Information exchange between patients and nurses during routine nursing care in ward settings: A qualitative multiple case study

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Declaration

I declare that this thesis is entirely my own work.

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Abstract

Aim: This study explores what type of information patients and nurses share with, or provide to, each other, and whether or not the information received was relevant and sufficient for their needs.

Background: Information exchange, as part of shared decision-making, is advocated in policy and practice throughout the healthcare sector. Much of the literature on information exchange relates to one-to-one consultations with consultants or GPs. To date, no studies have explored information exchange between patients and nurses in ward settings. Nursing literature on patients' information needs focuses on one-way information provision from nurses to patients, rather than on two-way information exchange between patients and nurses.

Methods: Interactions between patients and nurses were observed and audio-recorded using a remotely controlled audio-recording system. Semi-structured individual face-to-face interviews were then conducted to clarify and add to the observation data. A multiple case study design was used for this study: each case comprised one patient, the nurses caring for that patient, and the interactions between them. A pilot study was undertaken to inform the methods for recruitment and data collection for the main study.

Results: The pilot study comprised five cases (patients n=5, nurses n=3). Changes to the recruitment strategy for the main study included surgical patients being invited to participate in the same way as medical patients. There were no difficulties with the data collection methods. The main study comprised nineteen

cases (patients n=19, nurses n=22). Information exchange seemed unfamiliar to ward-based nurses. The findings show that information exchange may not be a one-off event but a complex series of interactions. Patients did not distinguish between clinical and non-clinical information in the same way as nurses. Primary reasons for patients' hospital admission were not discussed and nurses did not share information about nursing interventions. The relevance for patients and nurses differed; patients generally wanted information for reducing anxiety and socialization; nurses wanted information for assessment and care planning. In terms of sufficiency, observation sessions highlighted that insufficient information was provided, often due to lost opportunities and paternalistic practice. However, the majority of patients and nurses perceived that they had exchanged sufficient information.

Conclusion: This multiple case study provides insights into the type, relevance and sufficiency of information for patients and nurses in ward settings. In ward settings, information exchange as conceptualised by Charles et al. (1997 and 1999) may be difficult to achieve due to the complexity of patient/nurse interactions. Therefore, there are implications for policy makers as policies are not context specific. However, information exchange may be helpful for reducing patients' anxieties. The concepts of shared decision-making and information exchange are not part of ward-based cultures and philosophies, which suggests implications for patient and nurse education. Research on information exchange between patients and nurses in other ward contexts may contribute to further understanding of information exchange in ward settings.

<u>Acknowledgements</u>

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List of Abbreviations

ADLs	Activities of Daily Living
AHPs	Allied Health Practitioners
AKA	Above Knee Amputation
ASSIA	Applied Social Sciences Index and Abstracts
BCG	Bacillus Calmette–Guérin
BP	Blood Pressure
CINAHL	Cumulative Index to Nursing and Allied Health Literature
COPD	Chronic Obstructive Pulmonary Disease
CSF	Cerebral Spinal Fluid
DM	Decision-making
ECG	Electrocardiogram
ENT	Ear Nose and Throat
ERIC	Education Resource Information Centre
FY1	Foundation Year 1
GMC	General Medical Council
GP	General Practitioner
HDU	High Dependency Unit
ICU	Intensive Care Unit
ID	Identification
INR	International Normalised Ratio
Int	Interview
IRAS	Integrated Research Application System
ISC	Intermittent Self-Catheterisation
IV	Intra-venous
MEWS	Modified Early Warning Score
MI	Myocardial Infarction
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
NHS	National Health Service
NIHR	National Institure for Health Research
NMC	Nursing and Midwifery Council
NMDS	Nursing Minimum Data Sets
NRES	National Research Ethics Service
Obs	Observation Session
PEG	Percutaneous Endoscopic Gastronomy
PIS	Participant Information Sheet
PLNS	Patient Learning Needs Scale
R&D	Research and Development
SDM	Shared Decision-Making
SREC	School Research Ethics Committee
TPN	Total Parenteral Nutrition
TURP	Trans-urethral Resection of Prostate
VAC	Vacuum Assisted Closure

Part 1: Introduction and literature review

Chapter 1: Introduction

This thesis explores information exchange between patients and nurses during routine nursing care. Information exchange as conceptualised by Charles et al. (1997) is important for shared decision-making, and necessitates patients sharing values and preferences in the healthcare encounter and the health professional sharing mainly medical information. Shared decision-making is advocated in policy documents and reports (Coulter and Collins 2011, Coulter et al. 2008, Scottish Government 2007), and applies to all areas of healthcare. Nurses have a duty to facilitate patients' decision-making (NMC 2008); however, no studies to date have explored information exchange between patients and nurses in ward settings. This qualitative multiple case study provides insights into the type, relevance and sufficiency of information obtained from observation sessions and in-depth interviews, and shows that information exchange as conceptualised by Charles et al. (1997) may be difficult to achieve in ward settings.

Section 1.1 offers a brief personal context and rationale for why I decided to study information exchange between patients and nurses in ward settings. Following this scene setting, I provide a plan of my thesis in Section 1.2, with a brief description of what is contained in each chapter.

1.1 Personal context and rationale for the thesis

My interest in information exchange between patients and nurses evolved from my role as a registered nurse together with my academic studies. Qualifying as a nurse in 2004, I continued my studies part time at the University of Stirling to obtain an Honours degree in nursing, which led me through modules such as Law and Ethics in Healthcare and Decision-making in Practice. It was not until studying decision-making that I encountered the term 'information exchange' and began to consider its potential significance for patient/nurse interactions. After completing my Honours dissertation I was given the opportunity to study for a Ph.D. Choosing a topic for study included discussions with my supervisors and reading widely around concepts that interested me, namely shared decision-making, information exchange and ethics. Over time, I became more and more interested in information exchange and its significance for decision-making.

When I considered patient/nurse interactions in ward settings, my practice experience led me to believe that these interactions were very different from one-to-one consultations with consultants or GPs. In one-to-one consultations there is likely to be more focus on a specific consultation agenda. Furthermore, I considered that information exchange might be useful for different types of patient/nurse interactions such as interactions relating to nursing interventions, and not necessarily for decision-making. Without adequate information exchange, patients might be unable to weigh up the risks, benefits and alternatives to proposed nursing interventions (Charles et al 1997).

Whilst constructing the literature review questions of interest, such as *a priori* concepts of type and amount of information, emerged. Informed by the literature review, the aim of this study therefore was to contribute to what is known about information exchange by exploring information exchange between patients and nurses during routine nursing care in ward settings. The research questions sought to establish what type of information patients and nurses shared with each other, whether or not the information was relevant, and whether patients and nurses perceived that they had received sufficient information for their needs.

1.2   Plan of thesis

Chapter 2 begins with definitions of 'information exchange' and 'routine nursing care', followed by an outline of the search strategy for the main literature review. Critique of the literature highlights the requirement for research on information exchange within the context of routine nursing care in medical and surgical ward settings. I conclude the chapter by identifying the research aims, and presenting clear research questions.

An overview of research methodologies and the rationale for the methodology and design chosen for my study are presented in Chapter 3. This study was a qualitative multiple case study and data were collected by non-participant observation sessions followed by individual semi-structured interviews. I describe the research process and address ethical considerations.

I undertook a pilot study prior to the main study (Chapter 4). The purpose of the pilot study was to ensure that recruitment and consent processes were acceptable to potential participants. In the pilot study, the methods for data collection were tested, including the use of equipment for remotely controlled audio-recordings during observation sessions, and audio-recordings during the interviews. The chapter concludes with a discussion of the changes made to the main study protocols, based on the pilot study results.

In Chapter 5, I present the findings related to the Type of Information exchanged or provided during routine nursing care. These findings relate to the first research question, "What information do patients and nurses exchange during routine nursing care?" The primary reasons for patients' admission are generally not discussed; instead, nurses focus on patients' presenting symptoms. Non-clinical information is perceived to play a significant role in interactions between patients and nurses during routine nursing care. Patients do not differentiate between clinical and non-clinical information as nurses do.

In Chapter 6, the findings related to the Relevance of Information exchanged or provided are presented. The findings in this chapter address the second research question, "Do patients and nurses perceive the information they have exchanged to be relevant? If so, for what?" In this chapter, a case study is examined, which illustrates the iterative approach to cross-case and cross-category analysis. A

key finding is that the relevance of information for patients and for nurses differed.

In Chapter 7, I explore the findings related to Sufficiency of Information. These findings address the third research question, "Do patients and nurses perceive they have exchanged all the information sufficient for their needs?" Five case studies are examined in order to demonstrate the iterative approach to the analysis and to demonstrate cross-case and cross-category analysis. Observation data suggest that lost opportunities and paternalistic practice limit information exchange. Contrary to the observation data, patients and nurses perceived that they had given and received sufficient information.

In the final chapter (Chapter 8), the key arguments of the study are discussed. The overarching argument is that information exchange as conceptualised by Charles et al. (1997) may not be an appropriate model for patients and nurses sharing information in ward settings. Information exchange between patients and nurses in ward settings appears to be very complex, and are not a one-off event. My findings suggest that nurses need to possess high-level communication skills not only to elicit relevant information from patients but also to ensure that patients' individual information needs are met. Also in Chapter 8, the strengths and limitations of the study are discussed, and recommendations are made for nursing practice, education and further research.

Chapter 2:   Literature review

2.1   Introduction to chapter

The literature review commences with the definitions of 'Information Exchange' (2.2.) and 'Routine Nursing Care' (2.3). The search strategy for the main review is outlined in Section 2.4. Next, I outline the literature review (2.5), leading to an examination of information exchange in nursing practice (2.6). A dearth of literature on information exchange in nursing practice led to a review of the literature on patients' information needs in routine nursing care (2.7). In the literature review, there is a candid discussion of the limitations of the research on information exchange in nursing practice and on information needs. That is not to say that there are no strengths. However, the purpose of the literature review was to examine what the literature reports about information exchange, the detail of which is lacking in the literature about nursing practice. I also reviewed the literature on information exchange in non-nursing contexts (2.8). The aims and research questions are presented in Section 2.9.

2.2   Definition of 'Information Exchange'

Information exchange is defined as a two-way sharing of relevant and sufficient information between patients and nurses. This definition is based on shared decision-making, conceptualised by Charles et al. (1999). In contrast, in paternalistic and informed decision-making, the information exchange part is akin to information provision (2.2.3); therefore, these approaches are not appropriate

for defining information exchange for my study. I also reviewed the literature on information exchange in other disciplines. These points are discussed next.

2.2.1 Decision-making models in healthcare

Shared decision-making is increasingly influential in health care, and has been widely promoted and developed (Baylor et al. 2007, Entwistle and Watt 2006, Montori et al. 2006, Elwyn et al. 2005, Gattellari et al. 2001, Guadagnoli and Ward 1998). There is a plethora of literature about information exchange. However, it has not previously been examined in the context of routine nursing care in ward settings. Models of shared decision-making, of which information exchange is a part, and instruments for measuring shared decision-making have been discussed in a variety of contexts and for different reasons, for example:

- Examining general practitioners' (GP's) communication strategies and identifying how they put shared decision-making into practice (Towle et al. 2006, Elwyn et al. 2001)

- Providing and exploring the effectiveness of training programs on the implementation of shared decision-making (Korner et al. 2013, Bernhard et al. 2012, Korner et al. 2012, Legare et al. 2012, Elwyn et al. 1999)

- Evaluating decision support tools (Elwyn et al. 2013, Balneaves et al. 2012, Durand et al. 2012)

- Exploring characteristics of decisions, such as importance and certainty (Whitney 2003).

Information exchange is discussed in the context of health professionals sharing information with each other either face to face (Weber et al. 2007) or via electronic communication systems (Payne et al. 2011, Clemow 2006), and health professionals sharing information with patients' relatives (Morris and Thomas 2002). My study is concerned with patients and nurses sharing information face-to-face and will be the first to explore information exchange as conceptualised by Charles et al. (1999) in routine nursing care in medical and surgical ward settings. I appraised the shared decision-making model against other models of decision-making in healthcare lest another model was more appropriate as a context for defining information exchange for my study. No literature search was undertaken at this stage, as the models identified are three commonly known models of decision-making in healthcare; paternalistic, informed and shared decision-making (Charles et al. 1997, Coulter 1997) (Table 1).

Table 1: Information exchange as conceptualised by Charles et al. 1999

Model/Element	Paternalistic	Informed	Shared
Type	Mainly medical	Medical	Mainly medical from professional, and personal from patient
Amount	Minimum amount required for informed consent	All that is relevant for decision-making	All that is relevant for decision-making
People involved	Health professional	Health professional	Patient and health professional
Direction	Health professional $\Rightarrow$ patient	Health professional $\Rightarrow$ patient	Patient $\Leftrightarrow$ health professional

$\Rightarrow$ = information flows in one direction $\Leftrightarrow$ = two-way flow of information

Information exchange in the paternalistic model of decision-making comprises the transfer of medical information, but not the sharing of preferences or values (Charles et al. 1997). Paternalism privileges the often male medical health professional as the expert, relies on patient passivity (Parsons 2012, Childress 1982) and assumes that patients' goals are the same as those of healthcare providers' (Coulter 2002). In paternalism, information is not 'exchanged' but 'provided' (2.2.3). Paternalism is appropriate in caring for non-autonomous patients (Mason and Laurie 2011) such as in an emergency, or in patients with incapacity. It may not be appropriate in the majority of situations, for example in routine nursing care. Thus, the paternalistic decision-making model was not chosen as the context for defining information exchange for my study.

Informed decision-making is underpinned by respect for autonomy, with sufficient information being provided to facilitate patients' decision-making (Charles et al. 1997). Information exchange in the informed decision-making model is characterised by the provision of medical information only, from the professional to the patient – preferences and values are not shared or explored. The informed model is useful when making decisions based purely on patients' personally held values and beliefs, for example, in making decisions based on religious beliefs, or in relation to genetic screening. Not all patients face such value-based decisions in healthcare. Therefore, the informed decision-making model was not chosen as the context for defining information exchange for my study.

Policies reject patient passivity as the norm and encourage patients to take an active part in their treatment and care (Department of Health 2012, Long Term Conditions Alliance Scotland 2008, Scottish Government 2007, Department of Health 2001). These policies support shared decision-making with its emphasis on dialogue and sharing of information. The shared decision-making model has been appraised against paternalistic and informed decision-making models (Elwyn et al. 1999, Charles et al. 1997). A two-way dialogue of both medical and personal information between patients and professionals exemplifies information exchange in shared decision-making. Patients share values, beliefs, and lay knowledge and professionals provide medical expertise and resources. The amount of information exchanged is all information that is relevant for making the decision.

From my comparison of the three main decision-making models in healthcare, and based on policy documents driving forward patient involvement in treatment, care and decision-making, I concluded that shared decision-making provided an appropriate context for defining information exchange in my study.

2.2.2 Information exchange in other disciplines

I reviewed the literature on information exchange in other disciplines lest there was another model for information exchange transferable to healthcare. I limited the dates of the review to 2010 – 2012 because I wanted to review current

practice of information exchange in other disciplines. Figure 1 summarises my search process for literature on information exchange in other disciplines.

Figure 1: Search strategy for information exchange in other disciplines

Databases	Limiters	Search terms
Sociological Abstracts	English	Information exchange
ASSIA	2010 – 2012	
Social Services Abstracts	Scholarly journals	
ERIC	Article	

951 Returns

Papers for further review: n=56
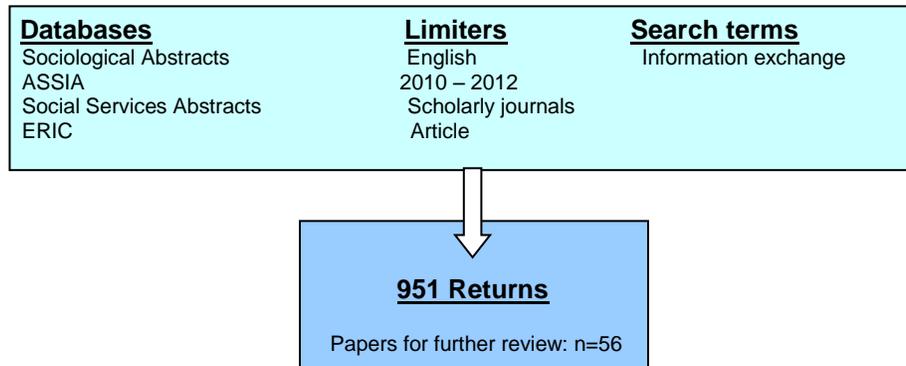
Exclusion criteria were applied to the 951 papers. Papers related to information exchange via the use of technology were excluded because my focus was on exchanging information face to face. Papers were also excluded if they did not relate to information exchange but were included in the returns because they had the word 'exchange' in the title or the abstract, for example, papers about the stock exchange or student exchange. Papers were excluded if they were related to healthcare because I was searching for papers in disciplines other than healthcare. Papers related to early childhood were excluded because my focus was on information exchange between adults. Other papers were excluded because they related to animals or plant life, were duplicates, or were not available in the English language. In total, 895 papers were excluded, leaving 56

for further review, which were from the disciplines of: education (n=16); psychology (n=16); management (n=7); sociology (n=5); business (n=5); politics (n=2); history (n=2); environmental research (n=1); tourism (n=1); and economics (n=1). Key issues were found in relation to information exchange in other disciplines. Information exchange in some disciplines was related to group information sharing for decision-making and evaluation purposes (Rodriguez-Campos 2012, Tzafrir et al. 2012, Emich 2012, Kolk and Lenfant 2012, Nevicka et al. 2011, Tubert-Oklander 2010). In Education, information exchange was utilised collaboratively to promote school reform (Massell et al. 2012), to sustain academic achievement (Henderson et al. 2011), to enhance school/parent relationships (Delgado et al. 2012), and to improve employee creativity (Gong et al. 2012). Some authors reported that information exchange was sometimes used to establish and maintain a sense of community (Yohe 2012, Forde 2010). However, in contrast, information exchange in Historical Studies and Marketing was sometimes related to personal gain (Piliavsky 2011), or to receiving favours (Guo and Miller 2010), respectively. In Social Psychology, information exchange was reported as being skewed by the sharing of preference-consistent information, which is persistent until people feel understood (Faulmueller et al. 2012), which concurs with findings reported from Business Ethics that pushing one's own goals can lead to ineffectual information exchange (Poortvliet et al. 2012). Akin to healthcare, information exchange in some disciplines meant information giving (Chentsova-Dutton and Vaughn 2012, Wong and McKercher 2011), or was related to persuasion (Liu and Wilson 2011, Gaffeo and Canzian

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2011). In the discipline of Economics one paper suggested that information was sometimes for sale (Cheynel and Levine 2012).

No model of information exchange in other disciplines was found that was suitable for defining information exchange for my study. My study does not relate to group decision-making, collaborative institutional information exchange, or exchanging information for personal gain. My study investigates information exchange between nurses and patients, and focuses on the patient as an individual. Therefore Charles et al.'s (1999) shared decision-making model continued to provide the most appropriate context for defining information exchange for my study.

2.2.3 Information exchange versus information provision

Within the literature the terms 'information exchange' and 'information provision' are frequently used interchangeably, although there are significant differences between them. The concepts of information exchange and information provision are underpinned by conflicting ethical principles: autonomy and beneficence respectively. Respect for autonomy supports patient involvement whilst acting beneficently results in greater patient passivity (Parsons 2012, Edwards 2009). Information exchange exemplifies a dialogue, a sharing of information, whilst information provision is characterised by a one-way flow of information from the health professional to the patient (Lee and Garvin 2003, Charles et al. 1999). Information provision is useful if the goal is to change patients' behaviours.

Changing patients' behaviours is contrary to promoting the sharing of patients' values and preferences – the latter of which I explored in my study. Having defined the differences, the concept of information provision is set aside.

In summary, I chose decision-making as a context for defining information exchange, because decision-making is influenced and facilitated by information exchange. I reviewed models of decision-making in healthcare and concluded that paternalistic and informed models of decision-making were not appropriate for defining information exchange for my study. Furthermore, I concluded that information exchange related to other disciplines was also not appropriate for my study. Information exchange, as described by Charles et al. (1999), and as defined for my study, involves a patient and a nurse sharing information together, and includes four elements: the type of information exchanged; the amount of information exchanged; the people involved in the exchange; and the direction in which the information flows. Charles et al's shared decision-making model, with its emphasis on the sharing of preference sensitive information, provides a suitable basis on which to define information exchange for my study.

2.3   Definition of 'Routine Nursing Care'

Routine nursing care is defined in my study as individualised physical and psychological care that promotes patient safety and comfort. It includes meeting patients' educational and informational needs. The definition of routine nursing care for my study is based on the meaning of routine nursing care presented in

the literature, a description of nursing care provided by Nursing Minimum Data Sets (NMDS), and on interviews with nurses who are lecturers.

Routine nursing care is discussed in the context of activities of daily living (ADL's) and is defined as: *'the link between stressful complicated procedures associated with treatment of the disease conditions, and the maintenance of everyday bodily and mental functions which are critical to the patient's comfort'* (Roper et al. 1996:4). Others discuss nursing care in relation to assessment, planning, implementation and evaluation of patient care (Hogston 2007), or in terms of procedures or psychomotor skills that promote safety and comfort (Baillie 2009, Bjork 1999). More recently, the Francis report refers to the fundamentals of care, for example: the *'fundamental importance of keeping patients safe'* (Francis 2013:67); *'provision of adequate food and drink is a basic and fundamental responsibility' (Francis 2013:94)*; and, *'privacy and dignity is a most fundamental right'*, and should be an expected level of care from nurses (Francis 2013:111).

NMDS represent an attempt to standardise nursing data on nursing interventions (Werley et al. 1991). One purpose of NMDS is to *'describe the nursing care of clients and their families in a variety of settings'* (Werley et al. 1991:422). A NMDS of nursing practice in Ireland identified five categories of direct nursing interventions: physical; psychological; educational; solving problems; and, advocating for patients. Physical interventions were identified as being the most

frequent, and of those physical interventions, those with the highest frequency were: assisting with daily living; meeting patient's basic needs; controlling pain; and full nursing care or specialist nursing care (Butler et al. 2006). Similarly, in the development of NMDS in the Netherlands, nursing activities included a high frequency of interventions related to ADL's, and also to monitoring of vital signs, giving information, patient education, psychosocial support, pressure area care, administration of medication, wound care, and care of tubes, drains and catheters (Goossen et al. 2000).

I met with five academic colleagues one-to-one, each with a background in nursing, and asked *'How would you define routine nursing care?'* Concurring with the literature and NMDS, these colleagues referred to routine nursing care in terms of ADL's, the nursing process, and hands-on skills. They initially used the term *'basic care'*, in which, attention is paid to assessing patients' personal hygiene, comfort, fluid balance, nutrition, mobility, and elimination needs. From this assessment routine nursing interventions would take place, for example bed-bathing, showering, toileting, and feeding, and would extend to routine clinical interventions such as, though not exclusively, monitoring of vital signs, administration of medications, venepuncture, wound care, removal of sutures, four layer bandaging, stoma care, and urinary catheterisation. They agreed with one another that routine nursing care involved a minimum standard of care that any registered nurse could carry out. Interactions between patients and nurses

relating to hands-on personal and clinical interventions provide the context for the exploration of information exchange in my study.

2.4   Search strategy for main literature review

My study is an applied health study testing the applicability of the theory of information exchange to the 'real-world' context of interactions between patients and nurses in ward settings (Patton 2002). Applied health research includes and integrates theoretical and empirical work from a range of disciplines, and its purpose is to clarify or interpret social phenomena. Applied research contributes to what is already known about a topic and facilitates understanding of social concerns in order to inform, as an example, policy. The questions explore the problems and concerns experienced by people and articulated by policymakers (Patton 2002). Current policy rhetoric implies that shared decision-making and information exchange are to be advocated in every area of healthcare. Thus, my research questions, which seek to explore how information exchange is implemented in the acute setting, fit with applied research. Kumar (2011) concurs with Patton (2002) and states that applied researchers use methods from a body of research methodology, apply them to a particular phenomenon, and can further enhance that phenomenon or make recommendations for policy and practice. As this study is an applied health study, I searched for, and identified literature from a range of relevant disciplines, for example, related to primary and secondary care nursing, GP practice, and consultant or nurse-led clinics.

Figure 2 summarises the main search strategy. I accessed the databases 'Health Source: Nursing/Academic Edition', 'Cumulative Index to Nursing and Allied Health Literature (CINAHL)', 'Applied Social Sciences Index and Abstracts (ASSIA)', 'Social Services Abstracts', 'Sociological Abstracts', and 'Social Sciences Citation Index'. The terms used were "informed consent and nurs* or health profession*", "information exchange and patient*", "information exchange and nurs*", "informed consent and decision-making", "informed consent and decision-making and patient*", and "informed consent and patient and nursing care". A search was made in Google Scholar within databases relating to 'Medicine, Pharmacology, and Veterinary Science', and 'Social Services, Arts, and Humanities', using the terms "information exchange patient/nurse", and "information needs patients". Initially, I limited the searches to years 1998 to 2009. Unlike the search for literature solely on current practice, such as in the review of information exchange in other disciplines (2.2.2), this search dated back to 1998 to include the seminal work on information exchange by Charles et al. (1999).

A total of 333 papers were considered. I included papers if they focussed on the following: information exchange between patients and health professionals; information exchange face to face; and, information exchange in general health settings. Papers, which focussed on the following, were excluded:

- Communication and information exchange between patients and other patients, or between patients and their families only

- Information exchange between professionals only

- Information exchange between professionals and carers, but not patients

- Information exchange online, or by telephone

- Mental health or learning disability settings (though not excluding vulnerable adults in general settings)

- Health promotion or health education literature only (as they tend to be about changing behaviour as opposed to facilitating choice)

- Others that were not relevant because the word 'information' arose due to the search terms but was not the focus of the paper.

In addition, I accessed relevant literature by cross-referencing from journals already available via the databases, and I set up alerts using the appropriate search terms in order to continue accessing further relevant up to date literature. As the review progressed there was limited information on patients' informational needs and information exchange in the context of nursing care, using the search terms outlined. Therefore I undertook further searches using the terms "information needs AND patients AND nursing care", "information needs AND patients and DE 'Adult'", and "patient participation AND information, and DE 'decision-making'".

Figure 2: Flowchart of search strategy for main literature review

Databases
Health source: Nursing/ac edition
CINAHL
ASSIA
Social Services Abstracts
Sociological Abstracts
Social Sciences Citation Index

Search terms
Informed consent AND nurs* OR health profession*
Information exchange AND patient*
Information exchange AND nurs*
Informed consent AND DM
Informed consent AND DM AND patient
Informed consent AND patient AND nursing care

Databases
Google Scholar:
 Medicine, Pharmacology, and Veterinary Science
Social Sciences, Arts and Humanities

Search terms
Information exchange patient/nurse
Information needs patients

Databases
Lexis Nexis

Search terms
Informed consent AND patient*
Informed consent AND nurs*

Papers included if they were about:
Information exchange between patients and professionals
Information exchange face-to-face
Information exchange in general health settings

Papers were excluded if they were about:
Information exchange between patients and other patients
Information exchange between patients and families
Information exchange between professionals
Information exchange between professionals and carers
Information exchange online or by telephone
Mental health or learning disability settings
Health promotion or health education

Outcome:
Dearth of literature on informationexchange in routine nursing care

Outcome:
Wealth of literature on information exchange in non-nursing contexts

Thus, the literature search was expanded as shown:

Databases
Health Source: Nursing/Ac Edition
CINAHL
ASSIA
Social Services Abstracts
Sociological Abstracts
Social Sciences Citation Index

Search terms
Information needs AND patients AND nursing care
Information needs AND patients AND adult
Patient participation AND information AND decision-making

Results
Papers reviewed, n=333

All 333 papers were identified in order of quality and strength, with empirical papers being taken first, as follows: mixed methods research; quantitative research; qualitative research; case studies; literature reviews; and theoretical discussions and editorial reviews. I reviewed the titles and abstracts assessing the papers for their applicability to the study, as follows:

- I looked for papers which focussed on information exchange or shared decision-making between patients and nurses in ward settings

- Next, I searched for papers that related to inpatients information needs. I wanted to identify whether or not they referred to information exchange between patients and nurses

- Finally, I searched for papers that related to information exchange between patients and other health professionals in contexts other than ward settings (in the review I call this 'non-nursing literature', which relates to information exchange between patients and health professionals in clinic or GP settings). I wanted to identify whether there were features of information exchange in these other contexts that could be extrapolated and used to inform information exchange in ward contexts.

No papers focussed on information exchange between patients and nurses during routine nursing care in ward settings. However, three papers commented on information exchange generally, and are reviewed in Section 2.6. Fourteen

papers were found that focussed on patients information needs in routine nursing care (Appendix 1), and thirty papers focussed on non-nursing literature on information exchange (Appendix 2).

2.5   Outline of literature review

The literature review highlighted a dearth of literature on information exchange during nursing care in ward settings. I found no literature that specifically looked at information exchange, or shared decision-making, between patients and nurses in ward settings. Three papers (Sahlsten et al. 2007, Sahlsten et al. 2005, Sainio and Lauri 2003) noted the importance of information exchange in nursing practice more generally. A key issue within the nursing literature in relation to information exchange is that often nurses' perspectives, rather than patients', are elicited. I expanded the literature search to include literature on patients' information needs. However, nursing research on patients' information needs focuses on information provision rather than information exchange. Also, there are methodological limitations within the papers, which are discussed later. Due to the lack of detail on information exchange in nursing practice, and the focus on information provision in the literature on patients' information needs, I undertook a review of the non-nursing literature. Patients want information from doctors and nurses related to treatment, including risks, benefits and alternatives. However, patients also want information from nurses about non-technical aspects of care, and follow-up care. Differing information needs between nursing and non-nursing

contexts pose difficulties with transferability from the literature. I discuss all these key points in detail.

2.6 Information exchange in nursing practice

No papers specifically examined information exchange in nursing practice in ward settings. Three papers noted the importance of information exchange more generally. Table 2 presents the aims of these papers, and identifies their limitations. A key issue is that these papers focussed on patient participation, not information exchange. The relevance of the papers is questionable due to their focus on nurses' perspectives of patient participation. However, they highlight the importance of information exchange and so are discussed here.

2.6.1 Importance of information exchange

The papers outlined in Table 2 highlight adequate information exchange as a prerequisite for patient participation and decision-making in nursing care. Two of the papers, based on the same larger study that the authors had undertaken in 2002, focused on patient participation in nursing care (Sahlsten et al. 2007, Sahlsten et al. 2005). Nurses reported that exchange of information was important to them for determining patients' abilities for self-care and decision-making. One paper focussed on cancer patients' decision-making in relation to treatment and nursing care (Sainio and Lauri 2003), and reported that adequate information exchange was essential for decision-making. All the authors argued that current literature is unclear about the elements of, and evidence for, patient

participation and decision-making. Focus groups with registered nurses (Sahlsten et al. 2007, Sahlsten et al. 2005) concluded that one of four elements of patient participation was information exchange.

Table 2: Nursing literature - the importance of information exchange

Authors	Study aims	Study design and sample	Results	Limitations
Sahlsten et al. (2007)*	To investigate the meanings of the concept of patient participation in nursing care from a nurse perspective.	Qualitative Grounded theory 7 focus group interviews with 31 registered nurses	Mutuality in negotiation seen as key to a dynamic nurse/patient interaction. A key sub-category of mutuality in negotiation encompasses information exchange.	This study only obtains the nurses' perspectives – not the patients'. Lack of patients perspectives in research design.
Sahlsten et al. (2005)*	To clarify registered nurses understanding of patients' participation in nursing care, and to investigate ward nurses' interpretation of the elements of patient participation and its implementation.	Qualitative Grounded theory 7 focus group interviews with 31 registered nurses	Information exchange is required to elicit patients' ability for self-care and decision-making.	This study only obtains the nurses' perspectives – not the patients'. Lack of patients perspectives in research design.
Sainio and Lauri (2003)	To identify to what extent cancer patients participate in decision-making, and to what extent background characteristics, information obtained and relationships with staff, explain cancer patients' participation in decision-making.	Quantitative Structured questionnaire 273 cancer patients	Patients receiving 'enough' information, and about 'different issues', participated more in treatment and nursing care decisions.	Unclear how questionnaire could measure 'enough' information. Unclear what all the 'different issues' are. Lack of patients perspectives in research design. Focuses on cancer patients only.

* *Sahlsten, Larsson et al. (2007) and Sahlsten, Larsson et al. (2005) are based on the same data that the authors collected in* 2002

2.6.2 Lack of patients' perspectives

One crucial gap in the Sahlsten et al. (2007 and 2005) papers is that they focused on nurses' perspectives and not patients' perspectives. The main study on which the Sahlsten et al. papers were based was qualitative – looking for participants' perspectives – but it involved focus groups with nurses, and not with patients. As the papers are concerned with patient participation, it would be appropriate to ask patients for their perspectives – a point acknowledged by the authors. However, the authors discussed nurses implementing patient participation and concluded that *'a comprehensive description of important factors for patient participation could be made on the basis of nursing experience'* (Sahlsten et al. 2005:41). Patient participation implemented by nurses, with a description based on the experiences of nurses, risks being paternalistic – with patient involvement being sanctioned by nurses rather than being initiated by patients (Elwyn and Charles 2001). Information exchange set in this context is akin to information provision.

2.6.3. Lack of detail on information exchange

The papers in Table 2 lack detail about information exchange, as they do not study it specifically. Detail and discussion is lacking in areas concerned with type, amount, and direction of information, particularly concerning patients and nurses. The lack of detail is particularly evident in the paper by Sainio and Lauri (2003), where it was reported that most patients received 'enough' information on

'different issues'. However, it is unclear what constitutes 'enough' and what these 'different issues' are.

2.6.4 Methodological limitations of research on information exchange in nursing practice.

Methodological limitations exist in the papers commenting on information exchange in nursing practice. These limitations include:

- A lack of patient perspectives in the development of the project (Sahlsten et al. 2007, Sahlsten et al. 2005, Sainio and Lauri 2003)

- The use of a predefined questionnaire (Sainio and Lauri 2003)

Sahlsten et al. (2007 and 2005) did not report on patient involvement in the research process or in the development of any focus group schedule used. Patient involvement in the research process can help plan research that is sensitive to the needs of patients and professionals (Thornton 2002). Patient involvement in the research process is a basic standard of good research practice (Department of Health 2005). INVOLVE, who advise the National Institute for Health Research (NIHR) on patient and public involvement in research, state that involving patients and the public in the research process is a *'core democratic principle'* , giving consumers of healthcare the right to have a say in how publicly-funded research is undertaken (INVOLVE 2012:8). Sainio and Lauri (2003) asked patients to complete a structured questionnaire, which was developed from previous research and qualitative interviews with patients.

However, only the perspectives of cancer patients were sought, which does not allow for any differences there may be in information preferences in patients with other diseases.

In the study by Sainio and Lauri (2003), parts of the questionnaire were developed from previous studies and interviews that the authors had undertaken (for example, Sainio et al. 2001). The questionnaire was structured, but the authors used it to identify the 'amount' and 'extent' of information exchange. However, these terms are likely to mean different things to different people. Patient participation about treatment and nursing care was measured on a three-point ordinal scale (1 = to a great extent, 2 = to some extent, 3 = not at all), and the importance of participation was also measured on a three-point scale (1 = important, 2 = important to some extent, 3 = not at all important). Relationships were found between the information received and participation in decision-making. However, three-point ordinal scales are unlikely to be valid (Jones and Rattray 2010). It is not clear how the scales were developed and how the amount and extent of information received was actually measured. It appears from the table provided, that patients stated that either they did, or did not, receive enough information, but the authors do not explicitly comment on how 'enough' information was measured. Further exploration of amount and extent of information is required.

In summary, detailed studies are required that specifically explore information exchange between nurses and patients, and that include patients in the research process. Research into information exchange between patients and nurses, be it a sub-part of participation or decision-making, or as a subject in itself, would be enhanced by asking patients for their perspectives of information exchange. A fuller account of information exchange might then be obtained, and from the perspectives of those who may be most likely affected when information exchange is lacking.

The lack of detail on information exchange in nursing practice in ward settings led to expanding the literature search to include patients' information needs in routine nursing care. Knowledge of patients' information needs assists with information exchange, with patients and nurses exchanging sufficient information to meet their individual needs. Patients' information needs in routine nursing care is discussed next.

2.7   Patients' information needs in routine nursing care

After applying the inclusion and exclusion criteria (2.4) each paper was read fully and appraised for its quality and its applicability to the study. Papers were appraised according to the strength of the evidence, starting with quantitative papers (n=7) and working down through qualitative research (n=5), literature reviews (n=1) and theoretical discussions (n=1) (Appendix 1). A substantial body of literature relates to health education and health promotion; however, as the

focus was on patient education, information provision, and behaviour change I did not include these papers in the review (2.4). Fourteen papers on patients' information needs in nursing care were reviewed. Appendix 1 summarises these papers' aims and limitations. The discussion that follows determines what is known about patients' information needs from the literature, and identifies the gaps and limitations. However, to bring clarity, a definition of information needs is given next.

2.7.1 Definition of information needs

Based on the nursing literature on patients' information needs I defined information needs in two ways as follows:

First, information needs is defined as the information that professionals, rather than patients, perceive as being important to the patient. Defining information needs thus is based on the concept of informed choice. Although patients may waive their right to certain information, to satisfy the criteria for informed consent patients need to know the nature and purpose of the proposed intervention (Kennedy and Grubb 2000). Many nursing interventions require obtaining informed consent (Aveyard 2002b). Nurses have knowledge of the intervention therefore the information that nurses think patients need is offered. Information that professionals perceive as essential to obtaining informed consent may protect patients from unwanted interventions (Alderson and Goodey 1998).

Second, the literature also defines information needs in terms of the information that patients want. However, methodological limitations point to a concept of information needs still being based on nurses' perspectives. The use of predefined questionnaires (May et al. 2006, Suhonen et al. 2005, Lithner and Zilling 2000, Turton 1998) is one example, where nurse researchers ask patients questions about their information needs based on the researcher's perspectives. Subsequently patients' self-reported information needs may not be truly representative of the information that patients want. Patients can only provide answers within the parameters of the questions asked, thus excluding the full range of potential responses.

Little is known about patients' preferences for information from the nursing literature (as evidenced by the focus on information provision). The nursing literature contradicts itself in its differing interpretations of patients' information needs. The difference between patients' information wants and needs is reflected in the mismatch between the information that patients want and the information they receive (Suhonen and Leino-Kilpi 2006, May et al. 2006, Suhonen et al. 2005, Jacobs 2000, Turton 1998). This mismatch may be indicative of paternalistic practice, with nurses seemingly imposing their perceptions of patients' information needs onto patients. Health professionals would be mistaken in providing unwanted information to patients based solely on professionals' decisions that patients need to know – thus strengthening the argument for research into information exchange in nursing practice.

In summary, information needs in my study includes the information that professionals perceive as important to the patient to satisfy the requirements for informed consent, as well as patients' self-reported information needs and wants. Throughout the following critique of the literature, I argue for more research into the information that patients want – referred to as 'patients' preferences for information'.

2.7.2 The type of information patients want from nurses

Research to date does not convey a clear picture of patients' preferences for information in routine nursing care. Despite the lack of clarity, the literature is informative in relation to parts of information exchange, in particular the type of information. For example, knowing patients' preferences for information in nursing care is useful when engaging with patients in a dialogue about treatment and care. The nursing literature identifies the information that patients want from nurses:

- Condition, or natural history of disease (Logan et al. 2008, Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, Suhonen et al. 2005)

- Risk factors for disease (Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, Turton 1998)

- Treatment, including options, risks and benefits (Logan et al. 2008, Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, May et al. 2006, Suhonen et al. 2005, Sainio and Lauri 2003, Jacobs 2000, Lithner and Zilling 2000)

- Non-technical aspects of care (Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, Jacobs 2000, Lithner and Zilling 2000)

- Outcomes (Suhonen and Leino-Kilpi 2006)

- Follow-up care (Suhonen and Leino-Kilpi 2006, Suhonen et al. 2005, Jacobs 2000, Lithner and Zilling 2000, Turton 1998)

Less consistently, patients also want information related to resuming work, driving, and sources of support (Smith and Liles 2007).

Table 3 summarises patients' preferences for information from nurses. Patients want information from nurses about their condition, treatment, and risks/limitations of their treatment. These aspects reflect the type of information exchanged in the shared decision-making model (Charles et al. 1999). Patients also want information from nurses on non-technical aspects of care and on follow-up care. The information that patients appear to want least from nurses relates to treatment options, benefits to treatment, and outcomes. Patients prefer to receive these types of information from doctors (see Section 2.8)

Limitations exist in the research approaches and in how patients were asked for their preferences for information. Not all patients were given all the options for information contained in Table 3; therefore, what we know about patients' preferences for information in routine nursing care is limited. These limitations are discussed in Section 2.7.4.

Table 3: Analysis of the literature about the type of information patients want from nurses

Patients' info needs / Authors	Condition, or natural history of disease	Risk factors for disease	Treatment	Treatment options	Risks/ limitations of treatment	Benefits of treatment	Non-technical aspects of care	Outcomes	Follow-up care.	Other
Turton (1998)		√							√	
Jacobs (2000)			√		√		√		√	
Lithner, Zilling (2000)							√			
Sainio, Lauri (2003)			√							
(Suhonen et al. 2005)	√		√						√	
(May et al. 2006)			√							
Suhonen, Leino-Kilpi (2006)	√	√	√	√	√	√	√	√	√	
Smith, Liles (2007)	√	√	√		√		√			Resuming work, driving, and sources of support.
(Logan et al. 2008)	√		√	√						

2.7.3 The amount of information patients want from nurses

Studies on patients' preferences for information differ in their settings and methods but consistently comment that patients do not receive enough information. However, 'enough' is difficult to quantify as it means a different thing to each individual, and perhaps needs an individual assessment. Very little is understood about the amount of information that patients want about routine nursing care and for what purpose. Suhonen and Leino-Kilpi (2006) and Doherty and Doherty (2005) asked questions about whether patients would like more or less information than was provided, but it is unclear why or for what purpose, patients want, or do not want, information. For example, 'enough' information may be relevant for decision-making, or to alleviate anxiety, or to share with family members, or for any other reason that motivates the individual patient to want more information. Lack of discussion on adequate information exchange is a reflection of the focus on information provision, and of methodological limitations. Some patients do not feel they receive enough information (Suhonen and Leino-Kilpi 2006, Doherty and Doherty 2005); whilst others feel they receive too much because they prefer a passive role (Doherty and Doherty 2005). A literature review (Suhonen and Leino-Kilpi 2006) found that about two-thirds of the studies on surgical patients information needs were quantitative. No comment was made on whether or not patients were involved in the development of the research tools, thus full exploration on whether or not patients receive enough information may be limited. Furthermore the review (Suhonen and Leino-Kilpi 2006) focussed on surgical patients information needs and may be unlikely

to fully reflect the information needs of medical patients, or patients from other specialties, which may differ due to, for example, living longer with a chronic condition (Montori et al. 2006). One study reporting that some patients receive too much information and others do not receive enough information (Doherty and Doherty 2005) was based on the perspectives of patients over sixty years of age, thus not eliciting the perspectives of younger patients. Nevertheless, a contribution is made to what is known about the amount of information that patients want. Doherty and Doherty (2005) did not specifically examine information exchange, but examined patients' preferences for involvement in decision-making. This focus on patients' preferences for involvement leads to a lack of detail on information exchange on which to base the premise of whether or not patients receive enough information. Furthermore, patients' preferences for involvement may change with the level of information they receive. Reasons for not exchanging enough information were cited as nurses being too busy, lack of time, minimal nursing contact, and lack of personalised information (Suhonen and Leino-Kilpi 2006). The lack of information exchange perhaps reflects task-centred practice, resulting in limited opportunities for dialogue between patients and registered nurses.

2.7.4 Limitations of the literature on patients' information needs

There is consistent use of terms such as 'information giving' (Logan et al. 2008, Jacobs 2000, Turton 1998), 'information provision' and 'education and learning' (Suhonen and Leino-Kilpi 2006, May et al. 2006), which emphasizes a

predominantly one-way transfer of information from nurses to patients. The introduction of standardised information in Swedish hospitals meant that eliciting patients' information needs for pre- and post-operative care was intended for use in developing standardised information resources (Lithner and Zilling 2000), rather than for informing information exchange. However, provision of standardised information focuses on nurses, whilst exchanging individualised information focuses on patients. The focus on information provision highlights difficulties with the interchangeable use of the terms 'provision' and 'exchange'. For example, one paper, with a focus on information provision evidenced by the use of the terms *'adequate information and effective training'*, *'motivation to comply with treatment',* and *'sensitive information provision'*, stated in the abstract that *'a friendly relaxed approach … facilitated information exchange'* (Logan et al. 2008:32-37). Similarly, Donohue (2003), in examining information as a resource to be exchanged between nurse practitioners and patients, reported that patients were provided with advice, opinions and instruction, which was not problematic as that was what patients expected of the encounter. These papers indicate that information exchange is often initiated and controlled by nurses, and primarily involves provision of information in health promotion and patient education, and not necessarily within an acute treatment context. The nursing literature does not report on information exchange as defined by Charles et al. (1999 and 1997) as a two-way equitable sharing of information between patients and nurses.

Similar to the literature on information exchange in nursing practice, a closer look at the literature on patients' information needs reveals methodological limitations. These limitations are: questions relating to the use of predefined questionnaires (May et al. 2006, Suhonen et al. 2005, Turton 1998); studies with specific contexts or small sample sizes that limit generalizability and/or transferability, and do not reflect the study design (Smith and Liles 2007, May et al. 2006, Doherty and Doherty 2005, Donohue 2003, Sainio and Lauri 2003); the use of retrospective accounts (May et al. 2006, Jacobs 2000); and what could be called misrepresentative reporting (Doherty and Doherty 2005, Aveyard 2002a).

2.7.4.1   Pre-defined questionnaires

Several authors used validated questionnaires or scales to elicit patients' preferences for information (Smith and Liles 2007, Suhonen et al. 2005, Sainio and Lauri 2003, Jacobs 2000, Lithner and Zilling 2000, Turton 1998). However further exploration of patients' perceptions, may require more qualitative work. Two papers (Smith and Liles 2007, Jacobs 2000) used the Patient Learning Needs Scale (PLNS) developed from patient perceptions and nurse expertise (Bubela et al. 1990), one of which added open-ended questions to strengthen data on patients' perspectives (Smith and Liles 2007). Conversely, developing data collection tools independently of patients' experiences can limit exploration of patients' perceptions. Two papers reviewed used such data collection tools: one tool was developed from recommendations in cardiac literature, and was assessed for validity by nurses and not patients (Turton 1998); another tool was designed with reference to national legislation and previous studies, although it is

unclear which previous studies the authors are referring to (Suhonen et al. 2005). Using pre-determined questionnaires may account for patients only wanting information on risk factors and follow-up care (Turton 1998), and on condition, treatment and follow-up care (Suhonen et al. 2005), where perhaps the questions did not reflect other possible preferences for information. Patients may have other perspectives on questions that were not asked.

2.7.4.2 Context and sample sizes

Studies that are very specific in context or small in terms of sample size are limited in the generalizability and transferability of their findings although they may have significance for similar groups (Knight 2002, Patton 2002). Research on patients' preferences for information regarding nursing care focuses on very specific contexts. For example, in cardiac care (Smith and Liles 2007, Turton 1998), care of the elderly (Doherty and Doherty 2005), cancer care (Sainio and Lauri 2003), care of patients requiring surgery (Suhonen and Leino-Kilpi 2006), and self-care (Logan et al. 2008, May et al. 2006)

Research on patients' information needs in nursing care, in covering a range of contexts, does report some common points, such as: the need for information on treatment (Logan et al. 2008, Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, May et al. 2006, Suhonen et al. 2005, Sainio and Lauri 2003, Jacobs 2000, Lithner and Zilling 2000); the need for information on follow-up care (Suhonen and Leino-Kilpi 2006, Suhonen et al. 2005, Jacobs 2000, Lithner and Zilling 2000, Turton 1998); the need for information on disease condition (Logan et al.

2008, Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, Suhonen et al. 2005); and, evidence that patient's information needs are not being met (Suhonen and Leino-Kilpi 2006, Suhonen et al. 2005, Doherty and Doherty 2005)

To exemplify the difficulty in generalizing the findings from across diverse contexts, information about resuming work and driving are found to be important for patients being discharged home post myocardial infarction (Smith and Liles 2007), but may not be as important to elderly patients (Doherty and Doherty 2005) or patients learning intermittent self-catheterisation (ISC) (Logan et al. 2008). Furthermore, one study in the current literature review has a relatively small sample size (Smith and Liles 2007, n=20) for quantitative research, and Donohue's (2003) qualitative study with a sample size of eight patients and two nurse practitioners cannot be used to generalize that all patients would be happy with little information exchange, and an expectation of instruction and advice.

2.7.4.3 *Retrospective accounts*

A further methodological limitation within the literature on patients' preferences for information is the reliance on retrospective accounts (May et al. 2006, Jacobs 2000). Retrospective-type questions may limit responses, as patients may not remember what information they had received – a point acknowledged by Jacobs (2000). Research is needed that avoids dependence on retrospective accounts and incorporates observation of patient/nurse interactions as being the most reliable way of collecting data about the interactions first hand (Watson et al. 2010).

2.7.4.4   Misrepresentative reporting

A final methodological limitation identified from the literature review is that which could be called misrepresentative reporting. There is a possibility in any research project that misrepresentative reporting may occur inadvertently. However, the misrepresentative reporting identified in the literature took three different forms, which could perhaps have been avoided:

1. Similar to retrospective accounts – Aveyard (2002a) conducted a study with nurses, listening to what nurses said they did in practice. However, Aveyard (2002a) then reported the findings as, and based the discussion of the findings on, what was actually happening in practice. Research in which the authors do not distinguish between what people say and what is known of the actual behaviour has been criticised for its lack of quality (Silverman 2013, Paley 2001).

2. A misuse of percentages – Doherty and Doherty (2005) reported their findings on factors influencing patient decision-making in terms of percentages. They said that 20% of patients chose an active role, 40% chose a shared role, and 40% chose a passive role. However, it was a qualitative study with a small sample size (n=20); therefore 40% amounts to only eight patients.

3. Ambiguity of terms used – one study examined the accuracy of information that patients received during their hospital stay by comparing patients' informational needs with the information actually received, and examining whether the amount of information wanted and received varied

among patients (Suhonen et al. 2005). However, the study discusses how some types of information are 'more' or 'less' important than others, describing how respondents reported that certain information about illness and treatment were of *'vital importance'* to them, whereas *'less importance was attached to information regarding anaesthesia and care options'* despite only having 'yes' or 'no' responses from participants (Suhonen et al. 2005:1170). Also, the information patients received about treatment risks, prognosis and progress was reported as being *'much less than the importance patients attached to these topics'*, and the conclusion states that *'patients attached great importance to information about their illness and its treatment'* (Suhonen et al. 2005:1173-1174). It is difficult to understand how degrees of importance could be discussed from a questionnaire with limited response answers – yes or no – and as such, the terms used in the discussion could be misleading.

These examples of misrepresentative reporting (Doherty and Doherty 2005, Suhonen et al. 2005, Aveyard 2002), strengthen the argument for rigorous research into information exchange between patients and nurses, and patients' information wants and needs – research that reports findings accurately and appropriately according to the research design, and that adequately defines the terms used, as my study seeks to do.

In summary, there is a lack of good quality research on patients' preferences for information from nurses to inform our understanding of information exchange. Based on this knowledge, my study explores information exchange and the information patients want, where: patients are involved in the research process; participant characteristics reflect a variety of disease conditions; sample sizes are appropriate to the study design; first-hand accounts take the place of retrospective accounts; and the results reflect patients' and nurses' self-reported perceptions of information exchange. A clear definition of information exchange as a two-way interaction between patients and nurses is provided. Distinguishing between information provision and information exchange is paramount because information provision does not promote the sharing of preferences and values. If information is missing from an interaction then it is possible that decisions made will not be relevant for the patient.

2.8   Information exchange in the literature not relating to nursing

A review of the literature on information exchange in non-nursing contexts was undertaken. The review is not exhaustive, as the focus of this chapter is information exchange between patients and nurses rather than in non-nursing contexts. By reviewing the non-nursing literature, it may be possible to extrapolate some of the findings into a nursing context. I included papers if they focussed on information exchange between patients and health professionals; patient participation in decision-making; and information exchange or patients'

information needs, in general health settings. I excluded papers if they focussed on patient self-care or treatment management; information exchange using electronic methods; information exchange which did not include the patient; and mental health, learning disability, or paediatric settings. After applying the inclusion and exclusion criteria (2.4), each paper was appraised for its quality and its applicability to the study. Papers were appraised according to the strength of the evidence, starting with quantitative papers (n=11) and working down through mixed methods research (n=1), qualitative research (n=12), literature reviews (n=4) and theoretical discussions (n=2) (Appendix 2).

2.8.1 Information exchange in non-nursing contexts

Information exchange and patient involvement in decision-making are discussed in contexts such as: in one-to-one consultations in GP practices (van den Brink-Muinen et al. 2006, Edwards and Elwyn 2004, Ford et al. 2003); acute care settings (Isaacs et al. 2013, Bugge et al. 2006, Entwistle and Watt 2006, Moumjid et al. 2003); in caring for patients with chronic conditions (Shortus et al. 2013, Zoffman et al. 2008, Nelson et al. 2005); and, in caring for patients with cancer (O'Brien et al. 2013, Ziegler et al. 2004). The literature consistently reports: that patients want more information than they currently get (Andreassen et al. 2007, Jepson et al. 2007, Ford et al. 2003); that adequate information exchange and involvement in care may be associated with improved health outcomes (Arnetz et al. 2010, Hubbard et al. 2007); and that there may be socio-demographic role preferences relating to information exchange and decision-making (Fullwood et

al. 2013, Hubbard et al. 2007, Florin et al. 2006, Pinquart and Duberstein 2004). There is consistent discussion on, and evidence to suggest that, younger people and those with a higher educational status prefer partnership and negotiation in information exchange and decision-making, with older and less well educated patients preferring a more passive role (Florin et al. 2006, Pinquart and Duberstein 2004). However, Fullwood et al. (2013) found that younger patients reported less shared decision-making, but the study was limited to one socially deprived area of the UK, and thus does not represent the entire UK population.

2.8.2 Differences in information wanted from doctors and from nurses

The non-nursing literature identifies the information that patients want from doctors, summarised in Table 4. There appears to be differences in the type of information that patients want from their doctors and the type of information wanted from nurses. Patients consistently want information on treatment, including the risks and benefits, from their GP's or consultants, and to some degree, from nurses (Beaver and Booth 2007, Andreassen et al. 2007, Entwistle and Watt 2006, van den Brink-Muinen et al. 2006, Nelson et al. 2005, Ziegler et al. 2004, Wade et al. 2000, Coulter et al. 1999, Beaver et al. 1999). Information on non-technical aspects of care and follow-up care seems to remain in the nursing domain (Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, Jacobs 2000), with only a few exceptions in non-nursing contexts (Beaver and Booth 2007, Andreassen et al. 2007, Nelson et al. 2005).

Sainio and Lauri (2003) investigated patients' participation in decision-making about treatment and nursing care. There was a distinction between treatment decisions involving patients and doctors and decisions about nursing care involving patients and nurses. The aim was not intended to compare nursing and non-nursing contexts but to identify and explain cancer patients' participation in decision-making. The study was not specifically about information exchange, although information exchange was seen as key to decision-making. It appeared that patients valued decision-making about non-technical aspects of care with nurses, and about treatment decisions with doctors. On closer inspection, the wording of the structured questionnaire was biased towards treatment decisions involving doctors, and the majority of items relating to nursing care were non-technical. No rationale was provided for this distinction. For example, items on the questionnaire about decision-making regarding treatment included: "I have shared decisions with physician"; "I have made decisions myself"; and "Physician has made decisions". No items on this section of the questionnaire included the role of nurses in treatment decision-making. The section on decision-making about nursing care included more non-technical items such as: personal hygiene, rest/sleep, food, scheduling for treatments or investigations, bed placement, room placement, and discharge, with only a couple of technical items such as amount of intravenous fluids, and medication required. Information exchange was perceived as key to decision-making; however bias in the study, coupled with a lack of research about nurses and patients on information exchange,

provides little foundation on which to base the premise of differing information

needs in different contexts.

Table 4: Type of information patients want from physicians

Patients' info needs / Authors	Condition, or natural history of disease	Risk factors for disease	Treatment	Treatment options	Risks/ limitations of treatment	Benefits of treatment	Non-technical aspects of care	Outcomes	Follow-up care.	Other
Coulter et al. (1999)	√		√	√	√	√		√		Alternative complimentary therapies
Beaver et al. (1999)	√	√	√		√			√		Social impact, support groups, and dietary advice.
Wade et al. (2000)			√		√			√		
Ziegler et al. (2004)	√		√	√	√				√	
Nelson et al. (2005)	√		√	√	√			√	√	
Van den Brink-Muinen et al. (2006)			√	√	√					
Entwistle et al. (2006)			√	√	√	√				
Andreassen et al. (2007)			√	√	√		√	√	√	Where family members go for help, emotional reactions.
Jepson et al. (2007)	√	√			√	√				
Beaver and Booth (2007)	√	√	√		√		√	√		Social impact, sexual impact, signs of recurrence, resuming work, others with same cancer type, and surrogacy.

2.8.3 Inconsistencies between information wanted and information received

Research to date demonstrates inconsistencies in terms of patients' information needs and current practice, in that patients report that they do not receive the information that they want and some patients are unaware that there are alternative treatment choices (Selman et al. 2009, Suhonen and Leino-Kilpi 2006, Entwistle and Watt 2006, van den Brink-Muinen et al. 2006, Krag et al. 2004, Ford et al. 2003). The literature itself on patients' information needs is inconsistent. For example, some of the reasons reported for patients wanting more information are either unsupported because they are not based on research (Coulter et al. 1999), or are significantly under-explored (for example, van den Brink-Muinen et al. 2006). Furthermore some differences between the information that patients want, and the information received may be due in part to methodological difficulties such as pre-defined questionnaires or interviews (Beaver and Booth 2007, van den Brink-Muinen et al. 2006, Beaver et al. 1999), and the use of hypothetical case studies (Krag et al. 2004) not allowing for exploration of patients' perceptions on the amount of information exchanged. For example, an information needs questionnaire elicited patients' needs for information (Beaver and Booth 2007, Beaver et al. 1999). The questionnaire was previously designed through a literature search and had been validated in previous research. The precise details of the questionnaire development are unclear, as the authors do not comment on patient input. Similarly, van den Brink-Muinen et al. (2006) used GP questionnaires derived from national surveys, but do not state how the patient questionnaires were developed. Other inconsistencies may be due to the motivation of the participants, such as an underlying paternalistic ethos (Krag et al. 2004). Inconsistencies between information wanted and received and also across the

literature, evidence a need for further research into the amount of information that patients want exchanged and why.

In summary, despite their limitations research in contexts not about nursing can be useful in informing nursing practice. Nurses care for a variety of patients of different ages and socio-demographic backgrounds. The evidence that suggests that younger people and those with a higher educational status prefer partnership and negotiation in the exchange of information and decision-making, and that older and less well-educated patients prefer a more passive role, is important to nursing practice. Knowledge of information exchange and decision-making role preferences may help to avoid coercing reluctant collaborators into an active role (Waterworth and Luker 1990). Furthermore, the evidence from the non-nursing literature that suggests that patients want more information than they actually receive also has significance for nursing practice. Nurses can be more aware that some patients prefer more information and can assess these preferences for information at an individual patient level. Despite all that we can learn from non-nursing contexts, what remains clear is the need to address the lack of research into information exchange as specific to patients and nurses in routine nursing care.

2.9   Statement of the problem

Information exchange between nurses and patients is supported ethically and professionally (NMC 2008, Scottish Executive 2003, Department of Health 1997). The critique of the literature highlights a dearth of literature specifically examining information exchange between nurses and patients during routine nursing care. The lack of examination of information exchange in the context of nursing care is

unsatisfactory and there is a need for further research. Research relating to information needs in nursing practice does not inform information exchange in nursing practice due to difficulty defining terms such as information wants and information needs. Research is needed into patients' preferences for information. Research studies investigating how information is exchanged have been carried out in the context of general practice, acute care settings, and in caring for patients with chronic conditions (Thompson 2007, Entwistle and Watt 2006, Edwards and Elwyn 2004, Moumjid et al. 2003). Research relating to information exchange between patients and physicians provides knowledge on patients' information needs and roles. As patients may have additional information needs in the context of nursing care, we cannot wholly extrapolate the findings of research that is not about patients and nurses and apply them to a nursing context. Furthermore, there are methodological limitations with the studies reviewed.

My study is the first to explore patients' and nurses' perceptions of information exchange, as conceptualised by Charles et al. (1999 and 1997), in ward settings. Patients' participation in an advisory group, sampling for maximum variation, observing information exchange, and interviewing participants in-depth may elicit rich data from the perspectives of both patients and nurses, and address gaps in the nursing literature.

2.9.1 Aim and research questions

I critiqued the literature and identified a lack of detail on the type of information that patients and nurses exchange during routine nursing care in ward settings and on whether or not the information received was relevant and sufficient for their needs.

Informed by this critique, I undertook a detailed study that aimed to explore information exchange between patients and nurses during routine nursing care in ward settings. The research questions are:

1. What information do nurses and patients exchange during routine nursing care?

2. Do patients and nurses perceive the information they have exchanged to be relevant? If so, for what?

3. Do patients and nurses perceive they have exchanged all the information sufficient for their needs?

Part 2: Methods

Chapter 3:   Plan of investigation

3.1   Study design

Based on the aim of the study and the research questions, the study design is an exploratory qualitative multiple case study (Yin 2013, Stake 2006, Stake 2005, Bergen and While 2000) using a multi-method approach incorporating non-participant observations and in-depth interviews. Adopting a qualitative approach was suitable for my study because little is known about information exchange between patients and nurses in the context of routine nursing care in ward settings (Lacey 2010, Miles and Huberman 1994, Becker et al. 1963). A qualitative approach maximizes the opportunity to explore information exchange without approaching the topic with explanations or pre-defined ideas (Lacey 2010). Eliciting the participants' perspectives should enhance an understanding of information exchange between patients and nurses during routine nursing interventions (Denzin and Lincoln 2005).

3.1.1 Rationale for study design

In studying a particular phenomenon, a case study approach is useful because it aids in-depth investigation whilst preserving the wholeness and integrity of the case (Yin 2013, Punch 2005). Yin (2013) suggests that the case study research method is useful when asking 'how' or 'why' questions. However, case study also helps us understand social processes in detail often with consideration to numerous contextual factors (Yin 2013, George and Bennett 2005), which statistical methods do not permit (George and Bennett 2005). A case study approach was suitable for my study as its incorporation of various sources of evidence such as observations, interviews, documentation, and field notes (Robson 2011), lent well to addressing my

research questions. My questions were not 'how' or 'why' but were 'what' and 'do'. I wanted to explore real life social processes and contexts, namely patient/nurse interactions, in depth, which case study research allows (Yin 2003). Non-participant observations and in-depth interviews were appropriate because they helped to explore information exchange as it occurred, and provided rich data on the participant's perspectives into the relevance and sufficiency of the information exchanged (Mason 2006) (and 3.5).

The multiple-case study design has been considered a variation within case study design (Yin 2013). Other authors perceive the multiple case study approach as being a research method distinct from case study research calling it the comparative case study method (Dion 1998). I used a multiple-case study design to undertake my study (Stake 2006) as it allows for a detailed examination of various entities, for example, people, situations, or problems that may not be possible by studying one case (Stake 2006). Multiple-case study also allows for cross-case and within-case comparisons, which are evident in my analysis of the data (see Chapters 6 and 7). In multiple-case study, each case is significant because it forms part of a group of cases, or particular phenomenon that has been defined at the outset of the research (Swanburn 2012, Punch 2005). Stake (2006) calls this collection of cases, or phenomena, a 'quintain'. In my study, the quintain is 'information exchange between patients and nurses in ward settings'.

Each case constituting the quintain in my study encapsulates a patient, the interactions that the patient is involved in relating to routine nursing care, and the nurses involved in those interactions. Observations and in-depth interviews also form

part of each case (3.5). In some cases, there may be only one consenting nurse involved in the patient's care. Figure 3 illustrates a case for a patient and one nurse.

Figure 3: Illustration of a case constituting one patient and one nurse
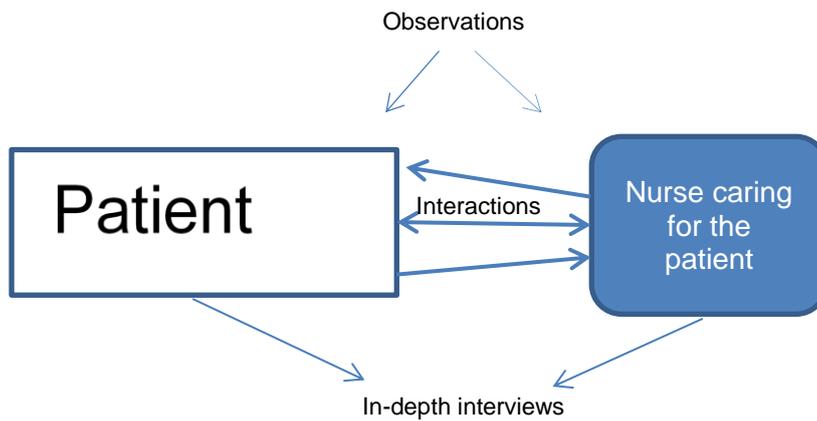
Other cases may constitute a patient and more than one consenting nurse. Figure 4 illustrates a case that includes two nurses.

Figure 4: Illustration of a case constituting one patient and two nurses
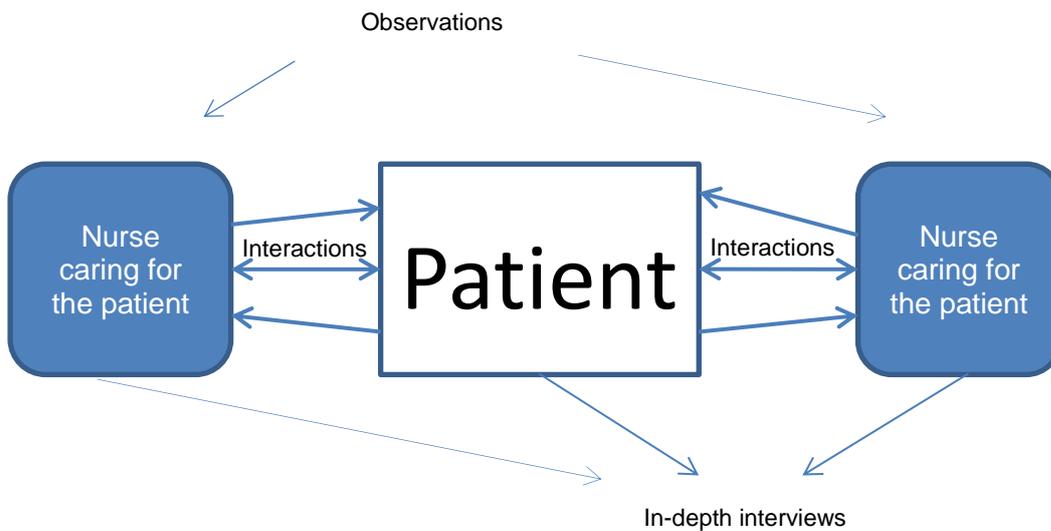
Interactions not related to routine nursing care, and not involving nurses, were not considered a case for my study. My study focused on the insights that each case could provide regarding information exchange, which may aid our understanding of this phenomenon in the context of routine nursing care in ward settings.

My study is atypical because I explored nineteen cases rather than the smaller number of cases typical of multiple-case studies. I set out to explore more than one case though I did not plan for a particular number of cases. Stake (2006) offers general criteria for selecting cases:

- *Is the case relevant to the quintain?*
- *Do the cases provide diversity across contexts?*
- *Do the cases provide good opportunities to learn about the complexity and contexts?*

(Stake 2006:23)

Cases can be decided upon either by sampling-based logic or case-based logic (Yin 2013, Small 2009). Sampling-based case selection is more akin to the type of sampling that is used for survey research. Case-based selection proceeds sequentially with each case informing the next, with cases being added as analysis dictates (Gobo 2007). Small (2009) concurs with Gobo (2007) and notes that:

> *In a case model, the number of units (cases) is unknown until the study is completed… The first unit or case yields a set of findings and a set of questions that inform the next case. If the study is conducted properly, the very last case examined will provide very little new or surprising information. The objective is saturation.*

(Small 2009:25)

In order to explore information exchange between patients and nurses in various situations and circumstances, I sampled for maximum variation, and continued

sampling cases until I was not hearing anything new either in the patient/nurse interactions or in the interviews.

3.1.2 Triangulation

Rigour was enhanced by adopting multiple methods or triangulation (Bryman 2012, Jones and Bugge 2006, Denzin and Lincoln 2005, Shih 1998). Triangulation has an early association with quantitative research (Webb et al. 1999) but is commonly used in qualitative studies (Mason 2006, Knafl and Breitmayer 1991), and increasingly used to integrate quantitative and qualitative strategies (Bryman 2012, Lathlean 2010, Knight 2002, Shih 1998, Jick 1979). Triangulation is also recommended for case study research (Yin 2013). I used triangulation in my study for completeness (Shih 1998, Fielding and Fielding 1986), which led to a more holistic analysis and wider understanding of information exchange between patients and nurses (Polit and Beck 2011). This differs from triangulation for confirmation, which attempts to counter the strengths and weaknesses of different methods, in an attempt to show robustness and validity (Fielding and Fielding 1986).

Based on the research questions, I used semi-structured observations and in-depth interviews for data collection. These methods enhanced the findings by producing different accounts of information exchange (Mason 2006, Shih 1998). Observations provided an account of information exchange as it occurred, and as I recorded and perceived it. In-depth interviews provided an account of the participants' perceptions of the observations of information exchange. Triangulation improved the rigour and transparency of my study through a process of explaining, clarifying and bringing together data from the data collection methods (Jones and Bugge 2006, Denzin and

Lincoln 2005), and facilitated the development of my research skills (Jones and Bugge 2006).

3.2   Population

The population of interest for my study was adult male and female in-patients admitted to acute medical and surgical wards, and the registered nurses caring for them. Perspectives of information exchange from across the adult age spectrum provided information-rich data from a typical sample of participants in the context of acute ward environments. The population of interest for my study included perspectives of registered nurses, irrespective of their seniority. This combination of acute medical and surgical ward settings, and all levels of registered nurses exchanging information with adult patients, provided rich data on a phenomenon that had previously been studied in one-to-one contexts, such as in GP consultations, rather than in ward settings.

3.3   Sampling strategy

The sampling strategy outlined here relates to sampling cases for observations and subsequently for interviews. Sampling for each data collection method is outlined separately. The sampling method I used for participants was sampling for maximum variation. Cresswell (2013) states that sampling for maximum variation can be used in case study research, particularly multiple-case study research where maximum variation can be used as *'a strategy to represent diverse cases to fully display multiple perspectives about the cases'* (Cresswell 2013:120). In contrast, Holloway and Wheeler (2010) state that sampling for maximum variation is not often used by

qualitative researchers, although they acknowledge that it does not sit exclusively within the quantitative researcher's domain. Sampling for maximum variation facilitates a broad range of perspectives and often the sample is larger than that which is often used in qualitative research, which is generally more specific and has a smaller sample. Although my study was not a large study, it was large in multiple-case study terms.

3.3.1 Sampling for observations

I sampled for maximum variation (Patton 2002) male and female nurses of varying levels of seniority, and adult male and female inpatients in medical and surgical wards (see Tables 8 and 9, respectively).

Sampling patients from surgical and medical wards was informed by previous theoretical literature highlighting that information exchange for patients with chronic conditions might differ from that of patients with more acute conditions (Montori et al. 2006). Patients with chronic conditions tend to gather more information as their condition progresses, and may want to share more information received from other professionals, their family, or from other sources. Patients admitted to medical wards are more likely to be experiencing chronic conditions. As much of their treatment takes place at home after discharge, it may be essential for the patient to share lifestyle and social circumstances.

Nurses were sampled for maximum variation of their gender, number of years qualified, number of years in their current post, and their NHS Banding. In the NHS, jobs are matched to profiles that have been evaluated nationally based on job

descriptions and person specifications (Royal College of Nursing 2014). Band 5 ward nurses plan patient care, undertake nursing interventions and provide clinical supervision to other staff and students. Band 6 ward nurses are perceived as team leaders and have clinical and managerial responsibilities particularly in the absence of a Band 7 nurse. Band 7 nurse responsibilities include: all the responsibilities of Band 5 and 6 nurses; staff management, appraisals and making up of rotas; involvement in recruitment and selection of staff; and may include holding and managing a budget.

I achieved maximum variation by sampling from the following:

- Patients admitted to hospital with a variety of medical conditions, such as respiratory and cardiovascular disorders, chronic or acute pain, infections, and diabetes

- Patients admitted to hospital with a variety of surgical conditions, such as urology, vascular surgery, acute orthopaedics, orthopaedic rehabilitation, colorectal surgery, upper gastrointestinal/hepatobiliary/pancreatic unit, and surgical receiving unit

- Patients across a wide spectrum of ages and socio-demographic circumstances

- Male and female nurses, regardless of seniority

The aim of my research was to explore information exchange as it happened. Based on this aim, it was essential that patients currently in hospital and the nurses caring for them, be observed and interviewed, rather than obtaining retrospective data after discharge from hospital.

3.3.2 Sampling for interviews

I interviewed participants who had been recorded during the observation sessions, which are described in Section 3.5.1. The purpose of the interviews was to explore participants' perspectives of information exchange. Therefore, I utilised purposive sampling for maximum variation (Patton 2002) of interactions evidencing elements of information exchange, and those not evidencing information exchange. Participants' perspectives on both such situations were important to my study as only they could tell whether the information provided, or not provided, was sufficient or problematic. Initially I proposed that an interview would follow the observation as soon as was convenient for the participants, to increase the possibility for accurate recall. However, following the pilot study the timing of the interviews was changed. I spent time reviewing the observation data prior to interviewing participants and used the observation data as prompts when necessary (see Chapter 4: Section 4.7 for changes made to the main study after conducting the pilot study). As qualitative research explores complex phenomena in depth, it was important to keep focussing on the sampling strategy, knowing when to continue and when to stop (Mason 2006). Numbers and measurement are not the priority of this type of research. Sampling continued until saturation was achieved (Polit and Beck 2011). I demonstrated saturation when repetition of participants' perspectives of information exchange confirmed that I was *'not hearing anything new'* (Morse 1991:135).

3.4 Research process

In the following sections, I discuss the research process for the main study. Prior to undertaking the main study, I conducted a pilot study to test the research process and the data collection methods and equipment. As a result of the pilot study some

changes were applied to the main study. Where applicable, the changes are referred to throughout the following sections however, I provide a more detailed account of the pilot study in Chapter 4. The role of the pilot study was to test all of the research processes including the process of obtaining necessary approvals.

3.4.1 Study setting

The setting chosen for the main study was surgical and medical overnight stay wards within a large urban-based hospital. This setting was appropriate as the wards admitted adult male and female patients with varying surgical and medical needs. I chose the particular geographical area because it included a population from which potential participants of various ages and socio-demographic backgrounds, dealing with a wide variety of conditions, could be sampled.

3.4.1.1   *Approvals*

Prior to obtaining access to the clinical site, I sought various and necessary approvals from key institutions, such as:

- School Research Ethics Committee (SREC) (formerly, and as noted on correspondence, Departmental Research Ethics Committee (DREC))
- NHS National Research Ethics Service (NHS NRES)
- NHS Research and Development (NHS R&D)
- NHS Caldicott Guardian

All approvals can be found in Appendices 3-5. NHS R&D approval must be obtained before a research project can be undertaken in an NHS site. An honorary staff contract issued by the R&D officer, and a letter confirming approval provided evidence to the clinical site staff that I had permissions from the appropriate

agencies. Issues with the length of time obtaining R&D approval were highlighted in the pilot study (4.5.1). Therefore, with R&D permission, discussion with key personnel took place prior to R&D approval finally being in place. However, not all challenges involved in obtaining R&D approval were evident in the pilot study. For the main study, before I could gain final R&D approval, I was asked to provide evidence that I had previously had a BCG vaccination. Despite providing documentation, my BCG scar was to be visualised by the occupational health nurse. However, they were unable to provide an appointment for me for a further three weeks after my receiving their request, which would have held up my study by almost a month. Therefore, the nurse at the University of Stirling Occupational Health department visualised my BCG scar and sent confirmation to Occupational Health staff responsible for the study site by fax. After confirmation of my health status, and once all ethical approvals were in place, the NHS R&D office approved my study.

I also obtained approval for my study from the Caldicott Guardian at the clinical site A Caldicott Guardian is a senior person who is responsible for the safe management and handling of patient identifiable material (Health and Social Care Information Centre 2013). The role of the Caldicott Guardian is to safeguard and promote appropriate levels of information sharing and to ensure high standards of data handling. I obtained Caldicott Guardian approval as I would be managing data containing the identities of patients and nurses, and I would be transporting data between the clinical site and my office.

Table 5 illustrates the process and timelines for obtaining approvals and access to the clinical site. Key timelines of note are:

- SREC process took approximately 3 weeks from submission of proposal to receiving final ethical approval.

- NHS NRES process took approximately 3 weeks from submission of proposal to receiving final ethical approval.

- R&D management approval process took approximately 13 weeks from submission of proposal to receiving management approval and an honorary research contract.

Although obtaining approval ran concurrently with discussions with key personnel at the clinical site, recruitment, consent and data collection did not commence until all approvals were in place.

Table 5: Timeline for obtaining access to the main study sites

Date	Comment
16th February 2009	Proposal submitted to SREC Provisional letter sent to Director of Nursing requesting meeting with senior nurses (response received from secretary by telephone confirming support – 20/2/09) Initial contact made with new R&D officer
20th February 2009	Proposal emailed to Director of Nursing's secretary for distribution to Heads of Nursing
24th February 2009	Letter received from Director of Nursing confirming support
27th February 2009	Letter emailed to Heads of Nursing for surgical and medical directorates requesting a meeting.
2nd March 2009	Proposal reviewed by SREC
4th March 2009	Provisional approval received from SREC
4th March 2009	Response sent to SREC
5th March 2009	Response received from surgical Head of Nursing offering appointment on Wed 18th March 2009.
11th March 2009	Final favourable response received from SREC
18th March 2009	Meeting with Surgical Head of Nursing
19th March 2009	Proposal submitted to NHS NRES Proposal submitted to NHS R&D
20th March 2009	Emailed surgical lead nurses requesting a meeting with 3 surgical Lead Nurses
26th March 2009	Initial response received from 2 surgical Lead Nurses
2nd April 2009	Meeting with Medical Head of Nursing
3rd April 2009	Proposal reviewed by NHS NRES Emailed surgical Lead Nurse who hadn't responded, requesting a meeting
9th April 2009	Favourable response received from NHS NRES
22nd April 2009	Meeting with orthopaedic ward manager
23rd April 2009	Meeting with orthopaedic Lead Nurse and 2 ward managers
24th April 2009	Response sent to NHS NRES (for info only)
28th April 2009	Response received from final surgical Lead Nurse Emailed urology Lead Nurse Response received from urology Lead Nurse Disclosure certificate received
29th April 2009	Emailed R&D officer to inform of disclosure and ask if anything else I need to do – no response
8th May 2009	Meeting with urology Lead Nurse and urology ward manager
22nd May 2009	Meeting with general surgery Lead Nurse and general surgery ward managers.
26th May 2009	Phoned R&D re management approval
2nd June 2009	Received letter from NHS Occupational Health asking for me to come in for BCG scar check (appointment 22nd June '09)
5th June 2009	Occupational Health at University of Stirling visualised BCG scar and informed NHS Occupational Health by fax (appointment for 22nd June '09 cancelled)
15th June 2009	NHS R&D approval obtained
16th June 2009	Ethics and R&D approval letters sent to Director of Nursing, Heads of Nursing and Lead Nurses
June 2009	Commenced nurse recruitment

3.4.1.2   *Obtaining access*

Following early discussions with the R&D officer, I determined that there was a hierarchical process to obtaining access. Therefore, I initially wrote to the Director of Nursing for Acute Services requesting permission to undertake my study in medical and surgical wards in one teaching hospital. The Director of Nursing provided contact details of the Heads of Nursing for Medical and Surgical services, and suggested I meet with them to discuss my study. Following meetings with the Heads of Nursing, I met with other key personnel at the clinical site; namely, lead nurses and ward managers. Figure 5 illustrates the hierarchy related to gaining access to the clinical sites. Sample letters sent to the Director of Nursing, Heads of Nursing and Lead Nurses can be found in Appendices 6-8.

The approval of all key personnel was imperative because, as 'gatekeepers', they control access to the clinical site and the potential participants (Gelling 2010). Discussion and negotiation took place in the early stages of the research, which provided opportunities for review of the proposal, asking questions, negotiating requirements such as areas of privacy for interviews, and for requesting assistance from key staff in the recruitment process.

Ward staff were informed of the study as a gesture of goodwill, irrespective of their participation, which facilitated familiarity with the study and with my presence as the researcher. It was important to generate a positive attitude towards the research, and remaining available and approachable was vital. All staff affected by the study were informed as to when and for how long the research would continue, were

provided with regular updates, and were assured of minimal disturbance to the ward

routine (Polit and Beck 2011).

Figure 5: The hierarchical process of obtaining access to the clinical sites

Director of Nursing for Acute Services

- Head of Nursing for Surgical Services
  - Lead Nurse for Orthopaedics
    - Ward manager: acute orthopaedics
    - Ward manager: orthopaedic rehabilitation
  - Lead Nurse for Urology
    - Ward manager: urology
  - Lead Nurse for General Surgery
    - Ward manager: surgical receiving
    - Ward manager: colorectal
    - Ward manager: vascular
    - Ward manager: upper GI; hepatobiliary; pancreatic
- Head of Nursing for Medical Services
  - Lead Nurse for Medical Services
    - Ward manager: coronary care
    - Ward manager: female gastroenterology
    - Ward manager: male gastroenterology
    - Ward manager: female respiratory
    - Ward manager: male respiratory
    - Ward manager: general medicine
    - Ward manager: female cardiology; diabetes
    - Ward manager: male cardiology; diabetes

3.4.1.3 The Patient Experience Panel

I met with an advisory group with the aim of discussing the research process with key staff and patients. An existing collaborative relationship with the Scottish Health Council facilitated discussion of an opportunity for patients to be included in the advisory group. Policy documents encourage involving service users and the public in research design, as it helps to ensure that their agenda is being met (Department of Health 2005). Resulting from discussions with the Scottish Health Council and NHS Forth Valley's Patient Focus Public Involvement advisor an already existing Patient Experience Panel was identified. I met with the panel on two occasions: first to discuss my study in general terms and distribute supporting documentation for comment; and second, to listen to their feedback. The Patient Experience Panel informed me that the average reading age in Scotland is 12yrs, and recommended that some of the wording in my supporting documentation be changed. Subsequently, the wording was changed and the amended documents were emailed out to panel members to view.

3.4.2 Inclusion and exclusion criteria

The criteria for patients' and nurses' inclusion in the study are set out in Table 6. Patients attending for day surgery were excluded as their shorter hospital admission may have limited the interactions required for this investigation. Patients within a 24hrs post-anaesthetic period were excluded due to the possibility of insufficient alertness or orientation. Interactions involving any nurse or patient who had not consented to the study were not included. Ward rounds involving a variety of health professionals were not observed, as my study specifically examined the interactions

between patients and nurses; doctors and other allied health professionals (AHPs) were not being included.

Table 6: Inclusion and exclusion criteria

People involved	Inclusion criteria	Exclusion criteria
Patients	1. Patients > 24hrs since admission to ward. 2. Patients who are ≥ 18yrs of age. 3. Patients who are fluent in English. 4. Competent to consent to and participate in the study.	1. Patients admitted for day procedures, or who are < 24hrs post-anaesthetic. 2. Patients who are < 18yrs of age. 3. Patients not fluent in English. 4. Patients who do not wish to participate, or who are unable to consent.
Nurses	1. Qualified at staff nurse level or above. 2. Working in a medical or surgical ward to which a consenting patient is admitted. 3. Nurses working either early or late shift. 4. Nurses who are contracted to work on the ward. 5. Nurses who are fluent in English.	1. Auxiliary nurses or nursing assistants. 2. Nurses working in wards with no consenting patients. 3. Nurses working night shift 4. Bank or agency nurses 5. Nurses not fluent in English

3.4.3 Recruitment and consent

Informed consent is a legal imperative in research (Mason and Laurie 2011), and was sought from all participants in my study. It helped to ensure that the participants understood the aims of the research, and protected them by providing an opportunity to say 'no' when asked to participate (Parahoo 2006). To ensure informed consent, the potential participants received all the information necessary to assess the pros and cons of involvement, and weigh up whether or not to take part. I drew attention to confidentiality and anonymity in the consent process, so participants were aware that their participation was respected, and that identifiable information would be kept confidential (Data Protection Act 1998). I informed all potential participants that they could withdraw from the study at any time without having to give a reason.

3.4.3.1 Recruiting nurses

I recruited nurses first, as their willingness to participate was crucial prior to asking patients. Through regular visits to the ward areas, I ensured that registered nurses were informed of the study. As I held an honorary contract with the relevant NHS trust, I provided an information sheet and a letter of invitation to participate (Appendices 9 and 10) for all registered nurses working in the relevant surgical (n=99 nurses) and medical wards (n=130 nurses). Table 7 presents the initial recruitment log showing details of how many letters were sent to the various types of wards and the resulting number of nurses who consented to take part in the study. No nurses were recruited from two surgical wards. In one ward, the ward manager did not provide a list of staff nurses to invite to participate. However, surgical nurse recruitment was progressing well; therefore, I decided not to pursue this list. I postponed staff recruitment from another ward due to already having sufficient nurses recruited from the same specialty, and due to the ward manager taking considerable time to respond to the invitation to participate. Nurses were recruited from all medical wards except one. The nurses in this ward did not consider the patients suitable for my study stating that many of them suffered from alcoholism and may lack the capacity to consent to taking part.

From the information sheet, nurses knew that even after consenting to take part, participation would only be required if a consenting patient was admitted to the ward on which the nurse worked. I was available by telephone to answer any questions relating to the study, and arranged to meet with potential participants who required further information. Some meetings with nurses were arranged and others were ad-hoc.

Table 7: Initial nurse recruitment process for each ward

Ward	Medical/ surgical	No. of letters	Arranged/ ad hoc appt	No. of nurses recruited	Comments
Surgical receiving ward	Surgical	20	Arranged	3	1 nurse said no to study Data collection started 10/8/09
Upper GI, hepatobiliary & pancreatic unit	Surgical	16	Ad hoc	3	Data collection started 20/10/09
Colorectal ward	Surgical	11	Arranged	6	Data collection started 15/9/09
Vascular ward	Surgical	14	Arranged	2	1 nurse said no to study Data collection started 2/10/09
Urology ward	Surgical	15	Arranged	9	Data collection started 7/8/09
Acute orthopaedics ward	Surgical	13	Arranged	5	Data collection started 20/11/09
Orthopaedic rehabilitation ward	Surgical	10	Arranged	2	1 nurse said no to study Data collection started 27/11/09
Coronary care unit	Medical	18	Arranged	4	Data collection started 19/10/09
Female general medicine, cardiology & diabetes ward	Medical	15	Arranged	4	1 nurse said no to study 1 nurse withdrew her consent Data collection started 15/11/09
Male, general medicine, cardiology & diabetes ward	Medical	12	Arranged	5	1 nurse said no to study Data collection started 10/11/09
Male respiratory medicine ward	Medical	17	Arranged	5	Letters given 18/10/09 Data collection started12/11/09
Female respiratory medicine ward	Medical	14	Ad hoc	2	Patient discharged: no data collected
Male gastroenterology ward	Medical	19	Ad hoc	1	2 nurses said no to study No patients consented to study so no data collected
General medical ward	Medical	15	Ad hoc	1	Data collection started 19/11/09

3.4.3.2   Procedures for consent – nurses

I met with nurses who were interested in taking part, where I discussed the study further and provided an opportunity for asking questions. The meetings either were arranged previously or were ad hoc. In some wards, the ward manager preferred not to arrange a meeting and suggested that I just 'pop in' to the ward any time I was passing and meet with the nurses on duty. In the wards where a specific meeting was arranged, nurses appeared to plan their day ahead of the meeting and subsequently more nurses were able to attend. Nurses unable to attend a group meeting met with me at another mutually convenient time and place. As nurses had had prior opportunity to read the information sheet, I provided consent forms (Appendix 11) for nurses to complete, if they wished, after the meeting. Some nurses returned the signed consent form immediately; however, most signed the form later and left it at a designated place on the ward for me to collect. One nurse stopped me in a hospital corridor and explained that he had been on holiday and had not managed to attend the meeting arranged on his ward. He asked if he could still take part in the study, and subsequently signed a consent form for me to collect from the ward. Each consent form was signed by the nurse and by me. In total, I recruited fifty-two nurses to my study.

Not all nurses who consented took part in the study. Having fifty-two nurses consented provided more scope in terms of patient recruitment. In other words, the more consenting nurses there were in the study, the easier it would be to match nurses with consenting patients, being cognisant of nurses' holidays, days off and any periods of illness. In Table 8, I present the characteristics of the nurses who actually took part in the study. Nurses were assigned pseudonyms alphabetically in

according to when they were recruited. The starting letters of their pseudonyms are not linked to the cases. The information for one of the nurses, pseudonym 'Hannah', is incomplete as it was not possible to interview her due to an emergency occurring on the ward.

Table 8: Nurses' characteristics

Ward	Gender	Pseudonym	Date recruited	Grade	No. of years' experience	Time in current place of work	Study ID
Surgical receiving	Female	Ann	05/07/09	5	9	9 years	N0610
Urology	Female	Cathy	06/07/09	5	2	2 years	N0634
Surgical receiving	Male	Duncan	07/07/09	5	27	4 years	N0640
Urology	Female	Helen	20/07/09	5	10	1½ years	N0684
Urology	Female	Ivy	19/07/09	5	10 months	10 months	N0694
Urology	Female	Kate	10/07/09	5	6	2 years	N6114
Upper GI, hepato-biliary & pancreatic unit	Female	Lesley	01/07/09	7	29	7 years	N6121
Upper GI, hepato-biliary & pancreatic unit	Male	Oliver	20/07/09	5	1	1 years	N6151
Colorectal	Female	Queenie	30/07/09	5	11	10 years	N6172
Orthopaedic rehabilitation	Female	Una	05/08/09	5	28	1½ years	N2217
Acute orthopaedics	Female	Wendy	07/08/09	5	4	4 years	N5231
Acute orthopaedics	Female	Xena	10/08/09	7	7	3 years	N5241
Colorectal	Female	Yvonne	23/07/09	5	4	4 years	N6252
Coronary care	Female	Carol	03/09/09	7	28	23 years	N4294
Vascular	Male	Frank	25/09/09	5	4	2 years	N6323
Coronary care	female	Hannah	25/09/09	5	Not known	Not known	N4344
Male general medicine, cardiology & diabetes	Male	Ian	17/10/09	5	5	1 years	N0355
Male respiratory	Female	Kirsty	19/10/09	5	32	5 years	N0376
Male respiratory	Female	Olga	21/10/09	6	9	9 years	N0416
Male medicine, cardiology & diabetes	Female	Pauline	17/10/09	6	14	12 years	N0425
Female general medical	Female	Yolanda	26/10/09	5	1	1 month	N2509
Female general medicine, cardiology & diabetes	Female	Andrea	27/10/09	6	23	16 years	N0514

3.4.3.3   *Recruiting surgical patients*

I initially proposed that consultants' secretaries would access elective surgical admission lists, identifying patients due to be admitted to hospital for surgery. An information sheet and an invitation to participate in the study were to be posted to eligible surgical patients, and I was to arrange a meeting with patients interested in taking part. It was hoped that this appointment would coincide with their pre-admission clinic appointment. Although I arranged to meet with surgical patients, changes were made to this process for their recruitment after the pilot study had been undertaken (4.5.2), consequently in the main study all surgical patients were recruited on the ward in the same manner as medical patients (3.4.3.4).

3.4.3.4   *Recruiting medical patients*

Ward staff gave an information sheet and a letter of invitation to participate in the study (Appendices 12 and 13), to eligible patients on the ward. My contact numbers were provided in the information sheet for patients who wished to participate. However, no patients contacted me in this way. Patients indicated their intention to participate to ward staff, who then contacted me. I met with potential participants on the wards to discuss the study further, providing opportunities for asking questions, and providing consent forms (Appendix 14) for signing, if that was still their intention. I met with patients no less that 24hrs after their receipt of the information pack.

3.4.3.5   *Procedures for consent – surgical and medical patients*

I met all interested patients on the ward. As patients had had prior opportunity to read the information sheet, I obtained informed consent at the time of meeting them. Two consent forms were signed both by patients and by me, with the patient retaining one copy. I initially proposed that a copy of the consent forms be kept in

patients' notes. However, after ethical review highlighted that I did not need to access patients notes for any other purpose, it was decided that it was sufficient to keep the original in my files without a copy being retained in patients' notes.

I invited twenty-one patients to take part in the study. One man withdrew from the study before any data were collected, as he was feeling unwell. One woman declined to participate without giving a reason. In total, I recruited nineteen patients to the study. Each case in my study involves one patient, the nurses caring for the patient and the interactions between them during routine nursing care, which meant that I had nineteen cases. Table 9 presents the characteristics of the patients who participated in the study. Confidentiality and anonymity were demonstrated by use of non-identifiable pseudonyms and study ID numbers. Pseudonyms were allocated alphabetically directly relating to each case. For example, Case 1 = Alice, Case 2 = Barry, and so on.

Table 9: Patients' characteristics

Pseudonym	Ward	Gender	Age	Date recruited	Previous admissions	Reason for this admission	Post-op days (if app)	Study ID
Alice	Urology	Female	28	7/8/09	Surgery to slow down growth when 11/12yrs old	Pyelonephritis Stones & cyst in kidney.	N/A	P0614
Barry	Surgical receiving	Male	23	10/8/09	Surgery to left hand	Punctured bowel due to stabbing	1	P0620
Colin	Colorectal	Male	64	15/9/09	Pancreatic problems	Formation of stoma related to problems with pancreas	6-7wks ago (patient unable to remember exactly)	P0632
Donald	Urology	Male	69	25/9/09	Peri-anal abscess; vasectomy repair	Transurethral resection of prostate (TURP)	3	P0644
Eddie	Vascular	Male		3/10/09	Surgery to right hand/arm due to nerve damage	Right above knee amputation	10	P0653
Fred	Surgical receiving	Male	59	9/10/09		Pancreatitis	N/A	P0665
Grace	Surgical receiving	Female	57	18/10/09	Surgery to remove gall bladder; seven admissions since with sepsis	Sepsis related to bile duct	N/A	P0675
Harriet	Coronary care	Female	81	19/10/09	COPD; Stroke	Exacerbation of COPD	N/A	P0484
Iris	Upper GI, hepatobiliary & pancreatic unit	Female	55	20/10/09	Childbirth; spinal injuries; fibroids; hysterectomy	Surgery to repair burst bowel after hysterectomy	7wks ago	P0691
Jack	Urology	Male	62	24/10/09	Tonsillectomy; hernia repair; gall bladder removal; parotid gland surgery; cartilage repair to right knee	Transurethral resection of prostate	1	P6104
Kirsty	Coronary care	Female	69	3/11/09	Tonsillectomy; appendectomy; rheumatic fever; mitral valve replacement; gastro-intestinal bleed & septicaemia; surgery for twisted bowel; aorta repair	Insertion of pacemaker	4	P4114
Larry	Male general medicine, cardiology & diabetes	Male	74	10/11/09	Gall stone removal; heart attack; chest pain	Chest pain	N/A	P0125

Mark	Male respiratory medicine	Male	69	13/11/09	Breathlessness; chest infections	Chest infection	N/A	P0136
Neil	Male respiratory medicine	Male	53	14/11/09	Diabetes; blood clots; heart attacks; bleeding from varices, tracheostomy insertion	Infection around tracheostomy site	N/A	P0146
Olive	Female general medicine, cardiology & diabetes	Female	59	16/11/09	COPD; diabetes; atrial fibrillation	Chest pain; chest infection; kidney failure	N/A	P0154
Peter	Male general medicine, cardiology & diabetes	Male	50	17/11/09	Gastroenteritis, pancreatitis	Viral infection in kidneys	N/A	P0165
Rose	Female general medicine	Female	47	19/11/09	Growth in breast; hysterectomy; gall bladder removal; ectopic pregnancy	Dizziness and headaches	N/A	P2179
Steve	Orthopaedic	Male	33	20/11/09	Appendectomy	Surgery related to having chondro-sarcoma; wound washout due to infection	7wks ago	P5181
Tracy	Orthopaedic rehabilitation	Female	41	27/11/09	Discoloured right foot – diagnosed with diabetes; dislocated and fractured left ankle	Left above knee amputation	8	P2197

3.5 Data collection

Options for qualitative data collection include observations, interviews, audio-visual materials, focus groups, participant diaries, written narratives and documents (Cresswell 2013, Denzin and Lincoln 2008, Mason 2006, Knight 2002). I used non-participant audio-recorded semi-structured observations of interactions between patients and nurses during routine nursing care. Following the observations, I conducted face-to-face semi-structured interviews with patients and nurses. Video recording equipment was not used because of the ethical difficulties with video recording in ward environments, where many members of staff and the public are likely to visit. Video recordings also present difficulties in relation to where equipment is situated, and which patient to observe at any one time. Focus groups were not appropriate for my study as they often introduce an element of social desirability, rather than elicit participants' individual responses in a one-to-one situation. Written data, for example diaries, narratives and documents do not lend well to clarifying responses, hence, were also not appropriate for my study. In Sections 3.5.1 and 3.5.2, I discuss the rationale for the use of semi-structured observations and in-depth interviews in my study. I also provide details of the observations and interviews including:

- The number of interactions per observation session in each case
- The length of time of each interaction
- The type of information patients and nurses discussed
- The length of time of each patient and nurse interview

3.5.1 Semi-structured observations

I undertook semi-structured observations as a method for obtaining data in relation to the first research question: 'What type of information do patients and nurses share during routine nursing care?' I undertook observations because they are the most reliable way of collecting data about the interactions between patients and nurses, first hand (Watson et al. 2010). Observing information exchange as it occurs prevents reliance on participants' retrospective accounts (Mason 2006), and may overcome problems associated with self-report (Knight 2002). For example, what people say they do in practice may differ from what actually happens (Myers 2002).

3.5.1.1 *Types of observations*

There are different types of observation, including participant and non-participant observation (Kumar 2011, Watson et al. 2010) and unobtrusive observation (Denzin and Lincoln 2008), with the researcher adopting roles such as participant, complete observer, or participant-observer (Mason 2006). I used non-participant observation in my study, adopting the role of complete observer, as my intention was to observe naturally occurring interactions whilst attempting to have no influence on them (Watson et al. 2010). Arguably, there is no such thing as non-participant observation. It was unlikely that my presence would have no effect at all on the participants (Knight 2002). Nevertheless, non-participant observation fits with the study aims, and I took steps to minimise any reactive effect (3.5.1.2).

Kumar (2011:119) describes observation as *'a purposeful, systematic and selective way of watching and listening to an interaction or phenomenon as it takes place'*. In my study, the purpose of using observations was to provide an indication of the type of information exchanged. Observations can be recorded in a structured manner or

in a narrative form (Watson et al. 2010). As no approach to observations can be completely unstructured (Watson et al. 2010), I used a semi-structured observation schedule, which included the characteristics of the type of information exchanged and of the types of interaction that may have been observed (Appendix 15).

The interactions between patients and nurses in my study were audio-recorded and analysis of the audio-recordings was used to provide information about the type of information that patients and nurses shared. There were potential ethical and practical challenges associated with audio-recording in ward settings, namely intrusiveness and possible contamination during data collection, for example accidental recording. I undertook a narrative review of observational research methods in ward settings (Dixon-Woods et al. 2004). The aims were to review how audio-recording had been implemented, and to develop an observational research method that was both ethically and practically acceptable. The search is summarised in Appendix 16. The search was carried out in two stages. Stage 1 involved an electronic search of the literature on observational research in ward settings. Stage 2 expanded the search to include: studies in a range of fields using technology to record data; and, studies accessed by searching for named authors who have published in the field of observation research. Criteria for inclusion in the final review were that:

- Studies had to have been peer-reviewed

- Studies included patients > 18yrs of age and/or registered nurses

- Studies focussed on adult nursing carried out in a hospital or hospice ward

- The use of the search term 'observation' yielded papers that focussed on observation as a research method, not the skill of observation (for example,

observing patients in psychiatric settings or undertaking measurement of patients 'observations' (vital signs)

From the review, I found that the majority of observation data were recorded in written form using structured or semi-structured observation schedules or scales, field notes, and reflexive journals. Some studies also used technology to record observation data, and often in the following ways:

- The use of a digital recorder and microphone attached to nurses' uniforms

- The use of a tape recorder placed in close proximity to the participants to audio-record one specific patient and nurse interaction

- The use of a portable tape recorder carried around by the researcher

- Audio-recording running commentary by the researcher, but not audio-recording the actual patient and nurse interactions

- Researcher audio-recorded main points of observations after observation session completed

- The use of video recordings

None of the above methods of audio-recording seemed acceptable for my study. My aim was to keep patients central to the study therefore attaching microphones to nurses' uniforms, or following nurses with portable recorders and providing a running commentary, were not appropriate methods to use. Also, as I was observing interactions over a period of time, and not limited to one specific interaction, it was not appropriate to keep a digital- or tape-recorder running in close proximity to the patient. Video recordings also had the potential to accidentally record other people in the ward who were not part of the study. Therefore, I used a remotely activated

radio-microphone placed near the patient, and all relevant verbal interactions were recorded on a digital recorder. Nurses and patients were not shadowed, and I sat at a discrete distance from the participants.

Only interactions between patients and nurses in relation to routine nursing care were selected for observation. Other interactions, including communications with families, ward rounds, and developing relationships between patients and staff, were not recorded.

3.5.1.2   *The practice of observations in my study*

In practical terms, observations involved me sitting at a discrete distance within a multi-bedded room, or outside of the patients' single rooms, positioning myself where I was able to see the consenting participants. Observation sessions lasted ninety minutes (the time period was identified by the pilot study - see Chapter 4). Observations were audio-taped using a digital recorder which I accessed remotely. A small microphone was placed near the patient and was switched on when a consenting nurse interacted with the patient. Recording only continued when it became apparent that the interaction was related to routine nursing care. During conversations not related to routine nursing care, the recording was discontinued. Audio-tapes were later transcribed verbatim. As well as observing, I took field notes relating to the actual interactions, and made journal entries relating to my own thoughts and feelings during observation.

Table 10 presents each case and includes the number of interactions per ninety-minute session, the length of time of each interaction, and the type of information that patients and nurses shared. The longest interaction lasted 24 minutes 33

seconds, and occurred when the nurse experienced difficulty when removing the patient's surgical drain (see Case 3 in Table 10). The shortest interaction lasted ten seconds, and occurred when the nurse offered the patient a choice relating to personal care (see Case 19 in Table 10).

Table 10: Characteristics of interactions between patients and nurses in main study

Case	Patient	Nurse/s	No. of interactions per session	Length of time of each interaction	Type of information shared
1	Alice	Ivy	1	1 minute 45 seconds	Nursing intervention (administering medication); treatment options (Ibuprofen or Paracetamol to reduce Alice's temperature); patient's preferences (Alice's preference for Ibuprofen)
1	Alice	Helen	1	57 seconds	Patient's preferences (Alice's preference for either a bath or a shower); nursing intervention (Helen will come back to administer intra venous (IV) infusion)
2	Barry	Duncan	1	1 minute 58 seconds	Patient's condition (recurrent cyst in bowel due to being stabbed); patient's understanding of condition; patient's preferences (Barry wanted cyst to be removed instead of excised); follow-up care/referral (referral to dietician); other (Duncan informed Barry that some information was not available as waiting for surgical consultants to review him)
3	Colin	Queenie	4	**1)** 32 seconds **2)** 3 minutes 9 seconds **3)** 2 minutes 54 seconds **4)** 14 minutes 23 seconds	**1)** Follow-up care/referral (dietician coming to review Colin) **2)** Patient's social context (Colin wants to try on his kilt in advance of family wedding) **3)** Nursing intervention (monitoring Colin's blood sugar); other (Colin asks if Queenie enjoyed her lunch) **4)** Patient's social context (free TV in hospital; how to position a kilt; wife's occupation; and wedding photographs); nursing intervention (flushing medication down PEG tube); emotional concerns (Colin's acceptance of not being able to continue working; feelings of loneliness)
3	Colin	Yvonne	1	24 minutes 33 seconds	Nursing intervention (Yvonne cleaning Colin's stoma bag as it had burst; Yvonne taking the Foley catheter out of a wound); patient's condition (Yvonne tells Colin he looks quite tired in the wedding photographs and reminds him he's been through a lot); patient's social context (Colin talks about his family photographs); patient's preferences (Colin asks if the physiotherapist can come back at a later time as he doesn't feel up to exercising at the present time); other (Colin's progress; general chat about what Yvonne had for breakfast)
4	Donald	Kate	1	1 minute 44 seconds	Patient's condition (Donald feels tired and has a headache); treatment (discussion between Donald and Kate about different medications (but not options, risks or benefits); treatment outcomes (temperature should come down and headache should be alleviated; prostate medication can be discontinued after surgery to remove Donald's prostate)
5	Eddie	Frank	4	**1)** 21 minutes 13 seconds **2)** 5 minutes 43 seconds **3)** 1 minute 12 seconds **4)** 16 seconds	**1)** Nursing intervention (Eddie spilt Lucozade and his bed sheets needed changing); patient's condition (Eddie has an itchy back); patient's preferences (Eddie wanted to keep the same pyjama top on despite having spilt Lucozade on it); patient's social context (wife's occupation); other (Eddie's progress; general chat about the weather and how Eddie missed sitting out in the garden; and chat about where Frank used to get his hair cut) **2)** Nursing intervention (Frank monitoring Eddie's vital signs; Eddie guessing what his blood pressure would be) **3)** Nursing intervention (Short discussion about effectiveness of Eddie's medication); other (Eddies humour about only wanting another type of medication if it tasted good) **4)** Nursing intervention (Frank gave Eddie a drink of water to take his medication)

6	Fred	Duncan	1	3 minutes 26 seconds	<u>Patient's condition</u> (Duncan acknowledges that Fred is tired; Fred states he feels less anxious than previously); <u>nursing intervention</u> (Donald is administering (IV) and telling Fred how to position his arm); <u>other</u> (Fred going for further investigations – ultrasound scan)
7	Grace	Ann	1	2 minutes 4 seconds	<u>Nursing intervention</u> (monitoring Grace's vital signs); <u>patient's condition</u> (Anne asks Grace if she has any pain or nausea, and if she is passing urine)
8	Harriet	Hannah	4	**1)** 6 minutes 15 seconds **2)** 4 minutes 41 seconds **3)** 3 minutes 2 seconds **4)** 18 seconds	**1)** <u>Nursing intervention</u> (personal care); <u>patient's condition</u> (Harriet experiencing pain) **2)** <u>Nursing intervention</u> (administration of medication); <u>patient's lay knowledge</u> (Harriet shows knowledge of her medication) **3)** <u>Nursing intervention</u> (administration of nebulizer therapy); <u>other</u> (information from ward round) **4)** <u>Nursing intervention</u> (Hannah asks Harriet if the nebulizer therapy had finished)
9	Iris	Oliver	2	**1)** 8 minutes 19 seconds **2)** 11 minutes 22 seconds	**1)** <u>Nursing intervention</u> (personal care; Oliver will ask doctor to prescribe something for Iris's itchy back); <u>follow-up care/referral</u> (referral to district nurses for wound care); <u>patient's preferences</u> (Iris prefers to take her medication after her personal care has been carried out); <u>patient's condition</u> (Iris's skin feels itchy); <u>patient's lay knowledge</u> (Iris thinks she was previously on Piriton for the itch); <u>other</u> (social pleasantries; Iris's progress and discharge home; what the VAC machine at home looks like; how the VAC machine works; Oliver tells Iris positive experiences of other patients in similar situations) **2)** <u>Nursing intervention</u> (personal care); <u>follow-up care/referral</u> (Oliver asks Iris if she needs home helps; district nurses will come in to change Iris's dressing); <u>patient's condition</u> (Iris's back and leg feels itchy; discussion about what is draining into wound drain); <u>patient's preferences</u> (iris chooses to sit up in her chair); <u>other</u> (care management – physiotherapist coming later)
9	Iris	Lesley	1	2 minutes 55 seconds	<u>Follow-up care/referral</u> (referrals to tissue viability nurse and district nurses); <u>patient's condition</u> (Lesley reiterates that MRSA in the TPN line is not making Iris sick); <u>social context</u> (Iris's husband can pop in to visit any time he wants); <u>other</u> (length of time it takes to get discharge home organised; wound care on discharge; Iris's progress)
10	Jack	Cathy	2	**1)** 2 minutes 45 seconds **2)** 3 minutes 13 seconds	**1)** <u>Nursing intervention</u> (taking irrigation bags down); <u>other</u> (patient education – Cathy encourages jack to drink plenty of water, and Cathy explains to Jack what to do if he feels uncomfortable or in pain; social pleasantries humour relating to removal of the catheter) **2)** <u>Patient's condition</u> (Jack is feeling unwell after going out for a cigarette); <u>risk factors for condition</u> (smoking); <u>patient's preferences</u> (Jack prefers to lie on top of the covers); <u>nursing intervention</u> (monitoring of vital signs; Cathy coming back to monitor Jack's vital signs again in about half an hour); <u>other</u> (Cathy advises Jack not to go back downstairs)
11	Kirsty	Carol	3	**1)** 27 seconds **2)** 5 minutes 21 seconds	**1)** <u>Patient's condition</u> (pacemaker site less swollen); <u>other</u> (health education – risk of infection) **2)** <u>Nursing intervention</u> (administration of medication); <u>treatment</u> (Carol explains to Kirsty what all the medication is for); <u>patient's lay knowledge</u> (Kirsty states that the Paracetamol helps her pain); <u>patient's social context</u> (Guy Fawkes night; family birthdays; Christmas);

				3) 2 minutes 7seconds	patient's preferences (Kirsty prefers water to take her tablets rather than Appletizer); patient's condition (painful arm and shoulder); follow-up care/referral (referral to physiotherapist); other (Carol apologises to Kirsty for having to be bled twice) **3)** Patient's knowledge (Kirsty's knowledge about international normalised ratio (INR) levels and what her INR levels should be); other (Carol explains why Kirsty had to be bled twice; light hearted humour as Carol and Kirsty guess what the INR level will be today)
12	Larry	Pauline	1	4 minutes 26 seconds	Patient's condition (Larry has asbestos scarring in his lung; nausea; admitted with chest pain; questions about pain, shortness of breath, and bowels); patient's lay knowledge of treatment (Atenolol makes Larry feel sick); treatment (possibility of other tablets making Larry feel sick instead of Atenolol); patient's emotional concerns (Larry upset about possibility of asbestos in his lungs); possible outcomes of treatment (Larry gets Digoxin to reduce his heart rate); follow-up care/referral (Larry is going for a 'jelly scan' (ultrasound) and an angiogram); other (banter between Larry and Pauline)
13	Mark	Olga	1	4 minutes 29 seconds	Patient's social context (Mark's family and neighbours); patient's condition (chest infection, shortness of breath and pain in his lungs); patient's lay knowledge of condition (Mark perceives that the chest infection causes pain in his lungs); treatment – benefit (antibiotics and steroids will help to clear chest infection); follow-up care/referral (home help has been arranged – Mark will accept it initially and then see if he still needs it); other (banter between Mark and Olga)
14	Neil	Kirsty	1	2 minutes 44 seconds	Patient's social context (discussion about Neil's mum coming to visit); nursing intervention (Kirsty asks Neil about his blood sugars and about the care of his tracheostomy site); patient's lay knowledge of treatment (Neil administers his own Insulin); treatment (Neil is taking antibiotics to clear the infection in his tracheostomy); possible outcome of treatment (that the antibiotics would clear the infection and Neil would be discharged home); other (conversation about what the doctor said at the ward round)
15	Olive	Andrea	7	**1)** 2 minutes 46 seconds **2)** 1 minute 4 seconds **3)** 42 seconds **4)** 1 minute 5 seconds **5)**	**1)** Nursing intervention (Andrea tells Olive she is going to check her blood sugar level) **2)** Nursing intervention (Andrea dispenses Olive's medication); patient's condition (Olive is constipated as she is on Morphine); possible outcome of treatment (Movicol can help bowels move); patient's preferences (Olive does not want to take the Movicol) **3)** Nursing intervention (Andrea brings Olive's Morphine and undertakes ID checks before administration) **4)** Nursing intervention (Andrea helps Olive on to the commode); patient's preferences (Olive wants her urinary catheter removed) **5)** Other (Andrea cannot find the doctor to ask if urinary catheter can be removed, however she has made the decision herself that it can be; some giggling and laughing, humour and banter)

				6) 9 minutes 10 seconds **7)** 26 seconds	**6)** <u>Nursing intervention</u> (Andrea removing Olive's urinary catheter, Andrea explains each step as she goes along; discussion about personal care); <u>patient's emotional concerns</u> (Olive is concerned that she might not feel the need to pass urine and is anxious about wetting the bed) **7)** <u>Nursing intervention</u> (Andrea asks Olive if she can manage to give herself a mouthwash)
16	Peter	Ian	2	**1)** 31 seconds **2)** 5 minutes 23 seconds	**1)** <u>Nursing intervention</u> (Ian was administering Peter's medication; Ian asks if Peter had his blood sugar checked); <u>patient's lay knowledge</u> (Peter knows what his medication is for); <u>risk factors for disease</u> (sweets will increase Peter's blood sugar) **2)** <u>Patient's social context</u> (wife's occupation; Peter's occupation; private MRI scan undertaken); <u>patient's condition</u> (questions about pain, passing urine and bowels moving); <u>risk factors for disease</u> (Peter is diabetic and is advised again to stop eating sweets); <u>nursing intervention</u> (Peter's blood pressure is normal); <u>patient's emotional concerns</u> (Peter is getting used to being in hospital); <u>follow-up care/referral</u> (scans; results of tests and investigations before discharge home; possible biopsy required; no preparation required for MRI scan); <u>other</u> (humour)
17	Rose	Yolanda	1	3 minutes 54 seconds	<u>Nursing intervention</u> (venflon removal); <u>follow-up care/referral</u> (awaiting test results; awaiting follow-up appointment with doctor at clinic); treatment (prescription for Piriton has been discontinued; Rose still to take Paracetamol or Ibuprofen); other (discharge home; programmes on TV)
18	Steve	Wendy	1	7 minutes 2 seconds	<u>Nursing intervention</u> (Wendy talks about Steve's wounds as she is dressing them); <u>outcome of treatment</u> (antibiotic appear to be working well); <u>patient's lay knowledge</u> (Steve knows a lot about his condition; knowledge of wound dressings; self-caring with stoma); <u>patient's preferences</u> (Steve tells Wendy how he likes the wound dressings fixed)
18	Steve	Xena	2	**1)** 15 seconds **2)** 51 seconds	**1)** <u>Nursing intervention</u> (administration of medication); <u>patient's condition</u> (Steve needs something for nausea; bowels are moving fine) **2)** <u>Nursing intervention</u> (Xena returns with an anti-sickness tablet for Steve; Xena states that she will need to keep an eye on the venflon as it is needed for strong antibiotics)
19	Tracy	Una	4	**1)** 10 seconds **2)** 1 minute 43 seconds **3)** 25 seconds **4)** 13 minutes 55 seconds	**1)** <u>Patient's preferences</u> (personal care – Una asks what Tracy would prefer i.e. shower) **2)** <u>Patient's lay knowledge of treatment</u> (Tracy administers her own Insulin; Tracy tells Una what dose of Amlodipine she gets); <u>nursing intervention</u> (Una states what medication she has dispensed for Tracy); <u>other</u> (Una states that some of Tracy's medication needs to be restocked from the drug cupboard; social pleasantries) **3)** <u>Nursing intervention</u> (Una tells Tracy she wants to take a blood sample from her) **4)** <u>Nursing intervention</u> (Una was taking a blood sample from Tracy but there was difficulty finding a suitable vein); <u>patient's social context</u> (Tracy's husband knows she is diabetic and yet brings cakes when he comes to visit)

Throughout the study, I reassured ward staff that my aim was not to criticise practice but to explore information exchange. This reassurance, coupled with my continued presence in the wards, helped to minimise any reactive or Hawthorne effect (Kumar 2011, Denzin and Lincoln 2008). The field notes, journal entries, and reflection all helped to minimise my own biases. Bias can be minimised, and studies strengthened, by triangulation (Denzin and Lincoln 2005, Webb et al. 1999). Arguably, annotations relating to thought and meaning in semi-structured observations may be nothing more than conjecture unless supported by other methods, such as interviews (Knight 2002). Simply observing a phenomenon does not elicit participants' perspectives (Denzin 2009). Further, there was the possibility that information had been exchanged with patients outside of the ward setting, and not witnessed by myself (Mason 2006). Thus, I used in-depth interviews as another method of data collection. Adopting interviews triangulated for completeness (Shih 1998, Fielding and Fielding 1986), which led to a more rounded and robust analysis and wider understanding of the information exchange between patients and nurses (Polit and Beck 2011).

3.5.2 In-depth interviews

Following the observations, I undertook face-to-face interviews with the patients and nurses involved. I used semi-structured interview schedules for patients and nurses (Appendices 17 and 18). In the majority of cases, I interviewed each patient, and one nurse per patient. However, in two cases, two nurses were interviewed as two consenting nurses were caring for the same patient, and in one case, the nurse was not available for interview as there had been an emergency on the ward.

Face-to-face interviews can be structured, unstructured (or open) or semi-structured (Tod 2010, Mason 2006, Walliman 2005). Arguably, interviews cannot be completely unstructured, as the researcher must put some thought into the interview process (Mason 2006). Semi-structured in-depth interviews were appropriate for my study as the research aim was to explore information exchange – at the very least, I had to ask the participants for their perspectives. Semi-structured interviews allowed for exploration into information exchange, without losing focus. I used semi-structured interviews for the following reasons:

- To help answer the second research question on relevance and sufficiency of information exchange

- To elicit the participants' perspectives on information exchange

- To clarify field notes or fill in gaps highlighted by the observations

- For triangulation (3.1.2).

The key area of inquiry was whether the amount of information exchanged had been relevant and sufficient for the needs of the participants. Participants' responses were clarified throughout the interview (Kumar 2011) with the aim of accurately and adequately reflecting their perspectives, which improved the rigour of my study.

Face-to-face interviews are common in qualitative research (Kumar 2011) although there are particular techniques that are essential for quality interviews. The quality of the interview is only as good as the quality of the interaction between interviewer and interviewee (Cresswell 2013, Kumar 2011). Initially, my interviewing skills needed refining. As data collection progressed, I began using higher-level listening skills (Tod 2010, Knight 2002), and prompts and probes with open-ended questions, to

elicit participants' perspectives and aid discussion (Tod 2010, Walliman 2005, Knight 2002). The field notes taken during the observation sessions served as prompts for the participants and for me.

I initially proposed that interviews with patients be carried out immediately following the interactions observed, so that the interactions were still accessible in patients' minds. However, after piloting the data collection process, it was found that it was neither appropriate nor helpful to undertake immediate post-observation interviews (4.5.3). Therefore, patients were interviewed later on the same day, at a time suitable for them, usually in the afternoon just prior to, or just after, visiting time. The unpredictable nature of ward environments and the staff workload presented challenges for interviewing staff. Generally, staff indicated a suitable time for my return to the ward to interview them. Nurses generally preferred to be interviewed in the afternoon during visiting time, or during designated rest period for patients prior to visiting time. Nevertheless, much time was spent waiting until the nurses were free for interview. Despite the challenges, all but two of the participants were interviewed. One patient was withdrawn from the study due to becoming very sleepy after being given Diazepam and one nurse was unavailable for interview after having been involved with a patient emergency. Nurses were interviewed in a room separate from the ward in order to maintain their privacy. All patients, but one, preferred to remain at the bedside for interviews. Curtains were drawn around patients' bedsides to maintain a basic level of privacy. In cases where patients were interviewed in a single-bed room, I closed the door. In all cases I informed the nurse in charge, and the nurses caring for the patient, when the patient interviews commenced. Tables 11 and 12 present brief details of the interviews with patients

and nurses respectively including any first impressions, and challenges faced, taken from my field notes. All of the interviews were audio-taped and later transcribed verbatim.

Table 11: Interviews with patients

Case	Patient	Length of time of interview	First impressions and/or challenges
1	Alice	15 minutes 3 seconds	Alice perceived she had received all the information that she wanted. She stated that she trusted nurses to make decisions on her behalf.
2	Barry	12 minutes 54 seconds	Barry was a young man who perceived that he had a right to information, and a right for freedom of speech. He asked questions that the nurse did not answer and stated his preference for treatment.
3	Colin	Interview 1: 30 minutes 42 seconds Interview 2: 21 minutes 48 seconds	Colin had been in hospital for 7 weeks. He perceived that he gave and received all the information that was relevant for him. He had a good rapport with the nurses and patients in the ward, and perceived the ward as his 'second home'. Colin spoke of sharing information and of being part of the 'community'.
4	Donald	26 minutes 27 seconds	Donald liked to receive lots of information, but did not want information for decision-making. Donald was uncertain as to whether he had received enough information. He still had questions about his prostate medication and about whether or not to continue taking it. He perceived there were inconsistencies in the information he had been given from the doctor and the nurse.
5	Eddie	24 minutes	Eddie's speech was unclear which was a challenge in terms of audio-recording and transcribing. Eddie liked to have information about his progress. He liked to be told he was doing well.
6	Freddie	No interview	I did not interview Freddie. He had been given Diazepam and was too sleepy to continue with study participation. I withdrew him from the study.
7	Grace	11 minutes 34 seconds	Grace perceived that she received enough information – although there was little evidence of information being passed on to Grace during the interaction. Perhaps more information had been shared previously. Grace did not use information to make decisions.
8	Harriet	12 minutes 53 seconds	Harriet had breathing difficulties and was on oxygen therapy, which led to her answers being very short. Harriet became more breathless and exhausted during the interview therefore I terminated the interview at an early stage to allow her to rest.
9	Iris	31 minutes 27 seconds	Iris had been in hospital for a long time and liked to receive information about her progress. Plans were being made for Iris's discharge home. Much of the information she had been given this morning was related to her discharge home and Iris perceived that she had received enough information.
10	Jack	31 minutes 16 seconds	Jack stated that he liked a good rapport with the nurses and used lots of humour when interacting with them. However, Jack was also an anxious man and was concerned about getting his catheter removed. Jack had heard from a friend that catheter removal was painful, that there would be significant blood loss, and that he might go into shock. This lay knowledge was at the forefront of Jack's thinking despite attempts from the nurse to reassure him.
11	Kirsty	38 minutes 57 seconds	At the beginning of the interview Kirsty appeared to be anxious. She told me she was nervous and hoped she would answer the questions correctly. I reassured her by saying there were no right or wrong answers. At the start of the interview I encouraged her to talk about social things that were not relevant to the study. I did this to put her at ease; however, this information was not transcribed or used for data analysis in any way. Kirsty lives with a long term condition about which she is very knowledgeable. She stated that she did not require lengthy explanations of her blood levels. However, Kirsty does like the nurse to tell her what medication is being dispensed. She stated that it gave her a measure of control over her medications.

Table 11: Interviews with patients (continued)

12	Larry	42 minutes 11 seconds	Larry's daughter died recently, however he was still keen to participate in the study. During the interview he began to cry. I asked him if he wanted me to stop the interview and inform the nurse that he was upset. However, he was still keen to continue. I gave him some time to compose himself and then continued with the interview.
13	Mark	19 minutes 9 seconds	Mark was nursed in a 6-bedded bay where there was a lot of background noise from patients' coughing, spitting, nebuliser therapy, and general hissing sound of oxygen therapy. Mark's speech was unclear at times as he was wearing an oxygen mask. Background noise and unclear speech are challenging for audio-recording and transcribing. However, there was sufficient information from the interview to be analysed. During the interview with Mark, his mobile phone rang and the interview was temporarily paused while he took the call. Mark stated that when he asked questions he was given all the information that he wanted.
14	Neil	17 minutes 11 seconds	Neil has an MRSA infection and therefore I adhered to infection control procedures for interviewing him in his room. Neil has a tracheostomy and therefore there may be challenges with transcription. The interview with Neil was interrupted twice. Neil perceived that he had received enough information. Neil perceives that showing the nurses the dose of Insulin that he self-administers is not for his benefit but is for the security of the nurses.
15	Olive	18 minutes 44 seconds	It was difficult to keep focussed in this interview as Olive tended to speak at a tangent and it was difficult to get her perceptions about the interactions she had earlier with the nurse.
16	Peter	12 minutes 14 seconds	Peter appeared to be conflicted about whether or not he received enough information. On the one hand he stated that he received sufficient information. However, later in the interview, Peter stated that he does not think there is ever enough information, therefore he asks many questions.
17	Rose	24 minutes 13 seconds	Rose perceived that she had not received enough information. She stated that the nurse encouraged her to ask questions, however she did not know what questions to ask.
18	Steve	Interview 1: 31 minutes 28 seconds Interview 2: 5 minutes 39 seconds	In this particular building there are often difficulties with picking up radio signals, which may prove challenging with audio-recording. After several tests, the equipment appeared to work well. My initial thoughts were that I had obtained some really good data from Steve's interviews. He was a young man who was very articulate and had good insight into his condition and into his interactions with the nurses. A new concept arising is that the success of information exchange may depend on the patient's mood at the time.
19	Tracy	20 minutes 9 seconds	The recording equipment failed during the observation session; however I had taken field notes to facilitate prompting during the interview. Tracy perceived that she had given and received all the information that was relevant for her. She also perceived that information sharing occurred on a continual basis with all members of the healthcare team. Tracy did not want information for making decisions as she preferred to leave decision-making to the health professionals.

Table 12: Interviews with nurses

Case	Nurse	Length of time of interview	First impressions and/or challenges
1	Helen	23 minutes 16 seconds	Helen is a nurse with ten years' experience. She appeared to be amenable and enjoyed building a rapport with patients. She gave the patient options in regards to personal care, and stated that she would give options relating to menus. However, for some aspects of nursing care she was not inclined to offer patients choices. For example, if a patient wanted to keep his/her medication on admission to the ward, Helen used phrases like 'refused to hand them over'. However, she also stated that she was not in the job to 'fight' with patients.
1	Ivy	14 minutes 37 seconds	Ivy is a junior nurse qualified for 1 year. She talks in terms of reading patients to assess whether or not they have received enough information. She also stated that often even when patients do not want information she continues to give them the information in different ways until she feels they have taken in what she is saying.
2	Duncan	16 minutes 32 seconds	Duncan appeared very nervous. He looked flushed, his mouth was twitching as if his tongue was dry, and he was sweating. I asked him if he still wished to continue. He stated he was not nervous and wished to continue taking part. During the interview we were interrupted by two members of staff and we had to relocate to a different room. Once there, we were interrupted again by the telephone ringing, which the Ward Manager had to answer. The interruptions perhaps negatively affected the interview. Duncan perceives that generally patients do not want to make decisions about their treatment or care
3	Queenie	29 minutes 6 seconds	Queenie seems to enjoy banter and humour with patients. She tries to build a rapport with them. Queenie perceived that she gave and received sufficient information when interacting with Colin.
3	Yvonne	24 minutes 36 seconds	The interview with Yvonne was interrupted once; however it did not appear to have a negative effect on the interview. Yvonne perceived that she had given and received sufficient information
4	Kate	26 minutes 45 seconds	Kate stated that she withheld information from patients at times particularly about side effects of medication. She stated that she wanted patients to comply with their medication regime. Kate also perceived that interruptions and the demands of her job prevented her from sharing information with patients.
5	Frank	18 minutes 45 seconds	Frank appears to be very relaxed. Frank stated that he felt ethically obliged to keep patients up to date with information. I'll need to look out for this notion of ethical obligation in the other cases. Frank was pleased to be able to give Eddie good news today. He stated that he shies away from giving bad news.
6	Duncan	No interview	This nurse was the same nurse in Case 2. The patient was withdrawn from the study after being given Diazepam, which made him sleepy. Duncan declined an interview.
7	Ann	12 minutes 17 seconds	I found this interview with Ann very difficult to conduct. Ann had relatively short answers to all the questions and it was difficult to draw her out to expand on her responses. Ann stated that she gives lots of information to patients. However, this was not evident in her interaction with Grace. It is possible that Ann had shared information previously with Grace, which was not captured in the observation session.
8	Hannah	No interview	Hannah declined an interview as previously during the shift there had been an emergency situation to deal with. This left her lacking the time to complete her usual tasks and she felt there was no time for an interview.
9	Oliver	26 minutes 9 seconds	Oliver is only qualified 1 year, yet he appears to work with patients and share information with them as though he had more experience. He perceived that he had given and received sufficient information.
9	Lesley	50 minutes 20 seconds	My first impression of Lesley is that she is very paternalistic. She talked about 'policing' patients, and about active patients being 'difficult'. Lesley also used a lot of medical jargon. Lesley also talked a lot about herself.

Table 12: Interviews with nurses (continued)

10	Cathy	16 minutes 28 seconds	Cathy justified withholding information at times as too much information may scare patients. She appeared to be of the opinion that if patients asked questions she would give as much information as they wanted to know. However, if they didn't ask, she didn't provide any information.
11	Carol	22 minutes 3 seconds	There were challenges with the recording equipment as the radio signal is weak in this part of the hospital. After several tests, the equipment worked well. Carol is a senior nurse, and seems paternalistic in her approach. During the interview she talked about coaxing patients until they did what she wanted them to do.
12	Pauline	13 minutes 25 seconds	Pauline justified withholding information particularly about the side effects of medication. She also assessed whether patients had enough information by noting that no more questions were being asked.
13	Olga	15 minutes 24 seconds	Olga noted that patients in the ward where she worked were usually living with long term conditions and were admitted due to an exacerbation of the condition. She perceived that patients were already very knowledgeable about their treatment and care; however she would provide answers to patients who had questions.
14	Kirsty	21 minutes 14 seconds	Kirsty was a nurse with 32yrs experience; however she did not come across as being a senior nurse. At the beginning of the interview Kirsty seemed nervous. Kirsty perceived that social interaction was useful for discharge planning.
15	Andrea	21 minutes 51 seconds	Andrea was a senior nurse (Band 6) who had been qualified for twenty three years and had worked in her current ward for sixteen years. She appeared very amenable and enjoyed developing a rapport with patients. She also appeared to put herself 'in patients' shoes' and tried to understand things from patients' perspectives.
16	Ian	15 minutes 23 seconds	Ian was a Band 5 nurse. He thinks of himself as being disorganised and often in a bit of a rush at the end of the day. However, he stated that he wouldn't reduce his interactions with patients just because he is busy. Ian also states that he would give patients a little information to start with and then wait for their questions. He says he doesn't like to overload patients with information and stated that 'they' tell you not to give too much information. When pressed to explain who 'they' are, he just says it's something that he's heard.
17	Yolanda	24 minutes 13 seconds	Yolanda was qualified for one year and was on a rotational programme. She had been in this particular medical ward for one month. She appeared to be eager to get the information that patient needed but due to her inexperience she wasn't sure when all the information would be available. Yolanda perceived that social information helps patient's relax and perhaps open up more about how they are feeling. Yolanda uses the extra information for assessment and management of patient care. She also perceives that social information and chit chat makes patients' stay in hospital a pleasant one.
18	Xena	22 minutes 4 seconds	Xena was a Band 7 nurse who left during the observation session to attend a meeting. The conversation that she had with the patient was brief. She was giving him his morning medication.
18	Wendy	14 minutes 45 seconds	Wendy had previously been on night shift and she was now back on her usual day shifts. She was good at trying to involve the patient in his own care. She was aware that he often helped with his own dressings. Wendy was quite paternalistic in other ways and with other patients. For example, she felt that she would call on those with more authority to speak to patients who were reluctant to take her advice about their care.
19	Una	20 minutes 27 seconds	Una had been a nurse for twenty eight years. She perceived that patients could 'sus you out'. During the observation session Una's conversations with the patient were very short. Una was focussed on the task of dispensing medication. Una perceives that patients should be involved in their own care to prevent them from becoming 'hospitalized'.

3.6   Data analysis

Yin (2013) describes four general strategies for data analysis: relying on theoretical propositions; working your data from the 'ground up'; developing a case description; and examining plausible rival explanations. Conversely, Simons (2009) suggests that there are no sets of rules or procedures that need to be followed to analyse case study data, suggesting that researchers use their intuition and cognition to interpret the data. My analytical strategy fitted into a combination of Yin's first two strategies and Simon's intuitive approach. I relied on theoretical propositions as I began with *a priori* codes developed from what is known about information exchange for example 'Type of information' but I also worked from the data upwards to develop inductive codes such as 'Factors affecting information exchange'. My intuition helped to interpret the things that participants said. Authors of qualitative research agree that the analytical process is iterative and begins as early as during data collection (Yin 2013, Miles and Huberman 1994), as it did in my study.

I used a process of data reduction, display, and conclusion drawing and verification (Miles and Huberman 1994), bringing focus to the data, organising it into an accessible form, and drawing valid conclusions. Data reduction involves selecting, simplifying and abstracting data from field notes, interviews or observations and applying codes and patterns to them. Data display allows the data and the results of data reduction to be seen in tabular, diagrammatic, or figurative form. Conclusion drawing and verification is the process used to identify *'what things mean'* (Miles and Huberman 1994:11). In my study, data analysis consisted of six stages, presented in Figure 6.

Figure 6: Six stages of data analysis

Stage 1: Initial annotation	→ Annotations in field notes & development of case summary sheets
Stage 2: Data transcription	→ Data transcribed verbatim using a Microsoft Word processor and entered into QSR NVivo
Stage 3: Data reduction (1)	→ Initial *a priori* and inductive coding
Stage 4: Data reduction (2)	→ Development of categories and sub-categories; move to manual analysis
Stage 5: Data display	→ Presentation of categories and sub-categories in tabular and figurative form
Stage 6: Conclusion drawing and verification	→ Search for deeper meanings within cases and across cases

<u>Stage one</u>

Analysis began in the field by making field notes before, during and after each stage of data collection. I made notes in my PhD journal about the following:

- Recruitment and consent processes and ward environments

- Whether any interruptions to the patient/nurse interactions were evident, and what effect those interruptions may have had on the interactions

- The recordings of the interactions including prompts and probes for use during the interviews

- Whether or not participants appeared, for example, tired or nervous during interviews, or about whether any interview was stopped.

Summaries of each case were prepared detailing the demographics of the participants, details of the interactions and interviews, and any other background factors.

<u>Stage two</u>

Data were transcribed verbatim and entered into QSR NVivo, a software programme suitable for facilitating the analysis of qualitative research (Richards 2009, Johnston 2006, Marshall 2002). I used QSR NVivo during this early stage of analysis solely as a data management tool. The advantages of using computer software are:

- Large amounts of data can be stored in one location (Bergin 2011)

- It provides mechanisms for good housekeeping in terms of coding and retrieval of the data within the codes (Knight 2002)

- It can reduce analysis time   (Tesch 1990)

- It can facilitate a team approach (Weitzman 2000).

However, there has been some debate about whether or not the use of computer software packages distances researchers from their data (Bong 2002, Roberts and Wilson 2002) and that much time and effort are required to learn the software (Robson 2011). Furthermore often when segments are retrieved they appear disjointed as they are removed from their original context (Knight 2002). I found QSR NVivo useful for storing the data and for the initial coding process (Kelle 2004).

Stage three

During this stage, I *'played with the data'* (Yin 2013:135). Text from transcribed data were selected and coded to *a priori* and inductive codes. My *a priori* codes were developed from what is known about information exchange, for example, 'Type of information', 'Amount of information', and 'Flow of information'. However as the transcribed data was read and re-read new ideas emerged, which led to development of two substantive inductive codes; 'Relevance of information' and 'Factors affecting information exchange'.

Stage four

Stage four comprised going back and forth over the transcribed data, interrogating the cases, reviewing the codes, and assigning data to categories and sub-categories under each code. Categorising is a process of taking frequently occurring codes and categorising them to a deeper theoretical level (Simons 2009). Ensuring that the categories and sub-categories were representative of the original data was vital. I examined the data for categories and sub-categories related to type, amount, and flow of information exchanged, and the participants' perspectives on whether or not the information exchanged was relevant and sufficient for their needs.

During stage four, I began to integrate computer software use with manual analysis. Manual data analysis has been termed as *'drudgery'* by proponents of computer based data analysis (Robson 2011:471) but I did not perceive it as an onerous task. As I immersed myself in pages of data I could recall the sights and sounds of the data collection days. I remembered my participants' voices, accents and emotions, none of which I could remember when working solely with the data electronically. I could 'hear' my participants in the data, and perhaps gained greater understanding of what meanings were associated with the things that they said. Full transcripts were reviewed, and categories and sub-categories were manually colour-coded so that I could easily see relevant correlations. These colour-codes were searched looking for various instances and early interpretations of the categories and sub-categories.

Stage five

Stage five comprised presenting the data in figurative form. Data displays help to focus a full data set from cumbersome unreduced transcripts or field notes (Miles and Huberman 1994). For example, Table 13 illustrates presentation of categories and sub-categories from Case 4 in tabular form. Some early visual displays incorporated extracts from field notes (for example, Tables 15, 16 and 17). As analysis progressed, the categories and sub-categories were renamed and data displays became more focussed (see Figures 8-14, Tables 18-22 and Appendix 19).

Table 13: Example of table of categories and sub-categories, from Case 4

Codes	Potential categories & sub-categories
Type of information *(a priori)* *Clinical* *Non-clinical*	Care management Lay knowledge Nursing intervention Patient's condition Treatment

Amount of information *(a priori)*	Expert patients
	Information not exchanged
	      Information withheld
	        Lost opportunities
	Information previously exchanged
	Nurse's remit
	Sufficient information
	      Questions
	      Too much information

Flow of information *(a priori)*	Information exchange Information provision
Relevance of information (inductive)	Being aware Breaks the ice Care management Better care Connection Decision-making Ensuring compliance Family Reducing anxiety Instilling confidence

Factors affecting information exchange (inductive)
 	
Barriers
	Assumptions
	Avoiding patients
	Lack of privacy
	Patients condition
	      Feeling unwell or in low mood
	      Unable to take in information
	Paternalism
	      Language use
	      Patient passivity
	Personality differences

Facilitators	Lay terms Opportunities regained Therapeutic relationship Ward admission The common touch

Stage six

During stage six, I moved away from full transcripts to interpret the data at a deeper

level. I printed off all the data references under each category and sub-category then

analysed them looking for meanings, patterns and explanations – a process called

categorical aggregation (Cresswell 2013, Stake 2006). I poured over the data going

back and forth over the categories and sub-categories, and over the cases. Specifically I searched for similarities and differences within cases and across cases. I interpreted the data looking for links between the cases, and found explanations as to why the links mattered. Finally, generalisations within and between the cases were made.

The iterative nature of data analysis meant that some decisions were made which changed the categorising and sub-categorising of data. For example, Appendix 19 provides evidence of decisions made around the inductive code of 'Factors affecting information exchange', illustrating the stages of analysis.

3.6.1 Methodological rigour

I used a recognised process of data analysis, which comprised data reduction, data display, and conclusion drawing and verification (Miles and Huberman 1994), which helped to bring focus to the data, organise it into an accessible form, and draw valid conclusions. Methodological rigour was achieved at each of these stages in a variety of ways. Data analysis was iterative, therefore, the methods for achieving credibility were also iterative, and were undertaken throughout the analytical process. Figure 7 illustrates the methodological rigour at each stage of data analysis.

Figure 7: Achieving rigour and credibility throughout data analysis

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                    ┌─────────────────────┐
                    │ Data analysis (Miles│
                    │ and Huberman 1994)  │
                    └─────────────────────┘
             ┌────────────┼────────────┐
             ▼            ▼            ▼
    ┌───────────────┐ ┌──────────┐ ┌──────────────────┐
    │Data reduction │◄►│Data display│◄►│Data verification│
    └───────────────┘ └──────────┘ └──────────────────┘
             │            │            │
             ▼            ▼            ▼
```

| Selection, simplification and extraction of data | Display data in tables & figures | Search for meanings, patterns and explanations |

Data reduction:

<u>Methods for achieving rigour and credibility</u>

Concurrent data collection and analysis adding depth

Method triangulation

Clarification of participants' responses

Use of extensive field notes

Peer debriefing with supervisors

Use of NVivo for data management and coding

Data display:

<u>Methods for achieving rigour and credibility</u>

Concurrent data collection and analysis

Use of extensive field notes

Peer debriefing with supervisors

Personal PhD Journal

Data verification:

<u>Methods for achieving rigour and credibility</u>

Exploring data within and across cases

Method triangulation

Peer debriefing with supervisors

Challenge from peers to look for alternative interpretations

Revisiting Records of Supervision

Appraising new insights against current literature

Data reduction involves selecting, simplifying and abstracting data from field notes, interviews or observations and applying codes and patterns to them. During the data reduction stage, data collection and data analysis were undertaken concurrently, which added strength and depth to the analytical process. Furthermore, method triangulation utilising observations and interviews added to the robustness of the

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analysis, particularly as the observations highlighted issues that were not obvious during the interviews. Other methods used to ensure that rigour was achieved during the data reduction stage, were: clarification of participants' responses during and immediately after the interviews; the use of extensive field notes where my biases could be reflected upon and checked; peer debriefing with my supervisors to check initial coding and extraction of categories and sub-categories; and the use of NVivo for data management and coding.

Data display allows the data and the results of data reduction to be seen in tabular, diagrammatic, or figurative form. During the data display stage, data collection and analysis were still being undertaken concurrently adding yet more depth and leading towards initial understanding of codes, categories and sub-categories. Other methods of achieving rigour during the data display stage, were: the use of extensive field notes; peer debriefing with my supervisors; and, the development of a personal PhD journal. In the journal I kept details of conversations I had with academic peers and supervisors and I detailed each analytical decision that was made and for what purpose. Looking back over the journal helped me to either adhere to, or review, the analytical decisions made.

Conclusion drawing and verification is the process used to identify *'what things mean'* (Miles and Huberman 1994:11). Rigour was achieved throughout this final stage of data analysis. Specifically, credibility was achieved by utilising the multiple-case study design, and method triangulation, which enabled exploration of different types of data within and across the cases. Peer debriefing with my supervisors played a vital part in achieving rigour. Throughout this stage, my supervisors would

challenge me to look for alternative interpretations of the data. I revisited the formal Records of Supervision regularly to ensure that the challenges presented were considered on an ongoing basis. Finally, rigour was achieved by the finding of new insights (Vaismoradi et al. 2013) and appraising these new insights against current literature.

Finally, I used an iterative approach, immersing myself in the data, throughout the data collection and analysis stages. This approach was facilitated by hearing the participants in the recordings, and understanding what meaning they associated with the things that they said, which contributed to the robustness and credibility of my study.

3.7   Ethical considerations

The main ethical considerations related to confidentiality and anonymity, data management, potential participant distress, and my role as the researcher. The steps I took to address each of these considerations are described next.

3.7.1 Confidentiality and anonymity

In order to comply with the Data Protection Act (Data Protection Act 1998) and the Research Governance Framework (Department of Health 2005), confidentiality and anonymity was maintained, and assured at all times throughout the study process. Written identifiable information, was kept confidential, and was archived on completion of my study. I assigned a study identification (ID) number and a pseudonym to participants for identification purposes during the study. Participants

were reassured that anything they said as part of the study would be kept confidential. Although nurses' line managers were aware that the study was being conducted, they were not told of any individuals' participation in the study. Interactions between nurses or patients who had not consented to being part of the study were not recorded, and those individuals were not approached for interview.

3.7.2 Data protection

In keeping with legal requirements, in particular the Data Protection Act (1998), digital audio-recordings were uploaded to my computer where all electronic data was password protected, and, for some information, doubly password protected. I maintained the audio-recordings electronically until they were transcribed, and after completion of the study I destroyed them (in keeping with the instructions given by NHS NRES committee). Other electronic data were also destroyed after the study was completed. Written transcriptions, field notes and other identifiable information were kept in a secure environment in a locked filing cabinet. After completion of my study, I sent them to the archives in the University of Stirling where they will be kept for five years. Confidentiality and anonymity was maintained at all times. Throughout the study, only my supervisors and I were able to access data via the NVivo file in a shared drive on our computers and as the data were discussed at supervision.

3.7.3 Potential distress

It was unlikely that the observations and interviews in themselves would cause any distress to the participants. However, one patient became upset during an interview when discussing his daughter's death. When this happened, I listened to him, gave him time to compose himself, and offered to end the interview and inform the nurse

in charge. However, he stated that he preferred to continue with the interview and that there was no reason to inform the nurse.

3.7.4 Researcher's role

Misconduct is defined as *'conduct which falls short of that which can reasonably be expected of a registrant'* (NMC 2004). Examples include physical or verbal abuse, theft, and deliberate failure to deliver care and keep records up-to-date. The issue of misconduct was discussed with the Heads of Nursing in the early stages of the research, providing clarity on my role. In the unlikely event that I would observe misconduct by a member of nursing staff, I knew to inform the nurse in charge and the Head of Nursing. Bringing incidents of misconduct to the nurse in charge is in accordance with existing practice. Careful wording in the information letter sent to nurses further clarified my role in the event of misconduct. No misconduct was evidenced in my study.

3.8   Practical considerations

3.8.1   Recording equipment

All equipment necessary for recording in the main study was checked and given approval by an electrician in the Estates Department of the hospital site. I was also provided with a longer extension cable in the event that I had difficulty accessing an electrical socket close enough to the interactions about to take place. I was issued with the following safety instructions from the electrician:

- The longer extension cable must only be used when absolutely necessary

- Cables must not trail across areas where safety to patients, staff and visitors may be compromised

- As soon as the recording sessions were complete, cables were to be removed from the electrical socket and stored away until next use.

- The nurse in charge must be informed when any of my electrical equipment was being used

I checked all audio-recording equipment to ensure that it was in working order prior to data collection. Despite the equipment being tested in the pilot study, I had been informed that in a newer part of the hospital site for the main study the radio signal was less strong and that there may be difficulties with using the radio microphone system. I spent more time in this area to extensively test the recording equipment and found that the closer I was to a window, the better the signal. In one case in the older part of the hospital, the audio receiver failed and a digital recorder was placed directly on the patient's bedside table with his consent. This meant that the recording could not be remotely controlled. The patient was having a drain removed, which was proving difficult and the doctor was called for assistance. Subsequently, and unintentionally, a conversation between the patient and the doctor was recorded. This part of the interaction was deleted prior to transcription.

3.8.2 Interviews

Through discussion with ward managers, I secured rooms for undertaking interviews, which offered an appropriate level of privacy, and minimised disturbance. The majority of nurse interviews were undertaken in these rooms; however, there were occasional disturbances, which may have affected the quality of the interviews. In

one particular example, I began interviewing a nurse in the staff tea room; however we were disturbed by staff taking their break. From there we went to the Ward Manager's office. The telephone rang several times during the interview and we had to wait until the ward manager had answered each call and vacated the room before reconvening.

To summarise, a qualitative case study approach was used to study information exchange between patients and nurses in ward settings. The case study approach incorporated observations and semi-structured interviews. Nineteen cases were examined, which included nineteen patients and twenty-two nurses. Recommendations from the pilot study greatly facilitated the research process (Chapter 4). Six stages of data analysis reflected Miles and Huberman's (1994) process of data reduction, data display, and verification and conclusion drawing. The findings are presented in Chapters 5 to 7.

Chapter 4:   Pilot study

The main aim of the pilot study was to assess the feasibility of the main study (Taylor 2010). Proposed data collection methods for the main study included audio-recording interactions between patients and nurses, and audio-recording semi-structured post-observation, participant interviews. A digital recorder and radio-microphone system would allow me to switch the recording on and off remotely during the observation period. The digital recorder would also be used to record the interviews. It was essential that the recording equipment be piloted to ensure that it worked satisfactorily. In addition, the observation schedule needed to be checked to ensure that it was sufficient for observing the type of information exchanged. As well as testing the methods proposed for the main study, the pilot study assessed environmental factors such as my positioning and distance from the interactions that took place. It was important that there was minimal disturbance to the ward routine (Polit and Beck 2011); however I needed to hear the interactions clearly whilst remaining at a discreet distance.

4.1   Pilot study aims

The aims of the pilot study were:

1. To review the research process, including participant satisfaction with the processes for recruitment, consent and data collection.
2. To examine the procedures for recruitment and consent
3. To test the methods for data collection and analysis.

4.2   Setting and access

The setting chosen for the pilot study was one medical and two surgical inpatient wards at one NHS district general hospital. The site drew from a wide socio-demographic area, and admitted adult male and female patients to both medical and surgical wards, thus linking with the sampling strategy of the main study – that of sampling for maximum variation (refer back to Chapter 3 for the sampling strategy). SREC and NHS NRES ethical approval, and R&D approval, was sought and obtained. Letters relating to obtaining all necessary approvals are presented in Appendices 20 to 22.

During the process of obtaining R&D approval and once all ethical approvals were in place I contacted senior management personnel at the hospital site to inform them of the study and to request their support. Furthermore, I sought approval and support from the Consultants in ENT and Urology, as I wanted to invite elective surgical patients in their areas to participant. Inviting patients from elective surgical lists also required secretarial support. I approached three Ward Managers, one each from ENT, Urology and Cardiology, to request their support and to confirm their willingness to act as clinical contacts.

4.2.1 Ward environments – room sizes

To test the recording equipment fully, including the range of the radio-microphone, the pilot study included patients in single side rooms as well as in larger four- or six-bedded bays. The practical issues in relation to the room sizes were as follows:

- Single side rooms – it was unknown whether or not the receiver unit and digital recorder, which I kept outside the room, could receive radio frequencies from the microphone and transmitter in the patient's room.

- Four- or six-bedded rooms – there was the potential for interference with the recording equipment due to increased general ward noise (for example from nebulisers, fans, television sets, radios, machines for monitoring vital signs, and patient and staff conversations).

- I wanted to check the feasibility of placing the transmitter near a patient in a larger room, whilst I remained in the ward corridor with the receiver unit and the digital recorder.

4.3   Recruitment and consent

Ward managers (one each from Urology, ENT and Cardiology) gave recruitment packs, containing an information sheet (Appendix 23) and a letter of invitation (Appendix 24), to nurses working in their associated area. The Urology and ENT consultants' secretaries sent surgical patients on the elective waiting list a recruitment pack containing an information sheet (Appendix 25), a letter of invitation (Appendix 26) and a response form (Appendix 27). Ward staff nurses gave information packs, containing an information sheet (Appendix 28) and a letter of invitation (Appendix 29), to medical patients during their hospital admission. I present a more detailed account of the recruitment and consent process in sections 4.3.1 and 4.3.2.

4.3.1 Nurse recruitment

Thirty-six nurses were invited to participate – surgical nurses (*n*=15), medical nurses (*n*=21). Of the surgical nurses, seven were from Urology and eight were from ENT. All twenty-one medical nurses invited to participate worked in the Cardiology ward. The ward manager in ENT facilitated a group meeting between the staff nurses and me. In Urology and Cardiology, nurse recruitment was managed on a more ad hoc basis as I visited the wards regularly and made myself available for answering questions.

4.3.2 Patient recruitment

4.3.2.1 Surgical patients

Eleven surgical patients from the elective surgical list were invited to participate. At this initial stage I was unaware whether the patients invited were due to be admitted to ENT or Urology as the consultants' secretaries undertook this part of the process. Patients were asked to contact me by telephone or in writing at the University of Stirling if they were interested in taking part in the study. I met with the patients who were eligible to take part, and discussed the study further. I answered their questions and provided an opportunity for them to sign a consent form.

4.3.2.2 Medical patients

Nurses on the medical ward gave recruitment packs to four patients. Patients who were interested informed the nurse who, in turn, informed me. I visited patients individually on the ward to explain the study further, answered any questions and provided an opportunity to sign a consent form. At least 24 hours elapsed between

patients receiving the recruitment pack on the ward and being asked to sign the consent form.

4.4 Data collection

I collected data by audio-recording non-participant observations of interactions between patients and nurses, facilitated by the use of a semi-structured observation schedule. The observations were followed by individual face-to-face semi-structured interviews. I discussed the rationale for these methods in Chapter 3. I describe the data collection process in Sections 4.4.1 and 4.4.2. One of the aims of the pilot study was to test the methods for data collection and to test the data collection equipment. Prior to describing the data collection process, I present sub-aims specific to the observations and the interviews.

4.4.1 Observations

The sub-aims related to the observation stage of the data collection process were:

- To check that the semi-structured observation schedule was sufficient for observing the type of information exchanged

- To give an indication as to whether one time period was better than another for capturing the relevant interactions

- To assess the feasibility of carrying out observations for ninety minutes per session

- To check the recording equipment was working correctly

I observed patients and nurses, and their interactions during routine nursing care. In practical terms, observations involved me sitting at a discreet distance within multi-bedded rooms, positioning myself where I was able to see the participants. Observation sessions lasted ninety minutes, a time-period that was identified during the process of obtaining SREC ethical approval. I audio-recorded the observation sessions using a remotely controlled digital recorder. The microphone was placed near the patient, for example on the patient's bedside table or locker, and I switched the recorder on remotely when a consenting nurse interacted with the patient. Only interactions taking place during routine nursing care were recorded. Conversations not occurring during routine nursing care were not recorded neither were patients' conversations with other AHPs, other patients, or visitors to the ward. I used an observation sheet derived from what is known about the type of information patients share with nurses and physicians (Appendix 15) to help focus my attention on the types of information shared during the patient/nurse interactions. The main categories on the observation sheet included:

- Section A – the type of interaction taking place (clinical or non-clinical)

- Section B – the type of information being shared

- Section C – whether or not the interaction evidenced elements of information exchange

The observation sheet was not intended for rigid use. There were no data entry areas, but rather it was a guide or a tool that I could use when making field notes for review prior to interviews. I entered field notes relating to the interactions into my PhD journal. I also made entries relating to my own perceptions, thoughts and feelings during the observation sessions. All audio-recordings were later transcribed verbatim.

4.4.2 Interviews

The sub-aims related to the interview stage of the data collection process were:

- To check whether the questions directed participants to the key areas of exploration

- To assess the feasibility of interviewing participants immediately post observation.

- To assess whether the way the field notes were written was suitable for prompting during interviews

- To assess the approximate timescale of the interviews.

- To check that audio-recording equipment was working properly

- To practice interviewing techniques.

All patient participants were interviewed almost immediately after each observation session. Nurses were interviewed at their earliest convenience after the observations sessions. I interviewed patients at their bedsides with the curtains drawn to afford privacy. Nurses were interviewed either in a separate room, or in the ward area, depending on their preference. I used information and notes taken during the observations sessions to act as prompts and probes during the interviews. I also used semi-structured interview guides (Appendices 17 and 18). The interviews were semi-structured, which meant that participants were free to talk about their experiences and perceptions, while at the same time I guided the conversation with questions such as, 'What kind of things were you and the nurse talking about today?' and, 'Do you feel you received enough information?' I also probed deeper with open questions such as, 'How do you know when you have had enough information?' or, 'How would you define 'enough' information?' At the end of each interview, the

participants were asked about their perceptions relating to the recruitment and consent process, the timing of observations and interviews, and the level of privacy offered during data collection.

4.5 Findings

4.5.1 Gate keeping and access

The process of obtaining SREC approval took approximately six weeks from when I submitted the proposal to receiving final ethical approval. The NHS NRES committee approval process took approximately eleven weeks from submission of the proposal to receiving final ethical approval. The R&D management approval process was the longest part of the approval process – approximately fourteen weeks elapsed from submission of the proposal to receiving R&D management approval, Caldicott Guardian approval, and a letter of access to the wards. The R&D officer advised that with clinical contacts in place a letter of access would be sufficient instead of requesting an NHS honorary research contract. However, she advised that an honorary contract would likely be required for the larger main study.

The process of obtaining access took approximately a further sixteen weeks from submission of my first letter to the Director of Nursing to receiving approval from Consultants, Lead Nurses and Ward Managers. The length of time was considerable, particularly as the process did not begin until after ethical approval had been obtained. The length of time was mainly due to waiting for responses from key personnel. One medical and two surgical Ward Managers agreed that the pilot study could be undertaken in their wards. Discussion with the surgical ward sisters led to a meeting with the Lead Nurse for Surgical Services, to explain the study further. In

one surgical ward (ENT), the Ward Manager actively facilitated three group meetings with staff nurses at the time of ward handovers. I obtained support from the Consultant Surgeons for ENT and Urology, whose secretaries would be involved in surgical patient recruitment.

In Table 14, I present the timelines for obtaining all necessary approvals and access to the wards.

Table 14: Timelines for obtaining access to pilot study site

Date	Comment
27th June 2008	Submitted proposal to DREC
7th July 2008	Proposal reviewed by DREC
17th July 2008	Provisional approval received from DREC
5th August 2008	Response sent to DREC
11th August 2008	Final favourable response from DREC Proposal submitted to NRES
12th August 2008	Proposal submitted to NHS R&D
2nd September 2008	Proposal reviewed by NRES
23rd September 2008	Provisional approval received from NRES
2nd October 2008	Provisional letter sent to Director of Nursing requesting meeting with senior nurses (no response)
6th October 2008	Response sent to NRES
29th October 2008	Final favourable response from NRES Phone call to Director of Nursing's secretary – she will bring letter to attention of Director of Nursing.
6th November 2008	NHS R&D approval obtained
7th November 2008	Emailed R&D officer for advice on access to wards
10th November 2008	Email from R&D officer – I need a named clinical contact before letter of access can be issues Made appointments to see 3 ward sisters on 11th Nov 08. Phone call again to Director of Nursing's secretary as no response as yet.
11th November 2008	Spoke with ward sisters for Medical, ENT and Urology and received their approval, however they indicated the need to write to senior nurses. All ward sisters will be named clinical contacts for purpose of management approval.
12th November 2008	Letter sent to Medical Lead Nurse (no response) Letter sent to Surgical Lead Nurse (response received by phone on 17/11/08) Second letter sent to Director of Nursing (no response) Letter sent to Surgical General Manager (response received on 17/11/08) Letter sent to Medical General Manager (he left a message on my answer machine 21/11/08 – repeated attempts to phone him back were unsuccessful)
17th November 2008	Request for minor amendment to the Participant Information Sheet sent to NRES Received letter from Surgical General Manager who has passed on details to Surgical Lead Nurse.
21st November 2008	Letter of access received from NHS R&D; however I was asked not to commence the study until other key personnel had given their approval
24th November 2008	Second letter sent to Medical Lead Nurse (no response) Third letter sent to Director of Nursing indicating my intention to commence the study if not heard from her by a particular date (no response)
25th November 2008	Minor amendment approved by NRES Met with Surgical Lead Nurses to discuss pilot study – received their approval
28th November 2008	Letters sent to Urology (favourable response on 5/12/08) and ENT (no response) consultants
2nd December 2008	Second letter sent to Medical General Manager
4th December 2008	Phone call from Medical General Manager's depute giving support and approval for the study
First two/three weeks in December	Visited wards regularly to talk to ward sisters and staff nurses, answering questions. Letters given out to surgical staff during this period. Letters given out to medical staff during the first two weeks in January.
22nd January 2008	Favourable response received from ENT consultant via his secretary.

4.5.2 Recruitment and consent

Twelve staff nurses in total (ENT n=7, Urology n=3, and Cardiology n=2) signed the consent form and either handed it to me directly, left it at a previously arranged place in the ward office for me to collect, or posted it to me at the University of Stirling. Of the ten surgical nurses recruited, one was male and nine were female. Both the medical nurses were female. The sample adequately reflected the female: male ratio of nurses working in the pilot study site.

One surgical patient contacted me by telephone to register an interest in taking part; however, she was to be away on holiday during the pilot study phase and therefore was unable to participate. One female and three male patients completed a form, which included their contact details, and returned it to me, by pre-stamped addressed envelope, at the University of Stirling. I contacted each of the four patients by telephone and arranged to meet with them to discuss the study further. It was not possible to meet with the patients at their pre-operative clinic appointment as they had already attended. Therefore, I arranged to meet them on the ward after their admission. Of these four patients, two were recruited to the pilot study – two patients' hospital admissions were cancelled due to bed shortages, and their potential date of admission had been moved to beyond the study timelines. I met with the other two patients (both male and both in the Urology ward), and both consented to take part in the study. However, one patient was subsequently withdrawn as he was too unwell after surgery to take part. In total, of the eleven surgical patients invited to participate, five responded favourably, but only one was able to participate in the pilot study.

At their request, I spoke with all four medical patients who were invited to participate and all four signed the consent form and were recruited to the pilot study. Furthermore, all four were well enough to participate on the data collection day. No medical patients were withdrawn from the pilot study.

In total, five patients participated, which meant that the pilot study comprised five cases. The gender and age of patient participants was atypical of the group of patients I wanted to sample for the main study. All patients recruited to the pilot study were male, and over the age of 60yrs. The lack of female patients and an insufficient age range is a limitation of the pilot study. However, as the aims of the pilot study were to review the research processes and test the recording equipment, the limitation was not problematic but highlighted potential changes to the recruitment process for the main study.

The surgical patient was admitted for a radical prostatectomy, two of the medical patients were admitted with chest pain, one medical patient was admitted with respiratory problems, and one medical patient was admitted with a recurrence of myeloma.

I noted the following points during the recruitment and consent stage of the research process.

1. There were difficulties with recruitment of surgical patients due to bed shortages and patients' surgery being cancelled; and the potential for elective patients being admitted to a ward with few consenting nurses.

2. Although almost all of the nurses in one surgical ward (ENT) had consented, none of them could participate in the study, as it was patients from this ward whose admission had been cancelled.

3. All four of the patients in the medical ward who were invited to participate were recruited to the study.

4. Discussion with staff and patients in the medical ward indicated no difficulties with recruiting and consenting patients in the ward area, and were satisfied with the recruitment and consent process.

Patients and staff understood the information provided in the recruitment packs and felt they were given plenty of time to consider taking part.

4.5.3 Data collection

Each case, including the number of interactions per ninety minute session, the length of time of each interaction, and the type of information that patients and nurses discussed is presented in Table 15. The longest interaction lasted seventeen minutes and five seconds, and occurred when the nurse went to check the patient's blood pressure. The shortest interaction lasted twenty-three seconds, and occurred when the nurse asked the patient if he was warm enough.

Table 15: Characteristics of interactions between patients and nurses in pilot study

Case	Patient	Nurse/s	No. of interactions per session	Length of time of each interaction	Type of information shared
1	P0001	N0002	5	1) 6mins 39secs 2) 1min 7secs 3) 8mins 15secs	1) Nursing intervention (drain removal; catheter care); social context (general chit chat); treatment (administration of medication) 2) Nursing intervention (attaching the leg bag onto a urinary catheter)
1	P0001	N0002	6	1) 23secs 2) 2mins 16secs 3) 30secs 4) 1min 22secs 5) 46secs 6) 2mins 18secs 7) 3mins 27secs	1) Patient comfort (checking he was warm enough): 2) Nursing intervention (checking patients temperature as he feels too hot) 3) Patient's condition (short discussion about insertion of suppository 4) Patients condition (mobility; bowels moved) 5) Changing patients theatre gown 6) Nursing intervention (helping patient back into bed) 7) Health education (changing the catheter bag); emotional concerns
2	P0002	N0002	1	18mins 29secs	Patient's personal care (shower and shave); nursing intervention (venflon insertion); lay knowledge (patient's previous experience of electrocardiogram (ECG) and angiogram); treatment (information about proposed stress echo test).
3	P0003	N0003	2	1) 2mins 21secs 2) 50secs	1) Nursing intervention (administration of medication); patient's emotional concerns (upset at not being transferred to other hospital for tests) 2) Nursing intervention (administration of medication); patient's social context (how the patient's wife would manage without him at home)
4	P0004	N0003	3	1) 5mins 37secs 2) 2mins 28secs	1) Nursing intervention (flushing patient's drain) 2) Nursing intervention (administration of medication); patient's social context (family coming up to visit); patient's condition (does nebuliser work for breaking up patient's secretions)
5	P0005	N0004	3	1) 17mins 5secs 2) 58secs 3) 1min 45secs	1) Nursing intervention (monitoring of vital signs); patient's previous treatment (radiotherapy and chemotherapy); patient's condition (previous fall and painful arm due to haematoma); follow-up care (clinic appointments and day centre at the hospice); patient's social context (wife, children and grandchildren); treatment (discussion of medication and if it is helping symptoms) 2) Patient's social context (received a bottle of brandy for doing something for another patient at the hospice). 3) Nursing intervention (admistration of medication)

Due to nurses' workloads, interviews with staff were generally shorter than interviews with patients. I found that it was neither appropriate nor helpful to undertake immediate post-observation interviews, as there was insufficient time to review the interactions prior to asking questions at interview. The unpredictable nature of ward environments and the staff workload presented challenges for interviewing staff.

The following seven points were noted during data collection:

1. The semi-structured observation schedule was sufficient for observing the type of information exchanged.

2. Mornings were a more appropriate time for observation sessions as most nursing interventions happened at this time. Patients were often tired or had visitors in the afternoon.

3. The recording equipment generally worked very well. However, some interference occurred during recording when a nebuliser was in situ or when a fan was operating nearby.

4. Observing patients for ninety minutes per session was feasible and appropriate.

5. The questions on the interview schedule were sufficient for directing participants to the key areas of exploration. Practicing interviewing skills in the pilot study was a learning experience, which sought to strive for more depth in the main study.

6. It did not prove useful to interview participants immediately post observation, as insufficient time was afforded for review of the recorded interactions prior to interviewing the participants. This could potentially lead to insufficient depth in the interviews.

7. All patient and nurse participants were satisfied with the data collection methods.

In relation to point seven, participants reported as follows:

> ***R_VC:*** *Do you have any suggestions or comments to make about the timing of the observations…?*
> ***N_0002:*** *No I think it's a good time, I mean obviously it's his first post op day so it's probably a good time to be observing.*
>   1_S_Int_Nurse_N0002

and:

> ***R_VC:*** *The letter I gave you yesterday, would you have liked a couple of days to look at it first before I came in today?*
> ***P_0003:*** *No, no it wouldn't have made any difference hen*
>   3_M_Int_Patient_P0003

Furthermore, patients and staff were happy with the level of privacy offered during the observations and interviews:

> ***P_0001:*** *I knew you were sat there and then once we started talking I forgot all about that.*
>   1_S_Int_Patient_P0001

4.6   Analysis

The aims of the pilot study were to review the research process, examine the procedures for recruitment and consent, and to test the recording equipment. Therefore, no formal data analysis was undertaken. However, data entry into QSR NVivo 8, and an initial attempt made at analysis, provided me with a practice run prior to the main study. I present my analysis of the research process and data collection methods as recommendations for the main study in Section 4.7.

4.7   Conclusion and recommendations for main study

This section details learning derived from the pilot study to inform the main study. To expedite the main study in terms of access, recommendations were that I could discuss the study proposal with key personnel at the clinical site at an earlier stage. These recommendations were suggested by the NHS R&D officer at the pilot study site, and were on an 'information only' basis until obtaining final ethical and management approvals. The willingness of key personnel to allow the study to proceed was crucial for commencement of the recruitment process, and within the timelines available.

More nurses were recruited from the ward in which the Ward Manager actively facilitated a group meeting with the staff. Therefore, for the main study, the recommendation was that I should meet initially with Ward Managers as a group to discuss the study, answer any questions and stress the importance of meeting with the staff nurses as a group.

Recruitment of surgical patients proved problematic in the pilot study. Patients on the elective waiting list for surgery were invited to take part. However, some patients who wished to take part were unable to as their hospital admission was cancelled due to a shortage of beds. It seemed unethical to invite patients to participate in a study to which they may never be recruited. One surgical consultant expressed the view that recruitment of elective surgical patients excluded patients admitted to a surgical ward but not necessarily undergoing surgery, thus making the study biased in favour of elective patients. In addition, it was difficult to match consenting surgical patients with consenting nurses, as the ward in which most nurses had consented

was also the ward from where patients' admissions were cancelled. Patients and staff in the medical ward reported a high level of satisfaction with recruiting and consenting patients on the ward. Patients were given more than 24hrs to read the information before being asked to sign the consent form. When asked if they would have liked more time to read the recruitment pack before being asked to consent, patients responded that they had had plenty time to consider taking part. It was recommended for the main study that I recruit surgical patients in the same way as medical patients, that is, on the ward. Recruiting surgical patients on the ward also fits with the sampling strategy of maximum variation by including patients with a greater variety of surgical conditions.

Based on the pilot study findings on data collection, the following four recommendations were made:

1. As most nursing interventions take place in the mornings, it would be appropriate to carry out observations sessions between, though not exclusively, the hours of 08:00 and 12:00.

2. In order to achieve greater depth in the interviews I should listen to the recordings of the interactions first, make more field notes and prompts, and then interview the participants in the afternoon, at their convenience.

3. I should be mindful of interference caused by electrical equipment such as nebulisers and fans when planning observation sessions.

4. Field notes written in a narrative form may aid prompts for interviews.

To summarise, undertaking a pilot study is both useful and advisable (Lacey 2010, Taylor 2010). The pilot study identified several difficulties particularly with recruitment

of nurses and surgical patients, but also with gaining sufficient depth from the interview data. Therefore, I undertook the recommendations made, which greatly facilitated the main study procedures. The patients sampled for the pilot study were all men, over 60yrs of age, and mainly medical patients. Subsequently, I monitored the main study throughout, looking for a wider range of characteristics, such as age, gender, varying disease conditions, and nurses' seniority and experiences.

Part 3: Findings and Discussion

Overview of the findings chapters

Chapter 5 presents the findings related to the type of information that patients and nurses exchanged, or provided, during routine nursing care. Chapter 5 is the keystone on which the other findings chapters are built. For example, to discuss the relevance and sufficiency of information exchanged or provided during routine nursing care the type of information must initially be established. Chapter 5 focuses on the type of information whilst being clear about further discussions on relevance and sufficiency of information that are developed in Chapters 6 and 7, respectively. Almost all of the data in Chapter 5 are categorised from the *a priori* code of 'Type of Information' into *a priori* categories and sub-categories (see 3.6 and 5.3).

Chapter 6 presents the findings related to the relevance of the information shared, or provided, by patients and nurses during routine nursing care. These findings build on those of Chapter 5 specifically in relation to the meanings that patients and nurses give to the types of information that they shared. For example, the finding that nurses share information with patients about treatment (5.4.4) may be relevant for reducing patient anxiety (6.3.1). Similarly, the finding that patients share information about their symptoms (5.4.2) may be relevant to nurses for assessing and planning care (6.3.3). The data explored in Chapter 6 are sourced mainly from participants' interviews exploring their perceptions of the relevance of the information shared. Throughout Chapter 6, I demonstrate within-case and cross-case analysis, and

present one case study to illustrate the complex linking of categories and sub-categories in relation to the relevance of the information shared or provided.

The findings related to the amount of information shared or provided by patients and nurses during routine nursing care are presented in Chapter 7. These findings also build on the findings from Chapter 5. Once the type of information was identified, data related to nurses' and patients' perceptions of sufficiency of that information were explored. This chapter differs from the previous findings chapters as the sufficiency of information from the observation data is explored first, followed by an exploration of participants' perceptions of the sufficiency of information gleaned from the interviews. Exploring the data in this way highlighted incongruities between what was observed and what participants described. In Chapter 7, five case studies are presented. I chose five case studies to demonstrate analytical consistency and the greater complexity of exploring and analysing similarities and incongruities between observation and interview data.

Most of the data in Chapters 6 and 7 are categorised into inductive categories and sub-categories indicating that the findings may be new and specific to information exchange in nursing practice in ward settings. In all of the data excerpts patients' pseudonyms are prefixed with P_ and nurses' by N_. R_VC denotes the researcher.

The key findings from Chapters 5, 6 and 7 are summarised at the end of each chapter. They key arguments of the thesis are discussed in greater detail in Chapter 8, making recommendations for nursing practice in ward settings, and for patient and nurse education.

Chapter 5: Type of Information

5.1   Introduction to chapter

In Chapter 5, I present the type of information exchanged, or provided, between patients and nurses during routine nursing care. The findings presented in this chapter address the first research question: 'What information do patients and nurses exchange during routine nursing care?' (see 2.9). I explore relevant data coded under the *a priori* code of 'Type of Information'.

In Section 5.2, I present an overview of the categories and sub-categories relating to the *a priori* code of 'Type of information' shared or provided. Two *a priori* categories, 'Type of interaction taking place', and 'Type of information shared or provided', are outlined, highlighting where the data were sourced. In Section 5.3, I provide an overview of patients' and nurses' perceptions of whether the interactions were clinical or non-clinical. In Section 5.4, I describe the data relating to the type of information shared or provided in greater detail. The key findings are summarised in Section 5.5.

5.2   Overview of categories and sub-categories related to 'Type of Information'

Under 'Type of Information', I coded two *a priori* categories, which matched parts A and B of the observation schedule. One category on the observation schedule was 'Type of interaction taking place' and coded under this are the *a priori* sub-categories of 'Clinical' or 'Non-clinical'. Many interactions were both clinical and non-clinical,

making the distinction difficult. It is likely that these difficulties are due to methodological issues, which are discussed in Section 8.3. However, it is also likely that clinical, and non-clinical interactions, do not normally take place independently in practice. Figure 8 summarises the categorising of data under 'Type of Information', specifically related to 'Type of interaction taking place'.

Figure 8: Categorising of data under 'Type of information' (1)
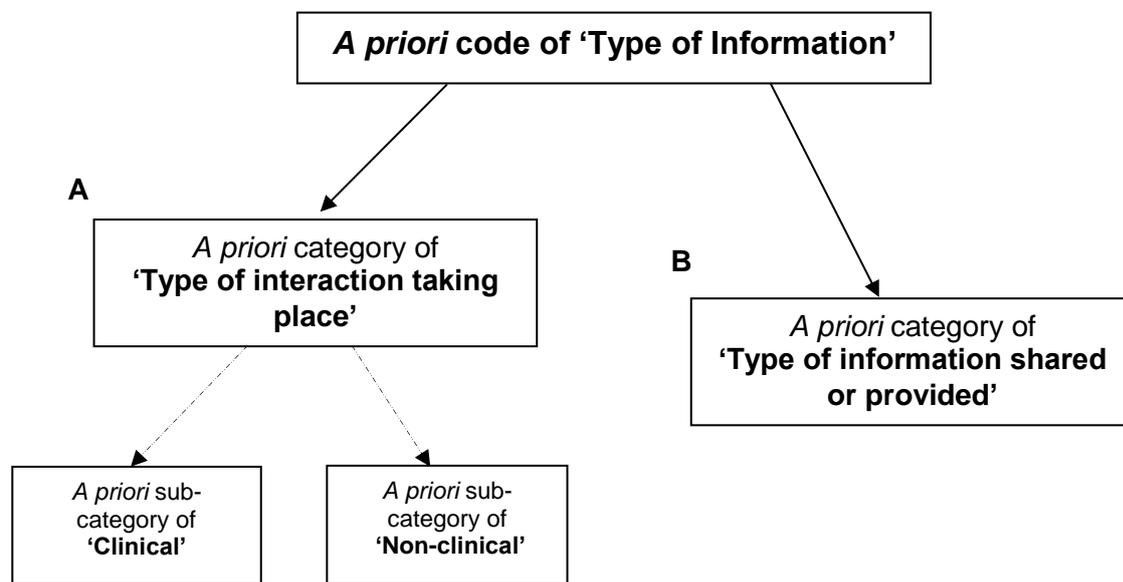
```
                    ┌─────────────────────────────────┐
                    │ A priori code of 'Type of       │
                    │ Information'                    │
                    └─────────────────────────────────┘
                      /                              \
                     /                                \
  A                 ↙                                  ↘              B
      ┌──────────────────────────┐          ┌──────────────────────────┐
      │ A priori category of     │          │ A priori category of     │
      │ 'Type of interaction     │          │ 'Type of information      │
      │ taking place'            │          │ shared or provided'       │
      └──────────────────────────┘          └──────────────────────────┘
            /            \
           ↙              ↘
  ┌──────────────┐  ┌──────────────┐
  │ A priori sub-│  │ A priori sub-│
  │ category of  │  │ category of  │
  │ 'Clinical'   │  │ 'Non-clinical'│
  └──────────────┘  └──────────────┘
```

A = Box which reflects part A of the observation schedule   B = Box which reflects part B of the observation schedule

Another *a priori* category coded under 'Type of Information' was 'Type of information shared or provided', under which I coded further *a priori* sub-categories. These *a priori* categories and sub-categories were chosen from what is known from the literature about the types of information that patients want either from nurses or from doctors (2.7.2 and 2.8.2). As analysis progressed, two new ideas related to the type of information shared or provided emerged from the data, subsequently sub-categorised as 'Apologies' and 'Self-care and Health Education'. Figure 9

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summarises the categorising of data under 'Type of Information', specifically related

to 'Type of information shared or provided'

Figure 9: Categorising of data under 'Type of information' (2)
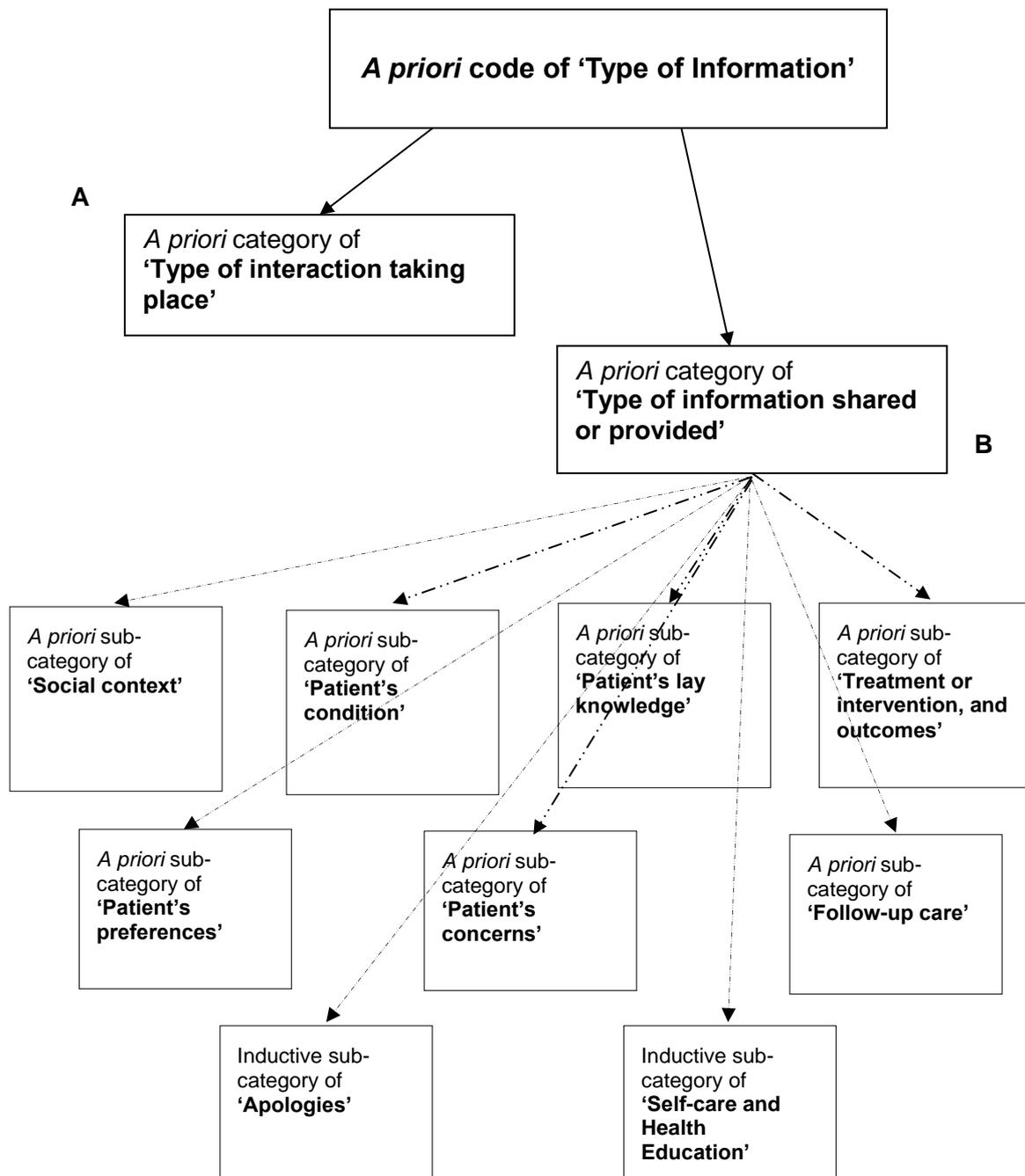
A = Box which reflects part A of the observation schedule; B = Box which reflects part B of the observation schedule

Data relating to the 'Type of interaction taking place', and the 'Type of information shared or provided' were sourced from:

- Observation data identifying whether the interactions were clinical or non-clinical

- Patient and nurse interview data on their perceptions as to whether the interactions were clinical or non-clinical

- Observation data identifying the type of information shared or provided

- Interview data supporting or conflicting with the observation data on the type of information shared

5.3   Type of interaction taking place

The *a priori* sub-categories of 'clinical' and 'non-clinical' interactions were considered because the literature differentiates between technical and non-technical aspects of care (Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, Jacobs 2000). Personal hygiene, rest/sleep, eating, scheduling for treatments or investigations, bed placement, room placement and discharge home are differentiated from technical aspects of care which are treatment-based and include administration of IV fluids and medications (Sainio and Lauri 2003).

In my study, explanations given by patients and nurses for interactions being perceived as clinical were that the interaction related to monitoring of vital signs, removal of urinary catheter, administration of medication, monitoring blood glucose levels, wound care, tracheostomy care, venflon removal, discussing health needs/condition, results of investigations, and discharge home. Non-clinical

information was characterised by general conversation, banter, humour, rapport, and discussion of patients' social contexts. These explanations are consistent with the existing literature.

A key finding in relation to interactions being clinical or non-clinical was that some patients did not understand the difference, or differentiate, between the terms 'clinical' or 'non-clinical', as evidenced in the two excerpts below:

> **R_VC:** *So would you describe that conversation [about medications] as a clinical conversation or a non-clinical conversation?*
> **P_Alice:** *I don't know what you mean. I was just sorta asking for…aye, just asking. I wouldnae…don't know what to say for that [question].*
> **R_VC:** *No…that's absolutely fine.*
>
> 1_S_Int_Patient_P0614

and:

> **P_Tracy:** *Well when she, when Una [the nurse] tells you what tablets you're getting I would describe that as being a kinda clinical conversation, because you know she has to make sure that you're getting the right tablets. I would say that, that's clinical, but we still kinda interact, we still laugh, you know, so it's, it's a combination really, you know…you just have a laugh you know.*
>
> 19_S_Int_Patient_P2197

Not all patients were asked for their perceptions of the type of interaction that took place. The interviews were semi-structured, and sometimes the opportunity to ask patients for their perceptions on whether their interactions were clinical or non-clinical, did not arise. It seemed that the distinction between clinical and non-clinical interactions did not matter to patients. It would also appear that distinguishing between clinical and non-clinical interactions was not helpful for patients, as one generally did not occur without the other.

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By contrast, all nurses interviewed did differentiate between clinical and non-clinical interactions, and described their interactions with patients as being mainly clinical. Nurses in my study concurred with nurses in other studies (such as, Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, Jacobs 2000), as they defined a clinical interaction as one where mainly treatment-based nursing interventions were being discussed, such as:

- Administering medication (Cases 1, 4, 11, 12, 14, 17, and 19)

- Stoma care (Case 3)

- Removal of wound drainage catheter (Case 3)

- Removal of urinary catheter (Cases 4, 10, and 15)

- Personal care of patients with a left BKA (Case 5)

- Checking vital signs (Cases 7 and 10)

- Wound care (Cases 11 and 18)

- Monitoring INR levels (Case 11)

- Discussion about investigations (Case 12)

- Tracheostomy care (Case 14)

- Monitoring blood sugar levels (Case 16)

- Removal of venflon (Case 17)

Interestingly, although during the interviews nurses described the interactions as being clinical, the observations showed that the interactions themselves were not clinical, but that the *actions* of the nurses were clinical. For example, although the nurse monitored the patient's blood sugar level, aside from gaining consent from the patient, the nurse did not discuss the intervention.

The findings in relation to the type of interaction taking place suggest that patients do not divide, or classify, interactions in the same way that nurses in my study (and as nurses in other studies) do. Patients perceive that nurses know clinical things, whilst patients know about their social context. These findings therefore have implications for practice and research, which are discussed in Section 8.4.1.

Two overarching points emerged from my data in relation to information being clinical or non-clinical: first, and perhaps most importantly, the distinction between clinical and non-clinical information perhaps did not matter to patients or nurses, and second, it seemed that distinguishing between clinical and non-clinical information was not helpful as one usually did not occur without the other.

5.4   Type of information shared or provided

A semi-structured observation schedule aided data collection relating to the type of information shared or provided. The findings are presented next.

5.4.1 Social context, banter, humour and rapport

Patients and nurses described social conversation, banter, humour and rapport as 'normal stuff' or 'the common touch'. Social context information is expressed here as information relating to, for example, how patients and nurses live, their families, their activities and their hobbies. The definitions of banter, humour and rapport are:

- *Banter: The playful and friendly exchange of teasing remarks.*

- *Humour: The quality of being amusing or comic, as expressed in literature or speech.*

- *Rapport: A close or harmonious relationship in which the people or groups concerned understand each other's feelings or ideas, and communicate well.*

(Oxford Dictionary Online 2013)

Exploring data related to patients' social contexts, banter, humour and rapport is important partly because of the environment in which these interactions are taking place. For example, in a ward setting patients are perhaps more vulnerable, often dressed in pyjamas and remaining in an environment that is different from living at home. Interacting about social contexts, enjoying humour and developing a relationship may be important to patients for reducing anxiety, for facilitating a balance of power between patients and nurses, and for planning care (Chapter 6). Patients' social contexts and how they interact in the healthcare setting may also be important for defining the support and resources that do, or do not, exist for the patient.

Most information about social contexts related to patients rather than nurses. The observed social information related to:

- Patient's previous employment (Case 3)

- Patients' husbands' or wives' employment (Cases 3, 5, 16)

- Family pets (Case 3)

- Special calendar dates, for example, a wedding, birthdays, Guy Fawkes' night, and Christmas (Cases 3 and 11)

- Do It Yourself (DIY) decorating (Case 9)

- General chat about patients' families and/or about their location (Cases 7, 12 and 13)

- Patients' families bringing food at visiting time (Cases 15 and 19)

- Nurse's family activities (Case 18)

Patients and nurses talking about social contexts is not a new phenomenon. Neither is the notion of social contexts affecting health status and therefore being relevant for planning care (Roper et al. 1996). The literature defines information exchange as a two-way interaction between health professional and patients, giving patients an opportunity to discuss their social contexts (Charles et al. 1999). However, the data in my study suggests that some interactions about social contexts could be described as 'fillers', perhaps not suiting any particular purpose other than to pass time. Nevertheless, other interactions were significant, as can be seen from participant-provided explanations about the relevance of this type of information (see Chapter 6).

The following data excerpts illustrate social context information being shared between patients and nurses:

> *P_Eddie: I told her [his wife] to bring the scissors today.*
> *N_Frank: Oh yes, is she gonna give you a trim?*
> *P_Eddie: Give a wee trim, you know. What do you think Frank?*
> *N_Frank: I'll get her to die me as well (both laugh).*
> *P_Eddie: Aye right, she'll do that nae bother. I've never went to the hairdressers since we were married.*
> *N_Frank: When I was in halls as a student nurse, eh it was four blokes and four lassies. And one of the lassie's mams was a hairdresser and she was quite good. So, aye, we used to get her to do ours. It was great. I have to go to the barber's now.*
> *P_Eddie: (Eddie lists the people whose hair his wife cuts) And if there was somebody else she'd say 'Aye'. It was as good as going to a bloody barber's you know.*
> 05_S_Obs_Patient&Nurse_P0653&N6323

and:

> *P_Colin: I wiz thinking if I'm fit enough to get a wee dog for us.*
> *N_Queenie: Oh right.*
> *P_Colin: We both [the patient and his wife], we both like dogs.*

> **N_Queenie:** *Aye, they're a lot of work right enough.*
> **P_Colin:** *Oh I know. I had one for fifteen years. Jack Russell.*
> 03_S_Obs_Patient&Nurse_P0632&N6172

In the first excerpt just cited, the social information appears to have no particular relevance in terms of information exchange and its role in decision-making but was merely a way of making conversation. However, the second excerpt just cited does appear to have elements of information exchange; Colin is exchanging information about his perspective of the reality of how his illness may affect him in the future, and about his ability and willingness to self-care in one area of his life. Queenie responds by acknowledging Colin's perspective and stating, perhaps more realistically, that dogs *'are a lot of work'*. This excerpt illustrates that even when sharing information of a social nature, some interactions evidence elements of information exchange and may go on to support shared decision-making and, in this example, self-care. Therefore, conceivably, information exchange is taking place in ward settings, even during seemingly incidental exchanges.

Patients and nurses stated at interview that they enjoyed bantering with each other. Sometimes patients and nurses made teasing remarks. The following extract illustrates these 'friendly' exchanges (Oxford Dictionary Online 2013):

> **P_Colin:** *I cannae argue the point wi' her [his wife] that she's got to stop workin'. It's entirely up to her.*
> **N_Queenie:** *I think work is a social thing as well isn't it.*
> **P_Colin:** *She enjoys it, that side. It's a social club tae. Obviously, she's worked in there for over twenty years.*
> **N_Queenie:** *Probably disnae want to be stuck in the house wi' you! (Laughs)*
> **P_Colin:** *(laughs) Aye, probably.*
> 03_S_Obs_Patient&Nurse_P0632&N6172

Banter was common in my study. The NHS site where my study was conducted was in the heart of Glasgow, which has a reputation of being the city of banter. Therefore,

perhaps patients and nurses expect that banter would be common in their interactions. It is not possible to know from my study whether the same level of banter would be evident, or as significant, in other areas. From the banter observed, it seems that these interactions do generally not evidence elements of information exchange.

Patients and nurses perceived humour as important during a patient's period of hospitalisation. It was generally patients who initiated humour, which sometimes went unnoticed by the nurse, for example:

> **N_Duncan:** *I think that's why they're gonnae be discussing with the two, well three teams obviously cos you've got Mr [consultant], sorry CJ's team, and then he'll talk with CK's team…*
> **P_Barry:** *Oh aye, and he'll talk with the A team [making reference to a television programme popular during the 1980s] (laughs)*
> **N_Duncan:** *…and he'll talk to the colorectal team… [No acknowledgement of Barry's A team reference].*
> 02_S_Obs_Patient&Nurse_P0620&N0640

Some patients used the tone of their voice or adopted a different accent, which resulted in their being funny or amusing:

> **N_Frank:** *That [towel] will do nicely (puts towel round Eddie's shoulders).*
> **P_Eddie:** *There we go (puts on a New York accent) Do you wanna shave? Do you wanna shave? Yeah I wanna shave.*
> 05_S_Obs_Patient&Nurse_P0653&N6323

and:
> **N_Una:** *Oh, so I'm going to go down the cupboard, take my trolley down, bring my trolley up, and bring your tablets up.*
> **P_Tracy:** *(In a put-on posh voice) I shall be waiting patiently!*
> 19_S_Obs_Patient&Nurse_P2197&N2217

Interactions involving humour did not appear to evidence information exchange. However, some patients who used humour in their interactions with nurses stated that it helped to *'keep you from goin mental'* (Cases 2 and 11), and it *'breaks the ice'* and makes patients *'feel at ease'* (Case 11). One patient summed up her use of humour as follows:

> *P_Iris: There's a lot of humour. I've got a good sense of humour; you need a wee bit humour in your day. If you don't, it's a sad time isn't it. Especially, well, if you've been through the mill. Everybody in here's fighting their own battles with their wounds and their illnesses and what not, and you've just got to try and keep that wee bit sense of humour.*
>
> 09_S_Int_Patient_P0691

Other patients who used humour in their interactions with nurses stated that humour was part of their every-day experiences. The implication here was that, for them, humour was not used to relieve anxiety while in hospital but was integral to their personality, for example:

> *P_Donald: Well I'm like that normally, well at least in my view is its humour, but, you know, that brought a smile to your face (researcher laughs) so there you are, see that was an example (researcher laughs), eh, so yeah, I definitely have got through life using humour, you know, and that…but not in that sort of cynical way it's just my nature.*
> *R_VC: It's your nature.*
> *P_Donald: I know, I kinda come away wi' one liners all the time.*
>
> 04_S_Int_Patient_P0644

Interactions involving humour may not evidence information exchange; however, it is possible that these interactions play a pivotal role in paving the way for interactions where information exchange may be more appropriate.

Rapport seems more closely linked with relationships and an understanding of one another's situation. The following excerpts from the observation data illustrate

incidences where patients and nurses had developed a rapport. The first data extract illustrates an interaction between a patient and the nurse caring for him. The patient was unable to take oral food and fluids. He had undergone extensive surgery, had multiple co-morbidities and had been fed through a PEG tube for approximately seven weeks. Despite the fact that he could not eat and drink, he initiated the conversation by asking the nurse what she ate at lunchtime:

> **P_Colin:** *Well, did you have a nice lunch?*
> **N_Queenie:** *I had a chicken roll, just cold meat chicken. I got it out the wee tearoom down the stairs.*
> **P_Colin:** *Wish I could have a chicken roll.*
> **N_Queenie:** *Oh, I know, I know…*
> 03_S_Obs_Patient&Nurse_P0632&N6172

The patient in this example seemed almost wistful about having something to eat, and the nurse appeared to show some understanding of his situation. The next data extract illustrates an interaction between a patient and a nurse, where the patient had been informed that she was being transferred to another ward:

> **N_Hannah:** *How do you feel about being moved to another ward?*
> **P_Harriet:** *Oh it doesn't matter. I'm better off…well I'll miss you.*
> **N_Hannah:** *I know. I'll miss you too.*
> **P_Harriet:** *And that other nurse.*
> **N_Hannah:** *You get used to people.*
> **P_Harriet:** *…see that other nurse she's been very, very nice.*
> **N_Hannah:** *Oh she is isn't she? She's a good laugh.*
> **P_Harriet:** *She's very nice.*
> **N_Hannah:** *Has she been really helpful to you?*
> **P_Harriet:** *So she has.*
> **N_Hannah:** *That's good. [Pause while the nurse looks out the nebuliser equipment] I know, I've had you for three days on the trot really haven't I? I've had you since you came in so we get used to each other (laughs).*
> 08_M_Obs_Patient&Nurse_P0484&N4344

From the excerpt just cited, it seems that the patient had built up a rapport or relationship with more than just the nurse caring for her at that moment in time.

None of the observed interactions showing a rapport between patients and nurses evidenced information exchange; however, rapport may be useful for information exchange. In both extracts just cited, the nurses could have used the rapport between them and the patients they cared for to exchange information about the patients' illnesses or conditions, for example, about the issues relating to Colin being 'nil by mouth' so many weeks post operatively, or about the events that brought Harriet into the acute coronary care ward and how her health was improving. However, in my study, some interactions, including some evidencing rapport, appeared to miss opportunities for information exchange (7.4.2)

5.4.2 Condition or natural history of disease

Nurses usually initiated interactions about the patient's condition. In only a few cases was the condition that resulted in the patient's hospital admission discussed. There was no evidence of nurses and patients talking about the natural history of the patient's disease, and the patient's prognosis. Instead patients and nurses spoke about patients' progress. This finding is interesting, and is discussed in Chapter 8 (8.4.1), but it may also be a feature of the snapshot data collection (8.3). I present the findings in relation to information about patients' condition and their progress next.

5.4.2.1 Patient's condition

Interactions relating to the patient's condition that resulted in admission to hospital were evident in Cases 2 and 17. In Case 2, the patient and nurse discussed the abscess on the patient's bowel, which developed as a consequence of him having been stabbed. In Case 17, the patient and nurse discussed the possible causes of

and the test results relating to the patient's headaches. The following data extracts illustrate these interactions, respectively:

> *P_Barry: Aye, I was wonderin if it would be better aff just maybe goin in and takin it [abscess] oot?*
> *N_Duncan: Well that's a thing…*
> *P_Barry: Cos I keep thinking if they keep bursting it it's just gonnae close o'er and keep fillin back up again.*
> 02_S_Obs_Patient&Nurse_P0620&N0640

and:

> *P_Rose: I take it that test came back clear then?*
> *N_Yolanda: Basically, I don't know, did the ophthalmologist say kinda say anything or was it, did he say…?*
> *P_Rose: He says it was fine, aye, says it was fine em, and he says…I need to go back in six, so…*
> *N_Yolanda: Six months*
> *P_Rose: Aye, cos I had immense em pressure behind my eye so I think they got to check it again.*
> *N_Yolanda: Yeah. But as far as what the headaches and everything they don't think it's related. You know that your eyes are related, so…em the junior doctor's gonnae speak to the doctor that you saw this morning em, and discuss it a wee bit…*
>
> 17_M_Obs_Patient&Nurse_P2179&N2509

Other interactions included information about the patient's condition at that moment in time, but not about the condition that resulted in the patient's admission. Table 16 summarises the type of information about patients' conditions mentioned in the interactions.

Table 16: Overview of type of information shared or provided relating to patients' conditions

Cases	TPR & BP	Pain	SOB	Nausea	Bladder function	Bowel function	Other
Case 1	✓	✓					
Case 2		✓					Tiredness and abscess on bowel
Case 3		✓				✓	
Case 4							'Funny turn'
Case 5		✓					Itchy back
Case 6		✓					Anxiety
Case 7	✓	✓		✓	✓		
Case 8		✓					Appetite
Case 9		✓					Itchy back, mobility and swollen tongue
Case 10	✓						Lightheaded and sweating
Case 11		✓					Swelling at wound site
Case 12	✓	✓	✓	✓		✓	
Case 13		✓	✓				
Case 15					✓	✓	Tiredness, mobility and swollen tongue
Case 16		✓			✓	✓	
Case 17		✓					Intra-cranial hypertension
Case 18		✓		✓		✓	

TPR = temperature, pulse and respiration; BP = blood pressure; SOB = shortness of breath

Without supporting data Table 16 could be misleading. For example, from the table it seems that pain was discussed in fourteen cases. However, pain was often not discussed in a two-way flow of information between patients and nurses. Instead, nurses used closed questions to ask patients if they were experiencing pain. Similarly, from the table it seems that information about patients' vital signs was provided in four cases. However, the evidence shows that nurses told patients that their vital signs were within normal limits, without sharing any further information. Information is asked for, and provided, in this manner for many of the other types of conditions mentioned in Table 16. Patients' conditions seem to be being referred to, but not discussed. The following data excerpts are typical of interactions in this study, and illustrate these points:

> **N_Anne:** *Are you sore at all?*
> **P_Grace:** *Nope.*
> **N_Anne:** *Nausea's gone too?*
> **P_Grace:** *Yep.*
> **N_Anne:** *And you're obviously passing urine okay since that…*
> **P_Grace:** *Yeah, mhm.*
>
> 07_S_Obs_Patient&Nurse_P0675&N0610

and:

> **N_Ian:** *Any pain at the moment?*
> **P_Peter:** *Nup.*
> **N_Ian:** *Any problems passing urine or anything?*
> **P_Peter:** *Nup.*
> **N_Ian:** *Bowels moving okay?*
> **P_Peter:** *Yep.*
>
> 16_M_Obs_Patient&Nurse_P0165&N0355

Conversely, in some interactions patients and nurses did discuss the patient's condition more fully, due to the patient presenting with a symptom that needed attention. Examples of these interactions are:

> **P_Iris:** *Did you know that my back was so itchy last night? I scratched myself til I bled.*
> **N_Oliver:** *Do you find you're itchy quite a lot?*
> **P_Iris:** *Aye, especially ma back.*
> **N_Oliver:** *Right. I can see if you're, you're in [consultant's name] team. Are you written up [prescribed] something for the itch?*
> **P_Iris:** *Oh aye.*
> **N_Oliver:** *So that it's not quite as bad as…*
> **P_Iris:** *He [consultant] is just away too.*
> **N_Oliver:** *Let's have a wee look.*
> **P_Iris:** *I was on Piriton, but I think I'm off it.*
> **N_Oliver:** *Aye. I think you could maybe do with going back on it then…if the itch it quite as bad.*
>
> 09_S_Obs_Patient&Nurse_P0691&N6151

and:

> **P_Olive:** *(Asks if urinary catheter can come out)*
> **N_Andrea:** *No, no. No' yet. See because…the reason it's in is because they wanted to keep a right close eye on exactly how much you were passing, right. And sometimes when you use a commode it's not quite as accurate. But everything's returning to normal now so I'm sure it will be fine [taking the urinary catheter out] but I just don't want to wheech it out and then get into trouble.*
> **P_Olive:** *I'm really uncomfortable*

> **N_Andrea:** *And it's uncomfortable for you and I can understand that, and I will plead your case.*
> **P_Olive:** *Plead my case.*
> **N_Andrea:** *Plead your case.*
> **P_Olive:** *Do ma battles.*
>
> <div align="center">15_M_Obs_Patient&Nurse_P0154&N0514</div>

The data from my study show that nurses can limit information exchange by their use of closed questioning about patients' conditions. Interactions evidencing information exchange about patients' conditions were few and occurred when patients first mentioned any presenting symptoms.

5.4.2.2 Patient's progress

Patients who were given information about their progress were those who had been in hospital for over a week, or who had been in hospital for approximately two or three days but who were feeling very low in mood (see Table 17).

Table 17: Overview of patients given information about their progress

Cases	Length of time in hospital	Other factors
Case 3	56 days	
Case 5	10 days	
Case 8	2-3 days	Patient very low in mood due to hearing that she was being moved to another ward
Case 9	49 days	
Case 12	2-3 days	Patient very low in mood due to recent unexpected death of his daughter
Case 16	29 days	
Case 18	50 days	

Nurses in this study reported to like giving positive information to patients who have been in hospital for a long period of time. Nurses also perceived that it is good for patients to be given positive information about their progress:

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> *N_Yvonne: I was just kinda trying to highlight the progress with him and make him aware, I mean he knows he's coming on but I think sometimes he just needs a wee bit reminding how well he's doing.*
>
> 03_S_Int_Nurse_N6252

and:

> *N_Frank: Well in this patient's case, he's been in hospital for a very long time so, and fortunately for me at that point in the discussion with him, anything that I was telling him was quite encouraging news. So it's very good, it's a nice thing for me to be able to do, to give good news and it's also very good for him to be encouraged, that there is light at the end of the tunnel, he's not deteriorating, and he is improving.*
>
> 05_S_Int_Nurse_N6323

Patients who had been in hospital for over a week perceived that positive information about their progress was important as it illustrated an improvement, and signalled the possibility of getting home soon:

> *R_VC: Yvonne was talking to you about your progress at one point.*
> *P_Colin: This morning, aye. (Pause) I was coming on fine.*
> *R_VC: Tell me a bit more about that.*
> *P_Colin: Mmm…Just that we're moving on. We're going in the right way. Cos there's so many of them [wound and drain sites] just got plasters on. Took some drains away, and they've just got a plaster on it. So that's, that's the right road. There's nothing leaking, which is good, you know. It means it's another step in the right direction.*
>
> 03_S_Int_Patient_P0632

Information is constructed of a sequence of signals (Pitasi and von Glasersfeld 2001, Shannon and Weaver 1949). When like signals are reported frequently, or are channelled, the signals take on meaning (Kasper et al. 2012, Pitasi and von Glasersfeld 2001). Patients who had been in hospital for a longer period of time received more information about their progress and for them appeared to mean that they would soon be discharged home. This is important for information exchange, for

example about discharge planning, as patients might then bring to the interaction the meanings that they had formed from previous incidental interactions.

5.4.3 Patient's lay knowledge of disease or condition

Some patients demonstrated knowledge of their medication. Kirsty, the patient in Case 11, had knowledge of her normal International Normalised Ration (INR) levels, and her subsequent dosage of Warfarin. She also stated that when her INR reached a certain level, she would be able to go home:

> **N_Carol:** What was it [INR level] yesterday?
> **P_Kirsty:** Eh, my Warfarin?
> **N_Carol:** Uh huh, the INR.
> **P_Kirsty:** 1.4
> **N_Carol:** That's right. And you had 6mg of Warfarin.
> **P_Kirsty:** And the one before was 1.7
> **N_Carol:** That is right. So, we'll see, hopefully today's is higher than 1.4, which means we're slowly…
> **P_Kirsty:** When I get to 1.9 I should get out the door!
> > 11_M_Obs_Patient&Nurse_P4114&4294

During the interview, Kirsty (patient in Case 11) stated that the staff knew of her previous anxiety around her INR levels:

> **P_Kirsty:** In the past, I think, if you were to go back in my records it must be written somewhere that Mrs Parker [Kirsty] is a pest or a…she's always asking how's her Warfarin, how's her Warfarin? Because I used to be desperate to get home.
> > 11_M_Int_Patient_P4114

However, Kirsty stated that now she realised that her body *'works at its own pace'* (Case 11). Other patients also knew about the doses and side effects of their medication, as illustrated by the following data excerpts:

> **N_Una:** (Pauses while she looks out medications and speaks to another patient.
> **P_Tracy:** Its 10mg I think, the Amlodipine.
> > 19_S_Obs_Patient&Nurse_P2197&N2217

and:

> **P_Larry:** *It was when I was in [hospital] the last time. That's when they gave me Atenolol, and that's when I didnae feel so good.*
> **N_Pauline:** *The same thing.*
> **P_Larry:** *So, that is it, I'm just assuming it's that, you know.*
>
> 12_M_Obs_Patient&Nurse_P0125&N0425

During the interviews patients also demonstrated their own knowledge of:

- Medication (Cases 1, 4 and 19)

- Stoma care (Case 3)

- Nursing intervention (Case 4)

- Heart condition (Case 11)

- Infection control (Case 11)

- Blood pressure and stress (Case 19)

- Anaemia (Case 19)

The following data excerpts are further examples of patients' lay knowledge:

> **P_Alice:** *I'm sorta telling them what I want now, cos I know, like there I knew I needed a Tramadol and Paracetamol, but I know…but when it's a new nurse like that girl was…she disnae know…*
>
> 01_S_Int_Patient_P0614

and:

> **P_Tracy:** *Stress is to do with high blood pressure, because if you're stressed, your blood pressure just goes through the roof.*
>
> 19_S_Int_Patient_P2197

Having lay knowledge of a health issues however, does not necessarily equate to knowing the facts about that health issue. For example, Donald (patient in Case 4) had lay knowledge of a nursing intervention, namely, removal of a urinary catheter.

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However his knowledge was gained from a friend who had gone through, and reacted badly to, the same procedure:

> **P_Donald:** *I was dreading it, right, because of a friend who'd had this operation. He actually went into shock when they took it [urinary catheter] out, right. That's what was in my mind.*
>
> 04_S_Int_Patient_0644

Donald's knowledge of urinary catheter removal was knowledge conveyed to him by his friend. However, it was probably inconsistent with most patients' experiences of urinary catheter removal. Nevertheless, it was an important piece of knowledge for him, and would remain in his thinking until he himself experienced the removal of a urinary catheter. However, if his experience had been the same as his friend's, then his lay knowledge – that urinary catheter removal induces shock – may have been reinforced.

Similarly, in Case 1, Alice's knowledge of Amoxicillin was that it was a universal medication that was used for every condition:

> **R_VC:** *Do you know what all your medications are for?*
> **P_Alice:** *Eh, aye well painkillers, the Brufen temperature, and the Tramadol pain, painkiller. And I know Amoxicillin, that's the monkey one isn't it? They give you that for everythin.*
>
> 01_S_Int_Patient_P0614

Whilst the data suggest that some lay knowledge is helpful, other data show that lay knowledge can be detrimental to the patient. For example, it may be unhelpful that Alice considers Amoxicillin to be a *'monkey'* medication that is used for everything. However, the knowledge that Donald had of urinary catheter removal was detrimental to him, as it caused him an unnecessary degree of anxiety. These types of lay knowledge that patients adhere to are significant in terms of information exchange in nursing practice. An exchange of information between patients and

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nurses may help to identify negative thinking, challenge the sources of lay knowledge, and provide support for patients whose lay knowledge is causing them anxiety.

5.4.4 Treatment or intervention

There was little evidence of nurses offering patients choices regarding treatment. It is possible that discussions about treatment choices occurred at a different point in time, which was not observed. Some data suggest that patients discussed treatment options with physicians, for example during ward rounds or in clinic settings prior to hospital admission. For example, in Case 4, Donald stated at interview that the doctor at the clinic had discussed his prostate medication with him prior to admission to hospital, and advised that Donald should continue taking one of his medications post-operatively:

> ***P_Donald:*** *And I'm sure he [doctor] told me that I'd keep going with this Xatral tablet even after the operation.*
> 04_S_Int_Patient_P0644

Nurses in my study provided some information related to the benefits and side effects of treatment. These interactions usually related to medication. Interactions about treatment and/or interventions were coded under three sub-categories: care management; nursing interventions; and, treatment, including benefits and side effects. I present the findings related to these sub-categories next.

5.4.4.1   *Care management*

Information about care management was usually provided by the nurse, and in a manner of telling patients about their care, rather than discussing treatment plans together:

> **N_Duncan:** *I think what they're going to do today is speak to the [consultant] the two consultants. They're gonna speak to who you were under normally and maybe talk to the colorectal team, the team that deal with the lower part of the bowel and, eh, see what we should be doing to get proper sort of management for you.*
> 02_S_Obs_Patient&Nurse_P0620&N0640

In the example just cited, after the nurse had given the patient information about care management, the patient shared his perspective and preference about his care. However the following extract illustrates that some patients accepted information from nurses without question:

> **N_Kate:** *So, they've started you on antibiotics today. You get them twice a day. You've had it this morning, you get it again at dinner time, five o'clock tonight, and that course will probably run about a week. And once they're happy with your bloods and things, you're getting better, I think [doctor] probably told you earlier on they'll take your catheter out and see if you can manage.*
> **P_Donald:** *Aye.*
> 04_S_Obs_Patient&Nurse_P0644&N6114

The example just cited is consistent with patient passivity (7.4.3) and paternalism (7.4.4) in healthcare, factors that inhibit information exchange.

5.4.4.2   *Nursing interventions*

Most nurses in my study did not discuss nursing interventions with patients, but instead told patients what the intervention was and/or when it was likely to be undertaken. For example, wanting to check a patient's blood sugar levels, the nurse said, *'Just goin to do a wee sugar'* (Case 3). No other information was given at that time. Table 18 summarises instances of providing information about nursing interventions. Patient's responses were not extracted from the data set into Table 18 if their responses were only given in response to prompts from the nurse, for example:

> **N_Carol:** *Now let's see. Still got your name band on, so I can give you your drugs, Kirsty, and your date of birth?*
> **P_Kirsty:** *(States her date of birth)*
> **N_Carol:** *And allergies Kirsty?*
> **P_Kirsty:** *None*
> **N_Carol:** *None, that's great. I'll get your medication for you.*
> 11_M_Obs_Patient&Nurse_P4114&N4294

The explanation for why these types of responses from patients were not included in Table 18 is that although information was provided, there was no evidence of information exchange. Patients were answering questions but were perhaps not fully engaged in the conversation.

Table 18: Information about nursing interventions

Cases	Nursing intervention	Who was involved	Data extract
Case 1	Administering medication	Patient & nurse	**Nurse:** *Do you want anything for pain?* **Patient:** *No, but for my temp*
"	Reconnecting IV infusion	Nurse only	**Nurse:** *Once you're all organised, I'll put your drip back up*
Case 3	Monitoring blood sugar	Nurse only	**Nurse:** *Just gonna do a wee sugar on you again, alright?*
"	Flushing a PEG tube	Patient & nurse	**Patient:** *It's no' flushing* **Nurse:** *What I'll maybe do is get a new giving set…oh do you know what it'll be, it'll be the clamp…Aye, clamped off. So, I've opened the clamp* **Patient:** *That's what you were fighting with.* **Nurse:** *That's better now. Do you feel anything trickling or anything?* **Patient:** *No' yet* **Nurse:** *Can you…?* **Patient:** *…no' trickling, only movement goin in*
"	Removal of wound drain & changing stoma bag	Nurse only	**Nurse:** *We're sorted. Doctor passed on to me about your catheter, it's to come out, but we'll do that once we've changed your stoma bag*
Case 4	Removal of urinary catheter	Nurse only	**Nurse:** *I'll take your catheter out and see if you can manage*
Case 7	Monitoring vital signs	Nurse only	**Nurse:** *It's [vital signs] all absolutely fine*
Case 8	Administering medication	Nurse only	**Nurse:** *What I'm going to do is do your medications and then we'll come in and get you a wee wash*
"	Administering medication	Nurse only	**Nurse:** *Hiya, I've got your medications Harriet. Can I just check once again, now I mean I should know this off by heart shouldn't I, your date of birth please*
Case 10	Taking irrigation fluid down	Patient & nurse	**Nurse:** *Hello. Will we take all this down? I turned it off.* **Patient:** *Did you turn it off?* **Nurse:** *Aye*
Case 10	Monitoring vital signs	Patient & nurse	**Patient:** *I went down for a smoke an' I only had two puffs and I went…I stopped and I came back up here and I was sitting here and went…very light-headed* **Nurse:** *Right, I'm going to get you back into bed. I think with you having smoked it's not helped…Take your time getting up [to lie on bed]. I'm gonna get your blood pressure as well. Just lie and relax, I'll be back in two wee seconds*
Case 11	Administration of medication	Nurse only	**Nurse:** *Now let's see, still got your name band on, so I can give you your drugs, Kirsty, and your date of birth?*
Case 12	Monitoring vital signs and administration of medication	Nurse only	**Nurse:** *Pop your legs up (pause) check your blood pressure and that, and then I'll get your tablets okay?*
Case 15	Monitoring blood sugar	Patient & nurse	**Nurse:** *Can I take your blood sugar?* **Patient:** *Yes certainly*

Table 18: Information about nursing interventions (continued)

			Nurse: *I'll get this all ready and wash my hands…right that's us nearly ready. Which finger are we having this time?* **Patient:** *What one would you like?* **Nurse:** *Well one that isn't sore with us jagging you*
"	Administration of medication	Nurse only	**Nurse:** *Right, that's your tablets for lunchtime…and I'll come back with your Morphine okay?...Right I've brought your Morphine for you. We'll just check that you are who you are*
"	Removal of urinary catheter	Patient & nurse	**Nurse:** *Knock knock! Alright for me to come in? Right. You'll be glad to get rid of this won't you.* **Patient:** *Don't know* **Nurse:** *Eh?* **Patient:** *Is it sore coming out?* **Nurse:** *It shouldn't be sore, no. You'll maybe just feel it a wee bit uncomfortable. In fact it should be better than going in. What I'm gonnae do is…holding it in is just a wee balloon in your bladder. So I'm just gonnae take the water out the balloon for you. You won't feel anything here, and then basically, I'll just slowly pull it out if that's alright?* **Patient:** *Aye* **Nurse:** *Right now, it's just this bit and you'll just see the water. Wait and I'll show you, look. That's just the water in the balloon. It's the balloon that's holding it in to make sure it doesn't dislodge* **Patient:** *Oh in the name, I can feel the water coming out that* **Nurse:** *Can you feel that? Can you feel it cold?* **Patient:** *Mhm* **Nurse:** *Right, so basically, that's it out, okay?*
Case 16	Administration of medication	Patient & nurse	**Nurse:** *Tablets here for you* **Patient:** *Right cheers, nurse* **Nurse:** *Again there's a wee half tablet in there just for you...* **Patient:** *Right is that the Gliclazide?* **Nurse:** *Aye…*
"	Monitoring of vital signs	Patient & nurse	**Nurse:** *I'll get a wee blood pressure from you, alright?* **Patient:** *Okay, what side do you want?* **Nurse:** *(Checks BP) Blood pressure, everything's fine there*
Case 17	Removal of venflon	Nurse only	**Nurse:** *We'll get this wee venflon oot, right*
Case 18	Administration of medication	Nurse only	**Nurse:** *That's your tablets, okay?*
"	Wound dressing	Patient & nurse	**Nurse:** *Is this getting done every day then?* **Patient:** *Nah, hardly at all* **Nurse:** *Naw, just every couple of days* **Patient:** *Been about three or four days sometimes* **Nurse:** *Oh that's quite good, when was it last changed then?* **Patient:** *Would have been last week* **Nurse:** *Oh, right, as long as that* **Patient:** *You want to check that one…?* **Nurse:** *Aye might as well*

Some patients did engage in the conversation (see Cases 1, 3, 10, 15, 16 and 18 in Table 18). The data from Case 15, in particular, illustrates an example of the patient expressing her concerns about catheter removal, and the nurse responding with a description and explanation of what was happening at each stage. Also, in Case 1, the nurse asked the patient if she needed painkillers. The patient did not require painkillers, but she wanted something to reduce her temperature. A discussion then ensued about whether or not the medication of choice for reducing temperature was Paracetamol or Ibuprofen:

> **N_Ivy:** *Do you want anything else for pain?*
> **P_Alice:** *No, but for my temperature.*
> **N_Ivy:** *You had your Paracetamol earlier. That should bring down your temp. (Conversation then occurred between them with the patient stating that Ibuprofen works better at reducing her temperature than Paracetamol).*
> 01_S_Obs_Patient&Nurse_P0614&N0694

The examples shown in Table 18 of patients and nurses engaging in conversation about nursing interventions indicate that some information exchange was taking place in my study. However these examples were not the norm. Furthermore, even in those examples of information exchange the interactions did not last long and patients' perspectives were not fully explored. Short interactions may be indicative of the demands on nurses' time (7.4.2.2).

5.4.4.3 Treatment

The majority of information about treatment was related to medications. For example, patients were told they had been commenced on new medication:

> **N_Kate:** *So, they've [doctors] started you on antibiotics today.*
> 04_S_Obs_Patient&Nurse_P0644&N6114

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Some nurses told patients about the benefits of their medication, which included creams for tender skin and itching (Cases 5, 8 and 18). Information about the benefits of the medication was sometimes given at the time of the drug round when the nurse explained the indication for each tablet, or was given during another nursing intervention, for example, during wound care where information was provided about the benefits of antibiotics. The following two excerpts illustrate these points:

> **N_Hannah:** *Right, so, I'll explain what you've got here. Em, we've got your Atrovent nebulisers, got your stomach tablet Omeprazole which you're normally on. We have the Verapamil; remember your heart rate was going really quickly so that just helps keep that down.*
> 08_M_Obs_Patient&Nurse_P0484&N4344

and:

> **N_Wendy:** *(Changing Steve's wound dressing) Well the antibiotic's doing its job.*
> **P_Steve:** *Mmm, still some bits leaking. Keeping my fingers crossed wi the pills.*
> **N_Wendy:** *…This [wound] looks a lot smaller as well…so it has innit? A lot smaller*
> **P_Steve:** *Aye, this is definitely getting shallower.*
> **N_Wendy:** *That's quite good.*
> **P_Steve:** *Totally dry as well…no' wet at all*
> **N_Wendy:** *Yeah, it's [antibiotic] doing its job. We're doing something right (both laugh).*
> 18_S_Obs_Patient&Nurse_P5181&N5241

Patients also discussed medication with the nurses; however it was generally related to the side-effects rather than the benefits of the medication:

> **N_Pauline:** *You didn't feel sick at home? Just happened since you came in and you thought it was that tablet or…*
> **P_Larry:** *No. It was when I was in the last time. That's when they gave me Atenolol, and that's when I didnae feel so good.*
> 12_M_Obs_Patient&Nurse_P0125&N0425

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5.4.5 Patient's preferences

Patients in this study stated their preferences in relation to:

- Medication (Cases 1, 8, 11, 15 and 18)

- Personal care (Cases 1, 5, 8 and 9)

- Nursing interventions (Cases 3, 15 and 18)

- Comfort (Cases 9, 10 and 15)

- Diet (Case 8)

- Discharge home (Case 11)

Sometimes patients initiated the conversation about their preferences, in this instance about keeping his pyjamas on after spilling juice:

> **P_Eddie:** *I think it was just the sleeve of my jacket that got it [Lucozade], so it's, it's dried in so don't worry*
> **N_Frank:** *Are you sure?*
> **P_Eddie:** *Aye, I'm fine oh aye. Nae bother, all dried in.*
> 05_S_Obs_Patient&Nurse_P0653&N6323

At other times, nurses offered choices to patients:

> **N_Andrea:** *Do you want to get up to sit?*
> **P_Olive:** *Not really*
> **N_Andrea:** *Not feel like it? Did you not have a good sleep last night?*
> **P_Olive:** *Yeah I had a sleep*
> **N_Andrea:** *Did you. Are you just tired this morning?*
> **P_Olive:** *Bit tired, aye*
> 15_M_Obs_Patient&Nurse_P0154&N0514

Mostly, nurses acknowledged patients' preferences. However data from Cases 11 and 15 show instances of patients' preferences being noted, but not followed. In Case 11, the patient wanted to go home once her INR level reached 1.9, but the nurse would have liked the INR to be at least 2 before the patient was discharged:

> *P_Kirsty:* When I get to 1.9 [INR level] I should get out the door!
> *N_Carol:* Do you think?
> *P_Kirsty:* Yes. It's in my card [Warfarin card] (laughs)
> *N_Carol:* It's in your card is it? I think what…2 and 2 ½, okay; I think normally the figure in here. But I will check though if that's what's written in your card, normally we like above 2.
> *P_Kirsty:* Yes I do appreciate…
> *N_Carol:* And then we're happy with that
> *P_Kirsty:* I do appreciate…
> *N_Carol:* But equally I think it's fair to say we don't want it coming up too fast because of that swelling you've got in that pacemaker site
>
> 11_M_Obs_Patient&Nurse_P4114&N4294

The excerpt just cited demonstrates a patient trying to speak up about her preferences for discharge home when her INR level reaches 1.9. Her use of language is interesting when she says, '*Yes I do appreciate…*' It seems that Kirsty is acknowledging Carol's perspective, and yet is still trying to establish her own perspective. However, Carol's tendency to control the interaction rather than engage in information exchange resulted in Kirsty's preferences not being ignored.

In Case 15, the patient, Olive, stated that she did not want to take her Movicol as she perceived that it was not required. However, the nurse, Andrea, explained why the Movicol had been prescribed and that she would get the doctor to review whether or not the dose could be reduced:

> *P_Olive:* Don't want to take one of those [Movicol] just now.
> *N_Andrea:* You don't want one just now, your Movicol?
> *P_Olive:* No' just now
> *N_Andrea:* Right, and are your bowels moving most days?
> *P_Olive:* Aye
> *N_Andrea:* Aye, no problem. So do you…but do you think that's because you're on your Movicol three times a day? See how the Morphine what you're getting? The Morphine can sometimes constipate you and I think that's why they've got you on the Movicol. So I'm wondering if maybe you should keep taking your Movicol. If it's working for you and things are alright…you're no' too soft or anything are you?

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> *P_Olive: Aye, it's quite soft, aye.*
> *N_Andrea: Right, will we maybe get it [Movicol] cut down a wee bit then?*
> *P_Olive: Aye*
> *N_Andrea: Do you want to take this one then and I'll talk to the doctor*
> *P_Olive: Aye, that's fine*
>   15_M_Obs_Patient&Nurse_P0154&N0514

5.4.6 Patient's emotional concerns

Table 19 illustrates patients' expressed emotions. Generally, nurses communicated with patients about their emotional concerns either by prompting a reaction from the patient by asking a question (Case 8), or by responding to the patient with some consideration to the patient's thoughts and feelings (Cases 3, 10 and 12).

Table 19: Overview of patients' expressed emotions

Cases	Expressed emotion	Data extract
Case 3	Loneliness	*Colin: Oh, well I will miss it. I'll miss the company.* *Queenie: Uh huh. There's a lot of camaraderie [at work]* *Colin: And my wife works part time, she'll no' give up work so it means it'll be, I'm gonna be stuck in the hoose.* *Queenie: Aw right, yourself* *Colin: Four days a week on my jacksy.*
Case 8	Missing the staff	*Hannah: How do you feel about that? How do you feel about having to move [to another ward]?* *Harriet: Oh it doesn't matter. I'm better off…well I'll miss you.* *Hannah: I know, I'll miss you too.*
Case 9	Feeling good within herself	*Iris: I'm fine. I actually feel good within myself*
Case 10	Anxiety regarding catheter removal	*Jack: Well that's no', I knew that bit's okay. It's the other bit that's making me…* *Cathy: Listen, taking out the catheter's quite, its fine.* *Jack: Aye, you don't feel a thing, don't you no'*
Case 12	Feeling upset as thought doctor said he had asbestosis	*Larry: I was a wee bit upset when that doctor came back in an' he told me I had, eh, what do you call it, asbestos in my lung* *Pauline: Aye, but all he's saying is…it's just you've got some scarring on your lungs* *Larry: What? It's only scarring?* *Pauline: It's like scarring, just where your lungs have maybe been damaged wi' the asbestosis.*

Although this section relates to emotional concerns, Case 9 illustrates that patients'

emotions are not always negative. The patient in Case 9, Iris, had been in hospital for

a considerable amount of time and had previously been depressed. During the

interaction, she was explaining to the nurse, Lesley, that, within herself, she feels

much better and feels more positive than she did previously. However, Lesley did not

acknowledge what Iris had said, as we see from the following data extract (see also

7.4.4):

> **P_Iris:** *I'm fine. I actually feel good within myself*
> **N_Lesley:** *Yeah, the thing about the MRSA in your TPN line it's not making you sick so we don't know, so…the doctor…that's why they screened you everywhere else to say is it actually in the body you know is it?*
> 09_S_Obs_Patient&Nurse_P0691&N6151

5.4.7 Possible outcomes of treatment or intervention

Data coded here related to expected outcomes of prescribed medication (Cases 4, 6

and 18), removal of irrigation fluids (Case 10), and urinary catheter removal (Case

10). For example, it was expected that antibiotics would help to clear up an infection:

> **N_Kate:** *I think you've got a wee bit of an infection the now as well, which is why you're gonnae be kinda tired*
> **P_Donald:** *Aye*
> **N_Kate:** *So they've started you on antibiotics today. You get them twice a day. You've had it this morning, you get it again at dinner time, five o'clock tonight, and that course will probably run about a week.*
> 04_S_Obs_Patient&Nurse_P0644&N6114

It was also anticipated that by drinking plenty of water after discontinuing the

irrigation fluids the patient's urinary catheter could be removed:

> **N_Cathy:** *What I'll do is I'll take it [irrigation fluids] down. What I'll say to you is drink plenty. So drink about a glass of water an hour, okay.*
> **P_Jack:** *Mhm, fine.*

> **N_Cathy:** *Eh, the more you do that the better it stays clear, alright? And here's hoping tomorrow I take it [catheter] out, alright?*
>
> 10_S_Obs_Patient&Nurse_P6104&N0634

Furthermore, it was expected that when the urinary catheter was removed, the patient would be able to pass urine naturally:

> **N_Cathy:** *And once they're happy with your bloods and things, you're getting better, I think (doctor) probably told you earlier on they'll take your catheter out and see if you can manage.*
>
> 10_S_Obs_Patient&Nurse_P6104&N0634

However, the data from my study suggests that nurses provide, rather than exchange, information about possible outcomes of treatment or interventions.

5.4.8 Follow-up care

The sub-category of follow-up care was divided into two headings: referral to other health professionals; and, further investigations.

5.4.8.1   *Referral to other health professionals*

The data shows that information related to referrals to other health professionals was mentioned during the interactions. These other health professionals were:

- Dietician (Cases 2 and 3)

- Colon specialist (Case 2)

- District nurses (Case 9)

- Home helps (Case 9)

- Tissue viability nurse (Case 9)

- Physiotherapist (Case 11)

There was little information exchange about referrals to other health professionals. Usually nurses told patients who they had been referred to and why. The following data extracts exemplify this type of information provided by nurses:

> **P_Duncan:** *Well hopefully, I gave the dieti…remember I spoke to the dieticians. I left a message for them…the dietician should come and see you.*
> 02_S_Obs_Patient&Nurse_P0620&N0640

and:

> **N_Lesley:** *I can phone up the tissue viability sister and she'll come and say that's fine. And then phone the district nurses, give them a few days' notice, ask them to come up and see us, look at your wound before you go home, they come out, the girls that are looking after you at home come to the ward…*
> **P_Iris:** *I know them*
> **N_Lesley:** *Uh huh, they come to the ward and then if they're happy they've got all the supplies and everything, that's you…*
> 09_S_Obs_Patient&Nurse_P0691&N6121

Nurses sometimes asked patients rather than told them, if they would like to be referred to another health professional. The following two examples illustrate patients being asked if they wanted to be referred. In the first example, the patient was agreeable to the referral, however in the second example the patient declines the referral:

> **N_Carol:** *I was wondering Kirsty if from an arm and shoulder point of view, you're having difficulty lifting that arm with the bruising you've got, if I could get the physiotherapist in to have a look and assess you, 'cos they're the best people to have a look at that and let you know what you can…okay?*
> **P_Kirsty:** *Yes*
> **N_Carol:** *I'll give the physiotherapist a shout and let you know when she can come and see you.*
> **P_Kirsty:** *Thank you very much.*
> 11_M_Obs_Patient&Nurse_P4114&N4294

and:

> **N_Oliver:** *Iris, do you have home helps or anything when you're at home?*
> **P_Iris:** *No*
> **N_Oliver:** *No. do you think you would need any or…*
> **P_Iris:** *No Oliver*

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> **N_Oliver:** *No.*
> **P_Iris:** *I've got…got a big family Oliver.*
> **N_Oliver:** *Oh well, no bother.*
>   09_S_Obs_Patient&Nurse_P0691&N6151

Oliver's last statement in the example just cited appears to contain an element of indifference as to whether or not Iris receives home help. However, Oliver was also an inexperienced registered nurse having only been qualified for one year. He did not provide any further explanation of what home help or social carers could offer. Oliver would have been aware of Iris's previous employment in healthcare, which may have led to his assuming that she would know what the services would entail. However, it seems that an opportunity for further explanation and information exchange was missed. Further information exchange may have elicited information from Iris about her knowledge of home care services and also about her decision not to take up the offer of help.

5.4.8.2   *Further investigations*

The data also evidenced nurses talking to patients about referrals for further tests or investigations. The types of investigations patients were referred for were:

- Colonoscopy (Case 3)

- Heart ultrasound (case 12)

- Angiogram (Case 12)

- MRI scan (Case 16)

- Renal biopsy (Case 16)

- Lumbar puncture for cerebral spinal fluid (CSF) analysis (Case 17)

Some patients were still awaiting these investigations (Cases 3, 12, and 16), and one patient was waiting for the results of an investigation after it had been undertaken (Case 17):

> **N_Ian:** *We're still waiting for these scans, this MRI, there's no' been any word.*
> **P_Peter:** *I'd need to ask them when am I getting oot, but (unclear but makes a comment about the scan)*
> **N_Ian:** *Aye, well when, til they get all these results and then we'll see where we're goin fae here. I think there's talk o' a biopsy as well.*
> **P_Peter:** *Aye, that's right, yeah*
> **N_Ian:** *They can phone anytime for this MRI cos you don't need any preparation and you don't need to fast or anything like that.*
> 16_M_Obs_Patient&Nurse_P0165&N0355

and:

> **P_Rose:** *That other test [CSF analysis] must have come back clear then.*
> **N_Yolanda:** *Oh the (struggles to pronounce the name of the test), it's a big funny word*
> **P_Rose:** *It's a new one they said, aye.*
> **N_Yolanda:** *Aye, that, I don't know I'll check up on that.*
> **P_Rose:** *Aye, that was the one that the [name of other hospital] had been sent, so they were just waiting on that coming back.*
> 17_M_Obs_Patient&Nurse_P2179&N2509

5.4.9 Other – Apologies, self-care and health education

The *a priori* categories in my observation schedule captured most of the types of information that patients and nurses, in my study, provided or exchanged. However, other types of information were discussed between patients and nurses that were not accounted for in Part B of the observation schedule. These were: apologies that nurses made to patients; and, information about self-care and health education.

Apologies were given to patients if a nursing procedure was painful or if it was to be repeated. For example the nurse in Case 11 apologised that venepuncture was to be repeated as the laboratory had not received the first blood sample:

> **N_Carol:** *For some reason, they've [laboratory] not received it [blood sample]. So that's why the phlebotomist, the girl who takes the blood, she took another, so I'm on the case, I'll chase that up, I'll phone them to find out where that first sample went. So that's why it's [obtaining the result] taken a wee bit longer and you've had to be bled twice. I apologise for that.*
> 11_M_Obs_Patient&Nurse_P4114&N4294

In Case 3, the nurse was attempting to remove a drain, however, it was difficult to remove and the patient was experiencing considerable discomfort:

> **N_Yvonne:** *Okay Colin, you take a nice couple of big deep breaths for me, in and out. Okay, another big breath in. That's good, another big breath (Colin breathes deeply). Just keep taking nice big breaths, that's it. Is it sore when I'm pulling it?*
> **P_Colin:** *A wee bit.*
> **N_Yvonne:** *Wee bit. Being as gentle as I can here. It is coming, it's just quite… (Colin takes sharp intake of breath). Nup.*
> **P_Colin:** *Oh it's sore.*
> **N_Yvonne:** *I'm sorry Colin (Colin breathes heavily). I'll go and get the doctor to come and have a wee check that, okay? (Yvonne returns with the doctor). Are you alright there Colin?*
> **P_Colin:** *Aye*
> **N_Yvonne:** *You're doing really well (pause). Are you happy for me to give it another wee shot?*
> **P_Colin:** *Aye.*
> **N_Yvonne:** *Okay. Nice big deep breaths again…*
> 03_S_Obs_Patient&Nurse_P0632&N6252

At interview, Colin stated that Yvonne *'kept on apologising'*. Colin did not appear to find this repeated apologising irritating or uncomfortable. Rather, he seemed to take some comfort from it, at the same time stating that she was *'gentle'* and, *'she reassured me everything was fine'*. He also stated that he told Yvonne that it was not her fault, and that he knew the drain had to be removed. Colin did not require an apology from Yvonne, as he did not blame her for his discomfort.

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Some information shared during the interactions related to self-care and health education. For example, some patients administered their own Insulin:

> **N_Una:** *So are you doing your Insulin then?*
> **P_Tracy:** *Yeah, that's been done.*
>   19_S__Obs_Patient&Nurse_P2197&N2217

Other patients received health information related to smoking, wound healing, catheter care, and infection control. Table 20 illustrates instances of patients receiving health education. In the examples of health education about wound healing, smoking and catheter care, the patients appeared to understand the information the nurses were providing and how it related to them. However, in Case 11, it is less clear whether the patient understood why she was not to touch the pacemaker site. The nurse assumed that the patient would know that the advice related to infection control:

> **R_VC:** *Does Kirsty know why people should keep their hands off it [pacemaker site]?*
> **N_Carol:** *I probably assumed that she knew that. I didn't actually say because…I didn't use the words, 'in case of infection'.*
>   11_M_Int_Nurse_N4294

Table 20 also illustrates that although Jack, the patient in Case 10, appeared to understand the information that Cathy was providing, there was little discussion about infection control and about how to care for the catheter to prevent infection. The information that Cathy provided was more about how to undertake everyday activities, such as walking and showering, with a urinary catheter in situ. It seems that an opportunity was lost for exchanging information about various aspects of catheter care.

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Table 20: Patients receiving health education

Cases	Health topic	Data extract
Case 9	Wound healing	*Lesley: And what about your eating now? Is your eating better would you say?* *Iris: Och* *Lesley: It's your appetite. It's the healing of the wound that is, food, or it's the protein, protein…* *Iris: Proteins* *Lesley: …that builds you up.* *Iris: Something…I'm no' a morning eater, em (pause) I'd rather drink water* *Lesley: Ah rather than fresh and, up there [on the locker]* *Iris: Aye* *Lesley: But I mean but if you get regular rest and you get plenty of protein and stuff…* *Iris: Well that's what I'm saying…* *Lesley: …it'll all work together and that's all you can do.*
Case 10	Smoking	*Jack: I went down for a, down for a smoke…and I only had two puffs, and I went…I stopped and came back up here, and I was sitting here and went into a sweat and I was very, very light-headed* *Cathy: I think with you having a smoke it's not helped* *Jack: Aye, but I just, that's what I was saying, I just had two puffs* *Cathy: Two puffs and that was it* *Jack: Sweating as well* *(Jack's vital signs were checked and were found to be within normal limits)* *Cathy: Yeah, I think that's all that's been with you to be honest…it's just the fact that you've had a wee bit of a smoke* *Jack: Went down, two puffs and that was it, went 'oh no'* *Cathy: Yeah* *Jack: And I had to…* *Cathy: Yeah, so I would just hold off doing that [smoking] anymore*
Case 10	Catheter care	*Cathy: Right, that's you, you can get up and move about…you just need to carry that [catheter bag] with you* *Jack: I just need to carry that about?* *Cathy: Okay, just watch cos its under your foot there* *Jack: Aye, nae bother* *Cathy: Em, just put it through that way, alright.* *Jack Yep* *Cathy: And that way you can get a shower and you get a wash an' everything*
Case 11	Infection control	*Carol: It's important to keep hands off it [pacemaker site] – that's the thing you want to avoid. Try not to touch it at all with your hands* *Kirsty: I feel as if, eh, it's gone down a wee bit* *Carol: Yeah, definitely, definitely. I honestly think that's less swollen. So the thing you want to avoid is hand contact…from anybody, anybody's hand, anybody's fingers, doesn't matter who they are.*

5.5 Summary

My study offers new knowledge about the types of information evident between patients and nurses in ward settings. For information exchange to be taking place, the type of information expected is medical or nursing information from the nurse and personal information from the patient. However a key finding in my study is that information exchange did not appear to be taking place as very few interactions evidenced information of a medical or nursing nature. The lack of information exchange is discussed in Section 8.4.3.1. Other key findings from this chapter are: very few interactions related to patients' illnesses or the conditions that had resulted in their hospital admission (8.4.1); and, during interactions nurses and patients often referred to their social contexts (8.4.2.2).

This chapter is the building block for the subsequent findings chapters in my thesis. Important information was elicited from the data. Furthermore, new learning about types of information shared or provided in ward settings was shown. I will now expand on this knowledge about types of information by exploring the relevance of the information for patients and for nurses, in Chapter 6.

Chapter 6: Relevance of information

6.1   Introduction to chapter

In this chapter, I present my findings related to the relevance of information exchanged or provided between patients and nurses during routine nursing care. The findings I present here address the second research question: Do patients and nurses perceive they have exchanged all the information *relevant* for their needs?' (2.9). I answer this question by exploring relevant data coded under the inductive code of 'Relevance of Information'.

In Section 6.2 I present an overview of the categories and sub-categories relating to the inductive code of 'Relevance of information', highlighting where the data were sourced. Next, in Section 6.3, the data relating to these categories and sub-categories is described in detail. Then, in Section 6.4, a case study is presented, which provides evidence of the iterative analytical process (3.6), and greater depth of analysis. The key findings are summarised in Section 6.5.

6.2   Overview of categories and sub-categories related to 'Relevance of Information'

Information was important for patients and nurses for a variety of purposes. Five inductive categories were developed and coded under 'Relevance of information': 'Well-being'; 'Socialisation'; 'Assessment'; 'Patient involvement'; and 'Obligation'. These categories are summarised in Figure 10.

Figure 10: Categories related to 'Relevance of Information'
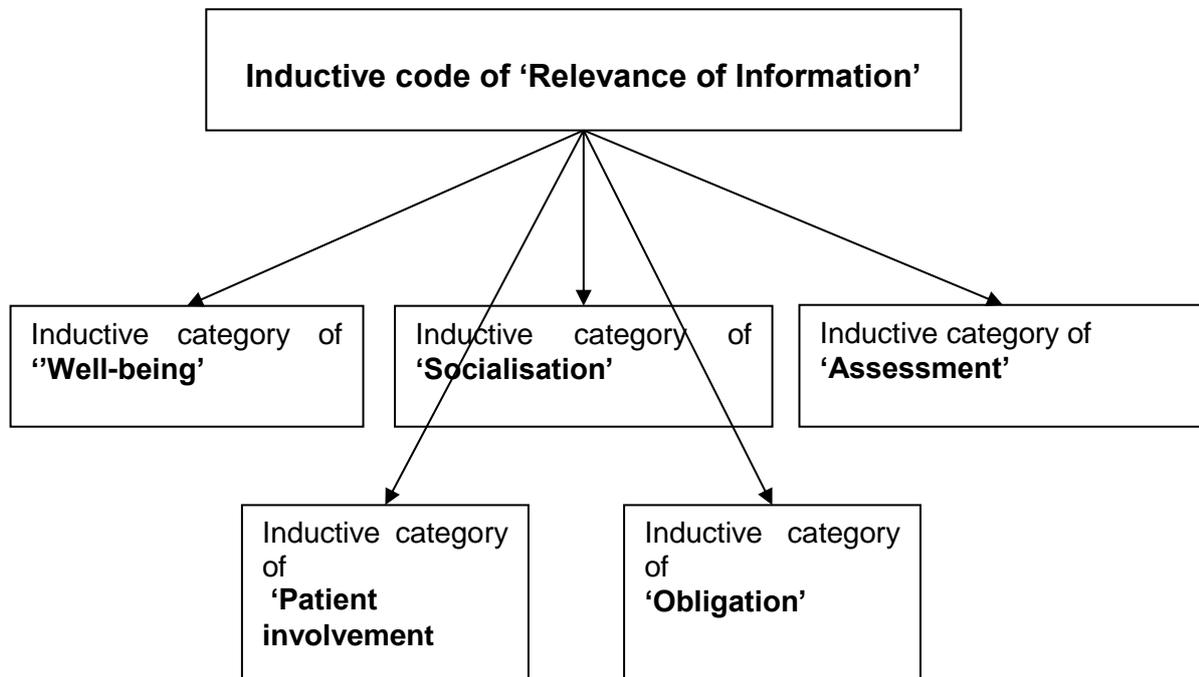
```
                    ┌──────────────────────────────────────────┐
                    │  Inductive code of 'Relevance of Information' │
                    └──────────────────────────────────────────┘
        ┌──────────────────┬──────────────────┬──────────────────┐
        ▼                  ▼                  │                  ▼
┌──────────────────┐ ┌──────────────────┐        ┌──────────────────┐
│ Inductive category│ │ Inductive category│        │Inductive category of│
│ of ''Well-being'  │ │ of 'Socialisation'│        │  'Assessment'     │
└──────────────────┘ └──────────────────┘        └──────────────────┘
              ┌────────────┴────────────┐
              ▼                         ▼
     ┌──────────────────┐      ┌──────────────────┐
     │Inductive category │      │Inductive category │
     │of                 │      │of                 │
     │ 'Patient          │      │'Obligation'       │
     │ involvement       │      │                   │
     └──────────────────┘      └──────────────────┘
```

Sub-categories emerged that reflected participants' perceptions of the relevance of the information shared or provided. Iterative analysis resulted in links emerging between the categories and sub-categories. For example, participants reported that a good patient/nurse relationship helped to keep patients' spirits up, which was relevant for patient wellbeing. However, these relationships could also be important for patients' socialisation and maintaining a sense of normality. The categories and sub-categories are summarised in Figure 11. The dotted arrows in Figure 11 illustrate cross-category and cross-subcategory links. Notably, the category of 'Obligation' did not appear to link with other categories, a possible explanation of which is provided in Section 6.5.

Figure 11: Categories and sub-categories related to 'Relevance of information'
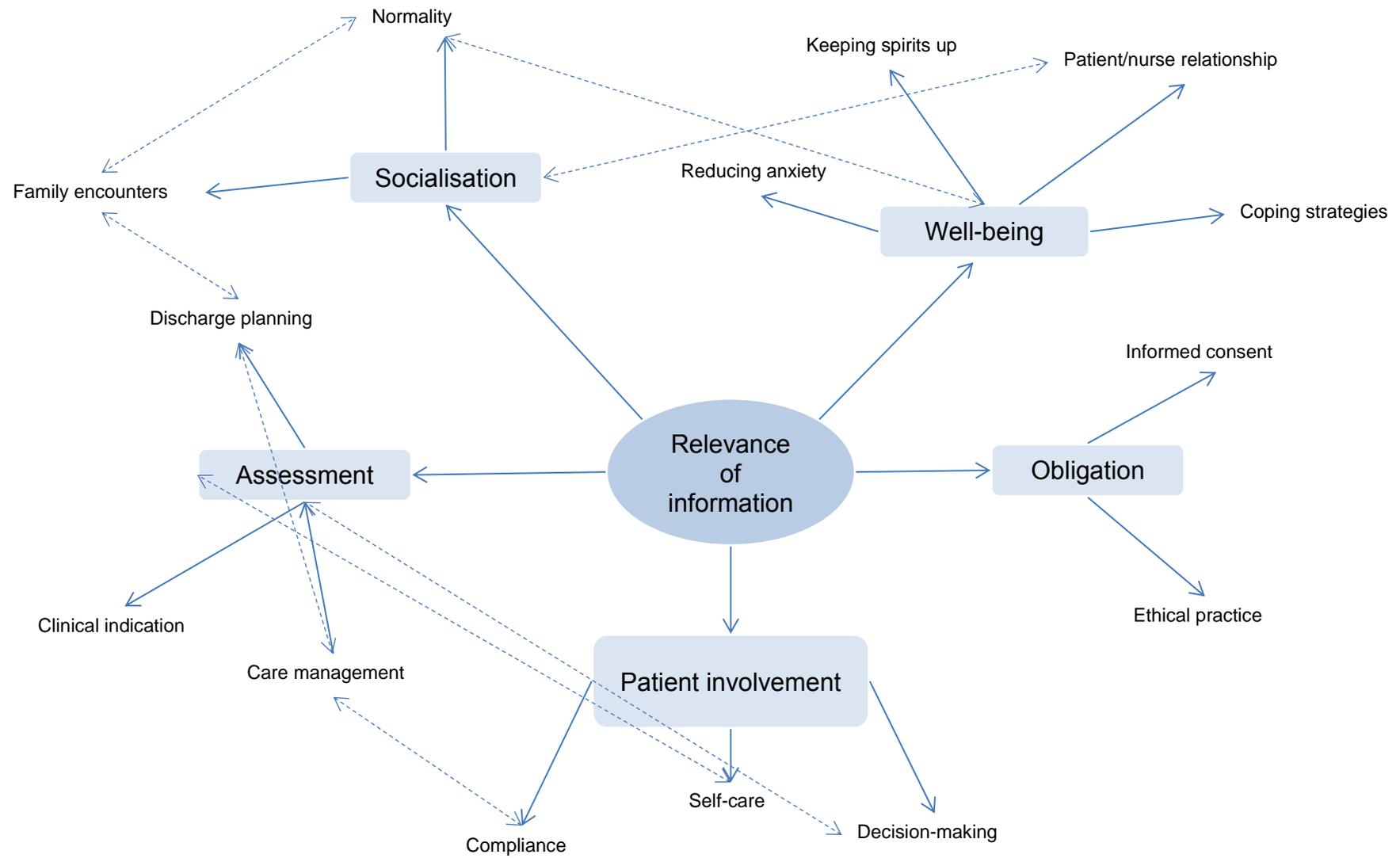
The data relating to 'Relevance of Information' derived from:

- Patient and nurse interview data on their perceptions of the relevance of the information they received.

- Patient and nurse interview data on their perceptions of the relevance of the information they shared.

6.3   Participants' perceptions of relevance of information

6.3.1 Wellbeing

Patients perceived information as relevant and important for their wellbeing by: reducing anxiety; coping, for example, with nursing interventions; and keeping patients' spirits up. One nurse reported that patients *'want to feel safe and feel happy under your care'* (Case 11). The data also suggest that patients like to know that nurses are concerned for their wellbeing:

> ***P_Neil:*** *Social interactions are quite important because it lets you understand that the nurses are…well to face value, that they're taking an interest in not only your wellbeing in hospital, but your wellbeing as a person.*
> 14_M_Int_Patient_P0146

Other data suggest that patients may only absorb information if it is meaningful for their wellbeing:

> ***R_VC:*** *What do you do with the information that nurses give you?*
> ***P_Tracy:*** *If it's important, if it's for my general wellbeing, if it's for my health, then, you know, I will let it register. And if it's not really that important, it's just kinda throw away information, I'll just forget about it.*
> 19_S_Int_Patient_2197

I present and discuss the findings related to wellbeing, namely, reducing anxiety, coping strategies and keeping patients' spirits up, next.

Patients needed reassurance, and stated that clinical and social information *'eased their minds'* (Cases 1, 2, 4, 11, and 14), for example:

> **P_Donald:** *Information just gives you more peace of mind, you know. A gap in the rationale to me is, you know, is a cause for concern, you know. I'd like to know. I mean, I'm an engineer by profession so...things have got to hang together logically, you know.*
>
> 04_S_Int_Patient_P0644

The data suggests that Donald likes logic and systems, which may explain why he wanted reassurance on an on-going basis, and not solely related to any one issue. The nurse in Case 4, Kate, identified at interview that Donald looked for reassurance:

> **N_Kate:** *(When asked about why Donald wanted information about his medication) It could've just been a reassurance thing, its like, 'Look, I didn't take those [tablets] last night, was that okay?' Think he's probably looking for me to tell him, 'Yeah, that's fine; you don't have to worry about takin them now'.*
>
> 04_S_Int_Nurse_N6114

What the data does not show is whether or not Kate identified Donald's need for on-going reassurance based on his need for rational and logical explanations of his treatment plan.

Other patients stated that having information reduced anxiety about nursing procedures (Cases 3, 9, and 10), or the potential for deterioration in their condition (Cases 7, 10, 12, and 15). The following data excerpt illustrates the importance of information for reducing anxiety about a nursing procedure:

> **R_VC:** *You were asking Oliver [the nurse] questions this morning about when the VAC dressing was getting changed... How important was it for you to know that information?*
> **P_Iris:** *Well, it's important because I like to know how the wound is coming on, and I'm kind of scared, you know. Aye it*

was important, but he [nurse] knows, he told me [the dressing will get changed] every 72 hours, so I'm quite happy with that.
R_VC: Why do you need that information?
P_Iris: Just for peace of mind I think, to know well it's not going to rot in there that sponge.

<div align="right">09_S_Int_Patient_P0691</div>

Oliver, the nurse, reassured Iris. However, their perceptions of why Iris needed reassurance differed. Iris seemed concerned that the sponge used in the VAC dressing would rot inside her abdominal wound. However, Oliver perceived that she was anxious about the discomfort often associated with re-dressing wounds:

> ***N_Oliver:*** *I think it's [information about frequency of dressing change] quite important, especially again someone like Iris with such a large wound, because there can be quite a lot of discomfort with the wound dressing being changed, and it's good to know that it's not going to be happening every day, and if it requires a bit of mentally psyching themselves up to get it done.*

<div align="right">09_S_Int_Nurse_N6151</div>

Oliver identified Iris's anxiety; however they did not discuss the cause of her anxiety.

The next excerpt is of a patient, Larry, receiving information about his potentially deteriorating condition. In this case, Larry and the nurse, Pauline, discussed his anxieties and the information Pauline gave was specific, and alleviated his anxiety:

> ***P_Larry:*** *I was a wee bit upset when that doctor came back in an' told me I had, eh, what do you call it, asbestos in my lung.*
> ***N_Pauline:*** *Aye, but all he's saying is that there's changes in your lungs that looks as if you've been exposed to that, but it's not causing you any illness or anything like that just now.*
> ***P_Larry:*** *What, it's only scarring?*
> ***N_Pauline:*** *It's like scarring, just where your lungs have maybe been damaged wi' the asbestos…but you don't have asbestosis.*

<div align="right">12_M_Obs_Patient&Nurse_P0125&N0425</div>

From the excerpt just cited, it was Larry who initiated the conversation with Pauline, whose response resulted in a positive outcome for him. Larry reported that the information Pauline gave him alleviated his fears:

> ***P_Larry:*** *That doctor just came in and said, 'Oh by the way, you've got asbestos in your lungs', and…he just turned and walked away, he didnae walk away, he ran away, you know. I spent a lot of time in the shipyards. And a lot of people there that I knew died of asbestosis. And that's what I thought that was. But the nurse came back and she told me, 'No it's a different thing. That's just scarring on your lungs. It's nothing to do wi' asbestosis. So that settled my wee old brain.*
>
> 12_M_Int_Patient_P0125

However, if Larry had not expressed his fears about his condition, and had Pauline not responded to Larry's fears, the opportunity to *'settle my wee old brain'* may not have arisen. Consequently, Larry may have remained anxious about a condition that he did not have.

One patient, Rose, reported she received insufficient information and commented that not having information resulted in her feeling anxious:

> ***P_Rose:*** *I don't know why this [hospital admission] has happened or why I've been here; do you know what I mean? So I think not knowing, well I'll probably be quite anxious.*
>
> 17_M_Int_Patient_P2179

The excerpt just cited also illustrates a link between sharing information and alleviating anxiety. However, this case highlights how not sharing information can increase, or at least not alleviate, patient anxiety.

6.3.1.2 *Coping strategies*

Patients coped with their conditions and the limitations that their conditions imposed (Cases 3, 9, 11, and 16). Patients perceived that diversion or distraction from their

condition or their reason for hospital admission helped them to cope whilst they were in hospital. For example:

> **R_VC:** There was some light-heartedness about bets on what your INR level might be today.
> **P_Kirsty:** Yes, I was hoping it was going to be 1.6, and she [nurse] says she would go one better at 1.7. And unfortunately, it was 1... (laughs)
> **R_VC:** (Laughs) So this idea of humour and rapport…
> **P_Kirsty:** It's got to break the ice doesn't it? You've got to have a laugh.
> **R_:** Why? Why do you have to have a laugh?
> **P_Kirsty:** Because it makes everything a wee bit more easier to cope with.
>
> 11_M_Int_Patient_P4114

Rather than distracting patients from their condition, nurses reported that general light-hearted conversations might strengthen the patient/nurse relationship. This strengthened relationship sometimes led to patients focussing on, and sharing more information about, themselves or their condition, rather than diverting them from their condition:

> **N_Queenie:** I think it [social interaction] builds confidence, from a patient's point of view, in the nurse. If they feel like you know them, I mean you've maybe met their wife, met their son, spoken to their wife, I think they feel confident in you that you know what you're doing, you know what you're talking about, you know them, you know their case.
>
> 03_S_Int_Nurse_N6172

and:

> **R_VC:** I noticed that the conversation [between you and the patient] was quite light-hearted and he [patient] was laughing.
> **N_Olga:** I think they need to kinda get that, just to trust you and feel quite comfortable.
>
> 13_M_Int_Nurse_N0416

Patients who perceived information was relevant for helping them cope with their particular condition were either surgical patients who had been in hospital for a

considerable period of time (Cases 3 and 9), or were medical patients with long-term conditions (Cases 11 and 16). These patients were also amongst those who received information from nurses about their progress, particularly positive progress (5.4.2 and 6.3.1.3).

6.3.1.3   *Keeping spirits up*

Patients reported that some clinical information helped to keep their spirits up. For example, for one patient, changing his medication was relevant because the side effects of the medication he was currently taking were *'getting me down'* (Case 12). Another patient stated that knowing when his urinary catheter was to be removed, helped to lift his spirits. He did not like having the catheter in situ:

> *R_VC: How important was it for you to know that your catheter is coming out tomorrow?*
> *P_Jack: Oh its, aye, very important.*
> *R_VC: Why is that, do you think?*
> *P_Jack: Because it's a nuisance. It's there and I sometimes forget and you go to move and I'm still attached to something on a very tender part of the body, so it's important to get it [catheter] out.*
> *R_VC: It is important to get it [catheter] out, but why would it be something that you needed to know today?*
> *P_Jack: Just to buck you up a wee bit, your spirit's low, well aye, just to put your spirits up a wee bit, knowing that I'm no' gonna be stuck with this for God knows how long. I think, aye, just to give you that wee gee up, you know.*
> <div align="right">10_S_Int_Patient_6104</div>

Nurses perceived that giving information to patients about their progress, particularly to patients who had been in hospital for a long time, had positive benefits for patients and nurses. Nurses liked giving *'good news'* to patients:

> *N_Yvonne: I think it's just nice to kinda say to them [patients], 'Look how well you're doing' and it makes them [patients] feel better I think, makes us feel a wee bit better as well I think when we see them coming on.*
> <div align="right">03_S_Int_Nurse_N6252</div>

Patients and nurses also identified that patients can experience *'long days'*, and that conversations can help to *'keep them going'* (Cases 14 and 15). The following excerpt illustrates this point:

> **P_Neil:** *General conversation relaxes you. When you're in hospital for…an amount of time that I've been in and out, it can be long. I mean I've been in for six to eight weeks at a time, sometimes longer. And I think it [general conversation] makes you feel, it'll pass the time.*
>
> 14_S_Int_Patient_P2509

The types of information most relevant for keeping patients' spirits up were humour, banter and rapport. These types of information were described in Chapter 5. Here, in Chapter 6 they are developed to illustrate their importance to participants. Nurses stated that they needed to *'keep things quite jovial'* (Case 12) or to *'have a wee joke'* (Case 13) because they considered that the ward environment was depressing for patients. One nurse commented that patients enjoyed being in the ward where she worked:

> **N_Andrea:** *We've got a kinda rapport with her [patient], you know, she's like that wi' us and we're like that, and it's all in good fun to try to cheer her up.*
> **R_VC:** *Do you think that rapport is important?*
> **N_Andrea:** *Oh I do, definitely. The patients love it here. They all ask to come back and, I mean, we get the radio on and we sing and we dance and we, you know, we do, and they all say, 'Everybody's that cheery here' and they do, they love it, they always ask to come back.*
>
> 15_M_Int_Nurse_N0514

Patients reported that rapport and banter between patients and nurses was common and helped to lift their spirits:

> **P_Colin:** *[Social interaction] is important for me…this is always a happy wee room. Used to have a sort of song and dance in here, couple of boys that's left you see, had a wee song and that, och you know, and Queenie [nurse] enjoys it, she joined in. I think it should be that way. Ye have tae be cured of yer,*

what ails you, but also to be happy at the same time. Aye, so I think its [social interaction] a great thing…

<div align="right">03_S_Int_Patient_P0632</div>

Information and interactions that reduce patient anxiety, develop patients' coping mechanisms, and keep patients' spirits up appear to be important and relevant for patients and nurses to maintain patients' wellbeing. Information is also relevant for involving patients in their treatment and care (6.3.2).

6.3.2 Patient involvement

There was some evidence of information being important in relation to patient involvement in self-care (6.3.2.1) and decision-making (6.3.2.2). However, this involvement tended to be more evident with patients who had spent a longer time in hospital. Nurses did not generally perceive patient involvement in care and in decision-making as the norm. The most basic form of patient involvement was merely an awareness of their condition and their treatment:

> **N_Cathy:** *I think he [patient] likes to be involved in his care. I think he [patient] likes to know what is happening.*

<div align="right">10_S_Int_Nurse_N0634</div>

and:

> **R_VC:** *Why do you like to get information from the staff [nurses]?*
> **P_Alice:** *Just so you know what you're…to know what's happenin.*

<div align="right">01_S_Int_Patient_P0614</div>

Some nurses perceived that information was relevant for ensuring patient 'compliance' with treatment (6.3.2.3).

6.3.2.1   Self-care

Patients reported that information was relevant for self-care in relation to stoma care (Case 3), passing urine (Cases 10 and 15), self-administering injections (Case 18), and maintaining control over medications and wound care (Cases 11 and 18). The following data excerpts exemplify patients' perceptions of the relevance of information for self-care. In the first example, Olive received information from the nurse about the importance of drinking plenty of water to encourage production of urine. In the second example, the patient, Steve, liked to be more in control of his care generally. He asked questions about how to administer his own injections, reset the IV fluid pump and care for his wounds (7.6.1):

> *R_VC: She [nurse] was explaining to you about your catheter, and the reason the catheter had been put in…Was that important information for you?*
> *P_Olive: Yes, it was my treatment cos I wasn't peeing enough, so this was to help me to pee more. It didnae dawn on me that I wisnae really peeing enough. I wiz still drinking but I still wisnae peeing. But the nurse says I don't drink a lot. I'm determined I'll be drinking and drinking from now on, know what I mean?*
> <div align="right">15_M_Int_Patient_P0154</div>

and:

> *P_Steve: The information that I like to know is what's happening to me, but I think there parts maybe to give you some kind of control over it…I'm quite an independent person, always have been and it's kinda hard leaving…you lose a lot of your pride…they [nurses] know best what they're doing but I just like to understand what they're doing. Like I got an injection to keep the blood flowing so I don't get clots in ma legs, and I can, I just administer that to maself now.*
> <div align="right">18_S_Int_Patient_P5181</div>

Some nurses perceived that information might be relevant for patients for self-care and independence. For example, one of the nurses in Case 9, Oliver, provided information about the VAC Freedom pump for wound care as he perceived that being smaller in size this particular pump might encourage the patient's independence:

> **R_VC:** *I heard you talking to her [patient] about the VAC Freedom, and you'd said it was smaller…and it would fit into her handbag. Why do you think that information would be important for her?*
> **N_Oliver:** *I think, especially with Iris, she's very very keen to become as independent as she can and as quickly as she can. She's ready to retire now as well, so she wants a kinda independent and very active retirement rather than adopting the sick role.*
>
> 09_S_Int_Nurse_N6151

Another example of nurses giving information to patients for self-care purposes was evident in Case 3 where the nurse, Yvonne, stated that patients are told to look out for *'pancaking'* (where the stool dries out and sits flat like a pancake over the stoma) when carrying out stoma care:

> **N_Yvonne:** *It's one of the things that we do tell our patients to kinda keep an eye on with their stoma bags because it can make them leak, and that is the term that they use, pancaking.*
>
> 03_S_Int_Nurse_N6252

The patient in Case 3, Colin, was learning how to care for his stoma. When asked at interview whether he helped the nurses with stoma care he stated, *'Yes, I dae that quite often'*.

The data illustrate that some patients prefer to be more involved in their care. Furthermore, we know from the literature that patients like to be involved in their treatment and care, even if they do not want to make decisions (Entwistle et al. 2006, Beaver et al. 2005). However, it may take a culture shift in nursing to make patient involvement the norm (7.4.4), particularly in ward settings.

6.3.2.2 Decision-making

Patients reported that information about their healthcare was important. However, they did not necessarily wish to be involved in decision-making. The following

excerpts are typical of patients' responses to being asked about the relevance of information for decision-making. The question they were asked was, *'Some patients like to have information because they like to be involved in making decisions about their treatment and care. What do you think about that?'*

> ***P_Colin:*** *Aye, no' so much decisions, say to understand why the treatment's coming to you…who are we to make the decision?*
>
> <div align="right">03_S_Int_Patient_P0632</div>

> ***P_Olive:*** *No, no, no, no…*
>
> <div align="right">15_M_Int_Patient_P0154</div>

and:

> ***P_Tracy:*** *Well, as far as I'm concerned, if I'm in hospital then the nurses and the doctors know what they're doing, so I just leave it down to them, you know. They're the professionals. I'm not.*
>
> <div align="right">19_S_Int_Patient_P2197</div>

The finding that patients want information without wanting to be involved in decision-making is consistent with what Entwistle et al. (2006) report. However, Colin in Case 3 poses an interesting question about who should make treatment decisions. The theme of who should make decisions dates back to Parsons (2012, original version 1951) who explored the sick role and the passive nature of patient involvement in healthcare. Edwards and Elwyn (2006) explore a similar theme and report a degree of uncertainty amongst patients about who made the decision in their GP consultation.

Nurses also perceived that some patients want information but are generally happy to let nurses make decisions:

> **N_Duncan:** *Some people [patients] who you would think would've been more informed do not want to make the decisions themselves.*
>
> 02_S_Int_Nurse_N0640

For patients who do want to make decisions, there may be a tendency for nurses to question their capacity for decision-making:

> **N_Lesley:** *Yes, well some patients do [want to be involved]. So the patients that want to be involved, that's fine, but you've got to make the judgements on do they understand, what are their expectations, are there any communication difficulties, are they disorientated?*
>
> 09_S_Int_Nurse_N6121

Nurses perceived that patient involvement in decision-making about treatment and care was not the norm. When asked about the relevance of information for patient decision-making, nurses stated that doctors make decisions (Cases 2 and 3), that the hospital environment is not conducive to patient decision-making (Case 2), or that patients can make smaller decisions, for example about whether or not to take laxatives, or what to choose from the menu (Cases 3, 10 and 16). None of the nurses in my study mentioned the concept of shared decision-making.

6.3.2.3   Compliance

Compliance with treatment was sometimes nurses' expected level of involvement that patients should have with their treatment and care. Examples included: nurses providing information about antibiotics so that patients complete the prescribed course (Case 4); providing health promotion information to encourage patients to stop smoking (Case 10); and involving other colleagues to *'put the fear of God'* into patients about treatments so that patients accept what healthcare staff perceive is *'best'* for them (Case 18). Putting 'the fear of God' into patients suggests coercion, and meant reiterating the risks of not receiving treatment, for example:

> **N_Wendy:** *Maybe they [patients] need the fear of God into them sometimes...it's like the fear factor, like 'this is what could happen…if you don't get this treatment you could end up really ill'. That's why you've got to tell them [patients] the risks if you [patients] don't comply with this treatment….*
>
> 18_S_Int_Nurse_N5231

The notion of pushing patient compliance is paternalistic and based on the ethical principle of beneficence. Beneficence underpinned nursing care for decades however current policy and reports are advocating a move away from this approach and supporting patients being more involved in their healthcare (Coulter and Collins 2011) (and 7.4.4).

Patient involvement in care and in decision-making was not the norm in this study. However, some patients *did* perceive some information as being relevant for self-care. Older patients received information that was relevant for self-care, whilst a younger patient actively asked how to manage his own treatment and care. This finding, although tentative due to the small sample size, concurs with a review of the literature which reports that of the studies investigating the association between age and decision-making preferences, most of them conclude that younger patients prefer to be more actively involved in decision-making (Say et al. 2006). The Health Belief Model (Rosenstock et al. 1988), although focussed on health promotion and information provision, may usefully describe levels of patient involvement in decision-making about treatment and care. Perhaps some patients need to believe that there is a threat to their health before they become involved in information exchange and decision-making. Men and patients with a lower socio-economic status may not perceive their health to be at risk sometimes due to low health literacy or lack of concern (Molina-Barcelo et al. 2011, Werner 2005). Patients with similar

demographics are known to be less involved in treatment decision-making. In my study, nurses' expected level of patient involvement was compliance rather than involvement with treatment and care, using information to encourage patients to accept the care that is *'best'* for them rather than involving them in information exchange. Nurses have reported that health promotion is effective but becomes more difficult with older patients (Kelley and Abraham 2007).

6.3.3 Assessment

Nurses generally used information to make assessments about patients. For example, patients reported conditions such as nausea and pain, which helped nurses to assess patients clinically and initiate care management plans (Cases 10 and 18). Conversations of a social nature helped nurses assess patients' home support for discharge planning (Cases 13, 14, 15, and 17). Patients also perceived that nurses used information for assessment purposes, either to improve their care (Case 4) or to establish a smooth transition from hospital to home (Case 9). I discuss these examples, and others, in the following section on care management and decision-making (6.3.3.1).

6.3.3.1   *Care management and decision-making*

Nurses used information to assess patients' immediate care needs and to plan future care. Nurses documented self-reported information from patients whether or not there was any change to the management of their care. Nurses' decision-making was generally collaborative with nurses passing on information to colleagues in both verbal and written form. Information from patients about their symptoms (or lack of symptoms) such as headaches, pain, nausea, and side effects of medication, was

considered by nurses as important and relevant for making judgements and decisions about patient care:

> **N_Kate:** It's when you go into the room just to say, 'Hi, how are yous all?' and that's when they'll maybe tell you something and you think, 'Oh I didn't know that'. That's maybe when you find out that they've got diarrhoea, or they've maybe started bleeding somewhere, or they've been feeling sick and nobody's mentioned that earlier on. So you would always use that to make you think as well, 'Do I need to increase my observations of this patient? Should I be starting monitoring my MEWS [Modified Early Warning Score] score a wee bit more...?
>
> 04_S_Int_Nurse_N6114

Sometimes nurses responded to patient information by making care decisions on their own:

> **R_VC:** The information that he [patient] gave you about how he was feeling on the Atenolol…what do you do with that?
> **N_Pauline:** Em, we can act on it ourselves so obviously if you're gonna give someone their medication and they say, 'Listen, that's gonna make me feel sick', so what I would normally do is not give it to them at the time.
>
> 12_M_Int_Nurse_N0425

Pauline made the decision to withhold Larry's Atenolol. However, the use of Atenolol has implications in terms of administration and withdrawal. Patients can suffer palpitations when stopping Atenolol abruptly (Joint Formulary Committee 2013). Therefore, when making decisions on their own, nurses should utilise best practice statements and up to date evidence in order to minimise harm to patients (NMC 2008).

Nurses generally informed other members of staff about patient-reported information, for example they would speak to nurses at the handover to the next shift, or to physicians:

> **N_Andrea:** I would pass it on at report [to other nursing colleagues] maybe that she's been tired today.
>
> 15_M_Int_Nurse_N0514

and:

> **N_Ann:** I took her catheter out yesterday…I wanted to make sure that she was still passing urine okay. She had been very hypotensive and pyrexial as well...very sore, had been vomiting…so it was quite important to make sure it had all settled.
> **R_VC:** And why would you need that information, why is it important?
> **N_Ann:** To plan our care, and to pass it onto medical staff and plan where we are going from now.
>
> 07_S_Int_Nurse_N0610

To support verbal reports to other healthcare colleagues, nurses documented patient information in writing:

> **N_Andrea:** When I'm writing up I'll probably write something like, 'tired and lethargic' and I would document about her bowels because she is on Morphine.
>
> 15_M_Int_Nurse_N0514

and:

> **N_Wendy:** I document it all, record it all, update him and reiterate again what he's told me.
>
> 18_S_Int_Nurse_N5231

Data also suggest that care decisions may be based on the information that patients provide, and on how that information fit with the patient's clinical picture:

> **R_VC:** The gentleman told you that he was quite tired and that he had a sore head. How important was that information for you?
> **N_Kate:** Well we knew that he'd had a bit of a vasovagal episode this morning. His blood pressure had dropped and the headache was probably a knock-on effect from that, but we'd seen throughout that day that he was improving and his obs [vital signs] had been checked again and they were better, so…I thought we'll see how his headache goes with the Paracetamol.
>
> 04_S_Int_Nurse_N6114

Basing some decisions on the patient's clinical picture also meant that nurses took decisions not to intervene in patient care. For example, the patient in Case 1, Alice, indicated that she was feeling very warm. After weighing this information against Alice's clinical picture, the nurse, Helen, decided it was unnecessary to check her temperature:

> **N_Helen:** Well she's been spiking temps, but actually her temp's been sitting now at 37, 37, 37 and she's not spiked wi' me…she is on regular Paracetamol and Brufen, and they've already taken cultures. She's on IV antibiotics. She's got an infection, but my first urge wouldn't have been to run get a thermometer and put it in her ear…her temps not like 39, she wasn't clinically unwell…if it was a new complaint, if she asked for a blanket but the sweat was pouring off her, I would've checked her temp.
>
> <div align="right">01_S_Int_Nurse_N0684</div>

Helen stated that she would have checked Alice's temperature had her presenting symptom been new. Similarly, other nurses stated that patient information was not always significant, and that nurses use '*your own kind of savvy*' to assess the significance of what patients share (Case 4). The data extract just cited is perhaps one example of assessing the significance of patient reported information. Nurses are expected to be autonomous practitioners and accountable for their actions (NMC 2008). However, if nurses' intuition is honed by experience (Benner and Tanner 1987) there is the potential for nurses' *'savvy'* to let them down, particularly if their experience is limited.

Conversely, some nurses reported that patient information might highlight a clinical indication of the patient's health.

> **R_VC:** [He said] he has an itch on his back, how relevant is that [information] to you?
> **N_Frank:** Well that can be a clinical thing, for example, that man has dermatological problems, so it can be a clinical thing

> *where you know it may be something that you want to take note of because it can affect the care that we are giving him.*
>
> 05_S_Int_Nurse_N6323

and:

> **R_VC:** *Why was it important for her to let you know if she sees fresh blood in the drain?*
> **N_Oliver:** *I think it's extremely important because that's going to show a marked change in what's happening with the wound…I said to her, 'If you spot fresh blood please let me know straight away, or another member of staff know straight away', because that does show marked change.*
>
> 09_S_Int_Nurse_N6151

These statements are important because they show that information provided by patients can have a direct impact on their care. They illustrate that nurses use judgments based on their clinical knowledge of the patient to manage patient care.

Data evidenced that patients use information from nurses to gain insight into their health status and care management. For example, the patient in Case 17, Rose, stated that information about her medication provided some insight into her condition:

> **R_VC:** *Why is it important for you to know what your medication is for?*
> **P_Rose:** *I think it's really important, because I want to know what…it gives me an indication of what the medical profession are looking for, or what they're trying to stop.*
>
> 17_M_Int_Patient_P2179

The data extract just cited is important, as Rose was the only patient in this study who reported at interview that she had not received enough information. Perhaps if the doctors, who had prescribed her medication, and nurses, when administering the medication and monitoring its effects, shared more information with her, she would not be looking for clues about her health status and care management from her prescribed medication.

Nurses used patients' self-reported information to assess patients. Assessing patients was important for care management and decision-making. Planning patient care and making treatment decisions was generally a multi-professional process between nurses and their healthcare colleagues, although a hierarchy appeared to exist. Sometimes nurses did not perceive patients' self-reported information as significant; therefore, they made no changes to the patients care. At other times nurses reported that information from patients might highlight a significant change in patients' health, resulting in making care decisions and changing treatment. Information for assessing patients was also relevant for discharging patients to their home. Although patients and nurses talked about patients' goals at interview, it is interesting to note that apart from incidental comments relating to patients' goals, no formalised goal setting appeared to have taken place. Not all information was used for patient assessment. Some information was relevant for socialisation (6.3.4).

6.3.4 Socialisation

Nurses and patients perceived banter, humour, rapport, and information about social contexts as relevant for helping patients feel a sense of normality (6.3.4.1). Patients reported of a sense of community (Case 3), and *'connection'* resulting in better care (Case 4). Their perceptions are important and have significance for nursing practice and the way nurses share information. Patients also reported that they conveyed clinical information to their families at visiting times (6.3.4.2).

6.3.4.1   Normality

Banter, humour and rapport played an important part in patients' wellbeing (6.3.1). However, they also played a significant role in helping patients maintain a sense of

normality. Arguably, a sense of normality could fit with a sense of wellbeing. However, I have distinguished between them for the following reasons. Patients' and nurses' discussion of wellbeing often related to emotional concerns such as reducing anxiety, finding coping mechanisms and keeping spirits up. However, normality seemed to relate more to patients' locus of control; how they could make their environment as normal as possible so that they could maintain a measure of control over it. Normality often related to being perceived as a person and not a number or a 'case'.

For patients, part of being normal was having a *'good laugh'* with the nursing staff, and knowing *'what's going on'*. Patients perceived that socially based conversations, or *'banter'* with staff helped to keep that sense of normality in their day. It also indicated that staff took an interest in them as an individual and not just as a number. The following data extracts illustrate these points:

> **P_Grace:** *Say they [nurses] were making your bed, and they'll say, 'Do you live locally?' and, 'Have you got a family?' things like that, just chatting, you know.*
> **R_VC:** *And how important is that, chatting?*
> **P_Grace:** *Well I feel it's quite nice, you feel as if people are taking an interest, that you're not just a number, that you're just lying there and you're seeing them when you need to see them.*
> 07_S_Int_Patient_P0675

and:

> **P_Iris:** *I just feel you need to keep some sense of normality, although you are lying here, you forget about other people's got a life and their days off and you know. I like to keep up with things and the goss [gossip] and, like every other person I like to know what's going on.*
> 09_S_Int_Patient_P0691

General conversation was also important for not feeling disadvantaged:

> **R_VC:** *And the conversation today, with what was on the telly…you said that was important, am I right?*

> *P_Rose: I think that's very important because you're in a total alien environment…in your nightclothes, totally right away you feel at a disadvantage. So for them [nurses] to make it as normal as normal as can be, do you know, I think it's advantageous, so I think it's very important that that happens.*
>
> 17_M_Int_Patient_P2179

Rose reported that wearing nightclothes in an unfamiliar environment put her at a disadvantage from the nurses who were familiar with the ward layout and routine. General conversation was important for Rose for maintaining a balance of power between her and the nurses caring for her.

One patient described social interactions as making a connection between himself and the nursing staff:

> *P_Donald: You just get to connect. You can latch onto something. I think they [nurses] connect with you if you connect with them. It's just normal social interaction.*
>
> 04_S_Int_Patient_P0644

Establishing this connection with nurses appeared to be important to Donald, as he perceived that it might result in him receiving better care:

> *P_Donald: I think it, anyway it just helps to connect with people, and you kinda perceive that you'll get better care if they like you, you know, instead of an old grumph, you know. But then again, maybe they think, 'He's a nosy old bugger', you know, so it's hard to assess that way, you know.*
>
> 04_S_Int_Patient_P0644

Donald appeared to want to be a 'good patient'. However, we do not know whether *'better care'* related to his relationship with staff, or whether it meant better physical care. Donald's perception is emphasised here as it potentially has important significance for the delivery of nursing care and for information exchange. Patients have a right to information and professional care (Department of Health 2012, NMC 2008) regardless of whether or not they are 'good' patients. Care should not be dependent on the acceptability of patients to nurses.

Nurses also perceived general information, shared by nurses and patients, as necessary for a sense of normality and for avoiding institutionalisation. Nurses defined normality for patients as:

- Patients in single rooms not feeling isolated (Cases 5 and 15)

- Patients knowing what is happening in the *'outside world'* (Case 5)

- Patients getting to know the nurse (Case 9 and 14)

- Patients being able to talk about things other than their condition (Case 1)

The following examples from the data illustrate some of these points:

> **N_Frank:** *It [social conversation] helps kind of make them feel, you know, normal and keep their hand on what's going on in the outside world because I think they [patients] do feel quite insular, in the hospital, especially in his case when he's in a single room.*
>
> 05_S_Int_Nurse_N6323

and:

> **R_VC:** *Why do you share information of a social nature with patients?*
> **N_Oliver:** *I think a lot of times, people [patients] just see us as the nurse, and I suppose it's to humanise ourselves as well. To let patients realise that we're not just the role that they see us in on a day to day basis at work, and that we do have the rigours of home life to face as well.*
>
> 09_S_Int_Nurse_N6151

From the data presented, it appears that information of a general nature shared between patients and nurses helps patients maintain a sense of normality. Comments from patients such as *'part of the people'* (Case 3), *'connect'* (Case 4) and *'not just a number'* (case 7), illustrate their desire for normality and socialisation. Some patients linked socialisation to *'better care'*, perceiving that the level of care would depend on nurses' likes and dislikes of patients. This finding concurs with

others who report that patients fear they may be labelled as 'difficult' long-term if they assert themselves in the physician/patient consultation (Frosch 2012).

6.3.4.2   Family encounters

Some patients liked to have information to pass on to their families at visiting time. The following examples from the data are typical patient responses to being asked what they do with information, particularly clinical information:

> **R_VC:** *What do you do with that [clinical] information?*
> **P_Eddie:** *I keep it tae myself then I tell my wife when she comes in.*
> 05_S_Int_Patient_P0653

and:

> **R_VC:** *What will you do with the information you receive?*
> **P_Kirsty:** *I'll pass it on to my family (laughs) when I see them.*
> 11_M_Int_Patient_P4114

Only one nurse reported that sometimes patients want information to pass on to their families:

> **N_Kate:** *A lot of people [patients] they want information more for their families and not for them[selves] because their families come up and go, 'What about this nah, nah, nah', and then, och, you can see the poor patient just sitting there shaking their head goin, 'Oh my God there's that woman getting on at me again'.*
> 04_S_Int_Nurse_N6114

Kate, the nurse in Case 4, perceived that passing on information, with consent, to their families was important for patients for alleviating any anxiety that the family might be experiencing, and perhaps to gain their support. In one isolated case, 'family encounters' included relationships with the hospital staff. Colin had been in hospital for 62 days and he reported that a sense of community was important to him. Colin had become accustomed to the ward environment and socialisation

seemed to equate with institutionalisation. He spoke about being a part of the hospital family, and that the ward was his second home:

> **R_VC:** *At the moment, talking about the wedding is the big important [issue for you]?*
> **P_Colin:** *Well, this is part of my life here. Whether I like it or not, it's like a second home. I go to sleep at night, get up in the morning and wash, change, whatever. I'm here all day, so it is the biggest part of my life…you should be able to communicate to the extent that you feel part of the people.*
>
> 03_S_Int_Patient_P0632

I interviewed Colin again a few days after the wedding. At the second interview, he reiterated this sense of family and community. During the wedding, he felt extremely tired and was keen to get back to the ward:

> **P_Colin:** *I feel as if this is my home. Friday [the day of the wedding] I couldnae wait to get back up here [to the ward]. I couldn't.*
>
> 03_S_Int_Patient_P0632

Patients, or residents, in nursing homes and hospices are encouraged to feel at home in their new situation, but it is perhaps more unusual for patients in acute wards to experience the hospital ward as *'home'*. Nurses perhaps need to be mindful of the length of time patients are in hospital and pay attention to what, and how, they share information.

Patients and nurses perceived that socialisation, specifically a sense of normality, was important for patients. Socially related interactions were relevant for making a connection with nurses. However, patients also perceived that socially related interactions were important for developing good relationships with nurses, perhaps leading to *'better care'*. Another aspect of socialisation was family encounters. Patients perceived clinical information as relevant for passing on to their families at

visiting time. Nurses reported that passing on information to family members helped to reduce family's anxieties. Uncommonly for my study, socialisation for one patient related to his perception of the hospital ward as *'home'*.

6.3.5 Obligation

Some data suggested that giving information to patients is a hallmark of ethical practice and is prerequisite to obtaining informed consent. Literature and policy documents and reports advocate informed consent and ethical practice in terms of patient involvement (GMC. 2008, Lemonidou et al. 2003). However, participants in this study reported them in terms of obligation and patients' rights. In this section, I present the findings from the data related to ethical practice and informed consent.

6.3.5.1   Ethical practice and informed consent

Patients may perceive it is their *'right'* to receive information (Case 17). Similarly, Frank, the nurse in Case 5, perceived keeping patients up to date with their condition as being an ethical obligation. The following data excerpts illustrate this point:

> **P_Rose:** *I think I've got a right to know what medication I'm taking…I think a patient, or maself, has got every right to make decisions and be informed, but I trust, maybe too implicitly, the medical profession to be able to make the primary decisions on my care, because, again, I don't have the medical knowledge.*
> 17_M_Int_Patient_P2179

and:

> **N_Frank:** *Ultimately, you are ethically kind of obliged to keep them [patients] up to date. You know it's his health that I am talking about, and if he is asking me questions, you know, you are kind of obliged to give him honest answers.*
> 05_S_Int_Nurse_N6323

Rose reported receiving information as a *'right',* regardless of what the relevance of the information was for her. However, Rose was also the only patient who stated

throughout the interview that she had not received enough information. Perhaps the lack of information received was a trigger that led her to discuss her 'right' for information.

One nurse, Carol, spoke about the relevance of giving patients the information required for informed consent:

> ***Carol:*** *As long as she's [patient] got all the facts, we'll leave it at that. Obviously you need her permission for no matter which expert you want to come and have a look at her (laughs). But I would have coaxed her…*
>
> 11_M_Int_Nurse_N4294

Carol stated that she would require the patient's consent when referring her to another healthcare professional. However, she talked of *'coaxing'* the patient, rather than engaging in decision-making with the patient.

Frank indicated after the interview session that he perceived ethics to be a fascinating topic that generated interesting discussions amongst his colleagues. However, ethical practice is more than a conversation point. It is an integral and recognised aspect of professionally regulated nursing practice. Sadly, this is not always the case as evidenced in the recent Francis report (Francis 2013).

6.4   Links between categories and sub-categories

Links between some of the categories and sub-categories became evident as data analysis progressed. I searched for patterns, similarities and differences utilizing an iterative process of going back and forth over the data. A thorough examination of these links provides a deeper explanation of participants' perceptions of the

relevance of the information shared or provided. To help explore the complexities of the data, I use one case study to illustrate the links between the categories and sub-categories (6.3). Case 3 illustrates these links and is summarised in Table 21.

Table 21: Characteristics of Case 3

Case	Patient gender	Patient age	Previous hospital admissions	Current admission	Nurse gender	Nurse grade	No. yrs. nursing experience	No. yrs. in current work	Ward type
3	Male	64	Gall bladder removal	Formation of stoma	Female	Grade 5	11	10	Surgical colorectal
"	"	"	"	"	Female	Grade 5	4	4	Surgical colorectal

6.4.1 Study of Case 3

Figure 11, in Section 6.2, illustrates that the linking of categories and sub-categories is a complex process. The majority of cases evidenced cross-category links, but I chose Case 3 to demonstrate these links because its complexity showcases the robustness of the analytical process. Case 3 comprised one patient, two nurses, and five interactions between them. Furthermore, Colin, the patient, had complex nursing care needs. The study of Case 3 begins with a description of the patient's, and the nurses' characteristics such as: age; gender; reason for patient admission; nurses' grading; nurses' number of years qualified; and the length of time nurses had spent in their current place of work. Next, I present an overview of the interactions.

Case 3 involved one male patient (Colin) and two female nurses (Queenie and Yvonne). Colin was sixty-four years of age. He was admitted to the surgical colorectal ward where Queenie and Yvonne worked, and had been in the ward for 62 days. He had surgery for a formation of a stoma but complications developed postoperatively. He also had Crohn's disease. Queenie and Yvonne were both Band 5 nurses. Queenie had eleven years nursing experience, with the last ten of these being in the colorectal ward. Yvonne had four years nursing experience, all of which were in the colorectal ward. Colin and Queenie had four interactions that lasted a total of nineteen minutes and fifty-eight seconds. Their interactions related to:

- Follow-up care – referral to dietician
- Patient's social context – a member of Colin's family was getting married the following week
- Nursing interventions – monitoring Colin's blood sugar and flushing medication down Colin's PEG tube

- Emotional concerns – Colin's acceptance of not being able to work again; and Colin's feeling of loneliness

Colin and Yvonne had one interaction that lasted twenty-four minutes and thirty-three seconds. The content of their interaction related to:

- Nursing interventions – changing Colin's stoma bag; and removal of a wound drain

- Colin's condition and his progress – he looked tired in the wedding photographs but Yvonne reinforced how much progress he had made

- Social context – the family wedding

- Patient's preferences – Colin preferred to see the physiotherapist later in the day

Figure 12 illustrates the centrality of Colin to the case, and the complex linking of the categories 'Wellbeing', 'Patient involvement', 'Assessment' and 'Socialisation' from Colin's perspective.

Figure 12: Cross-category links related to relevance of information in Case
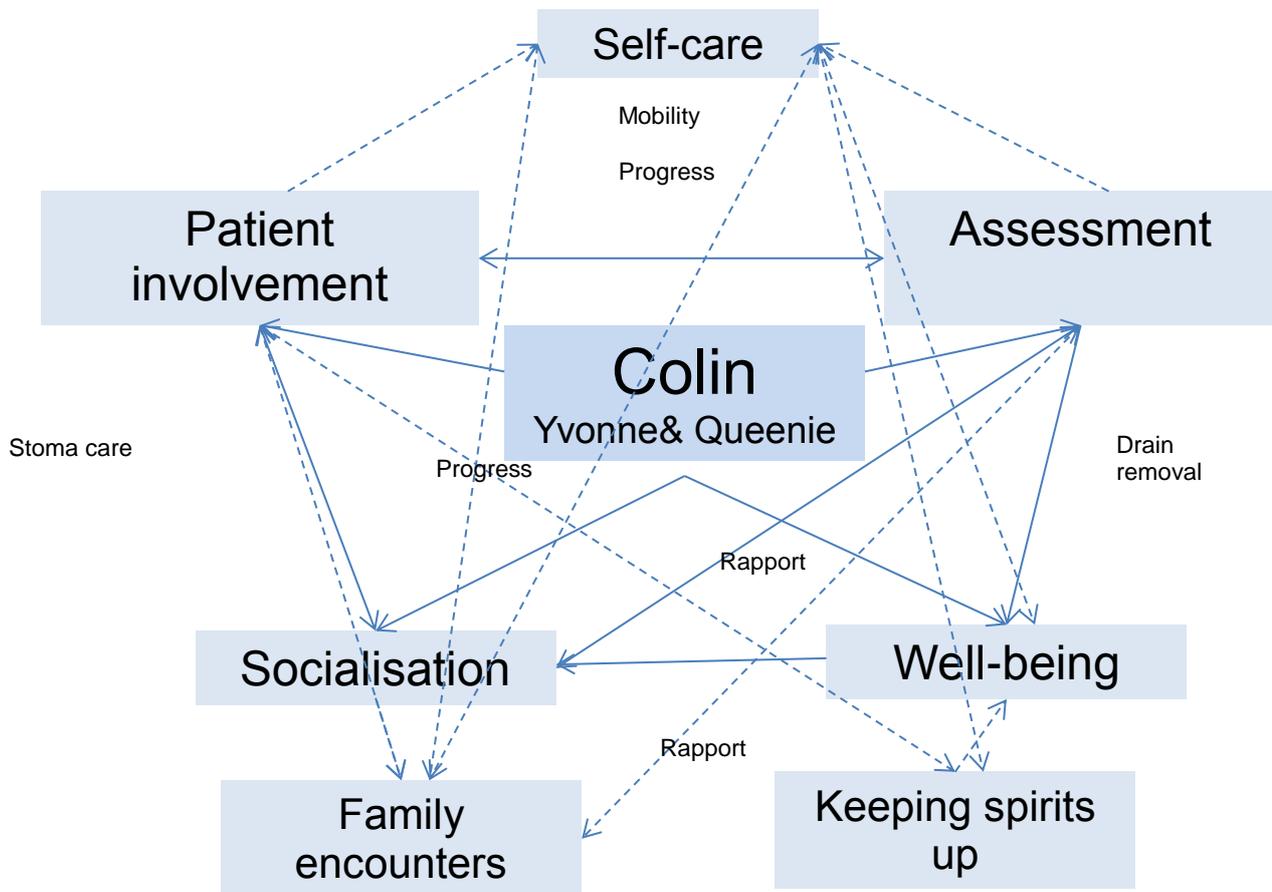
Colin received health related information from Queenie and Yvonne when they undertook a range of nursing/treatment interventions, such as: blood glucose monitoring; referral to dietician; walking with the assistance of the physiotherapist; drain removal; and stoma care. His perceptions of the information he received cut across the categories of 'Wellbeing', 'Patient involvement', 'Assessment' and 'Socialisation'.

Colin perceived health related, or clinical, information as being important to him for keeping his spirits up, involvement in his own care, for assessment of his progress,

and for sharing with his family when they came to visit. The following data excerpt illustrates Colin's perception of information as being relevant for his wellbeing:

> **P_Colin:** *The procedure itself (drain removal) was, well I'm no' saying nae bother, it was sore, but I was well reassured you know…she was good Yvonne, she reassured me.*
>
> 03_S_Int_Patient_P0632

and:

> **P_Colin:** *The staff are quite good cos they'll say to you, "I see you walking doon there [with the physiotherapist], you've done well". You know, thanks very much aye. You dae appreciate it.*
>
> 03_S_Int_Patient_P0632

However, the information he received was not only relevant for his wellbeing. From what Colin reported, I also found a link between well-being and assessment, as the information about the removal of his drains was also relevant to Colin for monitoring his progress:

> **P_Colin:** *So I'm getting there slowly, but a few more [wound drains] to go, and they'll all be out, hopefully.*
>
> 03_S_Int_Patient_P0632

and:

> **P_Colin:** *There's nothing leaking [from one of the wound drains], which is good, you know. It means it's another step in the right direction.*
>
> 03_S_Int_Patient_P0632

Further links cut across the categories of 'Patient involvement' and 'Socialisation'. For example, information about stoma care was relevant for an assessment of Colin's progress, but was also relevant for self-care:

> **P_Colin:** *I had to [put my hand on]; it was the pad next to the bag, next to the stoma. Just to keep the…so that the actual adhesive would stick to the skin, which it did…I dae that quite often…I don't mind helping.*
>
> 03_S_Int_Patient_P0632

and for family encounters:

> **P_Colin:** *I've got to explain it to the wife what happens as well*
>
> 03_S_Int_Patient_P0632

The data presented here is from a study of Case 3; however, there are similar links in other cases. Links between patients' progress and family encounters were evident in cases where patients had been in hospital for over one week. Information about progress was not as relevant to patients who had been in hospital for less than one week, with the only exception being in Case 10 where the patient was very anxious.

Links were also evident between 'Wellbeing', 'Assessment' and 'Socialisation' in information of a more relaxed and social nature. Colin seemed to enjoy having general conversations and building rapport with nurses. He perceived that these interactions were important to keeping his spirits up, and for improving his health:

> **P_Colin:** *She's [Queenie] always happy jolly type person, you know…Used to have a sort of song and dance in here, och you know, and Queenie enjoys it, she joined in. I think it should be that way. In another day they go yes sir no sir, but roon here ye hav tae, to be cured of yer, what ails you, but also to be happy at the same time. Aye, so I think it's a great thing. If you're feeling good just in yourself, it makes your health feel that bit better.*
>
> 03_S_Int_Patient_P0632

However, Colin also perceived these non-clinical interactions as being relevant to him for assessment of his progress and improvement in his health:

> **R_VC:** *What kinds of things do you like to talk to the nurses about?*
> **P_Colin:** *General things. News, what's on the telly? Was talking to Queenie this morning about her wee dog – won a prize. I always say when I'm better I'll get a dog…This might gie me an incentive…It's all part of the process I think – get me better.*
>
> 03_S_Int_Patient_P0632

Colin perceived that general conversation helped him to be *'part of the people'*, which links to 'Socialisation'. However, socialisation to Colin sometimes meant connection with staff within the ward, rather than a return to home life:

> **P_Colin:** *This is part of my life here [hospital ward]. Whether I like it or not, it's like a second home…You should be able to communicate to the extent that you feel part of the people.*
> 03_S_Int_Patient_P0632

Socialisation for Colin also related to his son's wedding that he was keen to attend. At this wedding, he would meet with family and friends from England and from the Scottish borders. It was important to him to *'see the wedding through'* and his conversations with the nurses often reflected his eagerness to attend. Talking about the wedding also provided an impetus to improving his health, in particular his mobility, by getting up to walk with assistance from the physiotherapist.

Queenie and Yvonne commented on the relevance of various kinds of information. They stated that information related to Colin's health might be important for him for, for example, reducing anxiety:

> **N_Queenie:** *It's just to re-emphasise to him so that he doesn't need to be sitting there panicking or worrying for the next couple o' hours, 'did that nurse remember and say to the dietician?'*
> 03_S_Int_Nurse_N6172

Queenie also reported that clinical information, and information about his progress, helps to alleviate any anxiety that Colin might have about whether or not he will be able to attend the family wedding:

> **N_Queenie:** *I think it's important for him cos I think everythin' is about this weddin'. So, I think it's very much to relieve anxiety about not goin to the weddin'.*
> 03_S_Int_Nurse_N6172

However, Yvonne reported that clinical and health related information would be important for Colin's general and mental wellbeing. The information might remind him of his progress and help keep his spirits up:

> **N_Yvonne:** *I was just kinda trying to highlight the progress with him and make him aware, I mean he knows he's coming on but I think sometimes he just needs a wee bit reminding how well he's doing.*
> **R_VC:** *How important is all of that information for him?*
> **N_Yvonne:** *I think it helps trying to keep his spirits up and it's important for him because it's a way of us letting him know that he's not just a patient and that we are paying close attention to him, his mental wellbeing as well as his health.*
> 03_S_Int_Nurse_N6252

Queenie and Yvonne perceived that non-clinical information was important for Colin's wellbeing and for keeping his spirits up. However, they also perceived non-clinical information as being important for improving his health and social outcomes, and as a coping mechanism to distract him from a nursing intervention:

> **N_Queenie:** *I think it's very important… he is a lot brighter today…we don't know if he's gonnae be fit to be able to go out for this wedding…I can see a difference in him. He's wanting to get up with the physios today, whereas a couple of weeks ago he was like that, gonna try and get the physios to go away, whereas today he's wanting up cos he wants to get the dance floor, you know. So, its gonnae help him in the long run to get up and about a bit quicker and a bit better.*
> 03_S_Int_Nurse_N6172

and:
> **R_VC:** *What would you say the role of this social interaction is between nurses and patients?*
> **N_ Yvonne:** *Just kinda trying to take his mind off the fact of what I was doing really, to be honest. Em talking about things that interested him.*
> 03_S_Int_Nurse_N6252

Despite the difference in the number of years' nursing experience between Queenie and Yvonne, the importance that they attached to both clinical and non-clinical

information was generally the same. However, from the data presented, their perceptions sometimes differed from those of Colin's. For example, Colin did not comment on the role of information as a coping mechanism for taking his mind off nursing interventions.

Case 3 exemplifies patients' and nurses' perceptions of the relevance of the information shared or provided during routine nursing care. Participants, within cases and across the cases, reported that information was relevant for various reasons. It also appeared that individuals' needs for relevant information were met, as examples: patients who were anxious perceived that they received information that helped reduce their anxiety; nurses planning patients' discharge home received information about patients' social contexts to facilitate the discharge planning process. Exploration of the relevance of information involved a complex analytical process in which three main hypotheses were identified. These hypotheses are summarised next.

6.5   Summary

The key findings lead to the generation of two hypotheses:

1. That patients' and nurses' perceptions of the relevance of information differed

2. That non-clinical information appears to play a more significant role in information exchange between patients and nurses in ward settings than it does in other contexts.

These hypotheses are explained next, and then discussed in Chapter 8 (8.4).

Information relating to coping strategies and progress was evident in cases where patients had been in hospital for a long time. These patients may perceive the ward as 'home', therefore tailoring information towards these patients may better prepare them for discharge. For example, perhaps disengagement techniques as part of discharge planning could form part of the information exchange process.

Nurses generally used all types of information for assessment purposes. Patients wanted information but not necessarily for decision-making, which concurs with the literature on shared decision-making and information exchange in one to one contexts (Entwistle et al. 2006). Nurses did not mention shared decision-making, which may suggest difficulties with translating the concepts of shared decision-making and information exchange into practice. The difficulty with translating concepts of shared decision-making and information exchange into practice is not a new finding. Coulter and Collins (2011) identify this problem and provide strategies for implementing shared decision-making in practice. However, their report focuses on shared decision-making between 'individual patients and individual physicians', and therefore their strategies for implementing shared decision-making into nursing practice may not apply in a ward context.

Non-clinical information was significant, particularly for patients. Non-clinical information appears to play an important role in the wellbeing of patients in acute ward settings, and in nurses' assessments of patients. The literature on shared decision-making and information exchange discusses the relevance of non-clinical types of information (Bugge et al. 2006, Charles et al. 1999, Charles et al. 1997). However, research and discussion on information exchange often miss the

complexity linked to the importance of non-clinical information, for example in terms of who shares non-clinical information and its relevance for patients. Undertaking my study in ward contexts with patients and nurses may have highlighted this complexity. I discuss this complexity further in Chapter 8 and suggest that in terms of non-clinical information, information exchange as we know it may not be appropriate in ward settings.

6.6   Conclusion

The findings I have presented in this chapter add to what is known about information exchange. I have described perceptions of the relevance of information from the perspectives of patients and nurses in acute general ward settings. However, it is not yet fully apparent whether participants have received *enough* relevant information. Therefore, I present the findings related to the sufficiency of information in Chapter 7, and explore whether or not participants perceived they had given and received enough information.

Chapter 7: Sufficiency

7.1 Introduction to chapter

In this chapter, I present my findings relating to the third research question: 'Do patients and nurses perceive they have exchanged all the information *sufficient* for their needs?' (2.9). Relevant data coded under the *a priori* code of 'Amount of Information' is explored.

In Sections 7.2 and 7.3 I   present an overview of the categories and sub-categories relating to the *a priori* code of 'Amount of information' and the inductive code of 'Factors affecting information exchange' respectively, highlighting where the data were sourced. Next, in Section 7.4, the data relating to these categories and sub-categories is described in detail, drawing attention to the potential for insufficient information being exchanged. Then in Section 7.5, five case studies illustrate links across the categories and sub-categories providing evidence of a robust iterative analytical process. Using these case studies I demonstrate links between information not exchanged and barriers to information exchange. In Section 7.6, particular attention is drawn to participants' perceptions of sufficiency of information, and a summary of the chapter is provided in Section 7.7.

7.2 Overview of categories and sub-categories related to 'Amount of information'

Coded under 'Amount of information' was an *a priori* category of 'Information not exchanged'. Two inductive sub-categories emerged from the data that reflected

instances and/or reasons why information was not exchanged. These sub-categories are 'Information withheld' and 'Lost opportunities'. Another *a priori* category coded under 'Amount of information' was 'Information exchanged'. Two inductive sub-categories emerged that reflected the participants' perceptions of the amount of information: 'Enough information' and 'Information overload'. Figure 13 summarises the categorising of data under the code of 'Amount of information'.

Figure 13: Categorising of data under 'Amount of information'
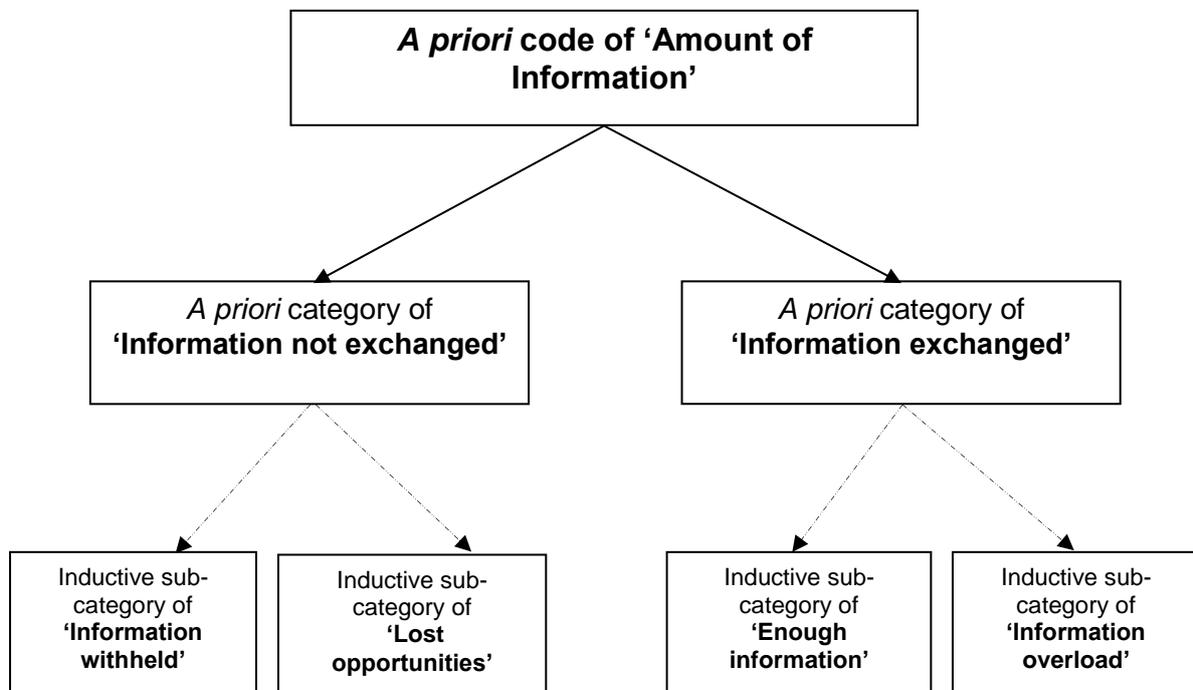
Data relating to 'Information withheld' and 'Lost opportunities' were sourced from:

- Observation, interview and field note data on whether patients or nurses, or both, withheld information

- Observation, interview and field note data identifying and questioning why information was withheld

- Observation and field note data on the potential for opportunities for information exchange being lost

- Observation, interview and field note data questioning and identifying why opportunities to share information were lost

- Interview data on whether lost opportunities for sharing information were problematic, and if so, to whom and why

Data relating to 'Enough information' and 'Information overload' were sourced from:

- Patient and nurse interview data on their perceptions on whether or not they had given and/or received 'enough' information.

- One example, from observation and interview data, where the patient did not receive the information she requested.

7.3 Overview of categories and sub-categories related to 'Factors affecting information exchange'

One inductive category coded under 'Factors affecting information exchange' was 'Barriers to information exchange'. Two inductive sub-categories emerged that reflected participants' perceptions of the level of patient involvement in treatment and care, and actual barriers to sharing information seen during the observation sessions: 'Patient passivity' and 'Power and control'. Another inductive category coded under 'Factors affecting information exchange' was 'Facilitators of information exchange'. The inductive sub-categories of 'Lay terms' and 'Relationships' developed from the importance that participants' gave to delivering information at the 'right level', and to developing relationships between patients and nurses. Figure 14 summarises the categorising of data in 'Factors affecting information exchange'.
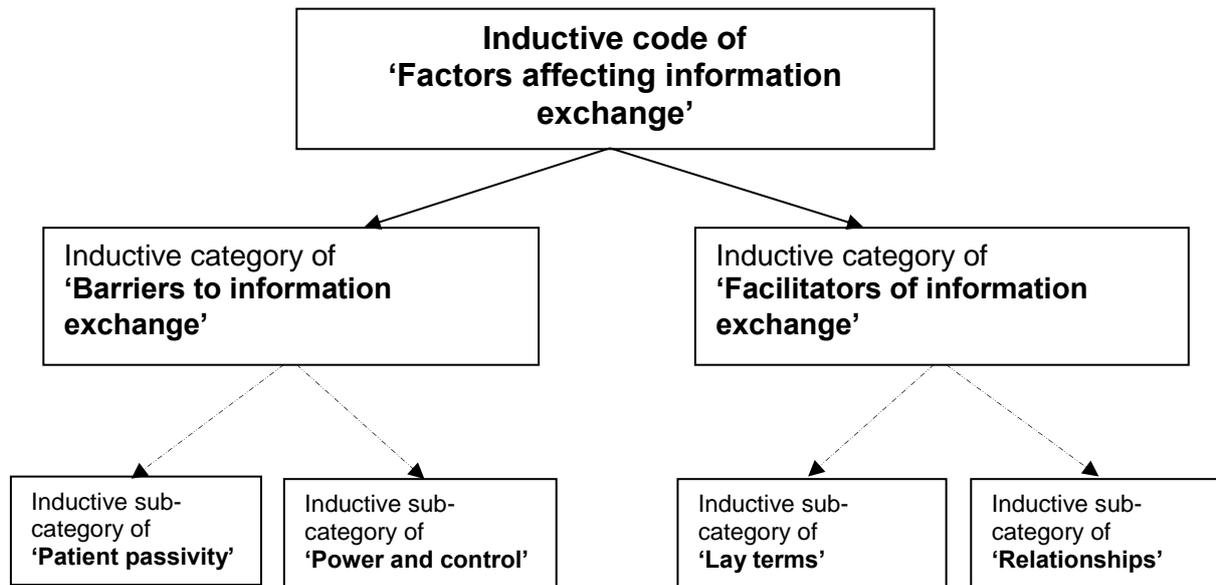
Data relating to 'Patient Passivity' were sourced from:

- Observation and field note data highlighting instances of patient passivity

- Interview data where patient participants commented on their preferences for treatment, information and decision-making

- Interview data where nurse participants commented on environmental factors affecting patients' choices, and on their responsibility to assess patients preferred level of involvement in decision-making

Data relating to 'Power & Control' were sourced from:

- Observation and field notes evidencing instances of power and control predominantly pertaining to nurses' use of language

- Patient interview data where patient participants commented on:

  o Not being able to make their own decisions

  o Nurses avoiding answering their questions

- o Being persuaded by nurses to comply with treatment (although patients did not necessarily perceive persuasion as problematic)
- Nurse interview data, which were largely nurse centred and evidenced:
  - o Limiting choices for patients as though it was the norm
 - o Nurses' assumptions about patients' information wants and needs

Data relating to 'Lay terms' and 'Relationships' were sourced from:

- Interview data related to nurses being the communicators for the doctors after the ward round
- Interview data related to nurses sharing information, not specific to the ward round, at the 'right level', in words that patients can understand
- Observation and field note data evidencing relationships between patients and nurses
- Interview data reflecting the importance that patients and nurses place on relationships and on how this affects the way that information is delivered.

7.4   The potential for insufficient information exchange

This section begins with a model that illustrates links between 'Information not exchanged' and 'Barriers to information exchange', which may lead to insufficient information being exchanged (Figure 15). The sub-categories developed – 'Information withheld', 'Lost opportunities', 'Power and control', and 'Patient passivity' – seemed inextricably linked. Exploring these links is important as they lead to patients and nurses potentially not receiving enough information. Following presentation of the model, I present and discuss the findings related to 'Information withheld', 'Lost opportunities', 'Patient Passivity' and 'Power and Control'.

Figure 15: Model of links between 'Information not exchanged' and 'Barriers to information exchange' that point to potential insufficient information exchange
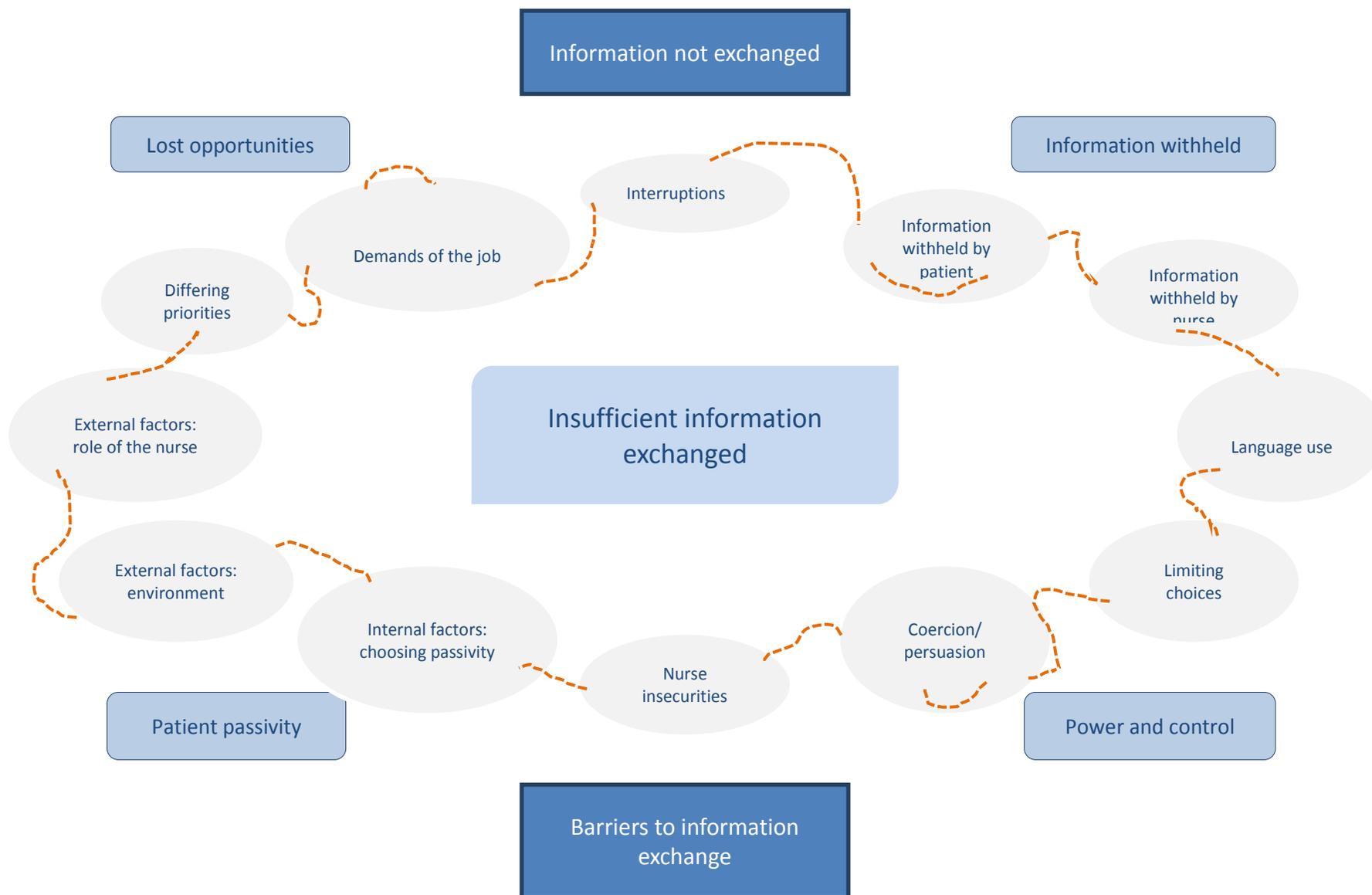
7.4.1 Information withheld

The notion of withholding information emerged from the data set. In my study, patients withheld information about emotional concerns (Case 8), and future intentions (Case 10).

In Case 8, Hannah, the nurse, informed Harriet, the patient, that she would be moved to another ward. Harriet stated that she did not mind being moved as she had been in that ward on a previous admission:

> **N_Hannah:** *Did you want to ask anything about the ward round?*
> **P_Harriet:** *No, I don't want to know anything.*
> **N_Hannah:** *Well, it was good. He thinks you've made some improvement…so much so that you actually don't need to be in this ward. As you know, this is coronary care…*
> **P_Harriet:** *I know I know.*
> **N_Hannah:** *It's a more kind of a tense environment. So I'll maybe try and move you to another ward, which might be Ward 4. So I'll phone the bed manager…*
> **P_Harriet:** *Good cos I've been in that one before.*
> **N_Hannah:** *Have you? There might not be a bed but if there is, obviously you're a candidate for moving. How do you feel about that? How do you feel about having to move?*
> **P_Harriet:** *Oh it doesn't matter. I'm better off…well I'll miss you.*
> > 08_M_Obs_Patient&Nurse_P0484&N4344

However, when asked at interview how she felt about moving to another ward, Harriet stated that she felt *'very depressed'*. Furthermore, she stated that she felt depressed because *'you don't know where you're going'*, despite having told Hannah that *'I've been in that one [ward] before'*. Harriet's reason for withholding information about her feelings or emotional concerns from Hannah is not known, however, she reported how she had established good relationships with the staff in the cardiology ward, and that she would miss them.

In Case 10, Jack, the patient, had left the ward to smoke a cigarette shortly after returning to the ward after surgery. He felt sweaty and light-headed afterwards. Kate, the nurse, suggested that his feeling unwell was probably due to smoking so soon after an anaesthetic. She advised him against smoking and against leaving the ward to smoke, to which Jack agreed (however, she did not endeavour to manage his addiction by the use of, for example, nicotine patches):

> *N_Cathy: Aye, but I, I think really it is first time up and, having a wee bit of a smoke, it does tend to do that to you… (P_Jack: Aye, mhm)…so I would advise you not to go back down.*
> *P_Jack: Nup, right.*
> *N_Cathy: Okay?*
> *P_Jack: Sure, yep.*
> *N_Cathy: Em, and just now, just lie there and relax and what I'll do is I'll come back and check on you again, em…*
> *P_Jack: That'll be nice.*
> *N_Cathy: …say in about half an hour.*
> *P_Jack: That'll be nice.*
> 10_M_Obs_Patient&Nurse_P6104&N0634

Jack appeared almost compliant when Cathy advised against leaving the ward for a cigarette. However, at interview he stated that he had no intention of stopping smoking, that he had heard health promotion advice before, and that as well as being addicted, he enjoyed smoking.

> *P_Jack: I've been smoking since I was a wee boy, I've been smoking an awful long time, probably about fifty years or so I've been smoking, I'm not been flippant when I say I've heard it all before, I know I shouldnae be doing it, I know it's bad for me, but I'm addicted, I mean, and not just the addiction, I enjoy a cigarette, you know, its part and parcel, I enjoy a cigarette.*
> 10_S_Int_Patient_P6104

Jack 'complied' with Cathy's advice for the rest of the day in order to avoid feeling unwell after smoking. However, he seems likely to continue smoking, even while still an inpatient, once he feels the anaesthetic is out of his system.

Information was withheld by nurses regarding: care management; the patient's condition; side effects of medication; bad news; and potential pain or discomfort resulting from invasive nursing procedures (7.5). The explanations that nurses gave for withholding information, varied. Some focussed on the effect that sharing more information might have on patients. Others were more focussed on what sharing the information meant for the nurse. One overarching justification for not sharing information related to nurses trying to 'protect' patients, or even protect themselves, as exemplified by the following example:

> **N_Donald:** *You can worry patients unnecessarily if you actually give them incorrect information or slightly erroneous information.*
> 02_S_Int_ Nurse_N0640

The same notion of protecting patients is expressed in the following examples about side effects of medication and potential pain/discomfort during invasive nursing procedures, respectively:

> **N_Kate:** *Better not to alarm him [patient] to something that might not even happen.*
> 4_S_Int_Nurse_N6114

and:

> **N_Cathy:** *If I say, 'Oh yeah, you might feel this, and this is why', it could probably scare him [patient] a wee bit, so I wanted to hold back from that.*
> 10_S_Int_Nurse_N0634

Similarly, regarding discussing bad news with patients, one nurse remarked:

> **N_Frank:** *Giving people bad news can be counter-productive and can kind of hamper any progress that they could make.*
> 5_S_Int_Nurse_N6323

Nurses expressed a notion of protecting patients generally; however, questions remain about how well nurses know patients individually in order to decide to withhold information from them.

Further explanations that nurses gave for withholding information from patients were as follows:

- The nurse's job involves knowing when to give and when to withhold information (Case 2)

- The nurse would look foolish if the wrong information was given (Case 2)

- The nurse decided that the patient had 'enough' information (Case 11)

- Patients may imagine that they have the side effects of medication if they knew what the side effects were (Cases 4 and 12)

- It was acceptable to withhold information about minor nursing interventions (Case 4)

- Nurses feel uncomfortable discussing bad news (Cases 5 and 18)

- It is the doctor's responsibility to share certain information (Case 18).

7.4.2 Lost opportunities

Lost opportunities for information exchange were evidenced by interruptions, the demands of the nurse's job, and patients and nurses having different priorities.

7.4.2.1   *Interruptions*

Interruptions during patient/nurse interactions were observed across all cases. Interruptions were made by other patients, other members of nursing staff, doctors, and the nurse's pager. Interruptions were also made by nurses within the interactions.

For example, nurses interrupted patients resulting in assumptions being made about what patients wanted to say. Interruptions often resulted in:

- The interaction being terminated (Cases 5, 7, 11 and 15)

- The nurse making assumptions about what the patient wanted to say (Case 8)

- The nurse changing the subject (Case 9)

The following two excerpts illustrate potentially problematic interruptions:

> *P_Olive: What is my blood sugar?*
> *N_Andrea: 5.7 it is this morning.*
> *P_Olive: That's all right isn't it?*
> *N_Andrea: It's fine. It's good for you.*
> *INTERRUPTION FROM ANOTHER MEMBER OF STAFF*
> *END OF INTERACTION – NURSE LEAVES WITH OTHER MEMBER OF STAFF*
> > *15_M_Obs_Patient&Nurse_P0154&N0514*

and:
> *P_Harriet: What about the…?*
> *N_Hannah: Your Aspirin?*
> *P_Harriet: No, the other one I get*
> > *8_M_Obs_Patient&Nurse_P0484&N4344*

Not all interruptions appeared problematic. For example, in some instances, where nurses and patients engaged in light conversation during a nursing procedure, other patients joined in, potentially adding to the lightness of the environment:

> *P_Colin: They're good rolls [bread rolls].*
> *N_Queenie: Aye, they're good rolls. They're crispy.*
> *INTERRUPTION FROM ANOTHER PATIENT ABOUT ROLLS*
> *N_Queenie: Aye, they're soft up here on the ward, aye.*
> *INTERRUPTION FROM ANOTHER PATIENT ABOUT FOOTBALL*
> *P_Colin: Burley's to remain the Scottish manager*
> *N_Queenie: Oh aye, they kept him, good.*
> *P_Colin: Burley's stayin*
> *N_Queenie: Stayin the Scottish manager*
> *INTERRUPTION FROM ALL THE OTHER PATIENTS IN THE WARD AND THE CONVERSATION REMAINED ABOUT FOOTBALL*
> > *3_S_Obs_Patient&Nurse_P0632&N6172*

Some patients in the study commented on interruptions, however most patients considered interruptions as non-problematic, for example, stating:

> *P_Larry: They'll only come over and interrupt the nurse if it's something important.*
>
> 12_M_Int_Patient_P0125

Patients stated that interruptions were not problematic because:

- Patient appreciates the nursing staff are busy (Case 5)
- As soon as one nurse leaves another one arrives (Case 8)
- The nurse usually tells other patients interrupting to wait until she is free to speak to them (Case 11)
- Interruptions do not occur often (Case 15)

Patients who expressed that interruptions were problematic did so because they perceived that it might be difficult to return to the conversation later. Interruptions also highlighted a lack of privacy. For example, when asked about interruptions by other patients, one patient stated:

> *P_Rose: Sometimes there's got to be a divide between having the chitchat and then having a one to one with the nurse where it is just between you. It's just the setting you're in; it's lack of privacy.*
>
> 17_M_Int_Patient_P2179

Interruptions were perceived by nurses to be inevitable, yet frustrating. Nurses' explained why interruptions were problematic, in the following ways:

- Interruptions may confuse patients if other patients interrupt with their own particular medical problems (Case 4)

- Inappropriate to interrupt if patient and nurse are engaged in sensitive or distressing conversations (Cases 5 and 9)

- To interrupt is rude (Cases 1 and 9)

- Interruptions take up more time in an already busy day (Case 14)

- Interruptions can negatively affect information exchange (Case 17)

- Interruptions may cause the nurse to forget something else (Case 18)

The following excerpts from the data illustrate nurses' perceptions of interruptions as being problematic:

> *N_Ivy: People can be downright rude; they just start asking you a question regarding their care when you're not dealing with them at that time. Oh it happens all the time.*
>
> 1_S_Int_Nurse_N0694

and:

> *N_Andrea: I'm used to it [interruptions] now. Just can be bugging that you cannae get on with something sometimes cos you're constantly somebody's asking you something or somebody wants you.*
>
> 15_M_Int_Nurse_N0514

Other nurses stated that interruptions were not problematic, stating that: patients understood that there were other unwell patients needing attention; nurses can speak with other patients who interrupt, later in the shift; and, nurses get on with their own work and are not often interrupted. The following excerpts from the data illustrate these points:

> *N_Anne: It is quite often that you get called away if you are with someone, and I think that most patients understand that there's other patients on the ward and sometimes they are not necessarily the sickest patient.*
>
> 7_S_Int_Nurse_N0610

> *N_Carol: One will butt in and ask about themselves during your chat, yeah. I don't find it a problem as such in that I hope I would deal with it later with each individual.*
>
> 11_M_Int_Nurse_N4294

and:

> *N_Pauline: I wouldn't say its [interruptions] too much because everyone's so busy dealing with their own patients. It's predominantly, if there's an issue it's you that's dealing with it...and maybe there is a lot more goin on, but I would say no,*

people just tend to do their own thing. There's kinda less interruptions there.

The point made by the nurse in Case 11, that nurses can speak with patients who interrupt, later in the shift, was also made by the patient in Case 11. None of the patients who interrupted nurses were my study participants. Therefore I was unable to follow up whether or not nurses went back to those patients at a later time. However, there is data which suggests that nurses often do not go back to patients with information at a later time in the day. This is mainly due to work responsibilities and demands on the nurse.

7.4.2.2   Demands of the job

Opportunities for sharing information were lost due to the demands of nurses' jobs. In Case 8 the nurse told the patient that she had been caught up with an emergency situation, and apologised for attending to the patient later than she had anticipated:

> **N_Hannah:** *I'm sorry, I've been kind of a caught up with an emergency there, so, how are you?*
> 8_M_Obs_Patient&Nurse_P0484&N4344

The demands of the job may have had a negative effect on information exchange in this case, as during the interactions Hannah made assumptions about what Harriet was asking, and they also appeared to have different priorities (7.4.2.3).

Some patients considered that the occupational demands on nurses were both problematic and a hindrance to information exchange. Several explanations were given to support their perceptions:

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- It is difficult to get an opportunity to speak with the nurses (Cases 4 and 7)

- The nurses being busy may put patients off asking questions (Cases 7, 9 and 18)

- Questions may remain unanswered as the nurse may not be able to come back at a later time (Case 12)

- Patients can be left listening to alarms for a long time as they wait for the nurse to come and reset equipment (Case 18)

- Patient perceived himself as a low priority (Case 18)

The following excerpts from the data illustrate some of these points:

> **P_Grace:** *I've known some nurses to go away and forget to come back (laughs). They get caught up in other things, you know, which I suppose it's not their fault either, cos they are so busy and they've got a hundred and one things to do.*
>
> 7_S_Int_Patient_P0675

> **P_Iris:** *I don't ask for a lot cos I know the nurses are busy.*
>
> 9_S_Int_Patient_P0691

and:

> **P_Steve:** *I think the nurses, they always seem to be busy, you know, they always have things to do. I mean, they've got so much on and I think a lot of the time that I must be quite a low priority but no' in a feel sorry for myself kinda way.*
>
> 18_S_Int_Patient_P5181

One patient perceived that the nurses were busy, but it was not problematic for him because the nurses still seemed to make time for the patients:

> **P_Colin:** *They're busy you know. Sometimes you don't see them for about five or six minutes (laughs) but they dae come back and talk to you, ask you what it is, you know. No, they've always got time for you, so…even night shift they've got, even got time for you.*
>
> 3_S_Int_Patient_P0632

In the case just cited, Colin had been in hospital for a long period of time and perhaps

was used to nurses being busy and then coming back at a later time. Another patient stated that even though the nurses were busy, it did not seem to affect how much information he received:

> *R_VC: Has that busyness affected how much information you've got from the nurses?*
> *P_Steve: Not really, no, I don't think so.*
> 18_S_Int_Patient_P5181

Other patients perceived that the demands of the nurses' jobs were a hindrance to information exchange, and they also commented that nurses treat many patients and cannot spend a long time with each one:

> *P_Larry: They're taught to take care of the patient, but they're taking care of him, they're taking care of me, somebody else doon there, you know, they cannae be everywhere, and everybody forgets…even me (both laugh).*
> 12_M_Int_Patient_P0125

Nurses generally perceived the demands of their job as a hindrance to information exchange. Their reasons were as follows:

- Patients hold back asking questions if they know the nurse is busy (Case 1)

- Nurses busyness may cause patients to feel ignored (Case 4)

- Nurses cannot spend necessary time with patients, for example, to talk with patients who have received bad news, or cannot get an opportunity to get back to the patient with information (Cases 3, 7, 14 and 17)

- Busyness may cause the nurse to avoid talking to patients (Case 3)

- Busyness in a general ward can be difficult for patients previously in HDU/ICU where the staff: patient ratio is higher (Case 9)

- Nurses can become stressed (Case 11)

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Nurses sometimes use avoidance when faced with uncomfortable or distressing conversations with patients, particularly when nurses are busy, for example:

> *N_Queenie: They've [patients] just been given bad news, you're away giving out the dinners, givin out drugs, you've got no time to spend with them [patients] so it's just, it's horrendous, it's a shame, I feel really bad sometimes…I know if I go over and say 'how are you?' I'm gonnae be caught there for ten minutes or fifteen minutes, and I've got this, this, this to do, it's a shame. It is such a busy ward with a high turnover [of patients]. I think at times you do avoid, you avoid patients or you avoid your room in total until you get this this this done, and then you'll go into your room.*
>
> 3_S_Int_Nurse_N6172

Nurses stated that they would try not to let patients know that they were busy:

> *N_Ann: Well you tend not to try and say, well you've been busy with another patient cos that other patient's really ill, things like that.*
>
> 14_M_Int_Nurse_N0376

Or, they would apologise to patients if they were busy:

> *N_Andrea: You know what they say about a nurse's two minutes, and it always isn't! I always apologise if I'm a bit later if the phone rings for me or something.*
>
> 15_M_Int_Nurse_N0514

The nurse in Case 8 who told the patient she was busy was not available for interview therefore her perception of the demands of her job could not be sought. One nurse stated that no matter how busy he was information exchange would not be affected as he would not reduce his interactions with patients:

> *N_Ian: I don't think I would not tell somebody something or like reduce ma interactions wi' them because of time, you know, but I certainly try and do things as quick as I can do them aye.*
>
> 16_M_Int_Nurse_N0355

7.4.2.3 *Differing priorities*

The data highlighted cases where nurses and patients had different information priorities (Cases 2, 4 and 8). In Cases 2 and 8, differing priorities between the

participants were observed. In Case 2, Barry, the patient, stated that he was experiencing pain, however Duncan, the nurse, responded with news about a dietician referral. Duncan appeared to be task-orientated, instead of listening to Barry. In Case 8, twice the patient and the nurse were talking about different things, which is an important point for information exchange as it appears that the nurse does not listen to the patient. In the first example, the patient wanted personal care as she felt wet, however the nurse responded with asking her if she slept well. In the second example, the patient expressed pain on moving, and the nurse focussed on whether the patient had slept well:

> **P_Harriet:** *I feel as if I want washed and I feel as if I'm soaking wet.*
> **N_Hannah:** *Mhm, okay, how did you sleep?*
> 08_M_Obs_Patient&Nurse_P0484&N4344

and:
> (N_Hannah moves P_Harriet)
> **P_Harriet:** *Oh my God!*
> **N_Hannah:** *(Name of night duty nurse) says you slept no' bad.*
> 08_M_Obs_Patient&Nurse_P0484&N4344

In both of the instances just cited, Hannah subsequently undertook Harriet's personal care and gave her something for pain. However, initially their priorities appeared very different. No priority differences were observed in Case 4, however, the patient stated at interview that he would filter out what the nurse wanted him to know if he did not consider the information relevant to him (7.5.2). The different patient/nurse priorities in Cases 2 and 8 are potentially problematic for patients because they may result in care needs not being met. In contrast, the priority difference noted in Case 4 may be more problematic or challenging for the nurse if the patient does not want to listen to the information given. The nurse in Case 4 commented that too much information may bombard patients, so she '*tells them about the bit that you're interested in at the*

moment'. It seemed that the nurse's goals dominated the interactions as she did not appear to consider what information the patient wanted at any given time.

7.4.3 Patient passivity

Data on patient passivity related to internal factors such as patients choosing to be passive in their care, and external factors such as the environment and the role of the nurse.

The data suggest that patient passivity is related to trust and compliance, however patients' perceived boundaries and their moods may also contribute to them allowing nurses to adopt a dominant role. Some patients trusted nurses to make decisions on their behalf and carry out appropriate treatment and care. Included in this was the notion of 'nurse knows best'. A typical example of trust came from the patient in Case 1 who said:

> **P_Alice:** *You trust them [nurses], I mean, that's their job, they know what they're doin; they're no' daft.*
>
> 1_S_Int_Patient_P0614

Other examples included patients who *'can turn to'* the nurse (Case 3) and patients who perceived they are *'in the hands of experts'* (Case 4), or who considered that *'they're [nurses and doctors] the professionals'* (Case 19). Each of these patients expressed that they would not want to become more involved in their treatment and care.

Patient passivity can also be explained by external factors such as the institutional nature of the hospital environment, which perhaps led to patients not expecting to be active partners in care. It is possible that patients expect to behave passively when in

hospital. This expectation of patient passivity is not dissimilar to other patients' reports of not feeling listened to, or that information should be jargon free (Scottish Government 2008). However, it is also akin to what Parsons (2012) described as the 'sick role'. Comments were made such as patients will just *'do as you tell them'* when in hospital (Case 3), a statement that correlated with that of the nurse in Case 2 who stated that hospital is '*an unnatural place to be'*, and that *'all decision-making and routines are practically taken away'* from in-patients.

Another external factor associated with patient passivity related to the roles and practices of nurses. For example nurses commented on their *'responsibility to assess patients' preferred levels of involvement and communication'* (Case 7), and that nurses should *'not try and force information on them [patients] that they just don't want to have'* (Case 4). However, there was no evidence in my study of nurses assessing patients' preferred level of involvement, and a nurse in Case 1 stated that she would continue to reiterate what she was saying until she knew the patient had listened:

> **Ivy:** *I could rein somebody in and say look right, listen to what I'm saying to you and you know, I don't know it depends on the person but generally I would say it's a wee bit frustrating sometimes because you're kinda wondering are you, you're not really taking this seriously enough but I tend to be able to kind of a, in a nice way rein people in and say right are you hearing what I'm saying to you here you know until they look as if they're listening to you.*
>
> 01_S_Int_Nurse_N0694

Another nurse identified that *'nurses make patients passive by their actions'*, and stated that nurses *'can make patients compliant as if they were in prison'* (Case 9). Although this particular nurse in Case 9 perceived making patients compliant as detrimental to information exchange, she stood out from the other nurses in terms of her strong paternalistic use of language during the interaction with the patient and at

interview (hence providing some evidence of a possible link between 'patient passivity' and 'power and control').

7.4.4 Power and Control

Data associated with 'Power and control' was related to nurses' use of paternalistic language. Paternalistic language in this study is defined as language used (either sentences or individual words) that perpetuates paternalism rather than promotes patient autonomy (Appendix 30). Nurses limited patients' choices regarding information and decision-making. They also used coercion/persuasion tactics to encourage patient compliance with treatment. There was also evidence of possible nurse insecurity, especially relating to patients self-administering Insulin. Paternalistic use of language, limiting choices, coercion/persuasion, and possible nurse insecurity all potentially result in insufficient information being shared.

7.4.4.1   Language use

The language that nurses used evidenced their power and control over patients. At interview, nurses used paternalistic language when talking about patients, including when talking about patient-centred care. The term, 'patient-centred care' was spoken by nurses, but their use of language was more nurse-centred. For example, at interview one nurse stated, *'I think I probably did cover what I wanted to cover with him'* (Case 4). Also, in Case 9, the nurse said:

> **N_Lesley:** *I'm not saying the patient is a child, but it's much like making people have some kind of conformity to realise that while you're doing your best for them at one point in time, you have other tasks in hand.*
>
> 9_S_Int_Nurse_N6121

Another indicator of power and control was nurses' choices of specific words. Words and abbreviations used by nurses had the potential to exclude patients, make patients compliant, or keep them passive. Examples include:

- *'Refused'* and *'fight'* – when the nurse comes across patients who do not want to *'hand over'* their medications (Case 1)

- *'Police'* – when talking about how many sweets a patient with diabetes takes when nursed in a single room (Case 9)

- *'Given rows'* – referring to what was said to a patient for not trying to improve her mobility (Case 9)

- *'MRSA in your TPN line'* – abbreviations used when talking to a patient about the patient's condition (Case 9)

- *'Difficult', 'awkward'* and *'obstinate'* – referring to patients who want to be more involved, or want more choice, in their treatment and care (Cases 9 and 18)

Further evidence of the way language was used by nurses that maintained their control related to care management and compliance with treatment. Nurses initiated interactions with phrases similar to '*What I'm going to do is…*' and throughout interactions about care management nurses used phrases such as, *'the best thing for you is…'* and, *'This is what's gonnae happen'*. Other statements from nurses were more specific to the patient they were caring for, for example, when referring to a patient prescribed antibiotics the nurse in Case 4 reported saying to him, *'For all you're feeling better, you really do need to complete the course'*.

7.4.4.2 Limiting choices

Nurses limited patients' choices for information, decision-making and about taking medication. With regard to limiting patient's choices for information, most of the

evidence related to nurses not giving 'enough' information. As examples: *'That's enough information for them [patients]'* (Case 3); *'That's what [information] he needs just now'* (Case 3); and, *'I just felt that's enough information for her just now'* (Case 11). There was also evidence of nurses infringing patients' choices and rights *not* to listen to information from nurses. For example, the nurse in Case 1 stated that she could *'rein somebody in'* and keep giving information until *'they look as if they're listening to you'.* Sometimes patients notice when nurses are avoiding sharing information (7.5.4); this avoidance potentially limits the amount of information patients receive.

Patient choice regarding decision-making was limited, evidenced by the nurse in Case 2 stating that in hospital *'all the decisions are practically taken away from you [patients]'.* Patients also noticed that, in effect, lip service is paid to decision-making. For example the patient in Case 4 stated:

> **P_Donald:** *They always ask you nicely, but they go ahead anyway.*
>
> 4_S_Int_Patient_P0644

Patients in my study had limited choice relating to medication. In Case 3 the nurse stated that patients had a choice in whether or not to take medications such as analgesics and laxatives. However, she would not offer choice over any other medications that were prescribed. There was evidence in the data to suggest that nurses did not like when patients chose to keep their medications with them rather than '*hand them over*' to nursing staff (Case 1). There did not appear to be any insight that discussions with the patients about storage of medications might lead to a solution that both patients and nurses could agree on. Instead nurses would document that

patients '*refused*' to give their medications to the nurse on admission, and the use of the word '*refused*' had the effect of patients complying with what was being asked:

> **N_Helen:** *I would just document that 'refused' and the minute they see refused getting written, 'Oh no have them, just have them!'*

<div align="right">1_S_Int_Nurse_N0684</div>

7.4.4.3 Persuasion

Some nurses in this study actively used coercion or persuasion to try and secure patient compliance with treatment or with follow-up care. The way in which nurses coerced or persuaded patients appeared to be a more active approach for securing treatment compliance than, for example, nurses' use of language. It could be argued that nurses did not intend to be controlling, particularly with nurse statements such as, '*It's just my way*' (Case 11), or '*It's kinda ignorance on my behalf*' (Case 16). However, nurses stated that they would '*coax*' patients (Case 11), *or 'talk them round'* (Case 13), so that patients will accept the treatment that the nurses think is in their best interests. However, patients do not necessarily perceive coercion or persuasion as problematic, but instead may perceive that the nurse is doing the '*right thing anyway*' (Case 11).

7.4.4.4 Nurses' insecurities

Another form of exerting power and control over patients was what could be regarded as nurses' insecurities. The situations in which these insecurities were evidenced related to patients' self-administration of insulin. Even though patients had been injecting their insulin, sometimes several times a day, at home, with no intervention from a nurse, nurses stated that they would have to observe this being carried out when the patient was in hospital:

> **VC:** *Ok. And what about her Insulin? You asked her if she'd had her Insulin. Is that something she does herself?*
> **Una:** *She does, she self-administers it. And I mean obviously if you're going to self-administer, its better if they're self-administering.*

<div align="right">240</div>

7.4.5 Summary of Section 7.4

I found that both patients and nurses withheld information. I also found that opportunities for information exchange were often lost. Furthermore patient passivity and nurses' power and control over patients occurred repeatedly with several contributing factors. The findings strengthen my argument that potentially insufficient information was exchanged between patients and nurses in this study. Links could be seen between 'Information not exchanged' and 'Barriers to information exchange', which are examined more closely in Section 7.5.

7.5 Links between 'Information not exchanged' and 'Barriers to information exchange'

Links between 'Information not exchanged' and 'Barriers to information exchange' became evident as analysis of the data progressed. 'Withholding information' 'lost opportunities', 'power and control', and 'patient passivity' seemed interlinked to such an extent that it was difficult to separate them. To help make sense of the data I present five case studies, which illustrate the links between 'Information not exchanged' and 'Barriers to information exchange'. Additionally, I make cross-case comparisons within each case study, showing how the links between 'Information not exchanged' and 'Barriers to information exchange' can be seen across the cases and not just within cases. A thorough examination of these links contributes to deeper explanations of why insufficient information may have been exchanged. Table 22

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presents an overview of the cases sampled to illustrate these links. I sampled cases for maximum variation in relation to the following:

- Patient gender

- Patient age

- Patients' previous hospital admissions

- Reason for current admission

- Nurse gender

- Nurse banding

- Number years of nursing experience

- Number of years in current place of work

Table 22: Characteristics of cases sampled to illustrate links between 'Information not exchanged' and 'Barriers to information exchange'

Case	Patient gender and pseudonym	Patient age	Previous hospital admissions	Current admission	Nurse gender and pseudonym	Nurse band	No. yrs. nursing experience	No. yrs. in current work	Ward type
2	M Barry	23	Surgery to hand	Stabbed in bowel	M Duncan	Band 5	27	4	Surgical receiving (s)
4	M Donald	69	Peri-anal abscess; vasectomy; vasectomy repair	TURP	F Kate	Band 5	6	2	Urology (s)
11	F Kirsty	69	Tonsillectomy; appendectomy; rheumatic fever; mitral valve replacement; gastro-intestinal bleed & septicaemia; surgery for twisted bowel; aorta repair	Insertion of pacemaker	F Carol	Band 7	28	23	Coronary care (m)
12	M Larry	74	Gall stone removal; heart attack; chest pain	Chest pain	F Pauline	Band 6	14	12	Male general medicine, cardiology & diabetes (m)
18	M Steve	33	Chondrosarcoma; appendectomy	Wound opened due to infection	F Xena F Wendy	Band 7 Band 5	7 4	3 4	Orthopaedics (s)

(M=male; F=female; s=surgical; m=medical; TURP=transurethral resection of prostate)

7.5.1 Study of Case 2

Case 2 involved one male patient (Barry) and one male nurse (Duncan). Barry was twenty-three years of age, and his current admission to hospital was an emergency admission due to being stabbed in the abdomen while on holiday with his family. He was transferred to the surgical receiving unit where Duncan worked. Duncan was a Grade 5 nurse who had twenty seven years nursing experience, with the last four of these being in the surgical receiving unit. During data collection, Barry and Duncan had one interaction which lasted one minute and fifty eight seconds. The content of their interaction related to:

- Barry's condition (problem with his bowel due to the stabbing)

- Barry's understanding of his condition

- Barry's preferences for treatment, and,

- Follow-up care.

There was evidence in Case 2 that Duncan might withhold certain types of information from patients. Duncan stated that he knew when to withhold information from patients:

> **N_Duncan:** *I'm experienced enough now to know when I can and when I can't [share information]. No it's not a problem it's just a matter of work.*
>
> 2_S_Int_Nurse_N0640

There was no evidence in the data of him sharing information with patients. Duncan's reasons for withholding information were that the doctors may have changed their minds about care management and that nurses may look foolish if they give erroneous information. Duncan also perceived that giving patients the wrong information may unnecessarily cause them concern.

In Case 2, there were instances of lost opportunities for sharing information. Barry and Duncan appeared to have different care priorities during their interaction. Barry stated that he was experiencing pain, but Duncan responded with news about a dietician referral:

> **N_Duncan:** How are you feeling?
> **P_Barry:** Just a bit sore. Didnae really get much sleep at all last night.
> **N_Duncan:** Well hopefully I gave the diet….remember I spoke to the dieticians? I left a message for them.
>
> 2_S_Obs_P0620&N0640

Duncan used paternalistic language when discussing Barry's care management with him. From the following data excerpt it appeared that neither Duncan nor Barry had sufficient information. Therefore, he would have been limited in what information there was available to share with Barry. However, Duncan used paternalistic language in the form of telling Barry what the 'best thing is' for treatment and care:

> **N_Duncan:** They'll [doctors] come up with the correct management for you at the moment…I think they might want to be doing something today with you. I don't know exactly what and you don't know either, but the best thing for you at the moment is maybe not get a drink or anything until we get a clearer picture.
>
> 2_S_Obs_Nurse_N0640

Barry was not given the opportunity to respond with his preferences or ask any questions. Instead, Duncan went on to ask Barry how he was feeling. Additionally, at interview Duncan reported saying to patients:

> **N_Duncan:** I'll say to them [patients] that when the surgeons come in they're the ones that's got the plan in their head, they'll tell you exactly what they're gonnae do and we'll take it from there.
>
> 2_S_Int_Nurse_N0640

Using paternalistic language was common across the cases, with nurses telling patients what to do, for example:

> **N_Cathy:** *What I'll say to you is drink plenty.*
>
> 10_S_Obs_P6104&N0634

Duncan was also the participating nurse in Case 6, where the patient was withdrawn from the study due to cognitive impairment after receiving a sedative injection. However, the interaction between him and Duncan was recorded prior to withdrawing him from the study. It was noted that in this interaction also, Duncan used paternalistic language and did not include the patient in decision-making:

> **N_Duncan:** *So what we have to do today is get you down for your scan, check and see what the scan says…*
> **P_Fred:** *Ok…*
> **N_Duncan:** *…and after that we can decide if we can let you drink, know, do we need to keep your fluids through a drip. But I think we'll continue with these tablets that are making you less anxious, until you're feeling a lot better, ok?*
> **P_Fred:** *(No reply)*
>
> 6_S_Obs_P0665&N0640

Although there were differences between the patients in Cases 2 and 6, such as patients' ages, conditions and cognitive ability, Duncan interacted with them in much the same way. It could be argued here that in Case 6 it was appropriate to advocate on the patient's behalf due to the patient's temporary cognitive impairment, however even in cases where patients are not autonomous, nurses should involve them in their care to the extent that it is possible. Despite Duncan's paternalistic approach, Barry indicated at interview that he could ask questions about his treatment and care:

> **R_VC:** *Do you find it easy to talk about your preferences for your treatment?*
> **P_Barry:** *Aye, well aye. It's always eh freedom of speech isn't it?*
>
> 02_S_Int_Patient_P0620

However, when Barry expressed his preference for getting the cyst excised, Duncan appeared to avoid any meaningful discussion.

Duncan also perceived limits to patient decision-making. He showed no insight into these limits having the potential to reinforce patient passivity. For example he expressed that a hospital is not a natural environment for people and that *'all the decisions are taken away from you'*. This comment from Duncan is perhaps indicative of an underlying assumption that patients are unlikely to be involved in decision-making whilst in hospital. From the data it appears that patient passivity is seen as the norm, and that there is a behavioural expectation of patient passivity in the healthcare environment.

The data presented from Case 2 shows links between information withheld, lost opportunities for sharing information, and power and control. Duncan withheld information about care management, and his priorities for care were different to those of Barry. Duncan also used paternalistic language, which could potentially exert power and control over patients, and he perceived there were limits to patient decision-making due to the institutional environment. All of these aspects may lead to patient passivity and insufficient information exchange, as evidenced in Case 2. Barry remained relatively passive during the interaction, apart from expressing his preference for the cyst on his bowel to be excised, which seemed to be ignored.

7.5.2 Study of Case 4

Case 4 involved one male patient (Donald) and one female nurse (Kate). Donald was sixty-nine years of age. Previous hospital admissions were for excision of a peri-anal abscess, a vasectomy, and a vasectomy repair. His current admission to hospital was for a TURP. He was admitted to the urology ward where Kate worked. Kate was a Grade 5 nurse who had six years nursing experience, with the last two of these

being in the urology ward. During data collection, Donald and Kate had one interaction which lasted one minute and forty four seconds. The content of their interaction related to:

- Donald's condition (tiredness and headache)

- Treatment (discussion about different medication), and,

- Outcomes of treatment (Donald's temperature should reduce, and his headache should be alleviated).

In Case 4, lost opportunities were evidenced by the demands of Kate's duties, and differing priorities between Donald and Kate. Donald perceived that the nurses were busy. The time constraints and demands on nurses potentially hinder information exchange, as it is difficult for patients to get an opportunity to talk to nurses:

> **P_Donald:** *You're kinda dependent on them [nurses] happening to come in, you know, eh. They don't seem overly proactive or that, you know, at coming round. When nurse comes round, that's your chance.*
>
> 4_S_Int_Patient_P0644

Similarly, Kate commented on the lack of time that she has with patients due to the demands of her job. She perceived that when patients see nurses they might capitalize on the amount of questions they have, as they may not know when the next opportunity will be to speak with the nurse:

> **N_Kate:** *Patients grab you when you go round the ward, as they don't know when they'll next see you.*
>
> 4_S_Int_Nurse_N6114

Sometimes the demands on nurses may cause patients to feel ignored, however Kate stated the importance of prioritising the delivery of care to patients who need it most, particularly in an emergency situation:

> **N_Kate:** *I'm sorry if you feel ignored but its priorities you know, I'm saving a life here.*

<div align="right">4_S_Int_Nurse_N6114</div>

The type of statement just cited has the potential to diminish patients' individuality as they perhaps feel informed that someone else is more important than them.

Information exchange between Donald and Kate may have been hindered by their differing priorities. Kate told Donald how long the antibiotics should last and encouraged him to complete the course. However, Kate was unaware that Donald's priorities were different, as he stated at interview that he would filter out that information, as he did not want to know:

> **P_Donald:** *How long the medicine's gonnae last? Well I don't really care, so if, eh, she's telling me that, it'll just wash over me cos I've filtered out what I want to know.*

<div align="right">4_S_Int_Patient_P0644</div>

There is a need for clarity around patients' and nurses' information priorities to avoid overloading patients with information, or providing unwanted information, that potentially may be 'filtered out'.

There was also evidence in Case 4 that Kate might withhold certain types of information from patients. Kate withheld information from Donald about the side effects of the antibiotics, stating that Donald may imagine he has the side effects:

> **N_Kate:** *[If I tell him], he might talk himself into having diarrhoea (laughs).*

<div align="right">4_S_Int_Nurse_N6114</div>

Kate did not want to cause Donald any anxiety about side effects, stating that she *'did not want to alarm him'*; particularly as the side effects may not occur. Furthermore, Kate perceived that administration of medication was a minor nursing intervention that did not require sharing all the information:

> **N_Kate:** *I thought it [administration of medication] was a pretty minor thing so I was quite happy at that point not to tell him.*
> 4_S_Int_Nurse_N6114

However, withholding information may also be a method used by Kate to gain patient compliance:

> **N_Kate:** *Maybe I should kind of warn him beforehand so that he can refuse to take them [antibiotics]. I suppose that's really withholding information isn't it. Cos you want them [patients] to take the treatment because they've got the infection…*
> 4_S_Int_Nurse_N6114

One finding from the data across the cases was that some nurses actively used coercion, or persuasion, to try and secure patient compliance with treatment or with follow-up care. Nurses stated that they would *'coax'* patients (Case 11), *'rein them in'* (Case 1), *'talk them round'* (Case 13), or *'put the fear of God into them'* (Case 18), so that patients accept the treatment that the nurses think is in their best interests. When sharing or withholding information, what potentially motivates nurses is a desire to see patients become well. Therefore their focus is on patients getting better rather than on sharing information and supporting patient involvement. Withholding information, and power and control, are linked in relation to patient compliance. Not only might verbal coercion and persuasion be used, but also withholding information may be used to gain patient compliance. In other words, the withholding of information may be a non-verbal type of coercion. Coaxing and persuading patients reinforces professional power. Nurses have justified coercion when trying to reach

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an outcome that they perceive is necessary for the patient (Vuckovich and Artinian 2005). However, other authors perceive coercion as 'morally indefensible' (Tuckett 1999) and as 'nursing in the grey zone' (Wolf 2012). Non-compliance with treatment is perhaps the strongest driver behind coercion and persuasion. My findings are at odds with the ideologies of shared decision-making, patient partnership and negotiation at the centre of discussions in policy documents (Department of Health 2012, Department of Health 2004, Scottish Executive 2003), professional codes (NMC 2008), and in the wider literature.

There was evidence that Kate used paternalistic language when talking with patients. The following two excerpts from the data illustrate how paternalistic language was used in the form of telling patients what to do to gain compliance with medication and care management:

> Kate reported saying to patients:
>
> **N_Kate:** *Look, this is the course, the length of the course [of antibiotics] so…for all you are feeling better you really do need to complete the course.*
> <div align="right">4_S_Int_Nurse_N6114</div>

and:
> Kate reported saying to patients:
>
> **N_Kate:** *Look, this is what was said [at the ward round] and this is what's gonnae happen.*
> <div align="right">4_S_Int_Nurse_P6114</div>

Data from Donald's interview suggested that nurses limit patients' decision-making:

> **P_Donald:** *You don't get too many decisions to make in here really, you know.*
> <div align="right">4_S_Int_Patient_P0644</div>

However, Donald previously inferred that he was content to leave decision-making up to the 'expert' health professionals, and his expectation was that the nurses would make the right decisions:

> **R_VC:** *Would you like to make more decisions?*
> **P_Donald:** *You mean other than what's for breakfast or something? I don't think you're probably qualified to really. I think probably not. I think, you know, when you're in the hands of you know, experts, you know, you expect to get the right decisions anyway.*
>
> <div align="right">4_S_Int_Patient_P0644</div>

There is an interesting contrast in Donald's perceptions regarding choices. Donald perceived that professional dominance can limit patient decision-making however it is also possible that he did not want to make decisions as he perceived that the nurses were the experts. Patients may perceive that there are boundaries to making decisions about their treatment and care, but they may still prefer a passive role. Perhaps patients make informed and conscious choices to remain passive. It is possible that Donald was managing a behavioural expectation of passivity. Power and control influences, such as professional dominance, withholding information, and nurses maintaining the 'expert' role, may reinforce patients' perceptions of boundaries to decision-making. Patients' perceived boundaries might in fact be actual boundaries, explicit or implicit, which limit patients' decision-making opportunities.

From the data presented from Case 4, I have shown links between lost opportunities for sharing information, information withheld, and power and control. Differing priorities and the demands of the job, linked with Kate withholding information about the side effects of medication, provide strong evidence that insufficient information was shared. Furthermore, Kate also used paternalistic language, which could potentially exert power and control over patients, and Donald perceived there were

limits to patient decision-making. All of these aspects within Case 4 may lead to patient passivity, as evidenced at times by Donald, and strengthen the argument that there was insufficient information exchange.

7.5.3 Study of Case 11

Case 11 involved one female patient (Kirsty) and one female nurse (Carol). Kirsty was sixty-nine years of age, and was an experienced patient. Previous hospital admissions were for a tonsillectomy, an appendectomy, rheumatic fever, mitral valve replacement, gastro-intestinal bleed and septicaemia, surgery for a twisted bowel, and an aorta repair. Her current admission was for insertion of a pacemaker, and she was admitted to the coronary care ward where Carol worked. Carol was a Grade 7 nurse who had twenty-eight years nursing experience, with the last twenty-three of these being in coronary care. During data collection, Kirsty and Carol had three interactions: the first lasted twenty seven seconds; the second lasted five minutes and twenty one seconds; and the third lasted two minutes and seven seconds. The content of their interactions related to:

- Kirsty's condition (pacemaker site less swollen, painful arm and shoulder)

- Health education (risk of infection in pacemaker site)

- Nursing intervention (administration of medication)

- Treatment (discussion about medications)

- Kirsty's lay knowledge of treatment (Paracetamol helps alleviate pain, knowledge of INR levels)

- Social context (Guy Fawkes night, Christmas and family birthdays)

- Kirsty's preferences (Kirsty preferred to take medication with water and not with Appletizer), and,

- Follow-up care (referral to physiotherapist)

Carol withheld information from Kirsty, as she perceived that Kirsty had been given 'enough' information and wanted to 'protect her':

> **N_Carol:** *I just felt that's enough [information] for you just now…maybe that's just trying to protect her or trying to…it's just my way.*
>
> 11_M_Int_Nurse_N4294

Carol made an assumption about the amount of information Kirsty might want. It may appear that Carol had a plan to give information to Kirsty a bit at a time. However, Carol could not explain why she withheld information from Kirsty stating, *'it's just my way'.* Making assumptions potentially exerts power and control over patients particularly if they are not tested against the amount of information that patients want.

Another form of power and control evident in Case 11 was that Carol did not listen to Kirsty, and used paternalistic language to reinforce her own perspective on Kirsty's treatment and care. Carol interrupted Kirsty on two occasions when discussing the level of INR required for discharge home (5.4.5). Kirsty may have been attempting to engage with Carol in exchanging information however, Carol controlled the interaction, which may have prevented information exchange taking place. By controlling interactions, nurses may be inadvertently losing opportunities for information exchange. Other examples of lost opportunities for information exchange in Case 11 are interruptions by other patients and members of staff, and the demands of Carol's job as senior nurse. Neither Kirsty nor Carol perceived interruptions as a hindrance to information exchange:

> **P_Kirsty:** It sometimes happens [interruptions], but usually they'll [nurses] just say, 'I'll be with you in a wee minute', so its no' really [a problem].
>
> 11_M_Int_Patient_P4114

and:

> **N_Carol:** One will butt in and ask about themselves during your chat, yeah. I don't find it a problem as such in that I hope I would deal with it later with each individual.
>
> 11_M_Int_Nurse_N4294

Carol commented on nurses being stressed on 'bad days' and when stress levels increase, day to day banter is lost. Carol does not state what impact these 'bad days' have on information exchange. However, she stated that when staff experience stress, she also becomes stressed. Increased stress levels have the potential to hinder information exchange.

There was also evidence of Carol potentially using coercion or persuasion to gain Kirsty's compliance with treatment:

> **N_Carol:** If she [Kirsty] had perhaps said no [to treatment for her frozen shoulder] then maybe I would have to explain further…I would have coaxed her. I would have tried that!
>
> 11_M_Int_Nurse_N4294

Using coercion and persuasion may limit information exchange (7.5.2). However, Kirsty considered that using coercion/persuasion was at times *'the right thing'* to do:

> **P_Kirsty:** Well I suppose if I wanted to go home even now, they couldn't stop me I suppose, but, in the safety of my own safety and for my family's presence of mind they [nurses] would try talk me out of it and make me stay, which I think would be the right thing anyway.
>
> 11_M_Int_Patient_P4114

Links are evident between lost opportunities for sharing information, information withheld, and power and control. Withholding information, interruptions, the use of

paternalistic language, and coercion and persuasion, even when not perceived by participants as problematic, combine to build a strong case for arguing that there was the potential for insufficient information exchange.

7.5.4 Study of Case 12

Case 12 involved one male patient (Larry) and one female nurse (Pauline). Larry was seventy-four years of age. Previous hospital admissions were for gall stone removal, heart attack, and chest pain. His current admission was for chest pain, and he was admitted to the medical ward where Pauline worked. Pauline was a Grade 6 nurse who had fourteen years nursing experience, with the last twelve of these being in a male general medicine, cardiology and diabetes ward. During data collection, Larry and Pauline had one interaction, which lasted four minutes and twentysix seconds. The content of their interaction related to:

- Larry's condition (asbestos scarring in lung, nausea, pain, breathlessness, and bowel function)

- Larry's knowledge of his medication (Atenolol makes him feel nauseous)

- Treatment (possibly other medications making Larry feel unwell)

- Emotional concerns (Larry upset about scarring on lung)

- Possible outcomes of treatment (medications reduce heart rate)

- Follow-up care ('jelly' scan, angiogram), and,

- Banter between Larry and Pauline and other patients on the ward

Larry perceived that opportunities are lost for sharing information due to the demands of the nurses' jobs:

> *P_Larry: When you ask them [nurses] a question they don't even bother acknowledging you asked it, you know.*
> *R_VC: And what do you do when that happens?*
> *P_Larry: I just ignore it, you know. I don't go and shout at them or that because, to me, doctors and nurses have a hard job, you know.*
>
> <p align="right">12_M_Int_Patient_P0125</p>

Although he found the lack of answering questions a hindrance to information exchange, he would not complain:

> *P_Larry: I wouldnae complain aboot it, because the nurses are that busy, especially among, it's mostly old people that's in here.*
>
> <p align="right">12_M_Int_Patient_P0125</p>

Larry noticed some problems with information exchange but would not mention them to the nursing staff. Larry was concerned with being a 'good' patient, particularly as he had previously come into contact with an 'awkward' patient:

> *P_Larry: I keep telling the nurses in here, 'You must have great patience in here, because of all the old people like me'. It can be awkward. I hope I'm no' awkward. But there has been one or two here that have been really awkward, you know. When I first came in here, there was a mean man there. And awkward! Jeeze!*
>
> <p align="right">12_M_Int_Patient_P0125</p>

There was evidence of nurses sometimes labelling as 'difficult' patients who wanted more involvement in their treatment and care and more involvement in decision-making (5.4.5). Being perceived as 'difficult' may limit patients' roles in information exchange and decision-making (Charles et al. 2004). Patients may choose to comply with treatment because they want to be perceived as 'good' patients. This argument is not new as it concurs with Waterworth and Luker's findings (Waterworth and Luker 1990), where patients were more concerned with 'toeing the line' and pleasing the nurses than they were in involvement in decision-making. Much has been written about the 'good' patient and the 'unpopular' or 'difficult' patient (Russell 2003, Playle

and Keeley 1998, Fawcett 1995, Moore 1995, Calnan 1987, Stockwell 1984). This labelling is concurrent with Foucault's suggestion that those who challenge power may be seen to be transgressing (Foucault 1980).

There is evidence from Case 12 that the nature and reality of a nurse's job appears to foster patient passivity and could be perceived as a way of exerting power and control over patients. This patient passivity may, in turn, limit further information exchange. Evidence of patient passivity was also seen in Case 10, where the nurse stated that '*the patient is happy that the nurses give him a little bit of a hand and are in control of some of the stuff*'. However, there was no evidence of the patient saying this to the nurse during the interaction or from the interview with the patient. This unspoken assumption of patient passivity, by both patients and nurses, may result from the everyday demands placed on nurses, which limit time for patient involvement, and also from the institutional nature of the hospital environment, as shown in Case 2.

There is evidence in Case 12 that some nurses limit patient choice for information by avoiding answering questions. Avoidance could perhaps be a strategy used by nurses when they do not have time to share information of a distressing nature (5.4.2.2). Larry stated that he knew when he wasn not receiving 'right' answers because nurses would avoid him:

> *P_Larry: Sometimes one o' them [nurses] will no gie you the right answer.*
> *R_VC: How do you know they're not giving you the right answers?*
> *P_Larry: Because they avoid you. They avoid the answer. They avoid giein you the answer…and I hate that.*
> 12_M_Int_Patient_P0125

Again, Larry appears to remain passive. He knew when his questions were not being answered, and the avoidance by nurses seemed to have an impact on him on an emotional level. And yet, Larry did not express his dissatisfaction to the nursing staff.

Some information was not exchanged in Case 12 as Pauline withheld information about the side effects of medication and for reasons similar to Kate in Case 4 – Pauline perceived that patients might imagine themselves to have the side effects, if they knew what they were:

> **N_Pauline:** *I don't actually go into the 'oh it might cause you to have…' all the things it [medication] may do, because people will sometimes go away and think, 'Oh I feel a bit odd, could it be that?'*
>
> 12_M_Int_Nurse_N0425

The demands of the everyday work of nurses may foster an environment of power and control over patients, and may lead to patient passivity and patients wanting to be 'good'. Furthermore, nurses avoiding answering questions, and withholding information, may result in limiting patients' choices for information, potentially limiting their decision-making involvement regarding treatment and care.

7.5.5 Study of Case 18

Case 18 involved one male patient (Steve) and two female nurses (Xena and Wendy). Steve was thirty-three years of age. Previous hospital admissions were for an appendectomy and surgery related to chondrosarcoma – removal of chondrosarcoma, and hip surgery after recurrence of chondrosarcoma. His current admission was due to the hip wound being infected, and he was admitted to the surgical orthopaedic ward where Xena and Wendy worked. Xena was a Grade 7

nurse who had seven years of nursing experience, with the last four years being in an orthopaedic ward. Wendy was a Grade 5 nurse who had four years of nursing experience, with all four years being in the orthopaedic ward. During data collection, Steve and Xena had one interaction, which lasted one minute and six seconds. The content of their interaction related to:

- Steve's lay knowledge (the red pill makes him nauseous)

- Treatment (discussion about medications), and,

- Steve's preferences (Steve asked for an anti-emetic)

During data collection, Steve and Wendy had one interaction, which lasted seven minutes and two seconds. The content of their interaction related to:

- Treatment outcomes (the antibiotic is 'doing its job')

- Steve's condition (how the wound healing is progressing)

- Nursing intervention (wound dressing), and,

- Steve's overall progress

There was some evidence from Case 18 that information may not always be exchanged between patients and nurses due to information being withheld and lost opportunities for sharing information. Xena stated that some nurses might be inclined to withhold information about poor prognoses perceiving that this is part of the doctor's role:

> **N_Xena:** *If there's a poor prognosis…they [doctors] should have been telling the patient. Nurses just kinda think the doctor should be honest with them [patients]. Don't leave it to me to tell them, you know.*
>
> 18_S_Int_Nurse_N5241

If neither doctors nor nurses are sharing information, then potentially important information is being lost. Lost opportunities for information exchange were evident in participants' perceptions of interruptions and the demands of the nurse's job. There was an interruption from Xena's pager during the interaction; however, on this occasion it did not appear to hinder information exchange, as it did not take her away from the interaction. However, at interview, Xena commented on interruptions stating that they were common to her as a senior nurse, and problematic in terms of information exchange:

> **N_Xena:** *I am the senior nurse…I get called upon quite a bit of the day and I get overloaded with information…They seem to come to me all the time…I can feel myself thinking, 'just let me get on with my job'. My priority is my patients, cos first and foremost I'm a nurse that wants to deal with the patients. It can put you off your stride if you're explaining something to somebody and there's a phone call…Then when you come back you think, 'where am I at?' I've forgotten, so you might have missed something.*
>
> 18_S_Int_Nurse_N5241

Xena's frustration about forgetting things concurs with one paper reporting that interruptions carry negative consequences such as loss of concentration (McGillis Hall et al. 2010). Xena's perceptions of interruptions being more common to her as a senior nurse also concurred with those of some other senior nurses in my study:

> **N_Lesley:** *Oh [interruptions] are very common for me.*
>
> 9_S_Int_Nurse_N6121 (Band 7 nurse)

and:

> **N_Andrea:** *I'm always getting interrupted. I always say to them [patients] I'm the worst person looking after you because I don't get peace. Everybody's always shouting at me for something. I'm used to it [interruptions] now. Just can be bugging that you cannae get on with something sometimes cos you're constantly somebody's asking you something or somebody wants you.*
>
> 15_M_Int_Nurse_N0514 (Band 6 nurse)

Xena's perceptions of interruptions were not reflected in the data relating to Wendy. There were no interruptions during Steve's interaction with Wendy, and Wendy was one of the few nurses that did not comment on interruptions. However, interruptions were not exclusive to Band 6 or 7 nurses, as illustrated in the following excerpts:

> *N_Ivy: People can be downright rude. They just start asking you a question regarding their care when you're not dealing with them at that time. Oh it happens all the time*
>
> 1_S_Int_Nurse_N0694 (Band 5 nurse)

and:

> *N_Ann: Phone calls when you're dealing wi' patients, phone calls, other nurses coming for the keys, pharmacies, everybody that wants you on the phone for something, other doctors, you know, coming asking for this, that or the next thing, you know. You don't have a lot of time to converse wi' patients, I don't think*
>
> 14_M_Int_Nurse_N0376 (Band 5 nurse)

Other authors have also commented on the number of interruptions ward nurses face in their day to day work, citing them as having consequences for nurses and patients such as a negative impact on nurses cognitive functioning and patient care being delayed (Myny et al. 2012, McGillis Hall et al. 2010). McGillis Hall et al. (2010) also reported that the source of the majority of interruptions was other members of the healthcare team. However, not all nurses perceived interruptions as a hindrance to information exchange:

> *N_Carol: I don't find it [interruptions] a problem as such in that I hope I would deal with it later with each individual*
>
> 11_M_Int_Nurse_N4294
>
> *N_Frank: I think for the most part interruptions and distractions are not a huge problem*
>
> 5_S_Int_Nurse_N6323

From Steve's perspective, the demands of the nurses' jobs appeared problematic at times but did not impact on information exchange. When asked at interview whether

the busyness of the nurses affected how much information he received he replied, *'Not really, no, I don't think so'.* However, there appeared to be a link between Steve's behaviour and the ward environment. Steve commented that the demands of the nurses' job prevented him from asking questions. In effect, when the nurses were busy, Steve became more passive:

> **P_Steve:** *You can tell if they're [nurses] busy. They're kinda scooting about. Then I don't really ask the questions. I can tell if they've come in on a more leisurely pace then I would ask the questions, you know. They're always really quite busy, and if they are that busy then I don't try and disrupt what they're doing*
> 18_S_Int_Patient_P5181

Other patients also stated that when nurses were busy, patients might put off asking questions:

> **P_Grace:** *I think it could have an effect [on how information is shared] if you weren't in the habit of asking [questions].*
> 7_S_Int_Patient_P0675

and:
> **P_Iris:** *I don't ask for a lot cos I know the nurses are busy.*
> 9_S_Int_Patient_P0691

Steve not asking questions because the nurses are busy is significant for him in terms of information exchange, particularly as he likes to ask lots of questions and to have lots of information:

> **P_Steve:** *I pay a lot of attention to what they tell me…they're [nurses] very good about telling you, you know, if you ask questions. All the nurses are good about explaining why they do certain things and, em, they'll tell you as much as you want to know. I would imagine some people don't want to know too much, but I quite like to ask a lot, know exactly what's going on.*
> 18_S_Int_Patient_P5181

In the interactions between Steve and Xena, and Steve and Wendy, there was little evidence of the nurses exerting power and control over Steve, other than Wendy

stating what nursing intervention she was going to carry out before discussing it with him, although she did ask for his consent:

> **N_Wendy:** *I'm just coming in to do your dressing. Is that okay?*
> 18_S_Obs_P5181&N5231

Both Xena and Wendy involved Steve by asking him questions, and responding to his questions, and there seemed to be a good flow of conversation particularly between Steve and Wendy. However, there was evidence to suggest that if patients were not cooperative, Wendy would exert power and control over them, using coercion or persuasion to gain patient compliance with treatment:

> **N_Wendy:** *Maybe they [patients] need the fear of God into them sometimes…you're trying to say, 'This is what might happen if you don't have the treatment', you know, so you kinda try.*
> 18_S_Int_Nurse_N5231

Wendy also used paternalistic language when discussing patients who are reluctant to accept treatment:

> **N_Wendy:** *We get that [patients reluctant to accept treatment] quite a lot, but sometimes you've got to reiterate to the patient, 'Look, it's for your benefit that you're here and you need to get this done'.*
> 18_S_Int_Nurse_N5231

And, although Wendy stated that she would respect a patient's wishes not to have treatment, she perceived these patients as difficult:

> **N_Wendy:** *Sometimes you will just get that awkward, obstinate patient that just won't do it [accept treatment], and that's it.*
> 18_S_Int_Nurse_N5231

Xena did not refer to patients as difficult, but stated that if nurses do not communicate well with patients then the relevant information may not get passed on:

> **N_Xena:** *If you're standoffish towards them [patients] then they'll be standoffish towards me, and then I'm not going to get the relevant information I need.*
>
> 18_S_Int_Nurse_N5241

However, Xena used paternalistic or patronising language when describing patients with dementia – the term she used was, *'pleasantly confused'.*

Withholding information, because sharing the information is deemed to be the role of the doctor, can lead to patient passivity, as can interruptions. The demands of the everyday work of nurses may lead to patients like Steve not asking questions, therefore not receiving sufficient information. Furthermore, coercion, persuasion, the use of paternalistic language, and underlying attitudes towards patients who do not want to accept treatment may foster further patient passivity, leading to the potential for insufficient information exchange.

7.5.6 The significance of 'Lost opportunities'

In every case in this study there was evidence of lost opportunities for sharing information, examples of which have been highlighted in the case studies. Lost opportunities to share information are significant in themselves because they potentially result in insufficient information being shared between patients and nurses. Lost opportunities for sharing information was linked with information withheld, power and control, and patient passivity, thus strengthening the argument that potentially insufficient information was shared between patients and nurses. Lost opportunities were evidenced in the form of interruptions, differing priorities and the demands of the nurse's job. The demands of the nurse's job sometimes resulted in patients not asking questions, therefore perpetuating further lost opportunities for

information exchange (Cases 7, 9 and 18). In Case 11, interruptions from another patient led to the interaction being terminated (a lost opportunity for information exchange). Interruptions highlight a lack of privacy (Case 17), can end conversations (Cases 5, 7, 11 and 15), may cause confusion for patients trying to glean information about their care (Case 4), and are perceived as inappropriate when patients and nurses are engaged in 'delicate' or distressing conversations (Cases 5 and 9). Lost opportunities for sharing information were evidenced in the form of differing priorities of the patient and the nurse (Cases 2, 4 and 8). However, when patients' and nurses' priorities differ there is the possibility that patients' care needs may not be being met. The demands of the nurse's job appeared to be the most common factor that resulted in lost opportunities for information exchange (Cases 1, 3, 4, 7, 8, 9, 11, 12, 14, 15, 17 and 18). Patients perceived that nurses were busy, and getting an opportunity to talk to nurses was problematic for both patients and nurses. Nurses being busy prevented patients from asking questions about their treatment and care.

7.5.7 'Power and Control': The importance of reflection

Although power and control is evidenced across many cases, nurses may have been unaware of their influence. For example, in Case 4, it was only during the interview that Kate appeared to consider that she withheld the information from Donald to gain his compliance. A further example is given from Case 16. It was only when asked at interview about who makes decisions regarding patients' treatment and care that the nurse responded:

> **N_Ian:** *It's almost as if I decide…it's just an ignorant thing on my behalf that I'm just giving how much [information] I think…I'm probably no' taking into consideration how much I think they [patients] know. It is kinda ignorant on my behalf probably. Who am I to say that they [patients] cannae take in the information?*
>
> 16_M_Int_Nurse_N0355

The data illustrates that given the opportunity to reflect on decision-making regarding treatment and care nurses may gain insight into the assumptions that they may make regarding patients' preferences for information. However the opportunity for reflection on practice did not arise during all the nurse interviews. Perhaps reflection could form part of educational programmes about information exchange and shared decision-making.

7.5.8 Summary of Section 7.5

The examples from the data presented so far, support the argument that 'Information not exchanged' and 'Barriers to information exchange' are interlinked. Withholding information can be a form of non-verbal coercion, and can inhibit information exchange. Withholding information, using paternalistic language that reinforces the power imbalance between patients and nurses, and using coercion or persuasion, often leads to patient passivity. Passive patients are less likely to ask questions therefore it is possible that insufficient information gets exchanged between them and the nurses caring for them. Lost opportunities for sharing information are evident across all the cases and can inhibit information exchange between patients and nurses. Thus the argument – that in my study often insufficient information was exchanged between patients and nurses – is strengthened.

7.6 Participants' perceptions of sufficiency of information

Despite the evidence from the observations to the contrary, participants generally perceived that they had exchanged sufficient information. Examples from the data are used to explain how 'Facilitators of information exchange' may have reinforced participants' perceptions of sufficiency of information.

The evidence presented in Sections 7.4 and 7.5 suggests that participants often did not give and receive sufficient information. However when questioned about 'amount of information' at interview, only one patient (Case 17) perceived that she received insufficient information, reporting that nurses were *'not forthcoming about discussing the medical condition'*. She stated that nurses engaged in *'information gathering'* rather than *'giving you information'.* She wondered if nurses were allowed to give certain information, and commented on specific, and important information that she felt was missing:

> ***P_Rose:*** *I'd prefer I was told maybe a bit more, but looking back, I've been here for four, five days, great everything's [tests] come back being all fine, but what do they think it is? One doctor says that…he thinks it's probably been a viral infection, but nobody's really…I'm bein discharged and it's like (shrugs shoulders). So do I come oot o' here, do I go to my work tomorrow do I? So I'm…maybe a lack o' information just now…What in their opinion could have caused this? What if it disnae get any better? How dae I manage the dizziness? Should I be driving, you know? I would like them [nurses] to be able to…if they're no' allowed at the moment…discuss your medical condition a bit more, more detail.*
> <div align="right">17_M_Int_Patient_P2179</div>

Rose also commented that when she asked questions often the nurse did not return with an answer:

> ***P_Rose:*** *Well, I had said to her [nurse], 'I take it that my last test has come back negative?' And she says yes she thinks it must have but she'd go and check, so but do I just get ready*

and leave, you know? Nobody's come back and said 'Oh aye it was fine'. And it must be, because they certainly wouldnae be letting me out the hospital, but they havenae come back and said so…so I still don't know, but I'm assuming that it's okay. I'm making that assumption, em, so I would think, if it wasnae then I wouldnae be goin home, but nobody's actually said, 'its fine'.

<div align="right">17_M_Int_Patient_P2179</div>

Rose stated that lack of information increased her anxiety. This is in contrast to nurses stating that they would withhold information in order to 'protect' patients and reduce their anxiety.

Patients who initially stated that they had received all the information they wanted, gave a conflicting account later in their interviews, as illustrated in Case 11:

R_VC: *Was there anything else that you would have liked her to tell you at that time? [About the wound dressing]*
P_Kirsty: *Well, no. I don't think so because I can't, she's looking at it, I can't see it unless I go into the toilet and look in the mirror.*

R_VC: *Was there anything else you would have liked her to have told you about your medications at that time?*
P_Kirsty: *I think she was quite thorough, yes. She mentioned every tablet I'm on so really and truly there was no reason for her to give me any more information cos I wasn't getting anything else.*

and:

R_VC: *How do you know when you've had enough information?*
P_Kirsty: *Can you ever get enough?*

<div align="right">11_M_Int_Patient_P4114</div>

Similarly, the patient in Case 16 stated that he did not want any further information from the nurse, however when asked how he knew he had enough information he replied:

P_Peter: *I don't think you ever get enough [information]*

<div align="right">16_M_Int_Patient_P0165</div>

Although patients may have received 'enough' information at certain times, there was a possibility that they would need to ask questions later. Patients in Cases 18 and 19 stated that other questions needed to be asked of other health professionals. For example Steve, the patient in Case 18, had a question to ask the nurse on night duty:

> **P_Steve:** *I meant to ask the night shift nurse about that [dose of medication] last night, but I can ask her again tonight, just ask her why she's only giving me half ones.*
>
> 18_S_Int_Patient_P5181

And, Tracy, the patient in Case 19, expected to receive more information from the doctors and physiotherapists involved in her care:

> **P_Tracy:** *I'll be getting more information probably later on because I need to go up to physio, so, you know, the physiotherapists give me a lot of information as well, you know.*
>
> 19_S_Int_Patient_P0620

Information exchange in ward settings may require information from across the healthcare team. Nurses play a pivotal role in information exchange as most other healthcare practitioners pass information to the nurse caring for the patient. Further research could focus on what information other healthcare professionals discuss with patients and whether or not they communicate with each other as to who has discussed what with the patient.

Despite the evidence presented regarding information withheld, lost opportunities for sharing information, power and control, and patient passivity, an overwhelming majority of patients and nurses stated that they *had* given and received 'enough' information. Their perceptions seemed to contradict the evidence therefore I

searched for explanations from the data as to why this might be so. Participants perceived they had given and received enough information because they had no further questions. There was evidence of information being exchanged prior to the observation sessions; for example, information that is shared between patients and consultants at clinic appointments prior to admission to hospital. Nurse participants said they could *'read'* patients and so assess whether or not patients have received enough information. From the data it emerged that, good relationships between patients and nurses, and nurses sharing information in lay person's terms, facilitated information exchange. The model presented (Figure 16) illustrates links between 'Information exchanged' and 'Facilitators of information exchange', and summarises how they may lead to perceptions of sufficient information exchange. I then discuss the following sub-categories – 'Questions', 'Information previously exchanged', 'Reading people', 'Relationships', and 'Lay terms' – and provide explanations as to why patients and nurses perceive that they have given and received sufficient information despite some of the evidence to the contrary.

Figure 16: Model of links between 'Information exchanged' and 'Facilitators of information exchange' that potentially reinforce perceptions of sufficient information exchange
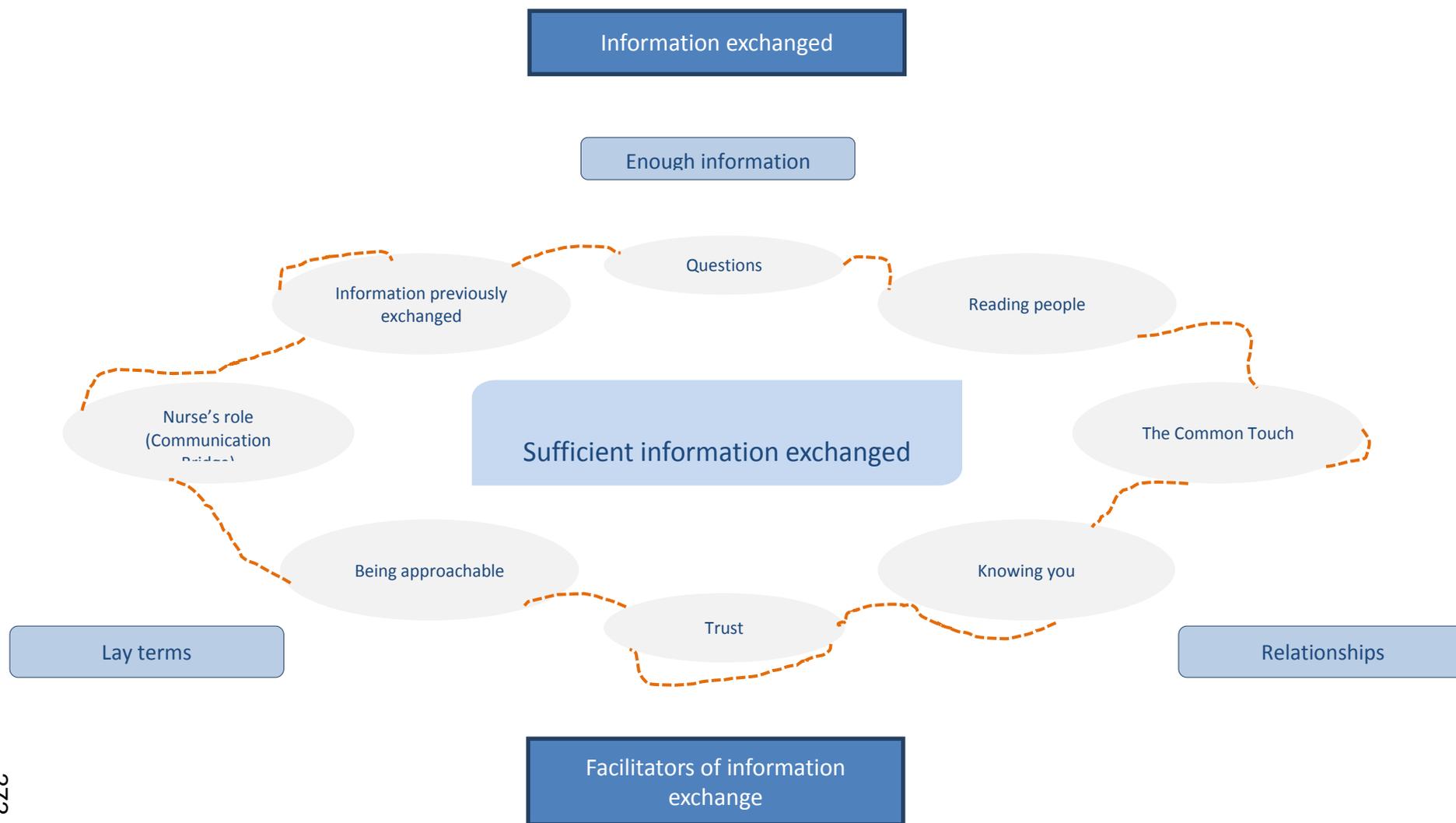
7.6.1 'Enough' information

7.6.1.1 Questions

Appendix 31 summarises the actual questions that patients and nurses asked in this study.

Nurses stated that they knew when patients had received 'enough' information because they were not asking any more questions. This concurred with patients who stated that if they wanted more information they would ask questions. Some patients perceived that they were given too much information at times, but not from nurses, for example:

> ***P_Tracy:*** *I've got a compression sock to help to reduce the swelling on my leg, so, there'll be information coming about that as well, you know, information from the physiotherapists and if any of the doctors just happen to show up with information, you know, you do get a lot of information. Sometimes you just feel as if you get kinda bombarded (laughs), you know, get used to it, you know. Its part of hospital life I suppose.*
> ***R_VC:*** *What do you do when you feel bombarded? (Both laugh)*
> ***P_Tracy:*** *I shut my ears off (laugh), you know, just shut down and look "No!" you know, that's what I do. I just shut down, and just like "Oh, enough, enough", you know.*
> 19_S_Int_Patient_P0620

No patients commented on feeling baffled with medical jargon from nurses, despite use of abbreviated language. Patients tended to associate medical jargon with doctors, and less technical conversations could be had with nurses (see 7.6.3).

Patients asked questions about non-technical aspects of care such as: personal care; nursing interventions; progress; discharge planning; medications, their condition, investigations, results, follow-up care, and social contexts. One patient

asked about a surgical procedure. He wanted to have a cyst excised instead of drained. Questions patients did not ask during the interactions, but mentioned at interview, related to menu items, cause of disease, self-care, driving and returning to work.

Nurses asked questions related to: patient's medications; patient's condition; social context; nursing interventions; patient's personal care; patient's preferences; referrals to other AHPs; test results; and any know allergies. Most questions that nurses asked related to patients' conditions, and the symptoms they experienced, or not, that day. As examples, questions were asked about bowel habits, passing urine, blood pressure, pain, nausea and breathlessness.

Nurses reported that some patients ask many questions. Other patients do not ask questions but *'just take the information on'* (Case 10). Nurses stated that anxious patients, and younger patients, ask more questions (Cases 17 and 18). Nurses also reported that older patients tended to ask questions of the nurse after the ward rounds, whereas younger patients *'they just ask the doctor'* (Case 18). Younger patients asking more questions and entering more easily into discussions with doctors, fits with the wider literature on how younger and more educated patients prefer to be more actively involved in their treatment and care (Florin et al. 2006).

Some patients in my study did not ask questions during the interactions observed. Patients not asking questions perhaps correlates with patients not wanting to ask questions if the nurses were busy. However, it may also correlate with patients stating that they had received 'enough' information. The difficulty with assessing

whether patients have had 'enough' information by the questions they ask is that patients may not know specifically what questions to ask. The patient in Case 17 who perceived that she did not receive sufficient information, was the only patient who identified the difficulty of not knowing what questions to ask:

> **P_Rose:** *As I say…the medical professionals say, 'Now remember, ask as many questions'. Give me a step for a hint before I start, do you know what I mean? I could ask totally irrelevant questions and if somebody could steer me in the right direction saying well that disnae really matter that, or do you know, a really important question is to ask A, B, C and D…I'm maybe no' asking the right questions cos I don't know. But I don't know how you get round it. Giving you information beforehand, I don't know…they say you can ask what you like, but…and I think that's why a lot of times I don't maybe ask as much because I don't really know what questions to ask.*
>
> <div align="right">17_M_Int_Patient_P2179</div>

Even though patients may have no further questions, we cannot be assured that they have received all the information relevant and sufficient for their needs.

7.6.1.2 *Information previously exchanged*

Another explanation for participants' perceptions of giving and receiving sufficient information is that some information may have been shared previously – prior to the interaction observed. This concurs with Bugge et al (2006) who suggest that sharing information previously may explain why information not exchanged during particular interactions is not necessarily problematic. For example, in Case 10, the nurse mentioned to Jack, the patient, that if he was still experiencing penile pain then she would get *'stuff'* sorted out for him. However, she did not elaborate on what *'stuff'* meant:

> **N_Cathy:** *Let me know though if you feel any pain or anything like that at all, or feel uncomfortable with it.*
> **P_Jack:** *Aye, it seems to be no' too bad.*
> **N_Cathy:** *And if you do we'll get stuff sorted out for you, alright?*

>   **P_Jack:** *Yep.*
>   10_S_Obs_Patient&Nurse_P6104&N0634

Jack was asked at interview if he knew what Cathy meant by 'stuff'. He stated that

they had discussed his discomfort and the treatment for it earlier in the day:

>   **P_Jack:** *Aye, yes you missed the conversation that I had this*
>   *morning, I would think, cos that's when she did mention cream*
>   *and everything…*
>   10_S_Int_Patient_P6104

There was evidence of information having been shared previously in the majority of

cases. Some participants perceived that sharing information occurred as an on-going

process, for example:

>   **N_Carol:** *We had the same conversation as I do every drug*
>   *round, just to ensure that she knows what she's on and that*
>   *we're giving her the correct information.*
>   11_M_Int_Nurse_N4294

and:

>   **P_Tracy:** *Yeah, [I get information at] various times of day, and,*
>   *more or less all day really, you know...*
>   19_S_Int_Patient_P2197

The on-going manner in which information is shared between patients and nurses in

ward settings differs from information exchange in one-to-one contexts between

patients and physicians. Information shared on previous occasions also links to the

notion of patients as experts. Sometimes it was not necessary for nurses to provide

any more information because patients already knew the information, perhaps due to

having a long-term condition. These patients had previously received information

about their condition from their GP or specialist nurse, and were expert in their own

conditions:

>   **P_Colin:** *I know the, I know the process…I know why. You*
>   *know I normally take my ain; I take my ain blood sugars when*
>   *I'm at home. I inject myself. But I know it all, well I'm no' tryin' to*

> *say I'm a know all, but I know what I've got to dae, [what's]*
> *required of you, so…*
>
> 03_S_Int_Patient_P0632

Nurses also commented on the on-going nature of information exchange. Information was shared with patients at various times and in a range of circumstances:

- Patients had prior knowledge due to living with a chronic condition or having been commenced on treatment over recent weeks and months (Cases 1, 3, 4, 5, 8, 11, 16, 18 and 19). In the majority of these cases, this prior knowledge related to medication.

- Information was often shared earlier the same day or in the days immediately preceding the observed interaction (Cases 1, 2, 3, 9, 10, 11, 16, 17 and 18). The information related to medications, dietician referrals, blood sugar monitoring, self-management of stoma care, wound care, and diagnosis. The information was shared either by nurses, other AHP's, or by doctors, and often at the ward round.

- Admitting patients to hospital appeared to provide an excellent opportunity for sharing information, which sometimes took place in a different ward (Cases 2, 3, 7 and 14).

- Information was often shared prior to the patient's admission, for example at a consultant or nurse-led clinic, a pre-operative assessment clinic, or at the GP surgery (Cases 3, 4, 10 and 19)

- Patients had prior knowledge of treatments and procedures based on their own previous experience of the same or similar treatments or procedures (Cases 3 and 19). Their experiences related to drain removal, and one-off episodes of pain for which strong painkillers were administered.

- One patient had previously received anecdotal information about urinary catheter removal from his neighbour (Case 4). However, the information received led the patient to perceive that catheter removal was painful and may induce a shock reaction. The nurse attempted to reassure him but the patient remained anxious.

7.6.1.3   Reading patients

Nurses commented on their ability to *'read'* patients *'non-verbal's',* that is, their body language and facial expressions, which may explain why they perceive that they share 'enough' information with patients:

> **N_Ivy:** *I think sometimes you do a lot of reading your patient…They would take it [information] without even asking but you can just tell by their face they've got a question they want answered…aye, their non-verbal's, and you can usually tell a wee bit you know, just confused about something and I would offer, I would volunteer the information.*
>
> 1_S_Int_Nurse_N0684

and:

> **N_Ian:** *You can always…och…sometimes you can tell by body…they just turn away fae you, or like you can see that they're no' really listening*
>
> 16_M_Int_Nurse_N0355

Nurses stated that patients 'turn away' or 'change the subject' when they do not want any more information. One nurse commented that reading patients is intuitive:

> **R_VC:** *When you said you assess to see how much patients want to know, how do you do that, how do you know?*
> **N_Oliver:** *I suppose in that respect, that's quite intuitive. You can pick up from a person's body language or their own terminology as they are talking to you, how anxious they are or how at ease they are with their own condition.*
>
> 9_S_Int_Nurse_N6151

Another nurse perceived that junior and inexperienced nurses are not as good at reading patients as experienced nurses:

N_Lesley: I think one of the key issues with being a very experienced communicator is that you are able to do non-verbal language very efficiently, while somebody who is junior and not that experienced doesn't often get the non-verbal cues, the body language, the avoidance of eye contact, that kind of stuff.
9_S_Int_Nurse_N6121

However the nurses in Cases 1 and 9, Ivy and Oliver, stated that they could read patients and were qualified for only one year. Being able to read patients may be an unreliable method of assessing sufficiency of information. This could be true of both experienced and inexperienced nurses, particularly as what we know from the pain literature is that nurses are not always good at reading patients (Dihle et al. 2006).

Other factors which facilitate information exchange, and which may explain why patients and nurses perceive they have exchanged sufficient information, relate to the relationships between patients and nurses, and to nurses providing information in lay terms.

7.6.2 Relationships

During the search for further explanations for why patients and nurses perceive they have exchanged sufficient information the theme of 'relationships' began to emerge. Four headings are used here to describe, and give meaning to, the data on relationships: 'Approachability'; 'Trust'; 'Knowing you'; and 'The common touch'. Each of these is discussed separately, however they are interlinked.

7.6.2.1   *Approachability*

Some nurses made it their aim to be approachable (Cases 3 and 9), which appeared to be effective as patients in Cases 1, 4 and 15 stated that many of the nurses were

approachable. Nurses being approachable may facilitate information exchange as patient/nurse relationships develop:

> *N_Oliver: You build up a mutual understanding of each other's environment, because… So we have an understanding of each other's lives and I think that does help when you have to go and the news that you have to tell the patient isn't as good as they expected or in some cases can be quite catastrophic. But it does help because they are then seeing you as, this isn't some random professional who has come to say you have this, that or the other wrong. This is somebody that I've built up an understanding of…*
>
> 9_S_Int_Nurse_N6151

Perhaps the first step towards building and developing good patient/nurse relationships is that of nurses being approachable. However one nurse perceived that being too approachable *'dilutes quality experiences'* (Case 9). She commented on over-familiarity and excessive chatting with some patients, which meant that there was little time for sharing information with other patients.

7.6.2.2   Trust

Patients trust the nurses to give them appropriate treatment and care, and trust the nurses to tell them the truth:

> *P_Jack: I don't think she's telling me any lies, you know, I mean she comes over as being honest. Know, when I say I take her word for it, it just basically means I don't think she's telling me any lies, I think she's telling me the truth, I think she's been truthful with me all along, so.*
>
> 10_S_Int_Patient_P6104

and:

> *P_Iris: Well, I think you're at ease with the person and, you know, if they're telling you something, it's about you, aye I trust the nurses. I trust the nurses to tell me the truth - if the wound's looking dirty, telling me, aye, aye. Or if I've been a nuisance, tell me, but I try not to be a nuisance.*
>
> 9_S_Int_Patient_P0691

Nurses may perceive that patients learn to trust them and feel comfortable with them as they get to know each other:

> **N_Olga:** *I suppose they [patients] just kinda, they get to know you and you get to know them, and they're quite happy to take and trust that you give them the correct medications and things…I think they need to kinda get that just to trust you and feel quite comfortable.*
>
> 13_M_Int_Nurse_N0416

Nurses may also perceive that patients learn to trust senior nurses to assist them or to advocate on their behalf:

> **Lesley:** *Patients, quite often I have found, see you also as somebody who is not involved in the day to day personal care of them, but somebody that they maybe would trust enough to say that persons got influence and they might be able to help me with something.*
>
> 9_S_Int_Nurse_N6121

Trust may be an important factor in deepening the patient/nurse relationship, which may facilitate information exchange further.

7.6.2.3 *Knowing you*

An interesting perception of relationships found in the data, which appeared to facilitate information exchange, and which warrants further investigation, was that of 'knowing you'. In a number of cases patients and nurses stated that they *'know'* each other, and indeed that a *'friendship'* had developed:

> **P_Kirsty:** *I've got quite close to some of them [nurses]…There's a friendship and all that. It's amazing.*
>
> 11_M_Int_Patient_P4114

Not only do they say they know each other, but they know each other *'quite well'* (Cases 2, 3, 5, 11 and 15). Knowing one another well appears to happen irrespective of how long ago they met one another. For example:

> **N_Duncan:** *I looked after him yesterday. I know him quite well.*
>
> 2_S_Int_Nurse_N0640

and:

> **N_Yvonne:** *I've looked after him for a long time really so I know him quite well.*
>
> 3_S_Int_Nurse_N6252

It would have been interesting to ascertain why it is they say they 'knew' one another even after a relatively short period of time. 'Knowing you' may also link with 'reading patients' (7.6.1.3). Perhaps the more the nurse and patient get to know each other, the easier it is to 'read' each other's non-verbal communication. Other authors have commented on patients and nurses 'knowing' each other (Bundgaard et al. 2012, Henderson et al. 2007, Luker et al. 2000, Kralik et al. 1997, Liaschenko 1997, Morse 1991). However, 'getting to know you' in these studies is related to delivering therapeutic care. No literature was found that discussed the significance of 'knowing you' and what that means for information exchange and shared decision-making.

7.6.2.4 The Common Touch

Good patient/ nurse relationships were defined by the patient in Case 1:

> **R_VC:** *How would you define a good relationship with the nurses?*
> **P_Alice:** *Just being able, I mean, being able to talk to them…talk to them about normal stuff no' just all medical things.*
>
> 1_S_Int_Patient_P0614

The *'normal stuff'* the patient was talking about was social interaction, and was described as 'The common touch' by one of the nurses:

> **N_Helen:** *Yes you're professional and you come in…but you kinda need to keep the common touch. I mean you can have somebody that's in hospital for months and months you know…they [patients] don't want to feel totally removed from the outside world.*
>
> 1_S_Int_Nurse_N0684

The common touch, as defined in this study, is not the same as physical touch. Rather, it appeared to help develop patient/nurse relationships through banter, and conversation of a social nature. For example, nurses stated that social communication helps '*build up a mutual understanding of each other's environments…and of each other's lives*' (Case 9) and helps you '*build a wee kinda relationship*' (Case 15). The common touch was described as a '*main technique for communication*' and some participants perceived that this more casual type of conversation '*lightens the day*' or lifts patients' spirits up (Cases 3, 5, 11, 12, 13 and 18). Other participants perceived that social communication creates a '*sense of normality*' (Cases 5 and 9), and helps patients to relax and '*take their minds off any worries or concerns*' (Cases 5, 10, 11, 14). However, it is difficult to know how the common touch was decided upon as it could mean different things to different people. For example, an acceptable level of banter may be appropriate for one patient but may not be appropriate for another. Also, some patients might tell you their life's history, and others prefer to remain relatively quiet.

Significantly, in this study, the common touch was perceived by participants to facilitate information exchange. For example, some perceived that social communication helps to pave the way for talking about '*bigger things*', for example something sensitive, embarrassing or distressing (Cases 3, 5 and 17). Other participants perceived that banter and social conversation helps patients '*open up*' and prevents patients from becoming '*stand-offish*' (Case 18). A tentative assumption might also be that the common touch is used by nurses to avoid serious conversations with patients. For example, nurses may want to keep the conversation light so that '*bigger things*' are not explored, particularly if the nurse is busy, or finds it

difficult to talk about difficult issues. Other nurses stated that the common touch makes dialogue with families easier (Case 19); whilst others commented that they may use the common touch to raise health promotion issues:

> **N_Ian:** *You can have a bit of a laugh wi' him, do you know what I mean? And he knows. He's either getting pulled up for eating sweeties [patient has diabetes], or getting pulled up for smoking in the toilet.*
>
> 16_M_Int_Nurse_N0355

Not all participants perceived the common touch as being helpful for information exchange and care management. Some nurses perceived that patients use banter to disguise anxiety (Case 10) or to avoid listening to what the nurse is saying (Case 1) perhaps if the information is serious. Furthermore, one of the nurses in Case 9 stated that the common touch made nurses too comfortable with patients, that social conversation was not therapeutic or educational, and stated that nurses are *'not here to chit chat'* and that she *'can't spend her whole day talking'.* This nurse preferred to discuss patients' goals and achievements, and use conversation as a health promotion tool.

7.6.3 Lay terms

Patients may have perceived that they have received sufficient information because nurses generally use terms that are easily understood by patients. Some nurses reported that a significant part of their job is to talk to patients 'on their level', and one of the ways they achieve this is by simplifying information for patients by not using jargon. Nurses reported that patients often ask questions after a ward round. Patients are less likely to ask questions of the doctor and often do not understand the content of the ward round discussion. Patients reported that nurses simplify

information after the ward rounds. One nurse described himself as a 'communication bridge' between patients and doctors:

> **N_Oliver:** *I think from a nursing perspective, we seem to be the communication bridge between medical staff and patients because doctors do tend to be very clinical and at times talk over the top of the patient.*
>
> 9_S_Int_Nurse_N6151

Patients preferred to hear information in 'plain English' (Cases 1, 2, 3, 9 10), further suggesting that speaking in lay terms facilitates information exchange. Hearing information in lay person's terms may reinforce patients' perceptions of sufficient information exchange because the information shared has been understood. In other words, there is the potential for 'easily understood' information to be perceived as 'enough information'.

7.7   Summary

The key findings in Chapter 7 lead to the generation of three hypotheses:

1. That information exchange between patients and nurses in ward settings may be insufficient perhaps due to information being withheld, lost opportunities for sharing information, patient passivity and issues of power and control.

2. That, contrary to my observation data, patients and nurses may perceive that information exchange between them is sufficient.

3. That Charles et al's (1997 and 1999) – (hereafter, the Charles model) concept of Information Exchange studied in this thesis is not applicable to ward settings.

These three hypotheses are explained next, and discussed further in Chapter 8.

My findings provide evidence of insufficient information being exchanged. The observation data point to participants withholding information, lost opportunities for

information exchange, patient passivity and issues of power and control. The fact that patients receive insufficient information at times is not new. However my study adds new insights to what is already known about information exchange by its focus on ward settings and its explanations of why insufficient information may be exchanged.

Nurses in my study exerted power and control over patients, albeit at times unwittingly. This power imbalance limits information exchange. Some nurses still refer to active patients as being 'difficult', 'awkward' and 'obstinate' if they do not comply with treatment, and some patients are still concerned with being 'good'. If nurses are socialised into paternalistic mind sets, and do not engage in meaningful information exchange with patients, then patients' preferences for information and for treatment risk being ignored. Nurses and patients may also be unable to reach agreement on which issues, or healthcare problems, are the most important. Consequently, the most positive health outcomes may not be achieved.

Patients and nurses in my study perceived that they received sufficient information despite the evidence to show that information was often not exchanged. All but one participant stated they had given and received enough information. Given that the observation data suggests otherwise, there may still be room for improvement in the amount of information exchanged between patients and nurses. Patients in my study perceived they had received enough information because they had no further questions. Nurses should perhaps be more aware of gaps in patients' knowledge.

I offer several possible explanations as to why patients may have stated that they received enough information.

- Information not exchanged is not necessarily problematic because information might have been shared previously, for example by a GP or clinical specialist nurse in primary care, or by a stoma nurse visiting the patient on a one-to-one basis on the ward. This explanation concurs with the findings of Bugge et al. (2006).

- Nurses working in a ward setting may present information differently than do health professionals working in a one-to-one context. For example, ward nurses may present information on an on-going basis, rather than all at one time. This repetition of certain information may give the impression that patients are receiving lots of information.

- Patients might be concerned with being 'good' patients, and feel that they have something to lose if they challenge nursing staff about the amount of information they have received.

- Patients and nurses perceived that they 'knew' each other, which appeared to equate with sufficient information.

Some of the explanations about the difference in patients' perceptions of sufficiency of information also form part of the basis of the third hypothesis above, that the Charles model may not be applicable in ward settings. For example, if information is being shared by other health professionals at different times, there may not be the same need for ward nurses to share that information. Furthermore, the ongoing manner in which nurses share information with inpatients may mean that there is not the same need to have one conversation in the same manner as in a one to one context. However, information exchange may still help in some patient/ nurse interactions. For example, patients sharing their social context, and nurses sharing

nursing knowledge, and both sharing all that is required for decision-making about discharge home, may help to decrease the number of failed discharges. Generally though, the Charles model may look different in ward contexts, taking account of the very different nature of patient/ nurse interactions in ward settings.

7.8   Conclusion

The findings presented in Chapter 7 add to what is known about information exchange. I have presented evidence to suggest that insufficient information was exchanged between patients and nurses during routine nursing care in ward settings. I have also described how participants perceived that they received sufficient information. I further suggest that the Charles model may not be applicable to ward settings. I discuss the key findings in greater detail in Chapter 8.

Chapter 8: Discussion

8.1 Introduction to chapter

In this chapter, the findings are discussed, based on the following research questions:

1. What information do patients and nurses exchange during routine nursing care?

2. Do patients and nurses perceive they have exchanged all the information relevant to their needs?

3. Do patients and nurses perceive they have exchanged all the information sufficient for their needs?

As suggested by Docherty and Smith (1999), this chapter begins with a summary of the main findings in Section 8.1.1, followed by a review of the strengths and limitations of the study in Sections 8.2 and 8.3, respectively. In Section 8.4, the main study findings are discussed and their importance for information exchange considered. Recommendations are made for nursing practice, education, research and policy in Section 8.5 and the thesis is concluded in Section 8.6.

8.1.1 Summary of the main findings

Two overarching findings from my study are; 1) that information exchange as conceptualised in the Charles model did not take place amongst the participants studied, and 2) that the Charles model is perhaps not applicable to ward settings. Other key findings are summarised by type, relevance and sufficiency of information, to reflect the research questions.

8.1.1.1 Type of information

Three key points emerged relating to type of information:

1. Patients do not distinguish between clinical and non-clinical interactions in the way that nurses and other health professionals do.

2. Few interactions related to patients' illnesses or conditions that had resulted in their hospital admission. Rather, information shared between patients and nurses was generally related to patients' presenting symptoms at the time of the interaction

3. Much of the information shared was socially based information.

There was evidence of information being shared previously but often between patients and health professionals other than ward nurses. These findings are discussed in Section 8.4.1.

8.1.1.2 Relevance of information

Two hypotheses were generated from the findings related to relevance of information, and are discussed in detail in Sections 8.4.2:

1. That patients' and nurses' perceptions of the relevance of information differed (8.4.2.1).

2. That information about social contexts appears to play a more significant role in information exchange between patients and nurses in ward settings than it does in other contexts (8.4.2.2).

8.1.1.3 Sufficiency of information

Three hypotheses were generated from the findings related to sufficiency of information.

1. That information exchange between patients and nurses in ward settings may be insufficient perhaps due to information being withheld, lost opportunities for sharing information, patient passivity and issues of power and control (8.4.3.1).

2. That, contrary to my observation data, patients and nurses may perceive that information exchange between them is sufficient (8.4.3.2).

3. That the Charles model is not applicable to ward settings.

The Charles model may not be applicable in ward settings because patient/ nurse interactions are different in ward setting to interactions in one-to-one contexts. Furthermore, lost opportunities, interruptions, and the demands of nurses' work may not be conducive to interactions involving information exchange.

Information was generally provided by nurses, and not exchanged, in the majority of patient/ nurse interactions. A one-way transfer of information from health professionals to patients is indicative of a paternalistic approach (Charles et al 1999). Patient involvement in treatment and care was not the norm and nurses often made assumptions about patients' information needs.

Contrary to the observation data participants perceived that they had given and received sufficient information. The nature of 'snapshot' data collection may explain this finding (8.3.1). However, some evidence suggested that information exchanged previously, therapeutic relationships between patients and nurses, and the use of lay person's terms, may explain patients' perceptions of sufficiency of information.

8.2   Strengths of the research

8.2.1 Uniqueness

My study is unique because no other studies have specifically explored information exchange between patients and nurses during routine nursing care in acute ward settings, to date. Government policies and reports detail best practice in relation to shared decision-making between patients and health professionals, of which information exchange is a part, across the healthcare sector (Department of Health 2012, Scottish Government 2007, Department of Health 2004). However, most of the research to date focuses on contexts out-with ward settings. Ward settings matter because of the acuteness of patients' illnesses, patients' stages of rehabilitation, and the potential difference in patients' information needs and preferred level of involvement in information exchange.

My study is also unique because I used innovative data collection methods during the observation sessions, which add new knowledge to the practical and ethical issues of observation research in ward settings. Specifically, I was able to collect observation data whilst remaining outside of patients' fields of vision, and often outside of patients' rooms. Collecting data in this way had certain benefits: it overcame the ethical challenges of recording conversations in wards; and it may have reduced any Hawthorne effect (Kumar 2011, and 8.3.1). However, the most important benefit was that it kept data collection patient-focussed.

8.2.2 Patient centeredness

Keeping patients at the centre of my research contributed to new understandings about patients' perceptions of relevance and sufficiency of information. Although the

participants in my research were patients and nurses, each case was patient-focussed, comprising a patient, the nurses caring for the patient, and the interactions between them. Previous nursing research into patients' information needs is often nurse-focussed (Sahlsten et al. 2007, May et al. 2006, Lithner and Zilling 2000). Patient centeredness is important given that it is high on the agendas of quality of care policy, good research practice, and other UK health strategies and reports (Francis 2013, Department of Health 2012, Coulter and Collins 2011, Scottish Government 2010, Long Term Conditions Alliance Scotland 2008, Scottish Government 2008, Scottish Executive 2006, Department of Health 2005).

8.2.3 Methodological strengths

Multiple-case study design facilitates a cumulative development of knowledge and theories (George and Bennett 2005), by the comparing and contrasting of within-case and across-case data. I used the strengths of case study methodology (3.6), including the use of multiple data collection methods, to arrive at new knowledge about the meanings participants attribute to the information they received. Deriving data from primary sources such as observations and interviews was crucial for the development of this new knowledge, as (Walliman 2005) argues, which is a primary concern for PhD study.

Observation and field note data captured real-time interactions. Real-time interactions facilitated within-case comparisons between the observations and the accounts given by participants during the interviews. Conflicting accounts resulted in a robust analysis of the data looking for deeper explanations for the differences found.

Method triangulation strengthened the within-case and cross-case analysis (Denzin and Lincoln 2008). I used non-participant observations, field notes, and individual interviews, to strengthen the robustness of the data analysis and to demonstrate my commitment to providing verification (Stake 2006, Miles and Huberman 1994). Using only one data collection method may not adequately solve issues around possible conflicting data, and can make the study more vulnerable to errors associated with that method (Patton 2002). However, using method triangulation, I analysed different types of data in the search for deeper meanings and explanations related to information exchange in ward settings. In particular, I used triangulation for completeness in order to capture varied, and even conflicting, data, giving more depth to the analysis (Jones and Bugge 2006, Shih 1998, Fielding and Fielding 1986).

I can make generalizations in the following terms: my sample size was large in case study terms; I demonstrated connections between concepts that emerged from within the cases and across the cases; and I have made *'moderatum generalizations'* (Williams 2000:215) because the ward types and participant characteristics were typical of teaching hospitals in the UK. These terms are explained next.

A particular strength of my study design was that my sample size was large in case study terms. Often case studies have one case, and multiple case studies may have six or seven cases. However, with nineteen cases in my study I am able to make some generalizations from the data I collected. Furthermore, in each of Chapters 5, 6 and 7, I consistently demonstrated connections between concepts that emerged

from within the cases and across the cases. Demonstrating these connections concurs with Bryman (2012) who states that the main question around generalizability in qualitative research is not whether it is generalizable to populations but whether or not it establishes connections between the ideas that have been developed out of the data. Yin (2009) calls this analytic generalisation. Therefore, taking Bryman's and Yin's stances, I made some analytical generalisations from the cases that may be useful to consider in other comparable situations. Williams (2000) disagrees with Bryman and suggests that generalizations can be made about populations, and that problems with sampling can limit generalization. However, Williams (2000) also states that not only can qualitative researchers generalize about their findings; but also it is inevitable that they do. He describes what he calls *'moderatum generalizations'* suggesting that they are found in *'instances of a broader recognisable set of features'* (Williams 2000:215). Concurring with Williams (2000), another strength of my study was that the ward types were typical of teaching hospitals in the UK as were some of the nurse and patient characteristics, for example, age, gender, and nurse banding. This typicality suggests that my findings may be transferable to other similar hospital contexts with similar socio-demographics. In the words of Williams (2000), I made *'moderatum generalizations'* from my findings that may be useful for future research in similar contexts (8.5).

8.2.4 Credibility

Using ethically reviewed protocols enhanced the credibility and reliability of my research. Good research practice includes a commitment to ethical and professional standards (MRC 2012, Department of Health 2005). A total of four ethical reviews

were undertaken. As a PhD student, my protocols required review by the ethics committee in the School as well as by the NHS Research Ethics Committee. Two ethical reviews were required for the pilot study and two for the main study.

One principle of good research practice is honesty and transparency (MRC 2012). The MRC suggest that one way of achieving this principle is to engage in a peer review process. Peer debriefing during supervision meetings, with supervisors experienced in qualitative research methods, enhanced the credibility of my study (Stommel and Wills 2004). My supervisors often adopted the role of devil's advocate (Lincoln and Guba 1985) questioning and challenging the methodological and analytical decisions I made. For example, to encourage me to move away from descriptive writing and attain depth of analysis, I was often asked of my work, *'So what?'*, or, *'What are the headlines?'* At other times, supervision was somewhat cathartic as I was given opportunities to reflect on how I felt about the research and about my progress (Cresswell 2013). To increase credibility and maintain transparency, I kept written accounts of my supervision sessions both formally in the form of 'Records of supervision' as required by the University, and informally in my research journal.

8.3 Limitations of the research

8.3.1 Methodological limitations

The observation sessions were limited to ninety minutes per session, which may have resulted in 'snapshot' data collection. 'Snapshot' data collection will likely have had a bearing on some of the core findings. For example, it may explain why some information was provided and not exchanged, or why some information appeared not

to be shared or provided. Snapshot data collection may also explain why few interactions related to patients' illnesses or conditions that resulted in their hospital admission. However, the data collection methods were tested in the pilot study, which informed the times of the observation sessions for the main study. Most of the observation sessions were undertaken in the mornings as the data from the pilot study showed that most nursing procedures, occurred at this time. Therefore, although the data collection was 'snapshot', a substantial number of nursing interactions were taking place during these times. Even if the observation sessions had lasted three hours, the maximum amount some recommend for non-participant observation (Barbour 2008, Casey 2007), the information given and received may still have been limited.

Using a remotely controlled audio-recording system appeared to be successful in limiting any Hawthorne effect. The Hawthorne effect is a phenomenon which means that participants may become aware of someone observing them and their subsequent changed behaviour can distort or confound the data (Kumar 2011, Patton 2002). Participants may become anxious or self-conscious (Patton 2002), or behave in the way they think the researcher wants them to behave (Wood and Ross-Kerr 2011). Because I used unobtrusive measures, and visited the wards regularly in an attempt to have the potential participants get used to my presence, I believe I limited the Hawthorne effect. For example, one nurse, when asked when she would be available for interview, replied: '*Oh, have you recorded us already?*' (Ivy, Case 1). It is not possible to eliminate the Hawthorne effect, but as Wood and Ross-Kerr (2011) and Patton (2002) suggest, it can be minimized or accounted for. The Hawthorne effect was only evident in one case. In Case 10, Carol, the nurse,

commented on how strange it was, knowing that she was being recorded. However, I reduced any potential Hawthorne effect as much as possible, anticipating that any confounding of the data in relation to information exchange would be minimal.

8.3.2 Volunteer bias

It is arguable that only nurses with self-defined good communication skills would consent to take part in a study where their interactions with patients were being observed and audio-recorded. The majority of nurses taking part in my study appeared to be personable and communicative. Accordingly, volunteer bias may have skewed the data, perhaps resulting in interactions involving more banter, humour and rapport. However, good communication was not the focus of this study. The information sheets given to participants prior to their consenting to take part stated that the focus was information exchange. Therefore, they took part in the study knowing that I was interested in how information was exchanged. However, even with that knowledge, nurses and patients tended to provide rather than exchange information.

8.3.3 Verification

Verification is used to assess the trustworthiness of a study and can be perceived as an indication of quality in qualitative research (Cresswell 2013). One way to assess the quality of a study is by member checking, which involves going back to participants to ask whether the researchers understanding of, for example, interview data is reliable (Cresswell 2013, Kvale and Brinkmann 2009). However, member checking is just one strategy used to assess the quality of qualitative research (8.2.4). Some authors criticize member checking stating that whilst participants have

much to offer, their comments should be regarded as further sources of data and insight and not be confused with validity (Silverman 2013, Bryman 1988, Fielding and Fielding 1986, Bloor 1983). I was unable to verify my understandings of the data with the participants, which may have resulted in some researcher bias. To minimize this problem, I kept field notes where I reflected on my effect on and understandings of the data as it was collected. I also discussed my biases with my supervisors. For example, my supervisors, on reading some of my analysis, would ask, 'Is this what the participant *actually* said?' providing me with an opportunity to review and reflect on whether or not I had misinterpreted, or misrepresented, the participants. Some authors argue that having the raw data is sufficient for verification (Patton 2002). I have illustrated my findings throughout with raw data.

8.4   Discussion of the findings

Information exchange during a variety of routine nursing interventions in ward settings is an under-explored area. My thesis demonstrates a contribution to knowledge of the existing discourse on information exchange. The main findings are discussed here in relation to the research questions (see Section 8.1), which related to type, relevance and sufficiency of information exchanged. Some findings overlap but are only discussed in one section. For example, a key finding from Chapter 5 is that patients and nurses share many social interactions; however in Chapter 6 the relevance of these social interactions is significant for patients' well-being and for nurses' assessments of patients. Therefore, the findings related to social interactions are only discussed once (8.4.2).

8.4.1 Discussion related to type of information

Data from my study suggested that patients do not distinguish between clinical and non-clinical information in the same way that nurses and other health professionals (and perhaps, researchers) do. Nor does it appear to matter to patients whether interactions were clinical or non-clinical. Instead, patients were more interested in information that affected them personally, for example, getting the appropriate medication or whether to see the GP after discharge.

My findings are similar to those about patients' perceptions of types of interactions. The literature evidences that patients do not consider whether or not interactions are clinical or non-clinical, but they are more likely focussed on interactions that provide information about any impact there may be on, for example, their quality of life, or their levels of pain. For example, when Beaver et al. (2010) asked about care needs information, the dominant theme from patients' responses was 'knowing what to expect' after bowel surgery. Patients did not divide interactions or information into 'clinical' or 'non-clinical'. Similarly, in Japan, Tsuchiya and Horn (2009) found that breast cancer patients perceived treatment information as important if it told them how they would be affected personally. These patients wanted to know how to minimise the impact of treatment, and how to lead as normal a life as possible; they were focussed on the effects of treatment rather than on information about the treatment itself. Similarly, Koutsopoulou et al. (2010) reported that patients with cancer liked information if it indicated the impact of symptom management on everyday life, and Paul et al. (2004) reported that intensive care patients and their relatives focused on information that told them what to expect about the impact on patients of transfer from intensive care to an acute ward.

Conversely, health professionals and researchers seem more focussed on information as being 'clinical'. For example, Grad et al. (2011) assessed the value of clinical information and found that physicians addressed clinical problems with clinical information. Information is labelled as 'clinical' or 'non-clinical' by Rowlands et al. (2012) who stated that MDT discharge summaries were a means of providing both clinical and non-clinical information. Other more nursing focussed literature also differentiates between clinical or non-clinical aspects of care (Jacobs 2000, Sainio and Lauri 2003, Smith and Liles 2007, Suhonen and Leino-Kilpi 2006). This emphasis on clinical information may result in health professionals' interactions with patients being clinically focussed.

The differences in the literature, about types of interactions, are important because they have an impact on research and on practice. Research with patients, which focuses on researchers' or health professionals' perceptions of types of information, is likely to gather more information from health professionals' points of view. However, research on information needs with patients, which does not pre-label types of interaction or information is perhaps more likely to achieve results from patients' perspectives, which in turn may be more meaningful to them. These results from patients' perspectives are less likely to be divided into clinical and non-clinical interactions. In my study, I initially explored clinical and non-clinical interactions as much of the literature distinguished them as such. In terms of practice, it may be more helpful and useful to patients if health professionals, including nurses in ward settings, shared information in a meaningful way to patients. Patients often want clinical information; therefore, if clinical information is to be shared, then it could be shared in a manner that takes account of any impact on the individual patient.

In my study, nurses stated that they had clinical interactions with patients, as well as distinguishing between clinical and non-clinical interactions. However, there generally appeared to be a difference in what some nurses said they did and what they did in practice. Although nurses stated that an interaction was clinical, there was often no evidence of this. For example, the action of the nurse may have been clinical, for example monitoring of blood sugar, however, the actual interaction was non-clinical, for example a discussion about dogs. Some nurses perceived that interactions were a combination of clinical or non-clinical interactions. However, the tendency of nurses was still to conceive of distinguishing between the two types of interaction, whereas patients perceived the same interactions differently. Few interactions related to patients' illnesses or conditions that had resulted in their hospital admission. Instead, there was a focus on patients' current symptoms at the time of the interaction, or on their progress. Similarly, nurses generally did not share information about the nursing interventions they were undertaking at the time, instead using the opportunity to ask patients about possible symptoms.

My findings are contrary to much of what is already known about information exchange in other healthcare contexts, and about patients' information needs from nurses. In the literature we read that patients consistently want information about their condition or natural history of disease, treatment (including risks and benefits), treatment options, and related treatment outcomes (Andreassen et al. 2007, Beaver and Booth 2007, Entwistle and Watt 2006, van den Brink-Muinen et al. 2006). Current nursing literature reports that patients want information about their condition or the natural history of their disease from nurses (Logan et al. 2008, Smith and Liles 2007, Suhonen and Leino-Kilpi 2006, Suhonen et al. 2005). Apart from the study by

Logan et al. (2008) which was undertaken in a nurse-led clinic, other authors reporting in the nursing literature conducted their research in ward settings (Smith and Liles 2007, Suhonen et al. 2005), or reviewed other research conducted in ward settings (Suhonen and Leino-Kilpi 2006). An explanation for the difference in findings could be due to methodological differences or to the authors not having a focus on information exchange. For example, Suhonen et al. (2005) and Smith and Liles (2007) undertook quantitative research using pre-determined data collection tools on patients' information needs, on which information about current symptoms was not cited. Furthermore, the review by Suhonen and Leino-Kilpi (2006) focused on the provision of information from nurses to patients rather than on information exchange between patients and nurses.

In my study, it was possible to establish that interactions relating to current symptoms took place, by using real time data collection methods. Interactions about patients' illnesses and conditions may have taken place at different times of the day, or, for example, on admission to the ward. However, it is also possible that this type of information may not have been given much importance. Patients in my study generally did not ask about treatment or about the illnesses or conditions that had resulted in their hospital admission. Nurses generally only asked patients about their current condition and did not offer information about illness, treatment or nursing interventions. Issues relating to asking questions and not offering certain information are discussed in Section 8.4. However, here I purport that patients may only provide nurses with the information requested by nurses, therefore if nurses' questions are mainly related to patients' current symptoms it is possible that interactions relating to other types of information may be inhibited. Questions remain as to why nurses in

my study did not discuss or ask questions of patients about information related to illnesses or conditions resulting in hospital admission, or about treatment or nursing interventions.

Turning the focus of research away from information provision, and towards information exchange, has been crucial in eliciting data about the information travelling between patients and nurses. This change of focus has helped to establish new knowledge in the areas of both information needs and information exchange. My study has highlighted an underexplored area of information exchange. Patients do not distinguish between different types of interactions in the same way that nurses do. Acknowledging this may help nurses engage in interactions with patients that offer information in a way that is more meaningful for patients. Acknowledging that patients and nurses in ward contexts may not share information about patients' illnesses or treatments, or about nursing interventions, but instead may share information about patients' current symptoms, such as pain and nausea, also adds a new dimension to what is known in this field. Not discussing all of the information that results in patients' admissions, in the context of current care interventions, may limit patient contribution to information exchange, and subsequently limit their involvement in decision-making (Towle and Godolphin 1999). I assert that not having all the information potentially affects decision-making and care outcomes.

8.4.2 Discussion of relevance of information

Two hypotheses generated from the findings are discussed in this section: the difference in perceptions of the relevance of information (8.4.2.1); and, the significance of information based on patients' social contexts (8.4.2.2).

8.4.2.1   Differences in perceptions of relevance of information

Patients' and nurses' perceptions of the relevance of information differed. Information was relevant to patients for a variety of reasons such as for wellbeing, self-care and socialisation. Nurses' perceptions of the relevance of information were mainly related to assessment and planning of patient care. Possible explanations for these differences in perceptions could be related to patients perhaps being less familiar with the ward environment than nurses, and nurse education perhaps being focussed on assessment and planning of patient-centred care.

My findings on the perceived relevance of information for patients and nurses illustrate how patients and nurses perceived information as relevant for different purposes. This new knowledge contributes to our understanding of information exchange. Information being relevant for different purposes may result in nurses making assumptions about why patients need or want information. From the literature, it is known that nurses make assumptions about patients' care needs. For example, nurses assumptions of patients' pain levels falls short of the actual pain that patients experience, resulting in inadequate pain management (Chung et al. 2001, Klopfenstein et al. 2000). Similarly, from my study data, there was the potential for nurses to make assumptions about patients' anxieties and therefore make assumptions about what type of information patients need, and the relevance of the information given and received.

Being unfamiliar with the ward environment may be the reason why patients perceive information differently from nurses. Patients in my study wanted information for reducing anxiety. Nurses have a role in providing information to help reduce patient

anxiety (Inman et al. 2013, Costa 2001). Not knowing how to behave in an unfamiliar environment can create feelings of stress (Paluck and Shepherd 2012, Leary 2010, Cialdini and Trost 1998). Patients already have the stress of being unwell as well as having the stress of being in an unfamiliar environment. Traditionally, the expected behavioural norm for patients is that of the 'sick role' (Parsons 2012). Current discourse in the UK advocates a move away from this traditional model of healthcare into a collaborative approach between patients and health professionals (Department of Health 2004, Scottish Executive 2003). However, paternalistic approaches are still evident in healthcare today (see Section 8.4.3.1 for references and further discussion). Perceived loss of control in an unfamiliar environment can cause patient hospital anxiety (Bailey 2010, Gillen et al. 2008). Patient hospital anxiety is well documented (McIntosh and Adams 2011, Shuldham et al. 1995, Wilson-Barnett 1976) and as well as being caused by loss of control, it has been attributed to anticipation of a procedure (Starkweather et al. 2006, Leach et al. 2000, McCleane and Cooper 1990) and negative professional encounters (Jangland et al. 2009). Patient hospital anxiety has been reported in various settings including pre-operative care (Coll and Ameen 2006, Costa 2001, Caumo et al. 2001) and in transferring patients from intensive care units to ward environments (Brodsky-Israeli and Ganz 2011, Margarey and McCutcheon 2005).

Assumptions about patients' information needs also occur in research where nurses are asked to identify patients' information needs (May et al. 2006, Lithner and Zilling 2000, Turton 1998). What weakens these studies is the failure to ask patients what information they need, if indeed patients know what information they need. In Chapter 5 I suggested that nurses do not always respond appropriately to patients'

emotional concerns and noted that nurses often did not discuss nursing interventions with patients – nurses generally told patients what intervention was going to be undertaken and when. A review by Suhonen and Leino-Kilpi (2006) reports that by assessing and identifying patients' problems and needs, relevant information can be given to patients. However, as patients and nurses in my study perceive information as relevant for different purposes there is a risk that patient information could be based on nurses' perspectives. Perhaps nurses could be more cognisant of the individuality of each patient, and assess patients' needs for reassurance, and not only in relation to nursing interventions, in order to tailor specific information to patients' specific needs. However, spending time to assess patients' needs for reassurance and socialisation may be difficult to achieve given the heavy demand on nurses. Nevertheless, even a brief encounter between patients and nurses with elements of information exchange might bring together each perspective and work towards outcomes that are inclusive of all parties in the interaction.

To highlight the difference in perceived relevance of information, while patients perceived information shared or provided during their interactions with nurses as being relevant for reducing anxiety and for socialisation, nurses perceived information from the same interactions as being important for assessment and planning of patient care. An explanation for why nurses perceive information as being important for assessment and care planning is that nurse education focusses on patient-centred care, about which assessment, care planning and decision-making play a significant role (Cliff 2012, Benner et al. 2010, McCarthy 2006). It is possible that this focus on patient-centred care, with an emphasis on nursing

activities such as assessment of patients' care needs, resulted in the information nurses received as being relevant for these purposes.

8.4.2.2   The significance of information based on social contexts

Information based on patients social contexts, which participants considered significant, were common in my study. They appeared to be significantly relevant for patients, for example for well-being (6.3.1) and for maintaining a sense of normality (6.3.4). However, information based on social contexts are not commonly reported in the shared decision-making or information exchange literature in terms of significance. Being set in a ward context may account for some of the differences in my findings compared to those of others whose research was based in primary care or in acute care consultations (for example, Entwistle and Watt 2006 and van den Brink-Muinen 2006). Perhaps the context of my study afforded these types of interactions, whereas other studies, set in one-to-one contexts, are more likely to have a specific consultation agenda. Another reason for information based on social contexts being significant in my study, and as illustrated in the literature review (Section 2.8.2), is that the information that patients want to exchange with nurses in wards may be different from the information that they want to exchange with consultants and GPs. The literature tells us that patients want information of a more technical nature from doctors than from nurses, for example about treatment and the risks and benefits of treatment (Andreassen et al. 2007, Beaver and Booth 2007, Entwistle et al. 2006). In a study reporting on patients' perceptions of doctors' and nurses' roles in primary care, patients perceived the roles of doctors and nurses as hierarchical (Redsell et al. 2007). They preferred to see doctors when they considered that their symptoms were serious and nurses when they presented with minor symptoms or when they wanted reassurance. Banter between patients and

nurses was common in my study, however *'the playful and friendly exchange of teasing remarks'* (Oxford Dictionary Online 2013) is perhaps not considered to be appropriate in a consultant or GP consultation particularly if patients do not perceive that this is the purpose of the consultation agenda. Furthermore, patients are perhaps not looking to physicians in consultations to help them maintain a sense of normality in the same way as to nurses when they have been admitted to a less familiar environment like a hospital ward.

Information exchange between patients and nurses in ward settings is an underdeveloped area. Authors reporting in the nursing literature on patients information needs do not report on the significance of banter, humour and rapport perhaps because these authors (for example, May et al. 2006, Suhonen et al. 2005, Jacobs 2000) are focussed on information provision from nurses to patients. My study is unique as it focusses on information exchange and therefore full interactions and not just instances of information provision, between patients and nurses during routing nursing care were observed and analysed. Using this approach meant that I found that it was patients who generally initiated information based on social contexts involving humour, banter and rapport, a finding that is not evident in other studies.

The frequency and significance of information based on social contexts, in ward settings, has implications for information exchange. These types of interactions are important for patients; however nurses also need to plan appropriate care with patients. Information exchange between nurses and patients in ward settings is not merely nurses passing on clinical information and patients passing on their values

and preferences, as described by Charles et al (1999 and 1997). Information exchange in ward settings may be more complex, and nurses need to recognise any clinical cues that patients may share, perhaps even inadvertently at times, in a socially based interaction. In my study, banter and humour were generally spontaneous and were perhaps helpful for forming relationships and alleviating anxiety. It is possible that these socially based interactions hold information about patients that only socially and emotionally skilled nurses would be able to glean. Perhaps, and as McCreaddie (2010) would suggest, banter, humour and rapport can be used as vehicles for getting other more serious points across. Furthermore, nurses' self-reported role as a *'communication bridge'* between patients and doctors means that they need to take clinically factual information from doctors, for example at ward rounds, and interpret it for the patient according to each patient's unique life perspective and preference for information. I suggest that information exchange between patients and nurses in ward settings is complex rather than being a one-off event, requiring vigilance and high-level listening skills from the nurse in order that information is exchanged in a patient-centred, relevant way and appropriate care is planned.

8.4.3 Discussion on the sufficiency of information

Three hypotheses were generated from the findings related to sufficiency of information.

1. That information exchange between patients and nurses in ward settings may be insufficient perhaps due to information being withheld, lost opportunities for sharing information, patient passivity and issues of power and control (8.4.3.1).

2. That, contrary to my observation data, patients and nurses may perceive that information exchange between them is sufficient (8.4.3.2).

3. That the Charles model is not applicable to ward settings (8.4.3.3).

8.4.3.1   Observed paternalism

Evidence of information provision rather than information exchange corresponded with the paternalistic model of decision-making described by Charles et al. (1999 and 1997). Findings related to paternalism were noted in Chapters 5 and 6; however, I presented more detailed evidence of paternalism in Chapter 7. Paternalism was evidenced by: information being provided and not exchanged; patient involvement in decision-making and in treatment and care not being the norm; and, nurses making assumptions about patients' information needs and their perceived relevance of information. The data suggest that nurses' approaches to patients were often paternalistic.

Information was provided rather than exchanged during many patient/nurse interactions. Similarities exist between my findings and others who report information provision, rather than information exchange, as being the norm (Logan et al. 2008, Entwistle and Watt 2006, Elwyn et al. 2001, Elwyn et al. 1999). The dates of these papers just cited suggest that, despite change in policy, change may not be taking place across various care delivery contexts. Information provision can be problematic as it may limit opportunities for dialogue, and reveals a power divide between patients and health professionals (Lee and Garvin 2003). In my study, information provision was linked to the differing priorities of patients and nurses, which resulted in lost opportunities for sharing information. Information provision was also linked to time constraints and the demands of nursing activities.

From the observation data in my study, patient involvement in decision-making and in treatment and care was not the norm. The literature identifies that advancement of the patient involvement agenda is slow (Forbat et al. 2009). The barriers to patient involvement and decision-making are reported as being: difficulties with conceptions of patient involvement (Forbat et al. 2009); shared decision-making being time consuming (Arnetz et al. 2008); shared decision-making increasing an already strained workload (Friedberg et al. 2013, Arnetz et al. 2008); and a lack of training (Friedberg et al. 2013). Data from my study concurred with Friedberg et al. (2013) and Arnetz et al. (2008). Lost opportunities for information exchange resulted from lack of time, interruptions and the demands of nursing tasks on nurses. Patients and nurses were unaware of the role of information exchange in decision-making and patient involvement, highlighting a lack of communication and training on such concepts. However, it is also possible that the observed paternalism prevented meaningful information exchange and patient involvement. In my study there was evidence of information being withheld and issues of power and control. Withholding information may be a type of non-verbal coercion. Several authors and reports, such as the one by Coulter and Collins (2011), recognise paternalism in healthcare, highlight barriers to shared decision-making in practice and suggest various strategies for improved shared decision-making practice. However, these strategies are based on what is already known about information exchange and shared decision-making, perhaps not taking account of any differences with the people involved or the context. Information exchange and shared decision-making perhaps cannot be perceived as a 'one size fits all' strategy for involving patients in their treatment and care. My study is an early exploration into information exchange between patients and nurses in ward settings. Therefore, it would be inappropriate to

propose major changes to education and training on information exchange and shared decision-making. However, even small changes in practice and education would improve information exchange until information exchange between patients and nurses in ward settings is further researched.

8.4.3.2 *Participants perceptions of sufficiency of information exchange*

The majority of participants in my study perceived that they had given and had received sufficient information. This perception of sufficiency of information appeared to be based on having questions answered (7.6.1.1); therapeutic patient/nurse relationships (7.6.2); and receiving information in lay terms (7.6.3). It appears that despite a paternalistic approach by nurses, as observed by the researcher, patients and nurses in my study stated that they *had* received enough information. This new knowledge is in contrast to what other authors have found. For example, a significant problem related to paternalistic approaches seems to be that where paternalism prevails, patients report that they have *not* received enough information (Frongillo et al. 2013, Selman et al. 2009, van den Brink-Muinen et al. 2006, Suhonen and Leino-Kilpi 2006, Entwistle et al. 2006, Doherty and Doherty 2005, Ford et al. 2003). I explain this dichotomy as follows:

- Interactions took place on an on-going basis

- Participants defined 'enough' information as 'having no more questions' and stated that they had received answers to their questions

- Patients equated good patient/nurse relationships with 'enough' information

- Receiving information in lay person's terms, particularly from nurses explaining what was discussed at ward rounds, increased patients' perceptions of sufficiency of information

- Some patients in my study were concerned about being 'good' patients and perhaps did not want to report that they had not received enough information

Each of these explanations is an important addition to understanding about information exchange, and I discuss them next.

In my study, there appears to be more opportunities for the provision or exchange of information due to the fact that patients spend longer in the ward environment than they would at a clinic. An important contribution to what is known so far about information exchange is that patient/ nurse interactions took place on an on-going basis, and the same information could be reiterated to patients over several days, as evidenced from the interviews. Furthermore, other health professionals, such as dieticians, physiotherapists, specialist nurses and doctors, provided information that patients and nurses would refer to when discussing patient care. These health professionals sometimes visited patients on the ward, but at other times, patients received information in clinics prior to admission to hospital. This provision of information on an on-going basis perhaps links to what Bugge et al. (2006) report; namely, that information not exchanged at a given time is often not problematic, as it may have been shared previously. I collected snapshot observational data which resulted in considering that insufficient information had been exchanged. However, at interview, some patients indicated that they had received information previously, which perhaps added to their perception of receiving sufficient information.

Another explanation for participants perceiving they had received sufficient information was that their definition of 'enough' information was 'having no more

questions'. The link between knowledge and question asking is not new, and is well known in psychology and education (Graesser et al. 1993, Ram 1991). The healthcare literature reports on patients' satisfaction with the information they received, both face-to-face (Mallinger et al. 2005, Yoon and Byles 2002) and electronically (Taha et al. 2009). However, these authors do not report on how patients knew that they had received enough information. Patients and nurses in my study linked knowledge with asking questions, stating that if they wanted more information they would ask. Nurses in my study stated that they knew when patients had received 'enough' information because they were not asking any more questions. Nurses stated that older patients tended to ask questions of the nurse after the ward rounds; in other words, nurses act as intermediaries between patients and other health professionals. Traditionally patients did not ask questions of the doctor; however, nurses in my study reported that younger patients ask questions of doctors during ward rounds. Younger patients asking more questions and entering more easily into discussions with doctors, contributes to the wider literature on how younger and more educated patients prefer to be more actively involved in their treatment and care (Florin et al. 2006). One significant difficulty with determining 'enough' information by the questions patients ask is that patients may not know which questions to ask. Compared with control groups, patients and care-givers receiving a question prompt list asked more questions than those who did not receive it, and had fewer unmet information needs (Clayton et al. 2007). However a limitation of their study is that the list was compiled by health professionals, who assumed insight into which questions patients and their significant others should ask. Patients having unmet information needs, whilst using a question prompt list skewed towards health professionals' notions of patients information needs, perhaps

demonstrates the benefits of service user reference groups such as patients experience panels. Patients and health professionals asking and answering questions are a quality indicator of good patient/health professional communication (Salt et al. 2012). This link between questions and good patient/health professional communication relates to my findings. For example, although communication was not the focus of my study participants perceived that when questions had been asked and answered, good communication had taken place and sufficient information had been exchanged.

An interesting phenomenon found in my study was that patients equated good patient/nurse relationships with receiving 'enough' information. Concepts of approachability, trust, and 'knowing you', appeared to be related to sufficiency of information. These concepts relating to sufficiency of information are new in terms of information exchange, and contribute to the literature that reports that good communication and rapport is important for positive health outcomes (Cole and McLean 2003, Connors et al. 1997). Other authors report that health professionals being approachable may facilitate information exchange (Suhonen and Leino-Kilpi 2006). In contrast, nurses communicating warmth, evidenced by non-verbal skills such as good eye contact, does not necessarily mean that information has either been provided or exchanged (Duxbury et al. 2010). Furthermore, Thompson (2007) suggests that patients who have a good relationship with health professionals may trust them to make decisions on their behalf, whilst receiving less information than those patients who had not established a relationship with the health professional. However, the concept of 'knowing you', although related to delivering therapeutic care (Bundgaard et al. 2012, Henderson et al. 2007, Luker et al. 2000, Liaschenko

1997, Kralik et al. 1997, Morse 1991) is as yet unknown in the literature in terms of what it means for information exchange and shared decision-making. In my study, the concept of patients and nurses knowing each other seemed to give patients an impression that they were receiving more information. Henderson et al. (1997) found that 'knowing the patient' was related to trust and rapport, and that it occurred as patients and nurses talked with one another. Bundgaard et al. (2012) related 'knowing the patient' to communication both verbal, and through the senses. Patients in my study related patients and nurses knowing each other to receiving more information because knowing each other required that they were sharing information with each other and building up a rapport with one another.

The majority of nurses in my study spoke in lay terms to patients, which was useful in terms of information exchange and adds to the current literature on information exchange. Speaking in lay terms also appeared to enhance patients' perceptions of receiving sufficient information. Adequate information exchange in language that patients can understand may help to reduce patient anxiety. Using lay terms may also facilitate the process of informed consent, particularly if the discussion relates to a particular treatment or intervention. Receiving information in lay terms, specifically information originally provided during ward rounds, may again be specific to ward settings. The difficulties with using jargon are well documented; jargon distances the patient from the health professional (Fields et al. 2008), can be used to exert control (Liu et al. 2013), and prevents clear communication, and increases dissatisfaction with the information received (Simon et al. 2013). Reiterating information that physicians and consultants have conveyed is perhaps more likely to occur in ward settings than in clinics. Although there was literature about nurses, physicians and

other health professionals during ward rounds (Liu et al. 2013, Weber et al. 2007), no literature was found that reported on nurses going back to patients after the ward round to explain, and to ensure the patient's understanding of, physician imparted information. Jargon is generally reported in the literature in relation to doctors; however, nurses in my study also used jargon. For example, a nurse in Case 9 said to the patient, "there's no MRSA in your TPN line". However, the majority of nurses in my study spoke in lay terms to patients, which appeared to add to patients' perceptions of sufficiency of information.

Of all of the explanations given for perceived sufficiency of information, perhaps the most concerning is the finding that some patients were anxious about being 'good' (6.3.4.1 and 7.5.4), which warrants further investigation in terms of information exchange. The 'difficult' patient has been well documented in terms of nursing care (Russell 2003, Playle and Keeley 1998, Fawcett 1995, Moore 1995, Calnan 1987, Stockwell 1984) and in terms of barriers to shared decision-making (Charles et al. 2004). In my study there was evidence to suggest that nurses may find patients wanting more information difficult. This interesting finding concurs with earlier work by Lorber (1975) and Wright and Morgan (1990) who report that patients are perceived as difficult if they ask too many questions or if they interrupt the professional's routine. Labelling patients as difficult matters, because it can reflect power struggles in the healthcare interaction. Koekkoek et al. (2010) found that these power struggles can result from the different expectations of the patient and the healthcare professional. However, Risor et al. (2013) found that patients were labelled as difficult because they are time consuming, do not take responsibility for their healthcare, and do not comply with suggested treatment. This would suggest

that the physicians in Risor and colleagues' study (Risor et al. 2013) considered that any patient not adopting the traditional 'sick role' would be considered difficult. Similar power struggles between patients and health professionals are evident within nursing. Trexler (1996) states that if an interaction does not result in the patient complying with expected behavioural norms, then the nurse will avoid the patient both physically and/or psychologically. However, as Michaelson (2012) reports, avoidance can result in serious symptoms being missed or overlooked. In my study, some patients perceived that they would receive better care and more information if they were 'good'. These perceptions have not been given much attention in the information exchange and shared decision-making literature; however, they may impact on information exchange between patients and nurses. It is conceivable that those patients may not want to engage in information exchange as it moves them from a position of doing what they are told, that is, being good, to a position where they are encouraged to ask questions and engage in discussion about their treatment and care. In terms of my findings about sufficiency of information, perhaps patients wanted to appear as 'good' patients, and therefore stated at interview that they had received enough information.

Understanding that information may be provided rather than exchanged in ward settings provides a basis for recommending changes in the way that nurses interact with patients, and a critical look at information exchange and its appropriateness, or otherwise, in ward settings. However, my study also sheds light on patients' perceptions of information exchange in ward settings. Despite the extent of information provision, patients' perceived levels of received information were higher

than what might have been expected, based on the literature, and on my observations.

8.4.3.3   The applicability of Information Exchange in ward settings

The literature identifies that advancement of the patient involvement agenda is slow (Forbat et al. 2009) even though active patient participation is advocated in policy documents (Department of Health 2012, Scottish Government 2008, Department of Health 2004, Scottish Executive 2003). Information exchange as part of shared decision-making is advocated in healthcare interactions at policy level (Department of Health 2012). However, no account appears to be taken of different healthcare environments.

Some attempt has been made at demonstrating how shared decision-making, and thus information exchange, could be implemented in practice (Coulter and Collins 2011). However, this report also lacks detail about various healthcare contexts and, in particular, the hospital ward context. The literature indicates that the Charles model can only be achieved in a particular way. As different healthcare interactions have different agendas, my findings demonstrate that information exchange and decision-making may be contextually determined. Tentatively, my findings also demonstrate that the Charles model may not be applicable to, or transferable to, patient/ nurse interactions during routine nursing care in ward settings. The focus on shared decision-making and information exchange in policy may not just prove difficult to achieve in ward settings, but rather it may not be possible to achieve in ward settings. The extent of lost opportunities, interruptions, and the demands of nurses' work may not be conducive to interactions involving all the elements of information exchange. Furthermore, it is possible that inpatients are content with the

status quo. That is, they are content with therapeutic relationships with nurses, having their questions answered, and being given information in lay terms. Practice may not be reflecting policy, but perhaps it is policy that needs to change.

8.5   Recommendations

The aim of my study was to explore information exchange between patients and nurses during routine nursing care in ward settings. I explored the type of information participants shared or provided, and the relevance of the information they gave and received. I explored whether participants perceived they had received sufficient information for their needs. Taking into consideration the aims of my study, I make recommendations for nursing practice, nurse education, research and policy. As this study is classified as applied health research, I have included informed reflections of information exchange between nurses and patients, and have made recommendations for policy (Patton 2002) .

8.5.1 Recommendations for nursing practice

The primary reason for patients being in the ward was not discussed between patients and nurses during the observation sessions. As previously discussed, the role of the nurse in sharing information may be different from that of the doctor, and that patients prefer more socially based information from nurses. However, this may not be true for all patients as some might like to share information about the reason for their admission. I recommend that patients and nurses engage in elements of information exchange to first establish what type of information patients and nurses want, or need.

Patients do not distinguish between clinical and non-clinical interactions and information in the same way that nurses do. Instead, they prefer to receive the information that tells them what to expect about any impact on their body or their quality of life. Therefore, I recommend that nurses should approach sharing clinically-based information in a manner that is clear to the individual patient about any potential impact the information may have.

Perceptions of the relevance of information differed between patients and nurses, which could risk making assumptions about information needs. Information exchange can help to reduce assumptions, and can facilitate patients' and nurses' understanding of each other's perspectives about what information is relevant, and why. Information exchange might also ensure that patient's holistic care needs are met, and that nurses gather the information that is relevant to them for continuity of patient care. I recommend that nurses encourage patients' contributions to information exchange by using high-level communication and listening skills. Encouraging inpatients in aspects of information exchange may lead to better decision-making and care outcomes, and may increase patient satisfaction.

8.5.2 Recommendations for education

I recommend that patients could be provided with leaflets explaining the concepts of information exchange and patient involvement in decision-making. These leaflets could be given to patients prior to elective admission or provided on the ward for those whose admission was unexpected. Patients' preferences for information exchange and involvement in decision-making could then be discussed and assessed on an on-going basis as their conditions change.

Ward-based nurses may be unaware of the concept of information exchange and of the opportunities that some aspects of information exchange might bring. Therefore, I recommend that ongoing education of nurses in shared decision-making and information exchange could be established as part of ward-based philosophy and quality standards. From my study it appears that it would be difficult to achieve Charles concept of information exchange when nurses are under time pressures and are facing constant interruptions. Therefore establishing information exchange, shared decision-making and patient involvement, and fostering high quality standards, may help to reduce such lost opportunities for sharing information.

8.5.3 Recommendations for research

It is important that further work is undertaken as my key findings have implications for information exchange, such as tailoring specific information to patients at different stages of their illness trajectory and exploring new strategies for implementing shared decision-making and aspects of information exchange in ward settings. However, recognising that patients do not perceive information in the way that health professionals do may inform the design and methods of future studies.

Given the lack of research on links between asking questions and having knowledge, I recommend that research be undertaken in relation to patients' search for information. The research could take the form of focus groups with patients and health professionals together examining what relevance and significance patients and nurses associate with different types of information, and how patients and nurses know they have received sufficient information.

I developed the use of a radio-controlled recording system for observation research in ward settings. This particular method could be tested for its suitability for larger observation research or research in other contexts.

8.5.4 Recommendations for policy

Current policies on shared decision-making and information exchange are not context specific. These policies seems to imply homogeneity across all areas of healthcare. However, not all areas of healthcare are the same. Due to the overweight of research on shared decision-making and information exchange in clinic settings, policies related to these concepts have been driven by an inherent bias. I argue that policies which do not take into account the significant social and environmental factors of different settings, are lacking. A one-size-fits all policy does not take into consideration the practicalities of a fast-paced ward environment that often constrains interactions between patients and nurses. Therefore, I recommend that policy makers take account of the needs of varying healthcare contexts, and create policies on shared decision-making and information exchange that are targeted effectively across a range of significantly different environments. Targeting policies to specific contexts has the potential to drive forward the implementation of some elements of information exchange in practice areas other than clinics. It would also empower nurses and patients in their interactions rather than set nurses up to fail in relation to inadequately drafted policies.

8.6 Conclusion

In conclusion, exploring information exchange in ward settings has not previously been reported in the literature. Therefore, a qualitative multiple case study approach

was a new and ambitious approach for exploring information exchange in ward settings. The methods used required to be ethically and practically acceptable to ethical reviews and participants. In terms of generalization, my study was a qualitative multiple case study, which was large even in terms of case study design. Therefore, some generalizations can be made for similar contexts. The strong study design and methods elicited real-time data to capture the type of information participants gave and received, and in-depth accounts of participants' perceptions of the relevance and sufficiency of information shared or provided.

The overarching findings from my study are: that information is generally provided, and not exchanged between patients and nurses; that patients do not divide information into clinical and non-clinical in the same way that nurses do; and that Charles et al. (1999) model of information exchange may not be applicable in ward settings. However, the data from my study are helpful in illustrating what kind of information patients and nurses talk about during routine nursing care, the relevance associated with the information received, and the sufficiency of the information.

My findings offer new knowledge about the type of information provided, which contributes to the literature on information exchange. The type of information that patients and nurses provided generally focussed on patients' current symptoms. Few interactions related to patients' illnesses or conditions that resulted in their hospital admission. My findings differ from those whose research was based in one-to-one clinic or GP settings, where interactions focused on specific agendas relating to patients' illnesses or conditions.

The relevance of information shared has not received much attention in the literature. In my study, participants were specifically asked why they like certain information and what they do with the information they received. Exploring the relevance of information potentially ensures that information given and received is targeted appropriately to either the patient or the nurse, but it also potentially adds a more holistic in-depth understanding of information exchange. Patients' and nurses' perceptions of the relevance of information differed, potentially leading to making assumptions about what information is relevant, to whom, and why. Making assumptions about what information should be shared means that the ideal of information exchange between patients and nurses in ward settings is less likely to be attained. Information based on social contexts appears to be more significant in ward settings than in clinic or primary care settings, which is new, as the significance of non-clinical information such as humour, banter and rapport has not previously been given much consideration in the information exchange literature.

A significant finding during the observation sessions was that some information could not be exchanged due to information being withheld mainly by nurses. There were also lost opportunities for sharing information due to interruptions and the task-related demands on the nurse. Issues of power and control also resulted in information provision instead of information exchange. Information not being exchanged due to interruptions is new knowledge and perhaps relates more to information exchange in ward settings. However, information not being exchanged due to withholding information, and issues of power and control, fit with what is already known about information exchange. Utilising information exchange might

help to avoid a traditional paternalistic approach, and facilitate patients in adopting a greater role in their own treatment and care.

Contrary to the observation data, patients and nurses perceived they *had* given and received sufficient information. The explanations given for sufficiency of information were that participants had no further questions, information had been exchanged previously, patients and nurses had developed a rapport through approachability and trust, and information was given in lay person's terms. Nevertheless, information exchange may help to determine how much information patients and nurses require in healthcare interactions, rather than each assuming that the information needed or wanted by the other has been exchanged.

My findings suggest that information exchange as described by Charles et al. (1999 and 1997), between patients and nurses in ward settings, may be difficult to achieve. Patients report that they prefer not to make decisions about their treatment and care. Nevertheless, I have shown that elements of information exchange may be useful for purposes other than decision-making. Information based on social contexts appears to be important to patients in ward settings. Nurses may need to share more socially based information in order to reassure patients, and elicit the information from patients that they need. The amount of information shared should also take into account that the patient may be in an unfamiliar environment and may be anxious.

The need for robust research into information exchange between patients and nurses in ward settings emerged clearly throughout the literature review (Chapter 2). The findings that I have discussed provide substantive evidence that this research

was justified. My findings illustrate the complexity of patient/nurse interactions during routine nursing care and provide the potential for further research into greater patient involvement in treatment and care.

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