get the old can you pop in and I don't think some agencies appreciate the time constraints – err the workload and the documentation that we have to do as for a new patient, I think".

D-Mmm

Z -"They don't understand why you've got to have an hour and a half to go and do an assessment. Well why can't you just go and put a dressing on and it'll take you 10 minutes – I do know that that does go on in some teams, but luckily we do feel valued here – practice nurses are excellent here as well – they liaise with us we're never told "you've got to go tomorrow – it's always, obviously contact the patient, but within your sort of work pattern – they're very good – very good."

D- "That's good".

Z -" and the hospitals have improved as well – so basically we don't have

inappropriate and I think we are quite valued".

D- "That's really good to know".

Z -"The doctors are very good at sort of popping up and you know explaining problems and stuff like that – so".

The above participant was notable in her unflagging attempts to maintain morale within the team. She felt that there was considerable support from G.Ps, Practice Nurses and Hospital staff. She used a phrase twice in her answers that is explored later in this chapter – the "pop in". Interestingly, the rest of this team (A) didn't share the positive views of the team leader:

D- O.K. errm the other thing I want to ask you about is how do you think other professionals like G.P.s or the practice nurses view the district nursing teams? What do they think you're here to do?

L - Whatever they want (laughs) errm sometimes you think that they think you're sitting by the phone waiting for a phone call all day and when we're in the office we spend time on what each other does, basically there are lots of parts of each other's jobs that we don't see – that we don't know of.
(interview 1 paragraph 58)

This participant could see that there were probably many aspects of other professionals' roles that are not apparent to "outsiders". The use of the phrase "They" could be viewed in a similar way as in the work by Lally (1999), who reported that the nurses within the study often referred to doctors as "they", which had an effect of increasing solidarity within the nursing group and a stronger felling of being "us".

D- Errm – how do you think G.P.s, social workers and practice nurses view district nurses – in your experience so far??

N - So far – I think that whatever field you work in – errm in the health

profession you're in, I think – errm I think G.Ps – I think from my experience they want us to go out and see somebody there and then – I don't think they realise that we've got other caseloads – other patients – and errm and again the the practice nurses we sometimes have patients that nine tenths – are quite capable of going to the practice nurse for a dressing but were getting them for referrals – errm
(interview 3 paragraph 63)

This was seen as a real problem – patients who were capable of getting out and about (and therefore, able to attend the surgery for treatments) being referred to the district nursing service. There did not seem to be an active response to dealing with this issue. Confronting the problem in an assertive way was not considered an option.

Suppression or Oppression?

Oppression has been the subject of a wealth of exploration from nursing writers (Roberts 2000, Valentine 1995, Daiski 2004, Mooney 2007, Woelfle and Mc Caffrey 2007). Sadly, there is a wealth of literature over the last twenty years supporting the notion of "horizontal violence" in nursing. Woelfe and Mc Caffrey (2007) undertook a review of literature to determine its presence and the possible effects upon patient care. They found that it was all too apparent and could impact upon the care that patients receive.

Groups feeling frustrated by powerlessness have been reported as resorting to "horizontal violence". This has been described as "aggressive and destructive behaviour of nurses against each other" (Woelfle and Mc Caffrey 2007,p123) and may include the demeaning of others. Roberts (2000) states,

in her exploration of liberation from oppression for nurses, that poor self-esteem and group identity are key factors in keeping oppressed groups from becoming empowered.

The participants in this study were notably supportive of those within the group. Rather there is a culture of "us" and "them". Within the group there is a culture of support, respect and belonging. Outside of the community nursing group things are not perceived to be so encouraging.

Daiski (2004) reports that the problems perceived around inequity between nurses and physicians were accepted as normal within her study.

This is part of the issue here. The suppression of the feelings and needs resulting from this compounds the problem further. Being in the team is what gets community nurses through and is highly valued within this group. The views of others are seen as the problem.

N - Social workers – I thnk errm it's, you know, with the errm community assessments that the nursing assessment – I think again – I don't think that they appreciate how heavy our workload is currently – errm when we say we can't do an assessment until.. the impression I get they might be a bit off with you cos, I don't think they appreciate really what we do – at all –errm I think they just see us all as dressings – and waiting by the phone, you know, for calls.
(interview 3 paragraph 66)

D- Just for them to ring?

N - You know it's almost as though we're on call 24/7 – although we are – it's you've still got your work allocation for that particular day - and they expect –I don't know – I think the just expect you to be at their beck and call a lot of the time.

D- Yeah?

N - That's the perception I've got at the moment.

D- They don't realise how busy you are?

N - No – I don't think that comes into it at all – so…that's the experience – I haven't really had a lot of experience with how to deal hands on – it's just what you pick up.

The above illustrates the perceptions of a newly qualified staff nurse and her feelings of not having expertise recognised by others. There is a feeling that community nurses are waiting for work, rather than juggling a busy caseload each day.

D-.We're doing very well actually we haven't got a lot more to look at. Errm How do you think other professionals view district nurses?

M - Oooh well- a bit like charity cases really – we're not really nurses cos – what do we do ? we just give injections you see – you see, my daughter is a senior sister on ITU (laughs).
(interview 2 paragraph 91)

This is an interesting insight into some tension between hospital and community staff. Within the teams there was a strong feeling of being marginalised at times by other professional groups. Along with the findings of other studies (Daiski 2004) this feeling was not translated into action. It was, however, verbalised between the community nursing group.

In her study of the occupational socialisation of nurses, Philpin (1999) found that nurses in more chronic areas fared better than their counterparts in acute settings. Philpin's study found that in the less acute settings there was encouragement to speak out for the patients and that there was more

emphasis on interpersonal skills. In agreement with this, I found that there was encouragement and support for staff nurses within this study.

Interestingly, in her study of Irish nurses, Mooney (2007) found that the staff nurses in her study (with one exception) feared the handover as it was a time when they could be publicly told off. This was not the case in my study. Mooney felt that nurses who were willing to be assertive may come from clinical areas where questioning was encouraged. Although the staff nurses within my study were supported within the teams, it is questionable whether they would "rock the boat" (Goodman 2001) when their more experienced team members do not.

Excerpt from my field-notes 16/12/03:

- L says "Mrs C has deteriorated a lot hasn't she? There was a case conference last week, but we weren't invited".

It is noteworthy that (again) the team complained about this amongst themselves, but did not do anything to let their feelings be known or rectify the situation. There is almost an acceptance of being left out. This, I suggest, is an example of suppressed need. The nurses were annoyed about their exclusion to the case conference, but did not deal with it.

M - And I educated her by saying – would you like our view of intensive care nurses? And said Oh yeah and I said our view is you have one patient to look after- right – you don't even have to talk to them cos they're unconscious and you still moan!!! And I showed her my book –you know and I said that's the sort of page I have of calls- you know I can have anything at that time – It was, could be 20 calls a day.
(interview 2 paragraph 94)

Quantifying the number of patients cared for in a shift may not be the best way to assist non community staff to understand the intricacies of community nursing, but this was an issue for this participant.

D- Yeah – I'm sure you're right – it's a common thing, isn't it ?

L - Yeah – like we think Health Visitors do nothing but sit (laughs) – but I'm sure we're wrong.
(interview 1 paragraph 61)

D- A different culture? Are they?

L - Yeah (laughs)

I missed the opportunity here, in the midst of the interview, to explore what the nurse's perception of the differences was. There is a strong sense within the group that no one (from outside) knows what they do.

Inter-professional Tensions

One of the teams (B) had what appeared to be a difficult relationship both with one of the practice nurses and an advanced nurse practitioner (ANP) working within their geographical area.

Excerpt from my field- notes 22/01/04:

- W says "has been showering and then leaving the leg (ulcer) open – it is full of cat hairs" – Y asks "why doesn't he go to the practice nurse? – W replies that she (the practice nurse) referred him in the first place. She goes on to comment "I think it's a lack of knowledge on the practice nurse's part and so the G.P. refers everything to us".

Again no attempt is made to address this issue. There seems to be a rivalry alluded to in the subsequent comment. The knowledge of the practice nurse is questioned in this remark. This could be an example of horizontal violence across professional groups. The demeaning comments could be destructive. These comments are articulated within the group, however, and no attempts made to discuss or improve the relationships were made during the six months of data collection. Additionally, there is an implication that the G.P. knows that the district nurse team is more likely to solve the problems than the practice nurse but issues are again suppressed within the group and not dealt with. By adding the G.P. into this discussion, there may be an attempt to make things right by gaining some kudos here.

The use of humour in the way in which things are said in the next quotation doesn't cover the tension between the community nurses and the ANP.

Field-notes 11/03/04 – 14.50p.m:

- P says "She's the Advanced Nurse Practitioner- don't call her the practice nurse PLEASE – she's very particular!!! Y replies "If she's an Advanced Nurse Practitioner – why is everything passed to us?" This implies friction between the nurses.

Y -Did you mention someone else – or?

D- Practice nurses?

Y - Oh <u>practice</u> nurses.
(interview 5)

This was said in a disparaging tone. I had noted several occasions where the practice nurses and an Advanced Nurse Practitioner were commented upon by members of one of the teams. This community nurse team were clearly unimpressed by the Advanced Nurse Practitioner role as perceived by their dealings with one individual.

At a later observation visit to the same team I noted the following comments:

– *"if she's an ANP, why is everything passed on to us"*

Again noted at a later date:

X – "The Advanced Nurse Practitioner couldn't cope with it and so the G.P. passed her to us".

This comment was said in an ironic voice with a smile. As two of the above comments were made by the same individual, I explored this area of potential tension within the interview. I prompted her by asking her about the Advanced Nurse Practitioner. The following exchange then took place:

Y – "(Laughs) – that's an interesting one"

D- "Yeah – I've picked that up"

Y- "Yeah – we have had a problem with one recently where she hasn't been happy to take out clips – errm when you think of an Advanced Nurse Practitioner – you think – you know"

D- "Who can't take out clips?"

Y-"who can't take out clips and you're wondering – what can she do .She also referred back a young patient with a surgical wound, which was a straightforward surgical wound, but that was more for our speciality to deal with – which was interesting – I just wonder what this nurse – you know –what

her particular forte was"

There is obviously a bit of friction here. It could be an issue of personalities clashing. Alternatively, it may arise from the feelings of frustration felt by district nurses who do not see their professional expertise recognised by other groups. This inter-professional disparagement is not helpful and could be described as passive aggressiveness (Roberts 2000), nothing is really achieved here.

This participant went on to say:

Y- "I suppose in that instance really – well we did try at the time – to perhaps go and speak to the GP and the nurse involved and perhaps discuss, you know, what sort of thing to pass to us. It would have been the ideal thing to do, but obviously since then we had a crisis in the x sector and we had to help out".
(interview 5 paragraph 86)

The opportunity to take the initiative and try to smooth out the situation was lost. It is interesting that this nurse would involve the G.P. as an initial reaction to the situation, rather than approaching the ANP directly. It could be argued that the most assertive approach would be to approach the ANP to discuss boundaries, instead nothing was done and the need is suppressed.

In her study of the use of metaphor, Goodman (2001) explores issues of powerlessness in her work with district nurses. Often DN's would take on inappropriate work rather than "rock the boat". The above could be an example of this in action. It seems to me that there is almost a feeling of "waiting to be rescued" by someone else.

In her study, Daiski (2004) explores dis-empowering discourses and practice. Some of these are recognisable within this study, for example "going along without thinking with interdisciplinary team in decisions about patient care". In the example above community nurses were not invited to the case conference and did not influence the outcomes. However, many of the practices are not apparent. Some of these will be now explored.

There was no indication of bullying within the community teams participating in this research; on the contrary, support was felt to be a major part of the culture. Also, there was no indication of withholding information from newcomers who were welcomed as part of the team quite openly. Competitiveness was not a feature of the relationships within the teams, with the exception of a few humorous comments.

Some of Daiski's suggestions for remedying the dis-empowering practices include: respecting and praising colleagues; building a community of sharing and caring and the sharing of knowledge. These behaviours were part of the culture of community nurses within this study. There was, however, a general lack of assertiveness in dealing with issues and other professionals outside of the group.

Founier (2000) writes about the ways in which professional groups cultivate their relationships and barriers across boundaries by making the rules inaccessible to the "lay person". She talks about a screen of mysteriousness putting actions beyond the scrutiny of those outside. There seems to be an

element of mistrust in the relationships between community nurse and the ANP. The community nurse does not appear to rate the skills of the ANP and speaks in demeaning terms whenever she gets the opportunity to criticise her, asking <u>what</u> exactly is the ANP's expertise. This could be a personal issue between two individuals, but sadly, the practice nurse also gets the same treatment. This would indicate a tribalistic view-point.

In terms of the history of nursing, the development of the ANP role is quite a recent one. At the time of writing, it would seem that the level of Specialist Practice may soon to be reviewed by the Nursing and Midwifery Council. This is the level that most district nursing team-leaders have been operating at for around the last ten years. As Advanced Level working is likely to be retained, this could add to the tension experienced here by the participants within this study.

So there appears to be an identified need to be viewed as "professional", but a scepticism relating to other groups of nurses and their expertise. Within the team, there is a culture of respect and support, but outside it is "us" and "them".

There was also a problem regarding the urgency of referrals – the groups of professionals, in primary care and in hospitals, did not share the same views as to how soon the district nurses should visit new patients.

X- I think they expect us to drop everything and run – they think we're an emergency service – we should be here just at the drop of a hat, really.
(interview 6 paragraph 55)

D- Yeah?

X- An emergency service – they still expect you to do it.

It seems that others are not aware of how busy the community nursing teams are. I found the following response to be very interesting.

V - "I think they think we're a mop up service- for everybody else. Every speciality you know are under pressure, but they expect the district nurses to absorb their pressure- that's as well as absorbing pressure within our own speciality ourselves –other nurses on the acute side but most of the one's we come into contact with in primary care comments that show what other peoples' opinions of district nurses are – they don't understand the role at all – they think that..."
(interview 8 paragraph 41)

D- "can you think of any of the comments?"

V-" errm I had a comment today from a specialist nurse that we were doubling up with to treat a patient and she said "do you go around in twos?" and I said "you're kidding aren't you?" and she said "how many patients do you see in a day?" and I said it depends how complex they are" – even managers, I think, even if they've come from a district nursing background, they see the service before they left it and don't see the changes and like I was trying to explain it at a meeting yesterday – but you don't feel that your views are actually listened to"
(interview 8 paragraph 43)

The above comment would support the findings of the Queens Nursing Institute and English National Board paper (2002) that district nurses frequently used the term "sponges" to describe how they were expected to absorb additional work. The term "mop up" was often used by the community nurses in this study.

More worryingly, this participant did not feel that managers within the service were listening to her concerns. This frustration was not translated into action and, therefore, is suppressed. There seems here to be a focus upon the

number of patients visited, but of course this only gives a small part of the picture in terms of community nurses workloads. The complexity of care and level of dependency of patients are of equal importance in the equation.

D- OK – so on the whole they don't realise how busy you are?

X – Definitely – I don't think they do – no.

D- Might be quite shocked if they did?

X- It's the same with the patients they think you only come to them – they say how busy the hospital is – you only go to their house and that's it – you're sat there.
(interview 6 paragraph 64)

The very nature of district nursing, in that patients are seen one at a time in their own homes, means that they (the patients) do not see the rest of the nurses' workload and may make judgements based on their perceptions of how busy the nurse seems to be.

This takes me back to when I was new to community work. A very experienced district nurse advised me to always appear to be busy – even if it was quiet! We had to agree to disagree on this one.

If community nurses do not take the initiative in spreading the word about their complex skills and expertise, then it is difficult to see how this situation will change.

The GPs sometimes referred patients who were felt by the district nurses to be inappropriate:

*Y -" Errm well the majority of – wound care –so we do get a lot of leg ulcer referrals and obviously pressure areas so it's more that type of thing – errm * (laughs) – some of our GPs I must admit do give us inappropriate referrals – I think they just think we.re here to take anything".*
(interview 5 paragraph 65)

D- Anything they're not sure about?

Y - Yeah – sometimes I think if they get problem patients they'll just off- load it onto us – just so they don't have the problems at the surgery – perhaps.

There could be a hint of the "unpopular patient" here? However, during analysis of the interview data, I felt that I may have led this nurse, although the two comments above are in keeping with each other. Again "they" is the chosen term to denote doctors (Lally 1999).

On the subject of social workers, it seems to vary depending upon which individual the nurse was working with.

D- Social workers?

Y- Social workers – errm it just depends which social worker you talk to really – we've got some very good ones, but we have got a particular one – errm I don't know if he didn't appreciate our role or he's just moved – one particular social worker who we've been dealing with recently –whether it's because he doesn't understand our role fully or just rude, bur he's been a particular problem – is that OK? (laughs).

It is noteworthy that the participant above seeks to give reasons why the social worker may not be easy to work with.

The "pop in" Service

Several participants in this study used this term. The phrase "pop in" seemed to describe a phenomenon, which was profoundly annoying to the community nurses:

D- What do they think that you do?

W – They think we just "pop in" and have cups of tea I think sometimes – I mean even though they're meant to be more aware of what we do and what we're capable of doing at the moment they think that – "can you just pop in and just have a look at so and so's leg or foot or something" and they just think that we've got no paperwork to fill in that we just tootle round…
(interview 7 paragraph 60)

The language used here is perceived to be disparaging and demeaning. It does not seem to recognise the skills or expertise required by the district nursing team members. I tried to encourage this participant to expand on this theme.

D- You're a little pop in service then?

W – Yeah – we –that's what we have a laugh in the office – the "pop in service", cos they all have ..

By this point, I had already heard the phrase many times during observation visits and decided to reflect the term "pop in" back to the interviewee to check out her feeling.

D- So that's the joke is it? – That you're a pop in service?

W - Yeah, but errm it does get annoying too sometimes you're thinking well they can actually get out – patients who can't get to the practice nurse – we've got to go into them – for whatever reason and it could just be – well she can't actually..or the GP can't actually see her for a couple of days – so can we just

pop in.

D- So you just pop in again to do the BP – even if she goes shopping?

W – Even though she goes shopping – she's out and about and she goes down W to do her shopping – She can't get to the walk in centre. Also – people have managed things for years and , all of a sudden, they can't do it no more – so can we just pop in and make sure they're OK?

D- Yeah? – because someone else has got involved?

W – Yeah
(interview 7)

This illustrates how the introduction of other professionals can alter the dynamics of the care provided within a home. Interestingly, I pursued the notion of the "pop in" visit with district nurses at a national conference following completion of my study – one comment was that rather than being a disparaging term, it could be viewed as a positive term for people to request a visit when they are fairly uncertain of what needs to be "done", but feel that a visit is needed. Additionally, community nurses use the phrase themselves, perpetuating the notion of "popping in". In her interview, Z makes the comment that the GP is good and helps by "popping up" and this seems acceptable to her. The use of the phrase, therefore, seems to produce a mixture of responses. This could be a minifism (Lawler 1991) serving to minimise the skills and knowledge needed by the "popper".

I mention earlier that the community nurses in this study had a way of minimising the work that they did – by using phrases such as "my little lot" – It would seem that they talk down what they do to each other, but resent others doing similar things.

Morale and Community Nursing

Poor morale in nursing has been raised as an issue throughout the 1990s. Many writers have warned of the effects resulting from this (Castledine 1997 and 1998, Tovey and Adams 1999, Callahan 2003 and Queen's Nursing Institute 2006).

A study by Callahan (2003) involved 58 nurses working in hospital wards within the NHS in Scotland. The findings, following analysis of semi structured interviews, showed morale to be very low for the participants of this project. Of the 58 interviewees, none felt that morale was good. Of the remainder, 37 described it as very poor, 20 as quite poor and one only rated it as all right. Nearly half of the sample regretted their decision to be a nurse. There was also dissatisfaction with salary levels and support for continuing education. Widespread feelings of insecurity and uncertainty were also reported in this study. Although carried out with participants from a hospital setting, the above would seem to translate into this project.

I felt that, as the nurses got used to me being there (and, hopefully, felt more able to trust me), they were more open about their general feelings about the district nursing service and its condition.

At about mid way through the participant observation visits, the participant who is consistently upbeat and positive about the future greeted me with the comment:

Z- "We're fed up today – we're <u>very</u> short staffed. X is off sick again for at least another two weeks"

She looked very down and clearly felt frustrated with the staffing situation. I did feel, however, that she has let her guard down with me and trusted me enough to be very honest in stating how she was feeling, as prior to this visit, she was always motivating and encouraging to all of her team members. This was seen as a breakthrough of sorts in the relationship between participant and interviewer (Coffey 1999).

A recent report by the Queen's Nursing Institute (2006) found widespread concern at a lack of national professional leadership for community nurses. They cited the development of new nursing roles (community matrons for example) as being introduced rather than developing the role of the district nurse. Certainly the ring fencing of monies to develop nurses with specific titles could be seen to be damaging the potential for community nurses. This also seems to have had a great effect upon role identity. The QNI (2006) report a blurring of roles within the community team and a greater diversity of roles. New models for case management have compounded this.

When the ENB and QNI (2002, p.5) set out to explore the views of practising district nurses, they found great differences in the morale of those included.

> - "as well as finding enthusiastic, well motivated nurses eager to continue with their individual and collective contributions to domiciliary based care, we also found a workforce that was some-what disenchanted with their present role and the perceived lack of recognition they receive"

The above section of this thesis, relating to how the participants perceived that other professionals viewed them, would concur with this statement. Generally, the nurses in this study did not feel valued by other groups. They did not feel that their expertise was either recognised or valued. Sadly, these strong feelings seem to then be suppressed and not translated into actions to improve their situation. This I have termed "suppressed need".

Along with the pressures of persistent staffing problems this appears to be having a detrimental effect upon the morale of the teams.

The QNI and ENB studies (2002, 2006) found that district nurses feared a loss of identity and believed that perceptions of their role, by other groups, were outdated. Additionally, workload was felt to be increasing without any corresponding increase in resources. Some expressed a sense of powerlessness. The report (QNI and ENB 2002, p18) summarises the district nursing workload as: *"under-resourced, overburdened and lacking in support".*

Sadly, the findings of this study would concur with the above.

Summary of Key Issues

The culture of community nursing is primarily expressed through speech (Helman 2007). The observation visit field-notes and interview transcripts offered insights to issues and values held by the nurses involved in this study.

This Chapter of the findings explores the suppressed views of the participants. This was a later decision taken in the data analysis process as it became apparent that some important issues were not expressed or dealt with by the nurses in this study. Role development and expansion is perceived to be an on-going issue within community nursing.

The perceived views of other professionals were very interesting and illuminating. This issue became apparently important to the community nurses during the participant observation data collection time. One person steadfastly maintained that other professional groups were well aware of the community nurse' role and worked well with them. Sadly, this view was not upheld by most of the other participants in this study.

There was a general feeling of a failure by other groups to recognise the expertise of community nurses. This resulted in problems with referrals. In agreement with the QNI and ENB (2002) findings, the notion is of nurses acting as "sponges", mopping up problems and tidying up issues that other professional groups did not want to address.

There was a view that community nursing was a "pop in service". This disparaging terminology was used by other groups during referrals or to request a further assessment. This was felt to be very undermining by the participants, who perceived that those using this term simply didn't have knowledge of the complex knowledge and skills required by the community nurses in the assessment of patients and carers.

The participants in this study displayed some of the characteristics of an oppressed group, but did not resort to infighting within the group. There was no evidence of horizontal violence within the community nursing group itself. On the contrary, members of the group were supported and encouraged to develop. Outside of the group it was a different story, with some disparaging remarks and criticisms of other professionals. This was carried out in a passively aggressive manner.

The subsequent result of the above appears to be that morale suffers. The culture of community nursing would appear to contain a tension between perceived job satisfaction and team identity and the perceived views of other professionals.

Chapter Ten

Conclusions and thoughts for Future Direction

This study aimed to explore the cultural behaviour, cultural knowledge and cultural artefacts exemplified during community nurses' handover. Thus the handover report is viewed as a vehicle to access broader cultural issues. Within this final Chapter, the methodology used and lessons learned will be explored. I intend to evaluate here the decisions taken throughout the study.

Next, the important issues of reflexivity and rigour will be examined. I will, present what has been learned from a personal perspective during this work. The findings of this study will be summarised along with congruency with other studies and the contribution made to the existing body of knowledge relating to handover reports and the culture of community nursing.

This Chapter of the thesis aims to revisit the three key themes identified in Chapter One in the light of the findings. These are: the exploration of the culture of community nurses; the functions of handover reports and knowledge for community nursing practice.

Following this, I will elucidate the limitations of this study. In conclusion, I will present a summary of the findings from the project and offer some thoughts as to directions for future developments.

This work explores the culture of community nursing through an ethnographic study of handover reports. Spradley (1980) explains that shared cultural knowledge generates cultural behaviour, cultural artefacts and speech messages. The ethnographer who, by inference, describes the informants' cultural knowledge observes these. I have elicited some of the cultural knowledge of community nursing by exploring the behaviour, artefacts and interactions of this group.

Firstly, I intend to review the selected methodology for this study.

Methodology - Evaluation

The use of ethnography resulted from the review of the literature (Chapter Two). It became apparent that in order to investigate the culture of community nursing, it would be beneficial to uses a number of data collection tools. Many of the studies reviewed had used ethnographic approaches to guide the design of the studies (Parker, Garner and Witshire 1992, Strange 1996, Lally 1999, Kerr 2002, Philpin 2006) and this seemed to be a valuable starting point.

I believe that an ethnographic exploration was a useful approach to explore the issues of culture and community nursing. I would, however, comment that the time period planned to carry out an ethnographic study was tight in the extreme. The initial plan for the study (page145) was revised several times

during the study to allow for slippage and each stage of the study took longer than originally thought.

Before the data collection began, following in depth discussions with my supervisor, I was encouraged to scale down my project. Initially, I had planned to carry out fieldwork for twelve months and undertake two interviews with each of the participants.

Thankfully, the experience of my supervisor helped me to approach a much more feasible study within the time frame open to me as a doctoral student.

Participant observation

Although I initially planned for double the length of time spent on this aspect of data collection, there were practicalities to consider relating to the amount of data collected and its analysis. I spent some of the earlier visits trying to note down what everyone said. As I became more immersed in the role of the ethnographer, I felt that I was more able to see things of interest to the cultural identity of the nurses. For example, noting their non verbal communication, the order in which they shared information and the roles taken by individuals rather than "just" what they were saying to each other. The latter observation visits were richer for this development of skills by the researcher.

As a "marginal native" (Gerrish 1997), I had previous experiences and involvement with community nursing, which enabled me to understand some

of the implications of interactions. Issues relating to the dual role of researcher and nurse proved challenging at times in trying to capture the emic view of participants. In the latter stages of writing this thesis, I realise how much more there is to know about the processes of participant observation. I missed important information, didn't always write well in my field-notes and would definitely expand them further in any future studies.

The use of a "key informant" to access teams who would be willing to participate in the study proved useful. The rapid changes within team staffing were not predicted and caused some tension for me. Fortunately, the newer members of the teams were happy to become involved in the study. This needed careful handling to prevent any possible coercion.

The key assumptions underpinning the ethnographic approach taken during this study were stated in Chapter Three. These were as follows:

- Firstly, that it is not desirable or possible for researchers to put aside their own knowledge of the social world in an attempt at objectivity (Koch 1998).

I found this to be a valuable starting point for the process of researching this group of community nurses. As a district nurse and senior lecturer running degree programmes for district nurses, I was not undertaking this study without experiences, knowledge and assumptions of this cultural group. Further issues of reflexivity will be reviewed later in this Chapter.

- Secondly, that a naturalistic viewpoint is also untenable in its ontological position that reality exists outside of the researcher (Gerrish 2003).

This assumption complimented the first one and was found to be helpful in the gathering and analysis of data within this study. My own "reality" formed a part of the data gathering and the process of interpretation. The third assumption was that:

- The constructivist epistemology of created and subjectivist findings (Denzin and Lincoln 2003b) seems to best address my standpoint throughout this study, as I accept the notion of interdependence and collaborative working to construct the data.

This notion was intended to attempt to bridge the potential gap between the researcher and researched (Van Maanen 1988). Van Maanen writes of "jointly told" tales that try to bring together the (often unequal in terms of power) perspectives of "native" and fieldworker. This became more important within this study as the long process of data analysis developed.

By including the contextual and historical relations of the research setting, I also interweave some elements of critical ethnography in my study. It is important to recognise the contextual issues surrounding this study. There are major reorganisations of community services and PCTs are reconfiguring their workforce currently. There is an uncertainty about the future developments of

community nursing and, also, consultation papers around the future of the preparation for nurse registration and also for the career development for post qualified nursing staff. These uncertainties were part of the context of this study.

Reflexivity

Mulhall (1997) suggested that reflexivity included exploration of how the researcher affected the study and how the study affected the researcher. This was briefly explored in Chapter Three of this thesis.

To revisit the first of these ideas, I will explore here how I influenced this study. Marcus (1998) offered four stances that may be taken in reflexivity. The third of these (termed the practice of positioning) has been useful within my study. The notion of a diverse field of representation allowing for alternatives was adopted here.

Coffey (1999) states that the real involvement of the researcher in ethnography is one of its particular strengths. I would agree with this position and believe that, as the researcher, I shaped what was seen, heard, and recorded during the process of undertaking this study (Denzin and Lincoln 2003b). This results in a sense of responsibility, particularly towards the latter stages of this study. All decisions taken within the selection of events, questions and issues for examination have the potential to alter the focus of the research.

I accept the notion of co-construction of data and have tried to include in this exploration of the culture of community nursing, the issues felt to be important by the participants. This works on a number of levels as a study of culture identifies the knowledge, behaviour and artefacts of the group. The values of the group are also exposed. For example, being a member of the nursing team was highly valued in terms of support within this study. As a "marginal native" (Gerrish 1997) and alternating between the insider / outsider position (Spradley 1980), I tried to build up rapport by telling stories from my own district nursing experience. As the data collection period progressed, I did feel that the participants opened up to me and I felt trusted by them. Detachment was not considered to be desirable in this study (Koch and Harrington 1998) and by making the tea and joining in the conversations (about nursing issues and more general chat) I sought to be accepted by the group.

Additionally, I would agree with Gerrish (2003) that it is impossible to measure the effect that I had, as a researcher, upon the activities and interactions of the teams in this study.

To examine the second notion (how the research has affected me), I would like here to offer a personal account of what I have learned during the process of this study. This section will be presented in two parts. Firstly, what skills have been developed relating to my role as researcher. Secondly, what I have learned about myself. I would accept that these overlap somewhat.

As intimated above, my experiences have led me to a better understanding of ethnographic research. I have developed the ability to observe in a meaningful manner – and I believe I will continue to develop this skill further. My reflective skills have enabled me to make sense of feelings and issues and contributed to the findings of this study.

I had some limited experience of interviewing for qualitative research, but none as a participant observer. This proved to be a complex and fascinating method of collecting data. I do feel that there is plenty of scope to work on these skills in the future.

The art of interviewing is seen as complex and highly skilled. I believe that my ability to undertake semi structured interviews has grown during this study. To be asking questions in a considered and sensitive manner, listening to the responses, responding to these in the way most likely to elicit further useful data is a difficult task. Additionally, all of the above needed to be carried out in a way that invited trust and encouraged the participant to open up. I do feel that my later interviews were an improvement on earlier ones.

However, there were missed opportunities during the interviews. For example, I noted in Chapter Nine that I "lost" a question after the first of the interviews. This was a general question asking the first interviewee "what community nursing is all about". I wish that I had realised the potential of this question and kept it in for the rest of the participants. As a "grand tour" question

(Spradley 1980), I feel that it could have provided some useful insights into the culture of community nursing.

I have noted in earlier chapters that some of my questions were of a leading nature. I think that further development is needed in my interviewing skills and I will actively attempt to improve my technique in this.

The choice to use computer software to manage the data proved to be a good one. Although my technological skills are not the most advanced, the time that it took to learn how to use MAXqda was repaid, as I could (and did) move data around with ease.

The most difficult lesson learned by undertaking this study, however, must be that unexpected findings may be very difficult to deal with. The personal and emotional aspects of undertaking fieldwork (Coffey 1999) were only accessed in a theoretical manner prior to undertaking this study. In the latter stages of this study, I found out how very real these can be. In writing about the suppressed needs of this group, I struggled to find the words to convey what I felt necessary. The real sense of responsibility caused major difficulties for me.

After much consideration, I arrived at a point in which I hope that this study will provide some insights into how community nurses, by suppressing their needs, compound issues of feeling devalued. It is my real hope that this may

be then viewed as a positive finding to assist with the recognition of how to move into more constructive behaviours and uses of language.

I have made mention above of the loneliness of the long distance writer (I do accept that students of traditional doctorates may think that this thesis is a shorter "distance" to write). I have learned that I have the ability to stick with a project over a long period of time, even when a whole day's work results in a few lines of writing. I have discovered that ideas can occur at the oddest times. Keeping a notebook handy has become a way of life. Dealing with the dips in confidence that I could ever produce a readable thesis at this level of thinking has also taught me to get on with it. I like the "Greenpeace" adage:

> *"The optimism of the action is better than the pessimism of the thought"*

This has led me to believe that even the smallest step towards my goal is a positive one and can ward off the feelings of not getting anywhere. A favourite author of mine (Janny Wurts) suggests that writers avoid trying to create and edit at the same time. This proved to be very good advice as the processes are very different and concentration upon one stifles the other! The need to juggle the management of doctoral studies, working full time, having a social life and living one's life is one understood by all students. To be able at times just to "put it away" is crucially important. Although, I am aware that this needs time limiting!

Rigour Revisited.

In Chapter Three, I outlined the steps intended to demonstrate ways in which rigour was to be exhibited within this study. These were identified as credibility, confirmability and transferability. It would seem to be a suitable point here to revisit these claims.

Credibility

Firstly, I suggested that "credibility" would be a useful notion to embrace (Sandelowski 1986, Guba and Lincoln 1989). Some of the safeguards employed to maintain credibility in this study include:

- A prolonged period of time to gather the data. Although within the ethnographic world six months is a short time, within the confines of this project six months was considered to be a reasonable compromise to encourage an immersion in the field of community nursing. The time period was considered to be an important way to minimise the effects of me being present at the handover reports.

- Regular debriefing with peers and supervisors was undertaken along with continual scrutiny of data .This happened by questions from myself to clarify issues and terminology, by asking during the data collection period how the participants were feeling about the research and the researcher.

- The preliminary analysis of data was discussed with the participants and proved to be a valuable component of the research process. Data was also gathered during this feedback session.

This latter point is an example of respondent triangulation. Triangulation is explored in Chapter Three of this thesis. Some aspects of triangulation are rejected in this work. For example the notion of "independent" researcher triangulation would not be in keeping with the key assumptions stated on page 311. It would not be in keeping with the notion of collaborative co-construction of the data (Guba and Lincoln 1989). Therefore, it was considered important to test out and discuss findings with the participants and research supervisors. Offering the preliminary analysis of data back to the participants carried out the former. Emden and Sandelowski (1998) suggest that "good" qualitative research should include textual evidence from researchers as to how participants responded to a "playback" of the findings. This also gives the opportunity to engage in the learning of those researched as a fundamental part of the research process (Lincoln 1995). This is to do with the partnership of the researcher and participants.

I say in Chapter Three that my district nursing background may have given me credibility with the participants, but also may set up expectations of the group. Of course, the participants of this study would clearly recognise themselves (should they decide to read this thesis).

I need to restate here the nature of some of the findings of this study. Not all of the findings were comfortable in nature and there is a responsibility in the reporting and writing of these issues to consider the participants carefully. Whilst being true to the findings of this study, the potential effects upon the individuals included must be borne in mind.

In Chapter Three of this work I asserted that carrying out the field work over a number of months may help to acclimatise the nurses to being observed. In my field- notes 24/12/04, I note that one participant was concerned at the beginning of the data collection and wondered "what will she (myself) write about me?" - and (she) thought at times "should I have said that?" She went on to say that she came to trust me and just carried on "as normal". Of course, I will never know if that was the case or to what degree my presence affected her language or behaviour (Gerrish 2003).

Confirmability

I wrote, also, about confirmability in chapter Three (Guba and Lincoln 1989). For the purposes of this study, data can be tracked to its source. Although, for reasons of confidentiality, individuals can not be named or identified, their words have been used verbatim. Examples of raw data are offered in the Appendices 7 and 8 of this thesis (anonymised). The intention of their inclusion is to give the reader the chance to confirm the authenticity of this study. The participants in this study are able to identify themselves from the findings.

The audit trail debate has been explored earlier in this work (Chapter Three). I include here a list of evidence relating to the decisions and actions within the process of undertaking this study, indicating where evidence may be located.

Figure 13: Audit trail evidence

Literature review Search strategy – notes
Draft and more drafts of earlier chapters/thesis sections
Fieldwork notes and analysis
Reflective diaries Notes and comments
Computer software and data analyses
Notes and records from tutorials and supervisors meetings
Appendices of this thesis

Excerpts from field- notes are included for the reader as examples of raw data in Appendix 8. I have also offered some of the thinking around decisions taken during the study for the reader to consider in this thesis.

Transferability

It is hoped that extensive description of the time, place and context of this study helps to provide a comprehensive data base for the reader. I have aimed to offer a detailed account of the methods used to enable identification

of issues and recommendations that may be relevant and applicable to other local situations.

The use of "thick description" (Schwandt 2001, James 2001) records circumstances, meanings, intentions, strategies and motivations. Thick description helps the reader decide whether their own setting is similar enough to transfer findings from this study to their own.

In addition to the testing out of preliminary findings with the participants of this study and with research supervisors, I have explored the reactions of community nurses to my findings through a number of methods.

I have had the opportunity to share my research with a group of experienced community nurses at a national conference in November 2006. The group chairing this event is the Association of District Nurse Educators (ADNE), who meet twice yearly to share innovations and good practice from around the United Kingdom. The feedback from my presentation was encouraging and indicated that my study did resonate with the experiences and understanding of those present. This could demonstrate that there is some relevance to other situations and contexts.

Emden and Sandelowski (1998) raise the importance of the "voice" in qualitative research. I am encouraged by recognition from community nurses of their voice in my work.

Additional evidence of transferability may be taken from the congruence of issues with the literature reviewed within this study. Although the research settings were not community based (and thus indicated a gap in the literature) there are some complimentary findings.

Finally, the work of Finlay (2006) talks of communicative resonance, in which the findings are conveyed in a way that draws the reader in. I hope that this work has been, at least, readable and, hopefully, interesting!

The conceptual framework used to present the findings of this study – a Critique

The use of Bradshaw's taxonomy of need, along with my analysis of data, will be explored further here. In Chapter Five, I share the journey towards my decision to do this. I found the early stages of data analysis to be frustrating. This was the result of managing such a huge amount of raw data and looking for a way to convey the complexity of the themes constructed from them. I do, however, realise that this is not an unusual position for a researcher to find herself!

In addition to the themes and categories created during the data analysis, the adoption of Bradshaw's work offered a way of exploring whose needs are being met and where. For example the professional requirements could be said to meet the needs of individual nurses, managers and patients. Other needs were more specific to the needs of the community nurses within their culture, for example, support mechanisms especially when new to community

working. The decision to adapt Bradshaw's taxonomy has been explored in Chapters Five and Nine.

Generally, I felt that there was a flow in attaching the framework to the themes and categories. I would accept that the researcher's worldview will always impact upon the outcome of research and this will affect the construction of the categories used in ethnographic description and analysis.

Meleis (1991) stated that nursing has a history of importing theories and (maybe) rating these theories higher than those devised by nurse themselves. McKenna (1997) also explores the importation of theories from other disciplines and suggests that reworking may be needed to "fit nursing's unique perspective" (p133). However, Adam (1992) warns that nursing needs to build a stronger nursing framework instead of borrowing from others.

Using existing literature is viewed here as a way of developing perspectives through which the data and its analysis may be represented (Coffey and Atkinson 1996). As a nurse and a senior lecturer in nursing, I have had a keen interest in health and health promotion for many years. The work of Bradshaw was already known to me through these activities.

However, in the latter stages of writing this thesis, I have questioned myself about the adoption (and adaptation) of the work of Bradshaw. It may be that I espoused this framework a little too rapidly during my data analysis. I now see that there could be a relevant criticism of this decision in that there is a real

opportunity here to create a framework based on nursing theory rather than developing an imported one.

I defend my position in Chapter Five of this work by stating that

"this decision to represent the findings of this study with reference to an "imported" framework was taken consciously as a vehicle to convey this account of social life to the reader" (page 202).

Now, much further along the road, I have some alternative ideas to offer, and present them later in this Chapter.

It remains, of course, for the reader to decide the extent to which this has been helpful.

Cultural Knowledge of Community Nurses- a Summary of the Findings

Here I will attempt to summarise the cultural knowledge, behaviour and artefacts exemplified through the vehicle of the community nurse handover report. This period of the handover was selected as an opportunity to study the culture of community nursing in a wider context. As this is the primary time when nurses meet, interact and display their tacit and implicit behaviour and speech, it was hoped that the wider culture would be observable. The first theme of this study was to explore the culture of community nursing.

A review of cultural behaviours observed within this study may be found in Chapter Five. These include patterns, rituals and repeated actions, forming part of the culture of the community nurses within this study.

The sharing of information about patient care is primarily the reason for the gathering of community nurses in the afternoons and is valued by the participants within this study for this purpose. Continuity of care is an important issue and this sharing of information is perceived to facilitate this, particularly as community nurses work mainly alone in patients' houses. There is opportunity within handover reports to discuss the care given, decisions taken and the generation of options relating to the planning of care for patients. These considerations are a professional requirement (NMC 2004) and are viewed within this study as constituting normative need (Bradshaw 1972) and are presented in Chapter Six.

Ritual and handover

I would conclude that the patterned behaviour explored in Chapter Five, describes handover as a ritual (Helman 2007). The place, the actors and the events presented in this section of the thesis demonstrate participation in the ritual of handover (Spradley 1980). The carrying out of rituals is a feature of all human societies (Helman 2007). This participation is viewed as a way to sustain common values (Holland 1993) and encourages group cohesion. Some of the symbolism noted in other studies of handover (in more acute settings) is not explicit in this study. For example, Wolf (1989) found patients

to be symbolically "handed over" to the next shift during handover time. As it is often the case that the same nurse will visit that patient again the next time, this is not seen to be the case in community nursing. Likewise the symbolic handing over of the keys (Strange1996) is not carried out in community nursing handover.

Symbolic actions were in evidence in the wearing of uniform, use of language and creation of artefacts (Holland 1993, Philpin 2006, Helman 2007). The exploration of symbolism and ritual may enable a better understanding of community nurses' work.

The handover time was an opportunity to explore "unwritten rules". This demonstrates an aspect of the cultural norms of the group. An example of this is that all members of the team (except for the auxiliary nurses who were not viewed as team members) were to attend for the handover. It was also not acceptable to be late for the report.

Artefacts

An examination of artefacts used by this group is presented in Chapter Six. There are many artefacts used by community nurses to aid the planning process such as message books, off duty rotas, personal folders and card systems. The two teams used different systems. For example Team B used named folders for each member of staff to put their work in, whilst Team A used a card system. Both methods of working seemed to be effective.

Systems of crossing off and ticking were noted as indications that work had been taken on or completed.

The two teams involved in this study had devised a number of methods to take messages and to order their patient information. The creation of folders with patients details enclosed offered a way to symbolically move that patients visit from one day to another by moving it into a different day slot.

Cultural knowledge may be expressed in speech. Both my comments noted during the participant observation period of data collection within this study and transcripts from semi structured interviews provided language from which to infer cultural knowledge.

The use of language

In their report, the QNI and ENB (2002) include the notion of nurses acting as "sponges", who tended to clear up problems that others did not choose to address. The findings from this small scale study would support this view. The participants, who felt that it undermined their role, deplored the disparaging terminology of the "pop in service". The complex knowledge and skills required by the community nurses in the assessment of patients and carers is not demonstrated by the use of such terms. Members from both of the two teams expressed their frustration with the above.

However, the use of language by the nurses themselves was found to include "minifisms" (Lawler 1991) that have the potential to render nursing work to be less complex and invisible. This is part of the culture of this group. It is acceptable for the nurses to make little of their expertise, but not for "outsiders" to do so.

The definition by Spradley (1980 p 6) is that "culture" is the:

> "*acquired knowledge people use to interpret experience and generate behaviour*"

This knowledge is not directly observable. Tacit and implicit culture is revealed by speech – both in interview situations and day to day interactions.

Functions of the Handover Report

This is the second theme as identified in Chapter One of this work. Both of the teams participating within this study felt that sharing information about patients was the primary reason to meet up. However, there are also organisational reasons to meet for handover report in the Health Centre or Clinic. These include the chance for the team to decide upon the workloads for the next shift, planning for major events and scheduling meetings. Particularly if there is sickness or understaffing within the team or other neighbouring teams, decisions are taken during this time relating to whether the team will need help from elsewhere or is in a position to offer other teams help.

The second of the themes introduced in Chapter One is that of the functions of handover. In congruence with other studies, the handover was found to be primarily to share information about patients with the rest of the team (Wolf 1989, Mc Mahon 1990, Holland 1993,Thurgood 1995, Strange 1996,Lally 1999,Philpin 2006).

Additionally, handovers provided opportunities for the following important events to take place.

Teaching and learning

The teaching and learning roles adopted during the handover report time are also valued by community nurses. Experienced staff are encouraged to share their knowledge with more junior members. Also, staff share information from articles that they may have read in journals or from courses that they may have attended. As specialism is encouraged within Community Nursing teams, more junior members of the team may develop specific expertise to contribute to the team's knowledge and skill base. This personal development is a useful way of enabling more junior staff to demonstrate their value to the team. There were differences across the teams within this study, for example, team A were generally more likely to request information from their peers. I fell that this was likely to be related to the willingness of the team leader to expose her learning needs. There was a real sense of all learning together, which fosters a good teaching and learning environment.

Support and development of professional confidence

There was a strong feeling, particularly amongst staff new to community work, that the interactions with team members in the clinic settings served as a vehicle to develop professional confidence. Learning to express ideas in the accepted language and demonstrating understanding of the accepted norms within the team are a part of professional growth within the culture of community nurses. This study would support the assertion that a shared culture is developed during handover processes (Lally 1999).

At the beginning of this work, I note that community nurses spend much of their working lives in patients' houses and working alone. This was one of the key considerations in the selection of topic areas for the creation of this study. In keeping with other studies, carried out in secondary settings (Kerr 2002; Lally 1999; Strange 1996), the process of handover report was perceived as a useful way of increasing social cohesion within the teams. These issues are presented within this study as being "felt needs" of the participants (Chapter Seven).

Being in the team

Being a member of the team was very highly valued, as was the sense of peer support experienced by the participants in this study. Feeling part of a team helps individuals to manage the complex and demanding work of the community nurse. This can help in situations where nurses may perceive their

managers as lacking in the provision of support. Individuals from both teams were very articulate around these issues. Team A contained a newly qualified Staff Nurse, who elucidated her need for ongoing professional support and guidance. In team B the newly promoted team leader explained her frustration with her perceived lack of support from her managers.

The role of staff nurses is evolving within this Primary Care Trust and this seems to be a pattern emerging nationally. With the current reconfigurations of Primary Care Trusts, following the release of the recent White Paper (DOH 2005), the structure of community nursing is being reconsidered on a local and national level. These considerations focus upon the role and responsibilities of staff. Additionally, the implementation of the Key Skills Framework (KSF) can depend upon the clinical structure in place within each PCT. The banding of staff is ongoing at the time of writing, but definitely impacts upon the staff nurse role within the mergers and reconfigurations. These issues will determine, to some extent, the professional boundaries and expectations of this group.

There was, within the participants of this study, a feeling that it was a positive move to develop staff nurses' assessment roles partly to address the perceived deskilling resulting from the previous practice of limiting their roles.

Informal clinical supervision

It would seem from the above that many of the functions of Clinical Supervision, which is not widely taken up within community nursing, are somewhat addressed during the handover report. In particular, Proctor's (1986) normative (Managerial) components of complying with standards and working to local and national guidelines feature in the meeting of normative need during handover reports. Additionally, the notion of a formative (educative) component of CS would also seem to be in evidence during the handover report. This includes the development of skills and evidence based practice. Support from other team members during handover could be, in some measure, addressing the restorative (pastoral) component of Clinical Supervision. It has been established that community nurses are not accessing CS formally.

Anxiety management

The participants within this study demonstrated that they obtained a feeling of being more in control of events by having a handover report within the Health Centre or Clinic. However, when understaffing is a problem or the team is particularly busy there is sometimes no opportunity for a report or the report is rushed. Often, in this situation, staff are unable to concentrate on what is being said as they are undertaking (necessary) tasks at the same time. Interruptions by telephones or visitors to the Centres can affect the quality of handover reports, affecting the ability to concentrate.

Not having report, therefore, could contribute to community nurses experiencing an increased feeling of anxiety about what is going on (Philpin 2002). This is in contrast to the findings of Mooney (2007), who found that the nurses in her study were anxious and stressed at the thought of having handover. In her study there was a real fear of a public reprimand at handover.

Handover may be reduced to a general enquiry when teams are in this position. This does little to relieve the anxiety relating to knowing what is happening. The gathering of information has been cited as an anxiety controlling mechanism (Strange 1996, Philpin 2006).

Additionally, community nurses within this study then reported feeling less confident of what is to be done when they visit patients. A subsequent result of this is that nurses reported a need for taking extra time to read notes and ascertain what is required. It should be reiterated here that whether or not report has taken place it is good practice to do these things, rather than relying upon feedback from a previous visit.

The use of humour was also raised as an important feature of the handover time. It was a time to "let off steam" and "have a laugh". This is important for a group who work in isolation for much of their working day.

As not having a handover (or having a poorer quality handover) were often associated with busy times, the notion of busyness was explored within this

study. It became apparent, amongst the participants of this study, that sometimes the team being helped out was actually less busy than their own. A related issue was that some teams were felt to be less helpful than others. There were humorous comments made about these teams not being offered help in the future, it is possible that there could be veiled truth in some of these.

Knowledge for Community Nursing Practice

This theme contains the notions of invisibility of community nursing work and the articulation of expertise for community nursing practice. Issues of suppressed need are included here in this section of this Chapter. The work of Liaschenko and Fisher (1999) will also be revisited here.

The invisibility of community nursing work

The ENB and QNI (2002) described community nursing as being largely invisible to others, taking place as it does within the homes of patients. This invisibility would seem to result in frustration for the participants within this study as expertise is not perceived to be recognised by other professional groups. The perceptions of the community nurses themselves are of interest in this notion of invisibility.

Legitimacy of work

Case knowledge (Liaschenko and Fisher 1999) includes biomedical knowledge and is apparent during handovers in the community setting. Community nurses understanding of anatomy, physiology, disease processes, pharmacology and technological interventions are manifest during handover report time. The use of medical terminology and discussion of the above demonstrate that case knowledge is a core component of the work of community nurses. It is the most easily recognised as legitimate work by the members of the teams.

Ways of managing across teams demonstrate knowledge of how to get things done (Liaschenko and Fisher 1999) are also very apparent in the handover time. The findings presented in Chapter Seven explore the knowledge needed to help other teams and to decide which patients may be handed over to other teams in times of busyness. This involves local knowledge and can take up time in organising work. This may not be perceived as real work by the team members or others. This is also potentially work that is largely invisible to other professional groups.

Busyness

The notion of busyness was raised here. Members of both teams commented upon their perceptions around the relative workload of teams. It was felt that

some teams and some individuals were less than helpful when assistance was requested. Everyone knows who is helpful and who is not.

"Busyness" in community nursing is seen as different to that identified by Manias and Street (2000). In their study of nurses on a critical care unit, nurses were required to be "busy" around the patients' bedsides. In my study, busyness is not readily visible. It is a concept that is perceived as being "out there". Other teams may claim to be busy, but this is not easily assessed.

Staff being away sick exacerbated busyness. It seems that when sick, there was also a burden of guilt experienced by the nurses within this study. They would consider the effects of their being away from the workplace upon their colleagues and patients. The above issues relating to not having report or compromising the quality of the event are classed here as comparative needs.

During very pressured times, it was revealed that there may be a resulting tension within teams. One team member cited the mistakes and blame attached to these. Without a team identity, which is strengthened during the handover report time, this could escalate, lead to damage to the groups' cohesion and, ultimately, destroy this supporting network. I feel that this is a crucial consideration for community nurses and their managers. It seems that community nurses need to feel valued as members of their teams and that this team identity balances the pressures that they deal with from outside of the team.

Participants identified isolation as an important issue. Without the opportunity to meet up with colleagues, this is likely to become greater.

It would seem that some of the pastoral functions of Clinical Supervision (Proctor 1986) are informally met during the time that teams meet for the handover report.

Group identity

Job satisfaction is expressed as a very important motivating factor amongst the participants of this study and has been related to feeling trusted, respected and being treated as a professional within the team. Team identity was found to be a key feature in the perception of job satisfaction. It could be that this need helps to balance the nurses' less than positive sense of how other professional groups view their knowledge and skills.

Being in the team offered opportunities to access support from colleagues. Group interaction included "letting off steam". Humour was highly valued by the participants within this study and was viewed as a way of diffusing tension and relieving stresses. Without the opportunity to meet up for the handover report, it is possible that this benefit would be lost to the team.

A need to feel valued by other professional groups was expressed through exploration of the views of others.

These views, relating to the community nursing service, were, generally, felt to be disparaging. In this study, there was a feeling of a failure by other groups to recognise the expertise of community nurses. One perceived outcome of this was a problem with inappropriate and poor quality referrals.

Suppressed need

There are some issues here, I believe, relating to professional confidence. There would seem to be a need here for assertive behaviour and further investigation of the value of the service as seen by other professional colleagues. This may identify the need to educate other groups. Kerr (2002) asserts that handover reports should be viewed as a valuable asset, containing hidden expertise. In Chapter Five, I comment upon the nurses' possible "dumbing down" of expertise amongst themselves. This could be an indication of a failure to realise (even to themselves) the complexity and value of their expertise and links with the work of Lawler (1991, p169) and the use of minifisms. She asserts that nurses often use minifisms to help each other but cautions that doing so "can also operate to render care invisible "and may contribute to care being, consequently, poorly valued.

Some of the hidden knowledge could be articulated by using Liaschenko's and Fisher's (1999) categories. Two of these have been considered above (case knowledge and patient knowledge including "how to get thing done"). I would like to revisit patient and person knowledge here.

Knowledge of patient experiences would seem to be of paramount importance to community nurses, who are privileged to witness the effects of ill health upon patients and carers in their own homes. Patient knowledge also embraces the individual patient's response to treatment, how to get things done and resource issues. By actively listening to the testimony of patients, community nurses increase their chances of finding meaning within their unique experiences. This is a fundamentally important type of knowledge that should be embraced and articulated by community nurses. This happens to some extent within the teams, but is probably invisible to other professional groups.

This work could provide community nurses with an opportunity to legitimise the aspects of their work that are crucially important, time consuming and require a wide knowledge of local resources. This could be useful in identifying this aspect of their work and in articulating it – within their cultural group and outside amongst other professionals. The contribution of relatives, carers, friends and neighbours in caring for people at home is also a vital part of the patient experience and should be valued, legitimised and shared.

The third of Liaschenko and Fisher's categories (1999) is that of person knowledge. There is evidence of this in depth understanding of individuals with desires, hopes and views of their conditions. The personal knowledge of patients' biographies is intricate and may be developed over a number of years. I believe that this aspect of community nursing work should be celebrated and shared within the teams and, also, with the wider audience of

professional groups. This did not particularly seem to be valued as key knowledge by the participants of this study; rather this information was shared informally during handover reports.

In her earlier work, Liaschenko (1998) talks of knowing the limits of medical science. This could be partly the source of the perception that other groups do not value the complexity of community nurses' expertise. Within this category, nurses are said (Liaschenko 1998) to become weary of stating opinions that are not heard within medicine and so suppress these ideas.

Things considered to be of importance to patients and carers (but not acknowledged by medicine) are discussed by nurses. These issues are perceived to be the "real" considerations. Community nurses are well aware that patients do not always hold medicine in high regard and not all feel that doctors have the answers.

The Articulation of Expertise

Rather than adopt a coercive position to avoid "rocking the boat"(Goodman 2001), it could be time for community nurses to revisit and state their values relating to respect for the individual and the promotion of independence for their patients. Articulation of their expertise needs to be assertively stated, both within nursing and other professional groups. Within Chapter Nine of this study, I explore the relationship between suppressed need and the behaviour of oppressed groups. This consideration is intended to illuminate ways in

which community nurses may contribute to their feelings of powerlessness. By suppressing their needs and not acknowledging this position it becomes difficult to break out of the cycle (Roberts 2000) and become empowered.

This could, perhaps, be carried out by reclaiming notions of holistic nursing care and provide a vehicle to articulate the complexity of knowledge needed for the challenging and highly skilled work of community nurses. This vehicle could perhaps take the form of the work of Liaschenko and Fisher (1999). At present, the nurses in this study feel, rather like those in Daiski's group (2004), that others do not respect them. Also, in congruence with Daiski's work, they remain silent.

However, the community nurses in this study do take care of those within the group. There is no evidence of undermining behaviours or disparaging remarks within the teams under study.

Knowledge of community nurses' expertise does seem to be confined to the teams themselves. Without addressing the above issues, it is likely that morale of community nurses will continue to suffer.

Alternative Developments

In the latter stages of writing, two alternative positions for developing this work have emerged. I offer these thoughts to the reader in the spirit of Sandelowski and Barroso (2002), in that all decisions to develop a conceptual framework

are contentious. Therefore, there is no one "right" framework, meaning that decisions need to be defended.

In Chapter Two, I explored some issues relating to Clinical Supervision. I rejected the notion that CS and handover were synonymous. However, during the latter stages of this study, I have been drawn back to the three functions of CS (Proctor 1986). I now feel that this work could have been a useful, alternative, framework

The second position that I would like to offer here is that the work of Liaschenko and Fisher (1999) could have usefully been developed as a framework to present the findings of this study. This emerged as a possibility in the latter stages of writing this thesis.

The above thoughts support the notion of Van Maanen (1988) that the act of writing is also part of the constructing process. The act of writing can create new insights and so the data analysis begins at the beginning of data collection and continues to the end of the final draft of subsequent writing. He continues with the notion that reading also fabricates meaning as the reader interacts with the text. I would also agree with this idea.

I refer back to the notion of Marcus (1998) of alternative representations. I have learned, through my experiences throughout the development of this study that this positioning is fundamental and the co- construction of data and findings contain many possibilities.

This small scale study would support many of the issues raised by other researchers in terms of the functions of handover reports.

Figure 14, below lists the areas that are similar.

Figure 14: Congruency with other studies of handover reports

Information sharing and planning are a feature of the handover report (Strange 1996, Hardey, Payne and Coleman 2000, Kerr 2002, Lamond 2000, Lally 1999, O'Connell and Penney 2001, Fenton 2006)
Teaching and learning are both features of the report meeting time (Lally1999 and Kerr 2002)
Handover is a ritual and symbolism is observable during the event (Strange 1996 and Kerr 2002, Philpin 2006)
Group identity is formed, sustained and celebrated during handover Strange 1996, Lally 1999 and Kerr 2002, Parker, Gardner and Wiltshire 1992)
There is a strong support mechanism within the process of handover (Parker, Gardner and Wiltshire 1992, Strange 1996, Lally 1999, Kerr 2002 and Hopkinson 2002)

There are, additionally, some insights from this study that add to the current body of knowledge around nurses' handover reports.

What this Study adds to Current Knowledge

Although many studies have been carried out exploring the handover, there is a dearth of work focussing upon community nursing. This ethnographic study set out to explore the culture of community nursing through the vehicle of handover report. The findings offer insight into the world of community nursing.

There are three areas of particular importance arising from this study of the culture of community nurses. These are, firstly, the importance of protecting time for handover report. Secondly there is a strong sense of group identity that carries individuals and the group through times of trouble and stress. The isolation of community nurses for much of their working day is relieved by the interactions, discussion and ritual of handover. Finally, there is a sense that community nursing is poorly articulated and appreciated outside the cultural group.

The Limitations of this Study

This small scale, qualitative, study was carried out in one PCT within the West Midlands. Generalisation is not considered to be possible by the naturalistic researcher (Guba and Lincoln 1989), but it is hoped that the provision of thick description of the data in the context of this study will allow for the reader to make judgements relating to transferability.

It is not possible to measure the effect that I had, as the researcher, upon the interactions of the nurses within this study (Gerrish 2003).

Thoughts for Future Direction

It is hoped that this work will be of interest and value to community nurses and their managers. However, a wider readership would be very much appreciated. Arising from the above presentation of the summary of findings, the following points for consideration are offered:

The case for protecting handover times

In the current climate when community nursing is under greater pressure than ever to meet the complex and challenging needs of patients (QNI 2006 and DOH 2006), when the Primary Care Trusts are merging and services being redesigned, handover time could be viewed as less important than other demands. I feel at the end of this study that the following issues need careful consideration by nurses and managers of services.

- It is important to recognise the professional requirements to share information about patients and carers in the community setting. Meeting up to handover serves as a vehicle for promoting continuity of care amongst community nursing teams. There is potential for miscommunication, which could impact upon the quality of patient care.

- Time together is valuable in terms of teaching and learning, developing skills and evidence based practice. As this is probably more difficult to do in isolation, it is therefore imperative that time together needs to be protected.

- It seems apparent within this study that many of the components of Clinical Supervision are informally met during this time. These benefits would potentially be lost without the handover report time. Handover should not, however, be viewed as a substitute for CS.

The importance of professional identity

The following thoughts relate to the real sense of identity as a member of a community nursing team. The participants within this study valued this aspect of their working lives very highly. In the climate of an ageing workforce and one with a high turn over of staff (QNI and ENB 2002) this should not be underestimated. It is of note that, during the very last phase of writing this thesis (February 2007), the QNI have stated that they wish to reinstate the title of Queen's Nurse for experienced nurses who have significantly contributed to community nursing. The nurses in this study coped with daily problems and pressure by drawing on their cultural inclusion within their team. I suggest that these issues need to be considered during workforce development and planning, locally and nationally.

- It is crucial to consider the perceived advantages of being a member of the team. This includes the development of professional confidence, support from others and the development of social cohesion. As reconfigurations of PCTs in the West Midlands are currently being undertaken, it is becoming apparent that teams are merging to form (in some cases) very large groups of nurses. Being a member of the team would appear to be a much-valued asset by the participants of this study. Consideration should, therefore, be given within future workforce development to protect team identity. This is developed during the interactions between team members in handover time.

- At the very least, staff new to the community setting should be carefully mentored if exposed to working as a part of a large team. Professional confidence is seen to be developed during the handover time. The use of terminology and checking that what has been done is "right" is a crucial part of developing confidence and embracing the cultural values of the group. Becoming part of community nurse culture is highly valued by new staff participating in this project.

- The above may be valuable considerations in the recruitment and retention of staff that have been identified as an "ageing workforce" (Audit Commission 1999) with one in five nurses on the United Kingdom (UK) professional register aged 50 years or older.

Hidden expertise in community nursing

Within this study, I have noted many instances of the community nurses themselves "dumbing down" what they do. Yet they become concerned and unhappy by other professional groups using disparaging phrases to refer to their practice. Phrases such as the "mop up service" and requests to "pop in" to patients occur on a regular basis and lead to a sense of not being valued. Much of the expertise known to community nurses is hidden. They work, often alone, in patients' homes where their real knowledge and skills are unseen. The handover report provides a time to articulate between community team members what they do.

- It would seem crucial for community nurses collectively to develop professional confidence within their discipline. In order to begin this process, the complex and skilled decision making carried out by community nurses needs to be explored and made "visible". Much expertise is hidden and goes unrecognised by community nurses themselves. The starting point for this, I suggest, is a conscious recognition by community nurses of their expertise.

- The effects of not meeting together for handover reports could be destructive – I suggest that the loss of the opportunity to articulate their expertise (even amongst peers) may be viewed as a threat to the development of community nursing. The exchanges and sharing of community nursing practices serve to construct and maintain the

values of this group. This interaction is necessary in producing cultural identity.

- Assertive re-education of other professional groups would perhaps logically follow from the latter point. This would not be an easy task. Ideas around "not rocking the boat" do not sit easily with this notion.

I suggest that by suppressing their need to feel valued and respected by other professional groups, community nurses may compound their invisibility. The use of minifisms to minimise the extent of their expertise may also have the effect of "talking down" the complex knowledge and skills needed to provide the care for patients nursed in the community. An understanding of the effects of the cultural uses of language may be a useful starting point.

Finally

I hope that the above will be meaningful to community nurses and their managers and will tie in with their understandings and experiences. There are many differing models for community nurse redevelopment at this time, but the issues raised above have been recognised by many community nurses across the United Kingdom. In my discussions during this study of the ideas presented above, I have been met with many instances that would give them credibility. It is also hoped that nurses from other settings may find this study of value.

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Appendix 1

Approval correspondence from Primary Care Trust Managers

Manager
X Primary Care Trust
XXXX

17th November 2003

Dear X ,

Re: research project –" An exploration of the reporting practices of community nurses following home visits".

I am planning to carry out a small - scale qualitative study into the above topic area, as part of my doctoral studies. It will be necessary to approach teams of district nurses and community staff nurses to seek their inclusion to the project. It is intended that data be collected over a six - month period.

Each of two teams of district nurses will be visited on one day, alternate weeks for observation of hand over information and analysis of records relating to home visits. It is anticipated that each member of the teams will be interviewed on a one-to-one basis towards the end of the data collection time.

As a key member of the PCT, I hope that you will be willing to support the project and will advise me of the teams of district nurses and community staff nurses within the Trust.

Yours Sincerely

Dee Drew
d.drew@wvl.ac.uk

Director of Health and Social Care
X Primary Care Trust
XXXX

3rd November 2003

Dear X ,

Re: research project – "An exploration of the reporting practices of community nurses following home visits".

I am proposing to carry out a small research project to explore the reporting practices of community nurses following home visits. The study will focus upon the sharing of information gathered during visits to patients' homes. It is hoped that the findings will be of benefit to nurses and future patient care.

Therefore, I seek your permission to conduct this study within X Primary Care Trust and enclose a copy of my research protocol for your information.

If permission is granted, then I will contact X to organise the most appropriate way to access the community nurse teams. I am hoping to begin gathering data from December 1st 2003. If any further information is needed, please don't hesitate to contact me.

Yours Sincerely

Dee Drew

Appendix 2

Studies for literature review

Studies of handover reports

Title	Author(s) and date	Sample	Methods	Findings	Other comments
1. "Scraps" – hidden nursing information and it's influence on the delivery of care	Hardey M, Payne S & Coleman P. 2000	5 X acute elderly care wards in the U.K. Study includes registered nurses/student nurses/care assistants	Ethnographic approach. Observed 23 handovers. Interviews x 34 Informal interactions noted. Analysis of records	Describes the use of scraps of paper to carry information from report. These "scraps" were often reworked during the shift.	Explores the role of nursing interaction within context of handover.
2. An analysis of handover function	Kerr M.P. 2002	2 X paediatric wards in the U.K.	Multiple and opportunistic data collection. 20 x handovers observed and taped. 12 individual interviews. 2 x group interviews and field-notes.	In addition to patient information – social support and dealing with stress also part of handover. Teaching and socialisation important factors.	Presents the interview guide within the paper – very useful.
3. The information content of the nurse change of shift reports: a comparative study	Lamond D 2000	1 x acute medical ward and 1 x surgical ward in two hospitals in the U.K	5 X consecutive reports audiotaped on each ward. Medical and Nursing notes examined. A quantitative approach using coded data and content analysis.	There was generally more information recorded in the notes than exchanged verbally in report.	Examines the role of shift reports in aiding nurses ability to process information and plan care.
4. An investigation into the functions of nurses' communication at the inter-shift handover	Lally S 1999	One ward in the U.K. – A total of 6 handovers studied.	Observation, data transcribed. Use of thematic analysis and ethnographic field-notes.	In addition to information sharing – handovers provide the opportunity for teaching, team building, group cohesion.	It was intended to audio tape reports – staff were unwilling to allow this. Data analysis well presented
5.	O 'Connell	5 X acute care	Grounded	Handovers	Importance

Challenging the handover ritual: recommendations for research and practice.	B & Penney W 2001	settings within 1 teaching hospital	theory. Looked a t 3 types of hand- over Participant observation and semi-structured interviews	more than just info. Debriefing, Clarifying Updating knowledge	of recognising importance of handovers – not just a ritual
6. Interactions between nurses during handovers in elderly care	Payne S. Hardey M & Coleman P. 2000	5 X acute elderly care wards – see study number 1 above	A different slant upon the study detailed above.	Handovers found to be formulaic, cryptic, high speed. Prioritised biomedical accounts.	
7. Handover: an ethnographic study of ritual in nursing practice	Stange F. 1996	One ward in the U.K.	Qualitative study using an ethnographic approach. Uses participant observation – does not make notes.	Writes about the psychological functions of ritual. – anxiety controlling, symbols of the handover of power during handover. The social functions of the handover are explored.	A very useful section on "ritual" and it's protective function. Exploration of hierarchy good.

One immediate observation to note from the Table above is that although much work has been focussed upon acute, secondary care settings, there is an identifiable gap in the literature relating to community nursing.

Appendix 3

Information sheet for participants

INFORMATION FOR POTENTIAL PARTICIPANTS

Study Title

An exploration of the reporting practices of community nurses following home visits

About the researcher – Dee Drew is a nurse as well as the researcher for this study. She has a real interest in community nursing and worked as a district nurse prior to moving into her present post in nurse education.

Introduction to the project and an invitation to take part.

You are being invited to take part in a research project. Here is some information to help you to decide whether or not to take part. Please take time to read the information provided and to decide whether or not you wish to take part.

What is the purpose of the study?

This study explores the sharing of information by community nurses. It is intended that, in order to gather information for this study, there will be will be attachment to two teams of community nurses for a total period of 6 months. Attendance by the researcher will be intermittent and, during the data collection period, she will observe and make notes relating to the research question. The researcher will visit each team fortnightly to gather data. Towards the end of the 6 monthly data collection period, one-to-one interviews with members of the teams will be carried out. Individual consent will be negotiated for this part of the project. Documentation and records will also be reviewed. Confidentiality will be strictly maintained. All data will be kept securely and will be destroyed at the end of the study.

Why have I been chosen?

Participation within this project is entirely voluntary. It is important, however, that each member of the team wishes to take part. Only teams with all members in agreement will be included.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

This project aims to explore how community nurses usually communicate. When the researcher is observing, try to carry on with work as you would normally. At the end of the six monthly period of observation, you will be asked if you would agree to be interviewed. There is no pressure for you to agree to this. A separate consent form will be given to you to sign prior to any interviewing. Interviews will be audio-taped. Again your consent will be sought prior to this.

What are the possible disadvantages and risks of taking part?

There are no foreseeable risks within this project. Participation is entirely voluntary. Participants are free to withdraw from the study at any time. No individual person will be named in the report following the projects completion. Confidentiality is maintained by not divulging information to any other personnel except for those directly involved in the research, such as the research supervisor and examiners. Any quotations will use a pseudonym and not your name.

What are the possible benefits of taking part?

The benefits will be in gaining a better understanding of the ways in which community nurses share the information gained following home visits.

Communication is seen as a vital component of patient care and areas of good practice may be discovered.

What if something goes wrong?

In the very unlikely instance of something going wrong during the project, the research project is covered by indemnity insurance.

Will my taking part in this study be kept confidential?

All information collected about you during the course of the research will be kept strictly confidential. You will not be named in any report relating to this project.

What happens if I decide to take part?

You will be given a consent form to complete, which is returned to the researcher. A copy will be made available for you to keep.

What happens if I change my mind during the research study?

Your participation is entirely voluntary and you can terminate your involvement at any time. Simply inform the researcher of your intentions.

What will happen to the information gathered by the researcher?

After codes have been attached to transcripts of tape recordings and observation notes, to anonymise them, analysis will be undertaken.

Following the gathering and analysis of data, the results of the study will be made available to you. You will not be named in the ensuing report.

Who is organizing and funding the research?
This study is performed as partial fulfillment of the requirements for a Doctorate in Nursing Science at the University of Wales Swansea.

Who has reviewed the study?

XXX Local Research Ethics Committee

Contact for further information

I hope that this information sheet answers any questions about participation in this project. If you decide to take part, you will receive a copy of the information sheet and the consent form. Thank you for agreeing to take part. If you decide not to take part, thank you for your time in reading this information sheet.
Please feel free to contact me, if you would like to discuss the project further or if you need any further information.

Telephone no. 01902 323070 d.drew@wlv.ac.uk

Dee Drew

Appendix 4

Consent form for participants

Title: An exploration of the reporting practices of community nurses following home visits

CONSENT FORM FOR INTERVIEWS

Please read carefully the information sheet attached to this consent form. Following discussion if you feel happy to be interviewed, please complete the following consent form and return it to me. Please note that the interviews will be tape-recorded for transcribing. Transcriptions will be anonymised for confidentiality.

If any further information is needed, please feel free to contact me.

Telephone no. 01902 518633
d.drew@wlv.ac.uk

I am willing to take part in a tape- recorded interview as part of the above project.
I understand that I will not be identified in transcripts and that confidentiality will be maintained in the final written report. I have the right to withdraw from the study at any time.

Signature ....

Name (block capitals please).......................................

Date ....

Contact telephone number ....

Base address ....
....
....
....

Dee Drew

Appendix 5

Framework for field- notes (adapted from Mulhall 2003).

- **Structural features**
  Diagrams/ descriptions of the environment
- **People**
  Roles/ participants/ interactions/ communications
  Daily activities
  Regular meetings/ report handovers/ breaks/ common events
- **Special events**
  Exceptional meetings/ celebrations/ unexpected events
- **Every day Diary**
  Chronologically kept notes of what happens before, during and following fieldwork

- **Personal reflections**
  Own thoughts, feelings and insights about entering and being in the field. Interpretations of events and experiences shaping views. Decision trail.

(Adapted from Mulhall A. 2003).

A	Structural features Diagrams/ description environment
B	People/ roles participants
C	Daily activities Meetings/ handovers/ breaks
E	Everyday diary Reflective diary

Appendix 6

Semi- Structured Interview Schedule

INTERVIEW SCHEDULE

Descriptive questions – tell me about?
Structural questions – how is knowledge organised?
Contrast questions – discuss situations in own terms – repeat back for clarification.

INTRODUCTION
Project about ...
Consent for interview and tape recording.
Will be no longer than 30 minutes.
Time allowed at the end for debriefing.

Key Areas

1. **Working in the team**

Q) What is it like working in this team?

(Partnership/ morale/ humour)

2. **Working across teams**

Q) How does this team interact with others?

(Across boundaries/ helping each other/ continuity of care)

3. **Handover reports**

Q) Tell me what happens during the handover report

(What is going on/ patterns/ social activities/ information sharing)

4. **Referrals**

Q) Tell me about the assessment of new referrals.

(Appropriateness/ staff nurses position/ who refers?)

5. **Other professionals' viewpoint.**

Q) How do you think other professionals (G.Ps/ Social Workers/ P.Ns) view the community nursing service ?

Summarise

Close interview

Debriefing/ make notes/ reflective account

Appendix 7

Excerpt from Interview transcripts (anonymised)

Excerpts from the interview transcripts (anonymised)

Interview number 1 - (L)

D- Okay L we are just about to kick off – at the end of the actual taped interview – I'll turn off the tape and we'll have a couple of minutes just to talk about anything that you might want to ask. First of all – I want to know how you feel it's like working in this team?

L- This particular team?

D-Yeah

L - It's very good – my role has particularly really blossomed since I've been in this team purely because they haven't got a G gradethere all of the time which gave me more of a chance.

D- What I've picked up actually from watching how you operate and ot's obvious that you're very confident in the role that you've got and errm that comes through – so being in the team is a positive thing for you?

L - Yes

D- Right – O.K. What about errm working across the teams. Sometimes you help other teams or they help you – what sort of – does it cause any problems when you do that?

L - Errm – generally no – you might be a bit slower to do the dressings because you've got to read about it first – read a little bit about the patient – (laughs).

Later in this interview:

D-You know who to ask really?

L- Yeah

D- I think that's fairly common really, but as you say, everyone knows who the helpful people are…

L – But the day will come when they need the help..

D- Very true

L - And the won't get it (laughs)

D- You reap what you sow they say.

L – Yeah (laughing together).

D- Yeah errm O.K. What about the patients? Are there any issues about continuity when you have help over a long period – cos this team's been quite short for a long time – hasn't it ?

L- Yeah – we get to patients and find they've got no dressings because people have forgotten to tell us or to ask us to order them – there aint many – who complain about it, but they do comment and the patients actually like us to stick with ours.

D- I hear things like – she'll only tolerate 3 layers, for example, and you knew that, but if someone from another team goes in – might be trying to pressure?

L- Yeah – or they won't have bandage from toe to knee – that's very common because they can't get their footwear on, which we'll understand.

L- But it's our policy to bandage from toe to knee and sometimes if you do it regularly –

Later on in this interview:

D- You tend to tell each other about how it's been and how you – I know Z had the zolodex injection to do and she was teaching you all about it during the report – I think that's something that you do as well – isn't' it?

L - Yeah – any new type of dressing or whatever.

D- It's a good time really for that sort of thing.

L - Yeah

D- Do you think every team meets like you do? To handover in the same sort of way? Probably an unfair question ? I'm just wondering.

L - In the teams that I've worked in –we did. Virtually every day discuss each patient – sometimes just to say – no problems – which is good (laughs)

D- But at least you've had that contact and you know that you're not waiting for someone to ring you or……O.K.

L - Yeah

D- And what looks simple on paper – sometimes…

D- I've actually covered all of the key areas that I wanted to ask you questions about – errm If I was to just finish off by asking you to sum up – how- tell me what district nursing is really about?

L - Oh errm

D- For you

L - For me – errm I do love helping people and I get so much job satisfaction from seeing wounds heal – I love it – sad- (laughs)

D- No it's not

L - I do – I really enjoy it – I dunno I think most of us have got a need to be needed in us – It's part of the job.

D- Yeah – thanks. I'm going to turn this off now.

Interview number 2 – (M)

D- O.K. M –and we're just about to start – So, can I ask you what is it like working in this particular team?

M - Brilliant

D- That's good

M - It's really, really brilliant – in fact it's its the best experience I've had

D- Right

M - It's –err –it's a very close team – we seem to have gelled well and errm I think it's because – not just becos, but one of the things that I think helps is that I worked with L before

D- Right

M- So I knew where I was coming, but Z who's the team leader, her attitude really makes a difference – her management style is excellent.

D- What's good about her management style?

M - Trust- she's built trust in the team.

D- Yeah

M- We trust her and she trusts us and you don't find that very often-

D- That's sad, isn't it?

M- It is – I've had some terrible experiences – absolutely dreadful, but here, you know, I feel trusted, I feel respected and I feel that I'm treated as a professional and they are the three things that I really wanted out of nursing – because I came into nursing late – I was a mature student and errm I was 53 when I started and I'm sixty next year

D- You don't look it mate!! (laughs)

M -So – and it's my own colour hair (laughing)

D- I know

M- Much to L's annoyance – laughing—errm you know – we've got a great sense of humour

D- Yeah

M- I think a good sense of humour helps

D- I've picked up on that

M- – But it's those other things that underpin it.

D- Yeah

M - You know – I mean we can laugh and joke but we don't get carried away – do you know what I mean?

D- You still respect each other?

M-Yes – very much

D- That's very good

M-Yes –it's lovely!

D- O.K. – so let's move away from being in the team now and we'll think about what it's like – how you relate to other teams?

M – Sighs!!

D- Yeah

Later in this interview:

M-- You see originally Dr X's patients were done by B clinic – now B team kept saying that their team – their workload was too big and we had a very bossy sister and she got rid of them on to L clinic

D- Right

M-There was no arguments – you know –she was adamant and I think it overloaded us

D- Right

M-- And that's why they've always had to ask for help- but now we've got another member of the team and she's coming along – when she's fully trained up this team will be brilliant, you know, absolutely the best and we won't have to ask for help – in fact they'll probably want us to help them and we'll probably have long memories! (Laughing).

D- (laughs)

M - Yeah – yeah – which is sad and it's a terrible thing to admit but we will!

Later in this interview:

D- O.K. –that's loveley – errm – you know that Ive been sitting in listening to handover reports – it's been really interesting – but I want you to tell me from your point of view- what happens when you meet at this time in an afternoon?

M - Well – we're usually exhausted (laughs) we sometimes make a cup of coffee and –and have a few minutes just generally chatting

D- Important?

M - To relax errm and then one of us will say Oh – can I do my handover now because I want to get off – to do – you know I've got a lot of insulins

D- Yeah

M - And that.s it and then we focus then – and er..it's just quite natural it's not – nightmare we've got to do this or anything like that – it's just quite natural – we all know we're going to do it – just one usually takes the lead

D- Yeah – so you share your information?

M - Oh gosh – yeah yeah – It's vital because you don't know if your going to go into that patient next time and it could mean something extra when you go in, things might have changed, things might have got better, worse – you don't know, but if you've got that bit of information it's – it's so much more, you know.. it makes a better visit.

D- Yeah

M - It saves you running around – a lot of the days – you know

D-That's really good – thank you – I think you do other things as well though – errm if somebody does something fir the first time you tend to teach each other – in report ?

M- Yes – yes we do

D- I think that's what I've seen?

M - If you've got any questions – that's always the thing with handover – if you've gone into a patient and they've got some kind of new cream or something – you read about it obviously before you put it on , but – you know – you come back and errm you discuss it – you know if somebody's been in . If, say, a specialist nurse has been in and prescribed this the treatment that they want and errm – you carry it out err and then you come back and discuss that and see – you know what the benefits of that will be – it was like that with Promogram errm – and it took some time for people to learn to use it- you know properly.

D I don't know it

M - Ah – you need to – you can't cut it or – you have to fold it in on itself.

Later in this interview:

M - Now – it wasn't a doctor from this practice and I said – well that's not acceptable. I said and it's unprofessional and I think he ought to go in and see her.

D- Mmm

M - And then when you've – he's been – will you ask him to write a proper referral and fax it to me.

D- Sounds right

M - And that's what I've asked them to do, but – we get very, you know – at the X hospital as well. You get the wards ringing up and saying – Oh yes er,, so and so is going out today blah blah blah and I say Whoa Whoa – that's not a referral – you know the referral line. "I don't know anything about it" you know and they pretend they don't know or we get referrals that really annoy us – errm from the 4th of this month and we got them 2 days ago-it's the 19th now!!

D- Yeah?

M - And that really upsets us

D- Yeah –because it could have been much better planned?

M - Well that's right and they don't like it when you complain – you know if you grumble, but it's not, you know, fair on the patient.

D- We're doing very well actually we haven't got a lot more to look at. Errm How do you think other professionals view district nurses?

M - Oooh well- a bit like charity cases really – we're not really nurses cos – what do we do ? we just give injections you see –

D- Right?

M - And I educated her by saying – would you like our view of intensive care nurses? And said Oh yeah and I said our view is you have one patient to look after- right – you don't even have to talk to them cos they're unconscious and you still moan!!! And I showed her my book –you know and I said that's the sort of page I have of calls- you know I can have anything at that time – It was, could be 20 calls a day.

D- Yeah?

M - Which was overload, but that's how it was

D- And you don't know what you're going to find at any house?

M - I said you don't know what you're going to find, you know it could be anything and I said – it's not just injections, I said there's a multitude of things we do and on top of it all that's palliative care, which is a big part of the job.

D- Part of the job ?

M - And that's not just sitting and listening to people and there's more about palliative care – it's not just cancer patients – it's other patients and I said it's being aware because I mean – like the other day – I went to see a patient and I looked at him and you just look and you know something – and you can't put your finger on it – he's in hospital with this pneumonia and then I went to another one and I thought Oh dear it's one of those days – I mean he was dehydrated, you know and he'd got this bossy daughter – you know cos you haven't just got the patient you've got the family and you are in their house. You're on their territory – you're an invader – so you've got to have tact, diplomacy, patience, but it's a wonderful job. I think it's the best job in the world. It's what I came into nursing for you know –this is what I thought nursing would be like in the hospital and it isn't – it's vile – I hated the hospital.

D- Not as personal?

Interview number 3 – Team 1 (N)

Excerpt:

D- How long have you been here now?
N - Well I actually started the 5th April, but it was about 3 weeks after that that I came over here – because I was originally at B clinic for a short period. .errm I'm enjoying it –you know – I mean there's nothing I'm frightened of asking

D- Good

N - Or if I'm at a patient's house I'm always on the phone to L - L will tell you – 3 times you know in a morning sometimes.

D- That's good

N- About, just little things – just a bit of reassurance for myself – and I'll get my confidence a bit more.

D- That's what it's about?

N - Well that's it – yeah

D- That's great

N- At first I thought Q Clinic – a bit further for me to travel and all the rest of it, but errm no –I'm pleased.

D- Good

N - I'm getting to know the area

D- That's great, thank you – errm – O.K. I know that you've been short of staff for a while....

N - laughs

D- And you've had to have help from other teams and I just wondered how that works from your point of view...?

N - Errm – in particular last week we were very short staffed – there was just myself so I liaised with x clinic – they were absolutely fantastic – Sister there and the team members – errm things like sorting the work – I've never done that before because of the staffing problems we've been experiencing. I haven't been able to do that, but as you can see I've been trying to – get to grips with it. They've been really really supportive. –errm.

D- It must have been quite daunting? Being left on your own?

N- Oh it was terrible (laughs) – Monday morning I was driving to work and I was thinking – Oh my goodness – how am I going to cope? I didn't know how I was going to cope – by Wednesday Thursday Sister x said "you look a lot better today than what you did at the beginning of the week – they realised that – you know- being a newly qualified as well.

D-Yeah?

N- The pressures were immense for me really and I was having, giving my patients away and getting – them feeding back, reporting back things to me, but some patients I didn't know them at all and I felt that was quite scary – errm. I was writing all these notes down and well as liaising with the teamleader errm at x clinic – I was thinking "these patients-I don't know them at all", but what if something goes wrong – you know and I was quite stressed. I'll be quite honest with you – I was very stressed last week. It's just – a big sigh of relief...

D- A bit of a baptism of fire by the sounds of it?

N - Yeah, but I think the occasional clinic and the occasional person would think I should, you know, know these patients and they were asking me things about them – can you get such and .. as they need this or they need that and I felt ..sometimes a bit honing in on me. .errm

D- Cos there was only you?

N - Yeah – cos there was only me in this clinic and that's that's how I felt to be honest last week... I felt "do these people know I've only just started?"(laughs) and I think, you know, that people were aware – at the same time people have got their own jobs and responsibilities to do – they're giving me information about our patient at the same time I'm thinking "what should I do now then?" ..apart from that..

D- But you survived it?

N - I survived it and I came back today after 2 days off (laughs) – of course it was my first weekend last weekend as well – so that was the wrong weekend to work, really – after the week I'd had, but err

D- Weekends can be very stressful, can't they?

N - Yes – so I must admit it was quite nice – we had a nice sister on the weekend as well – so – that was good.

D- O.k. – I'm just going to ..move us on now – I have sat in on quite a lot of handover reports – so I've got an idea of what goes on, but I'd like to know, from your point of view, what happens during the handover report?

N - Well – basically for me – I look forward to the handover – it's my way of – the patients I've seen during that day there might be just the slightest thing – I might think – Oh a bit concerned or even – we're running out of dressings – It's my time to say to the rest of the team, who've got more experienced members of the team, any problems, anxieties about the patients that I might have or anything relating to that patient and the part that I'd played in the care for that day – It's my way of letting off steam and saying ..errm..

D- It's important?

N - I think it's really important. I really do – you know- there has been occasions when you don't get a report and I'm like – but I always make sure that throughout the period that I'm in the office, I mention all the patients – (laughs) I get it in – just for..

D- You feel better if you do ?

N - Yes – definitely – you know. It's like last week, you know, we were having report- I was telling people about my patients, but they didn't know them anyway and I, again, you feel a bit isolated really, but no I think they're really important and also it's not only what I'm telling people – when people tell me about their patients it might jog my memory about something about that particular patient that I saw last visit and – you know – perhaps errm you think "Oh yes – it was like this and I wrote such and such in the notes ..and I do think that they're really important.

Later in this interview:

D- Errm – how do you thinkG.P.s, Social Workers and Practice nurses view district nurses – in your experience so far??

N- So far – I think that whatever field you work in – errm in the health profession you're in, I think – errm I think G.Ps – I think from my experience they want us to go out and see somebody there and then – I do't think they realise that we've got other caseloads – other patients – and errm and again the the practice nurses we sometimes have patients that nine tenths – are quite capable of going to the practice nurse for a dressing but were getting them for referrals – errm

N - Social Workers – I thnk errm it's, you know, with the errm community assessments that the nursing assessment – I think again – I don't think that they appreciate how heavy our workload is currently – errm when we say we can't do an assessment until.. the impression I get they might be a bit off with you cos, I don't think they appreciate really what we do – at all –errm I think they just see us all as dressings – and waiting by the phone, you know, for calls.

D- Just for them to ring?

N - You know it's almost as though we're on call 24/7 – although we are – it's you've still got your work allocation for that particular day.

D- Mm – Yeah?

N - And they expect –I don't know – I think the just expect you to be at their beck and call a lot of the time.

D- Yeah?

N - That's the perception I've got at the moment.

Interview number 4 – Team 1–(Z)

D –Ok Z? – I will use your name, but when I transcribe it I won't write your name

Z – Right

D – First of all can I ask you what is it like working in this team?

Z – Errrm It's a very happy environment – er very co-operative – we're very happy – errm sometimes it can be very stressful because of being a part-time sister – actual stress and strain.

D – Yeah

Z-And I also think it puts a lot of stress on the other team members because, obviously, they ? senior cover, but all in all- I think we compliment each other very well and it's very nice ..

D- Everybody says that in your team..

Z-Yeah? I mean, you know – obviously there are problems as in all teams, but on the whole we are quite a happy bunch.

D- Yeah

Z- Our personalities errm seem to get on very well – professionally but we also are I'd say – we're friends as well – not out of work, but you know- in the situation – yeah it's very nice.

D- Mm. That's what I've picked up really. I would agree with you.

D- OK Errmm- I know that you've had problems with staffing recently and that has meant that you've been having help from other teams..

Z- Yes

D- And I just wondered – from your point of view – errm – how does that work?

Z-Errm – to be honest – since I've come back from maternity leave, which is about 18 months now – it's been continuous, for some reason or another, that we've been having to have help and I think it's very frustrating – I mean the other teams are very co-operative and we do try to work, you know, together but you do get a feeling that you are – how you are seen by other teams and you get some of the team members from some of the teams can get quite short with you, you know, and they think, you know, (that) clinic are phoning <u>again</u> for help and it's also frustrating for us as a team because we can't follow our patients through and I spent a lot of hours on the phone trying to move patients and cancel patients and it's <u>very</u> frustrating and it's quite demoralising when it gets like that.

D- Yeah?

Z- That you can't do the job properly

D –I think that continuity of care must be a worry?

Z- It is a worry – I mean – we had a team meeting in the week and I do feel overall that it has been pretty horrendous – the last few months and I do feel that we have..

D.Yeah?

Z – Managed to keep the standards pretty high and that's down to the sheer hard work and motivation of the teams – to be honest and I'm very pleased that things haven't slipped and we are pretty up to date and that another thing as well – we do move our patients onto the weekends if it's our weekend so we do follow it up on the weekends and weekends are slightly quieter so we have managed to tick over.

D- Right

Z-But it's not the best way that it could have been and this week, having all the staff in, makes a big difference – it's like a pressure has been lifted off you and you can actually do your job properly again – instead.

D- And enjoy it maybe?

Z- Yes and also you start to feel that when you're asking for help maybe the help is there but because they're so fed up of you asking and they're having to cancel things that they need to do – that they've come to the end – people don't want to help – any more – so it's it can get quite nasty really – it can get quite, you know..

D- That's very honest of you..

Z- You don't want to – you get to the point where you don't really want to ask any more because you think they'll think "oh no not them again asking for help, but at the moment there's problems with other clinics and we're actually helping other clinics – that's a bit of a shock (laughs)

D- Yeah?

Z- So – it's swings and roundabouts but it has been particularly bad.

D- Yeah – OK that's great. Now you know that I've been sitting in on handover reports…mm?

Z- Yeah

D- But I'd like to know from your point of view – what happens during the handover time?

Z- What we actually try and do when we come in errm sort of half way through the afternoon is that we all sort of sit down and it should be that everyone is

actually not doing anything else – that sometimes is a problem because of the phones ringing or you're sorting work out, you know, for the afternoon. You should really be sitting down and listening to each person's list that they've done in the day – errm the progression of the patients and contributing to ideas.

D- Yeah?

Z - You know – changes of treatment – especially cos I'm part-time errm I do feel that we need a quite in depth report, because we have sort of quite errm one day there'll be 3 people and the next there might be 2, so I do try and get them to have quite a detailed report – if possible – sometimes that's not able and obviously we have to have a quick report – of is there any changes and the major patients that we have got problems with errm but on a day to day basis we do try going through the patients that we've seen.

D- Yeah?

Z- Sort out the patients that we'll see tomorrow – if there's particular problems as well – especially with junior members of Staff.

D- Yeah – so apart from sharing information about the patients, does anything else happen during that time?

Z- Errm – well I suppose we're looking at the wider aspects of care errm and sort of say well been speaking to the doctor or we spoke to the social worker or

D- Errm

Z- And we'll talk about the picture in general the wider picture in general, but also discussion sort of errm try to get other ideas it might even come down to somebody might suggest a treatment and they would say to them "well why do you think that?" – so it's because of a sort of learning environment as well.

D- Yeah – that's what I thought was happening.

Z- Yes – you say <u>why</u> do you think that or what do you think and I do hope that everyone's opinion is valued you know and everybody answers and they say things like you see that patient next time and then it sort of focuses upon patients that I should actually try to get out to see – so really it's more sort of like a learning environment.

Later in this interview:

D- Yeah – that's great thank you. I would agree with you – yeah errm can you tell me a little bit about the assessment of new patients? –so where do your referrals come from and who tends to assess patients?

Z- Errm – the majority of complex patients are done by myself as the G grade here or L who's an F grade and now L does community care assessments so we do the same sort of amount of new patients – my 2 D grades don't do any new patients at all because..

D- Right

Z- As you know, at the moment, D grades don't do any assessments – but that is changing.

D- Yes it is changing – I know about that..

Z-Yeah – it will be very useful – errm

D- You see that as a good step forward?

Z- I do yes – I do – I think that as trained nurses we are trained to assess and I think with the right teaching and the right mentoring it will do good for the staff as well and also it will enable us to do reassessments and follow up complex patients as well so I think it will improve everything really – patients and staff nurses errm the majority of the patients come from either the GPs here or our other GPs that we cover – or from the x hospital.

D- Right

Z - Or from other areas such as the Macmillan nurse – we've just had a referral, social workers, practice nurses..

D- Yes? So you get referrals you say from GPs and practice nurses and different agencies – that leads me very nicely into this next question which is – how do you think the other professional groups view the district nursing service?

Z - I think that we're very lucky here with the GPs I do think that they appreciate the role that we've got and 9 times out of 10 we don't get inappropriate referrals.

D- That's good

Z- I do know that there are some GPs that ask for errm for instance, a bp checkor, you know, something that is inappropriate or patient could have gone somewhere else and you still get the old can you pop in and I don't think some agencies appreciate the time constraints – err the workload and the documentation that we have to do as for a new patient, I think.

D-Mmm

Z -They don't understand why you've got to have an hour and a half to go and do an assessment. Well why can't you just go and put a dressing on and it'll

take you 10 minutes – I do know that that does go on in some teams, but luckily we do feel valued here – practice nurses are excellent here as well – they liaise with us we're never told "you've got to go tomorrow – it's always, obviously contact the patient, but within your sort of work pattern – they're very good – very good.

D- That's good

Z - And the hospitals have improved as well – so basically we don't have inappropriate and I think we are quite valued

D- That's really good to know

Z- The doctors are very good at sort of popping up and you know explaining problems and stuff like that – so.

Interview number 5 – team 2 (Y)

This was a problematic recording – I took back the transcription to this participant and asked her to check that it reflected her thinking and memories of the interview.

* = A GAP IN THE RECORDING – PROBLEMS WITH TAPE RECORDER

D- 14.30 on the 27th of ....and we're just about to start our interview.

Y - OK

D-So – first of all Y, I'd like you to tell me what's it like working in this team?

Y- Laughs – where do I start? Errm it's a very nice team, but errm as you know, there's been a lot of changes recently so it's unsettling with Q the G grade going it's more unsettling for me cos now I'm in charge for a short while.
Errm – as well I've had J which – she's the new E grade staff nurse in the team – she's been with us for a couple of weeks now.

D- Right.

Y- So there's been a lot of ..*....She just been made up to E grade she's just qualified – so the team is quite new and inexperienced really, from that point of view – apart from X She's our DEN – she's got years of experience of course.

D- Yeah – she has.

Y- So –yeah – it's quite a nice team – I always like working here.

D- Quite an interesting time, perhaps?

Y-Yeah – because we're a small team as well – I think that's nicer.

D- Yeah

Y- You can get to know all the patients *

D- And each other – you get to know each other better?

Y- Yeah.

D- OK – that's lovely – errm I know that you've had a few times when you've not been so well staffed and I know that people help each other out during those times – so – errm how do you feel that that works? From your point of view – when you're getting help from other areas ? Or helping other areas?

Y- Errm – we've helped other areas recently because we were better staffed than they – up until Q leaving.

D- Mm?

Y- Errm it works quite well – it's difficult (laughs) – I don't know what to say really on that one....cos....

D-Let me say it and see if you agree?

Y- Go on then (laughs).

D- You know who will help you and you probably know who won't?

Y- That's true – yeah. We are good at helping other teams, but it's difficult when you're asked particularly to help a team that you know would never..*

D- It's about knowing who – who's in which team?

Y- That's right.

D- It takes time to find all that out doesn't it?

Y- It does – yeah.

D- OK –does it affect continuity of care – do you think when you've got teams helping each other out?

Y- Obviously –yeah – for the team you're helping out with the patients – you don't always get the whole story so..* they end up with different nurses all the time – it's not nice for the patients.

D- Mmm?

Y- New faces every day – Yeah

D- New faces every day you were just saying?

Y - So from a patient point of view – I don't think they particularly like it.

Later in this interview:

D-No? -* You know I've been sitting in on lots of reports and making notes – I'd like to know from your point of view what sort of things happen during that handover report time?

y- Errm.. apart from updating each other on what's happening with a particular patient I think you also gain insight into that person's knowledge and their capabilities within the team.

D- Yeah? *

Y- As well as getting to know them and their personality..

D- Yeah?

Y- That comes over quite a lot in – errm and I suppose as well we do make some judgements about patients – I don't know if you've picked that up?

D- I think that's normal – it's just being a human being, isn't it?

Y- So – I think – I suppose with you coming in listening – I've thought more about it and very often we say "oh she's a nice lady" or – you know –

D- I think that's normal.

Y-Yeah – we shouldn't really –should we ? (laughs).

Y- Yeah – I didn't particularly worry about what I said in front of you it's just – I thought more about what people were saying and you pick up more on things yourself because someone is listening in on it. Perhaps you think more as an outsider would?

Later in this interview:

Y- A positive thing yes as well as for the E grade staff because otherwise you're deskilling them – you do forget how to do the assessment – for myself particularly it had been what – 6 or 7 years before I'd done full assessments and it was – it was quite an anxious time.

D- You need to build you confidence up?

Y- Yeah – you do – yes.

D- And they're going to be prepared to do it – so that's the right way to do it.

Y- Theory and they'll have mentorship *

Later in this interview:

D-Ermm – what about moving on to other people that you work with – the GPs, the social workers and the practice nurses – how do you think they view the district nurses? What do they think you're here to do?

Y- Errm well the majority of – wound care –so we do get a lot of leg ulcer referrals and obviously pressure areas so it's more that type of thing – errm * (laughs) – some of our GPs I must admit do give us inappropriate referrals – I think they just think we.re here to take anything *

D- Anything their not sure about?

Y- Yeah – sometimes I think if they get problem patients they'll just off-load it onto us – just so they don't have the problems at the surgery – perhaps.

D- Social workers?

Y- Social workers – errm it just depends which social worker you talk to really – we've got some very good ones, but we have got a particular one – errm I don't know if he didn't appreciate our role or he's just moved – one particular social worker who we've been dealing with recently – whether it's because he doesn't understand our role fully or just rude, bur he's been a particular problem – is that OK? (laughs).

D- Yeah

Y-Did you mention someone else – or?

D- Practice nurses?

Y- Oh practice nurses.

D- Or nurse practitioner even?

Y- (Laughs) - That's an interesting one.

D- Yeah –I've picked up.

Y- Yeah –errm we have had a problem with one recently where she hasn't been happy to take out clips – errm when you think of an advanced nurse practitioner- you think – you know.

D- Who can't take out clips?

Y- Who can't take out clips and you're wondering – what can she do?

D- I she a qualified ANP ?

Y- Oh right – no I believe she was taken on for that role.*

D- Right.

Y- She also referred back a young patient with a surgical wound, which was a straightforward surgical wound – but that was more for our speciality to deal with – which was interesting – I just wonder what this nurse, you know, what her particular forte was, sort of thing.

D- What can she do?

Y- I suppose in that instance really – well we did try at the time – to perhaps go and speak to the GP and the nurse involved and perhaps discuss, you know, what sort of thing to pass to us. It would have been the ideal thing to do, but obviously since then we had a crisis in the x sector and we had to help out.

Interview number 6 – team 2 (X)

D- OK then X –what's it like being a member of this team?

X – It's very good actually – it's a relaxed team though. There's new members at the moment – there are going to be changes.

D-There are changes as you say.

X -Yes.

D- So it's interesting times?

X- It is – it's confusing for patients as well, you know, who's going to be the boss and who's ..going to – so they're a bit concerned, I think.

D- Yes there's a problem there because Q used to do them (nurse prescribing), didn't she?

X- Yes

D- And patients are used to that now.

X- And the GPs.

D- And the GPs – OK that's lovely, so on the whole it's a good place to be?

X-It is – I like it here I'm settled.

D- Good – OK errm – sometimes you're short of staff, sometimes other teams are short of staff – how does it work out helping across the teams?

X - Well – we sort of tend to do more of the helping rather than getting help.

D- Right?

X -Cos I've been over to errm the south helping out there as well as doing patients here.

D- Right?

X –Recently it's been worse – but..

D –What here or in the south?

X -Well –everywhere really and we've sort of ended up helping more because errm – they seem to think that we've got more staff here than anywhere – but (laughs) – it has been hard this last few months.

D- Mmm? I think I've picked that up from other areas as well. Do the patients like it when you're not from the team and you go and visit?

X- I haven't had any problems at all.

D- It's probably how you are with them?

X- I think it probably is – but I haven't had any complaints to myself – nobody's ever said anything to me.

X- For them to ring – Yeah.

D- OK – so on the whole they don't realise how busy you are?

X – Definitely – I don't think they do – no.

D- Might be quite shocked if they did?

X- It's the same with the patients they think you only come to them – they say how busy the hospital is – you only go to their house and that's it – you're sat there.

Interview number 7 – team 2 (W)

D- Just after 2.30 – this is team 2 O.K. W– We're just about to start so – first of all – can you tell me what is it like working in this team?

W - I enjoy working in the team because I feel quite lucky – because we work quite close with each other.

D- Yeah?

W - Although we get a lot of work in we all have a laugh together and that – we make sure that the work's equal whoever's taking it out that they're capable of doing it -

D- You do seem to work well together-

W -We all seem to get on with each other personality wise and everything and although we do have a few ...

D- That's normal really.

W- Yeah – really we get on quite well with each other the majority of the time.

Later in this interview:

D- O.K – What about when you're helping other teams or they're helping you – how does that work?

W – Well (sighs) – what we have been doing is well we've been getting everybody's patient hours in – getting the actual nursing hours - and if someone is short and we're able to help – help them out.

D- You help them if you can ?

W - Yeah – errm some occasions we've had it where we're going out with more work than the team that we're helping are going out with.

D- Interesting?

W- And sometimes – well we never get any help – we never get any feedback back or asking to see if we're alright.

D- That doesn't seem very fair?

W- No and at the moment I'm having a problem cos I'm running a leg ulcer clinic errm on Tuesday I was having a right game trying to get somebody just to cover for 2 or 3 hours at the leg ulcer clinic and nobody wanted to help – the majority of patients were other teams and next week I've had to cancel it because no one's willing to help again, but they want the service to carry on running but they don't want to put any effort into it – it's unfair and it does sort of make us feel angry – because we're always helping other teams out and we're never getting anything back.

D- Why is that do you think?

W- Because – I think it's mainly because they see us as –we've got 5 staff on all the time – the majority of the time – errm they've got 2's and 3's, but they don't think that we've got work to fill all our hours and that – they think we're cushy all the time – a few hours each, but we're already going out.

D- It's a pity there isn't a way to let them know - isn't it?

W- Well – we're actually started doing it through someone else now – like all the old – but everybody's – nobody's helping out anyway and nobody realises how big our caseload is and they still think that we – because we only cover an area with about 6 GPs that our caseload is quite small – well it's not and we cover quite a large area.

D- It's not just about numbers is it?

JW– No – I mean we have a lot of people from out of areas that other teams don't have.

D- Cos you're on the border, aren't you?

W- We're on the border – we've got and we've got residential homes and out of area GPs and nobody else seems to take that into consideration.

D- I know from when I used to work in the community – I know you're right (W-laughs)

Later in this interview:

D – Well OK- as you know, I've been hanging around whilst you've been having your handover reports – and taking a few notes, but what I want to know from your point of view is – what sort of things go on during the report ?

W – Well we have a laugh about things.

D- Good.

W- We have a moan about patients sometimes and we'll all have a laugh and a joke – if somebody who we've been going into year after year we'll say "them the same" – no change in em really – we do have a laugh during it..

D- Its important isn't it?

W – You have to really just to .. I think it's important to have the handover cos if you – if you're taking on new patients or patients whose condition is changing, It's the ideal situation , there's all the information across where you've been and what you've done – the things you've put in so you don't damage or (*) what someone else's done really – we do find the handovers useful – admittedly sometimes we do switch off half way through.

D- It's interesting to watch – sometimes people are very –hanging onto everybody's word, but when you're busy trying to write your care plans and things it's difficult?

W – Yeah – it is now especially now Q (G grade) has gone we're finding it very hard to have the handover – and when we do it's like – OK I do this whilst your talking and we're on the phone and we're just carrying on.

D- Yeah – and then you lose that contact and don't have time for a laugh, don't you? And you need it more when you're so busy?

W – Well – Yeah and when you're going in you're not quite sure what's going on and whether it's this patient that needs. .and then you have to read all the care plans and ..

Later in this interview:

D- OK – that's great – just one more question then.

W – OK

D- How do you think the other professionals – the GPs, social workers and practice nurses view the service that the district nurses give?

W- Well..

D- What do they think that you do?

W – They think we just "pop in" and have cups of tea I think sometimes – I mean even though they're meant to be more aware of what we do and what we're capable of doing at the moment they think that – "can you just pop in and just have a look at so and so's leg or foot or something" and they just think that we've got no paperwork to fill in that we just tootle round…

D- You're a little pop in service then?

W – Yeah – we –that's what we have a laugh in the office – the "pop in service", cos they all have ..

D- So that's the joke is it? – That you're a pop in service?

W- Yeah, but errm it does get annoying to sometimes you're thinking well they can actually get out – patients who can't get to the practice nurse – we've got to go into them – for whatever reason and it could just be – well she can't actually.. or the GP can't actually see her for a couple of days – so can we just pop in.

D- So you just pop in again to do the BP – even if she goes shopping?

W – Even though she goes shopping – she's out and about and she goes down W to do her shopping – She can't get to the walk in centre. Also – people have managed things for years and , all of a sudden, they can't do it no more – so can we just pop in and make sure they're OK?

D- Yeah? – because someone else has got involved?

J – Yeah.

Excerpt from Interview number 8 (anonymised).

D – yeah – it's an easy thing to do to just pick one person out? O.K. I'm looking particularly at what happens during handover reports so – what sort of things go on during that time – in your opinion?

V – well – we have a lot of difficulty errm having set reports in the afternoon – we'll start a week off being really dynamic and promising that they'll have a report and we might do it the first day and then it goes to pot…

D- when it goes to pot, what happens?

V-well the phones are going – people are having to go to meetings or to see additional patients so you haven't got the whole team there that have worked the day – so what will remain is giving each other little titbits during the day –

if you come in and you've had an experience – you'll speak about it at that time – usually when people are on phones again and things are going on and people are popping in and out to do photocopying-

D- what effect does that have on the team do you think when you don't meet up?

V – errm well – you haven't got that kind of support with each other – you can't have like a debriefing – errm if you're having problems with a patient you're keeping all the problems to yourself and then taking them home and becoming frustrated – patients are suffering…we tend to rely on putting notes and post its on patients notes or documentation so that at the next visit things are getting done that need to be done.

D – it's not ideal is it?

V- no – and we like get frustrated because you follow up with your next visit, realise that something hasn't been done that you wanted done and then that's either delaying treatment or it's just – because you want something to be a continuous process and it's just being hampered all the time.

D- yeah?

V – and it's just – you try to have a report and say well this must be done there's never a time when they're all concentrating on what each other's saying – you're always preoccupied-

D- Do you think report is a necessary thing – is it needed?

V- yeah it's the first thing that we try to reintroduce every time that we've got all our numbers of staff back – errm because we can discuss things between ourselves – frustrations and that we're coming to or patients – you need other peoples' ideas on…

D – yeah?

V – and then you can make changes to that care – according to what your colleagues have said,

D – so it's about listening to your colleagues and continuity of care?

V – yeah

Appendix 8

Excerpt from field-notes (anonymised)

Excerpt from field-notes

<u>3rd February – team B</u>

Y/ W and X are in the centre.

2.25P. X and W are writing care plans.

Y is tidying up the office.

Y – "How's x?"

W – "alright – it's been sticking to it – she's got a sweat rash, but the carer said it's cancer – the daughter's a bit hyper – she's come out of hospital incontinent "
It is generally agreed that this is a common problem.

W – answers phone.

Y asks "seen any more houses W?

Y "they don't seem to like giving out laxatives in the care homes – every so often it builds up and we go in there. He can't bear a manual – he can only just take the enemas"

W asks advice from X re the care plan she is writing.

Discussed the diary sheet codes.

I ask "do they reflect what you do?"

General view = no "although it's better than before – there are sections on "giving advice" etc."

I obtained a copy of said codes.

A sharing of information during the tidying up.

X " is x still in a 3 layer?"

Y "yes – what was it like today?"

W " She shouldn't be too long (to heal up).

Note – there is an Auxiliary attached to team – she calls in to clinic on Fridays. "She does washes and folds up bags and aprons" saysW

2.50p.m. X reads Journal of community nursing.

Y is out of sight tidying up.

W is putting care plans in order – not much interaction between the three members of staff today so far.

(I feel a bit in the way today)

2.55 p.m.

X comes in with a singing stuffed monkey!! – all laugh. I talk with Y about the new manager – she has not met her yet- she says too many new staff.

W gets a call "I can't get there for 6p.m. tonight – we will have to view tomorrow"

Y rings care home – "will come and see Mr x – could you have him ready on the bed?"

X reports – 3p.m. name and medical condition are given – "Mr x – looking better- hoping to go away next week"

X "Mrs x doesn't want us on Friday – she is having workmen in"

X "Mr x – he's been in hospital with pneumonia – mobility is now gone – will now need a nursing home – so that's it"

W's report

W "I waited 20 minutes- no answer" discussed Mrs x's healing leg "3 layer on one leg, as she can't tolerate 4 layers. Mrs x out of hospital – her daughter was annoyed cos they didn't give her aspirin in hospital".

W "Mr x – he couldn't hear me although I could hear him – so I went to the neighbours and they let me in….they're a nice couple"

Y's report:

Y "Mr x – had been admitted to hospital">

Y "Mrs x – she never leaves the house but knows everything going on". – all laugh.

Y "Mr x is 86 and has got a girlfriend – she looks after him. He has meals on wheels".

Interrupted by telephone call Y answers.

Y "Mr x – I thought his foot was worse, but J thought it was better".

A debate follows about treatment

Y "I will go again on Friday to check the swelling. Mr x – she is OK – the funeral was on Friday- she will bring his notes in".

X "has anyone else had problems with Hampshire dressings- gloves splitting? No reply.

W is looking at the work for tomorrow. Q has "Earlies" in P (another area) tomorrow.

Discussion follows: the workload for each member of the team.

Inappropriate referrals discussed. "I don't know why he was referred to us in the first place – he never needed us".

15.15p.m. report ended

<u>11.3.04 – 14.50hrs – team 2</u>

present = P, W and Y

Also student – O

Still very busy – lots of new patients and blocked catheters.

2.55 – all writing up care plans.

W is happy –now has found a house.

Everyone is sitting in their usual seats "leave on X's desk" – each allocated space with a folder named for each member of the team.

Discussing new staff began at another clinic.

A "floater" on at the weekends – the "floater" fills gaps at least one team has too much work on at the weekend.

P "She's the Advanced Nurse Practitioner – don't call her the practice nurse PLEASE – she's very particular"

Y "If she's an ANP why is everything passed on to us"?

A bit of friction???

15.05hrs – chatting – not into formal handover yet. P is sorting out work for tomorrow = 18 hours work and 3 of us on.

Y "the weekend's going to be dreadful? 6 x diabetics plus a tetraplegic patient who needs a manual (evacuation) all for early visits at the weekend. A lot of new patients are diabetics.

15.10

Y "look at the time .....shall we have report.....I'll start with a new man –a complex new patient – only 49 – very obese and with heart problems – I've ordered dressings"

Whilst Y is presenting the phone rings – W answers

All laugh when Y says "her son was trying to nick my dressing pack"

Only W looking at Y – rest doing other things. W nodding encouragement.

W begins 15.20hrs

She launches straight in with no introduction or ceremony. "doesn't look his age"

W " it didn't stick so............unless I've done something wrong" – laughs and feels at ease saying this

Y "no- they do an adhesive one but we haven't ordered it" – laughs

Y is listening, nodding and encouraging.
P- 15.25 HRS

"right – (gives a big sigh) Mrs X virtually healed."

Other 2 Y and W – eye contact with P nodding and listening – more interactive non- verbals between the group now

P "Mrs x--- is Ok ---Mrs X couldn't get Doppler readings- could not get pulse – referred her to Dr* and left a message for - the Advanced Nurse Practitioner (said ironically and all laugh).

P "We've had a merry old time with J, haven't we (amusingly said).

3.30 – all animated now discussing/ joking.

This team seems to always report in the same order.

With Mrs J – you have to do what she'll let you do.

Y "Mrs x used to hide £20 notes in her bandages – from her daughter" – laughing.

<u>16th March 2004 14.55 hrs –team 1</u>

present = Z,L and M

NEWS: there is a list of patients who have recently died being kept in the Docs reception area. L decides to make a list of patients recently admitted to hospital to check with the list.

Discussing patients informally – lots of nodding and support going on.

They joke about M -her age (58) and claim she has alzheimers – probably got lost.

15.20hrs Z "would you like to begin?"

L begins – official start of formal proceedings.

Difficulties arise from "giving away" the same patients to other teams when busy. Lack of continuity

M – "lets face it – she's someone you WOULD give away" laughter.

N.B. this team is still one member short – a new member of staff will arrive beginning of April – hopefully.

L waiting for a patient to come home from hospital today to be assessed.

M "so!!! (begins 15.30hrs) a patient says that they have been visited by "that L" – but I'm glad that you're back" laughter.

Again continuity problems with "straightforward patients.

Z "hopefully things will get better now (M has just retuned from sick leave).

N.B. M influences the dynamics in a positive way – more light-hearted.

15.32hrs phone rings – L answers.

M "I've discharged someone today – hurray! (she waves the care plan in the air).

15.45hrs. M says she has visited mrs x "Who could walk to the practice nurse for her dressings – she doesn't tolerate the compression.

Z begins at 15.47hrs "I've seen……….is doing well"

Lots of leg ulcer patients on today.

Z " problems with the catheter..evening staff did a bladder washout, but still not draining so I recatheterised. The PH was high – now draining well and she's happy.

Z – bereavement visit. Outlined visit. "that's it of mine" – ending her report.

15.55hrs Z "right – lovely everyone's happy"

She calls a halt to the handover session.