Exploring the patient’s journey: a qualitative study of admission and discharge processes in a variety of Welsh healthcare settings.

Dr Aled Jones
Institute for Health Research
School of Health Science
Swansea University

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1. Background/ rationale

Admission into, and discharge out of healthcare are two important events which signify the beginning and end of a particular episode during a patient’s journey, events which nurses are closely involved in. Indeed both admission and discharge have been described in nursing literature and health policy documents as the most important and crucial of all nurse-patient interactions. Additionally, the patient admission and discharge have been identified by the NHS as areas of service delivery that need to undergo significant changes so that ‘every single patient’ receives ‘the best possible care, every single time’ (NHS Modernisation Agency 2004).

Whilst much has been written about the admission process in nursing there has been little in the way of research in this area, a claim supported by Latimer (2000) who states that neither the research nor the theoretical underpinning of research into the actual practice of patient admission is well advanced. The minimal research that has been published suggests that the actual practice of nurses during patient admission is at odds with the rhetoric of nursing as found in textbooks, policy and practice guidelines (Jones 2007). For example, Latimer (2000) discusses how nurses neglected to assess patients’ psycho-social needs during hospitalisation, consequently compromising efficient discharge planning.

In comparison there appears to be more research on the discharge of patients, perhaps because the discharge of patients has been considered to provide a ‘litmus test for the quality of care’ (Lundh and Williams 1997, p.435). Whilst the discharge process is a recurring theme of interest in nursing research, several authors (e.g. Pateman et al 2003) argue have identified serious problems in this area of service delivery. In an attempt to improve this area of patient care nurses and policy makers have advocated moves towards a distinct phase of patient care known as discharge planning. Defined by Parkes and Shepperd (2000) as the development of individualised plans for patients before they are
discharged home from hospital, discharge plans have been promoted as a means of improving care and cost containment through reducing both hospital length of stay and premature readmission of patients to hospital (Wales Audit Office, 2007).

However, despite the attention given to discharge planning in literature and nursing policy documents, the following factors have been identified as causes of delayed discharge from hospital (Department of Health 2003):

1. Inadequate assessment of the patient by health care professionals resulting in, for example, a poor knowledge of the patient's social circumstances.
2. Poor organisation, for example late booking of transport preventing timely discharge from hospital.
3. Poor communication between the hospital and providers of services in the community.

In an attempt to improve performance in this area practitioners have been discouraged from viewing a patient’s admission into, and discharge from hospital as isolated events existing either side of the treatment phase of hospital care. Instead, admission and discharge processes are promoted as “joined-up” or “seamless” stages of care. For example, over 2 decades ago it was stated that discharge planning should commence at the time of a patient’s admission to hospital (Waters 1987), or more recently in the case of elective hospital care discharge planning should start before patients enter hospital (NHS Scotland 2009). Linked to this notion of seamless care delivery is the concept of the “patient journey” which challenges the traditional view of hospital care as a series of isolated care episodes (e.g. admission, followed by treatment, followed by discharge), and instead characterises patient care as a continuum encompassing all aspects of care and treatment, even prior to admission (National Assembly for Wales 2005).

The concept of the “patient journey” is one that has been adopted by policy makers especially when exhorting health professionals to improve the processes around patient care
whilst also emphasising that the patient must remain at the centre of practitioners’ attention. For example, guidelines on effective hospital discharge reflect how the National Assembly for Wales endorse a person or patient centred care ethos and a co-ordinated approach to the patients’ journey

_The assessment and discharge process must be person centred and involve regular consultation with the patient and his/her family/carer/advocate, and where appropriate paid care staff or providers of services. The hospital discharge process should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the patient’s journey (National Assembly for Wales 2005, p.7)._

Whilst healthcare literature, guidelines and policy documents have adopted the concept of patient journeys into its vocabulary, few researchers have attempted to portray patients’ actual journeys through hospital. Thus the overall aim of this research project was to collect and analyse data that would give a better understanding of the key stages of the journey through hospital, namely at the point of admission into, and the point of discharge from hospital care.

2. **Aim**

A “good” discharge is often linked in literature and policy documents to an efficient assessment upon hospitalisation, however limited research exists which thoroughly describes these important procedures which exist at both ends of a patient’s journey through hospital. This proposal aims to address this gap in the knowledge base and positively affect the quality of patient care in this area.

The broad aim of this study is to explore nursing work relating to the admission and discharge of patients from a range of healthcare contexts. The research will, across a range of contexts:
- Observe record and describe how nurses, patients and the healthcare team manage the complex processes of nursing admissions and discharge from nursing care.
- Compare these processes across a range of contexts thus providing a clearer understanding of the patient’s journey.
- Draw implications for practice and policy from the findings.

Such insights will assist with future nursing and patient/carer decisions regarding how best to plan, perform and co-ordinate admissions and discharges.

3. Research Design

A key point which clearly emerges from reading the literature, research and policy documents is that social interaction lies at the heart of effective admission and discharge of patients and indeed underpins what is considered to be a satisfactory patient journey through hospital. Yet despite the importance ascribed to social interaction, and some of the problems with admission and discharge discussed above, details of the actual production of interaction remain surprisingly disregarded in nursing research. Consequently a qualitative study which scrutinises the social and interactional organization of everyday activities in hospitals is forwarded here as a means of addressing this gap in current knowledge. Qualitative research focussing on the interaction of participants has been seen to be particularly beneficial in gaining insights into the texture and weave of everyday life, the understanding and experiences of research participants and the ways that institutions work.

Methods of qualitative research which I used, namely conversation analysis (CA), semi-structured and ethnographic observations offer answers to hitherto unasked questions regarding how the organization of admission and discharge emerge and are sustained. Qualitative methods can also show how nurses and other members of the healthcare team develop routines, strategies, practices and procedures in this important area of healthcare. In
addition to qualitative data, routinely collected hospital data was collected and analysed. For example, patient safety incident reports, bed occupation statistics and staff sickness/absence frequencies were to prove an useful sub-set of data that, at times, added depth and context to the qualitative analysis.

This combination of methods has previously been employed by health service researchers to explore the relationship between policy and practice via policy ethnography, an approach which allows for the careful analysis of interactions at the level of service delivery to be related to the aims of policy makers and the organisational life which provides the context of such interactions. Policy ethnography can fill an important gap in nursing research as its commitment to the processual aspects of organisational life affords a perspective which can properly explore nursing and organisations in action (Griffiths 2003).

Overall, the final report focuses on 3 projects which span the patient journey. The projects contribute much needed insights into important phases of a patient’s admission into hospital and into the realities of how teams of health professionals interact and work throughout the patient journey. The initial intention was to somehow track patients throughout the patient journey but I realised that a project such as this would quickly become unmanageable in terms of logistics and that following a few patients throughout their hospital journeys would give only a narrow view of hospital practices.

The decision regarding the overall design of the research project was also made easier after discussing options with local NHS Trusts. It soon became clear during discussions with managers (nurse managers, directorate managers, research and practice leads) that the Trusts were very keen to host a qualitative researcher. Their interest in hosting a qualitative researcher seemed largely related to the fact that much of their thinking and understanding about health care delivery was supported by statistical or quantitative data e.g. waiting times were measured, patient length of stay quantified by days.
Following some reading and further discussion with NHS Trusts and my mentor (Professor Lesley Griffiths, Swansea University) I decided to focus on 3 distinct but related areas of interest. I chose to explore the working of bed managers as there was (and is) little empirical work published in this area which is of upmost importance at the beginning of the patient’s journey through hospital. I also chose to look at the admission of patients on to the ward, specifically how the patient records and hospital notes were used as a resource during the admission interview occurring between nurse and patient. I was also interested in the admission interview as this has often been presented as an ideal opportunity for nurses to acquaint themselves with the patient’s needs as identified by the patient. As will be discussed later a successful/timely discharge from hospital has often been linked to the information collected during admission, thus the admission interview seemed to have resonance throughout the patient’s journey through hospital.

Finally, in one of the numerous and productive discussion with Trust colleagues mention was made of a service improvement project designed to improve multi-disciplinary team working on a rehabilitation ward. The Trust were particularly interested in improving the timeliness of patient discharges and saw improved team working as a potential way of delivering improved discharges. The Trust merely had plans to evaluate the improvement project by collecting and analysing “audit” data consisting of numerical information. They were subsequently very encouraging when I proposed to undertake a qualitative evaluation and saw this as an ideal opportunity to gain an insight into the latter end of the patient’s journey in particular. Details of the projects can be seen in table 1 (below).
<table>
<thead>
<tr>
<th>Title of project</th>
<th>Data collection/data analysis methods used</th>
<th>Phase of the patient’s journey explored</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed management</td>
<td>Observations, semi-structured interviews, routinely collected hospital data.</td>
<td>Pre-admission, admission, treatment/ongoing care phase, discharge.</td>
</tr>
<tr>
<td>Creating history: documents and patient participation in nurse-patient interviews</td>
<td>Taped nurse-patient interaction, ethnographic observations, patient records. Conversation analysis, content/thematic analysis</td>
<td>Admission</td>
</tr>
<tr>
<td>“It’s like a fish trying to describe water”: A qualitative evaluation of multi-disciplinary team-working on a hospital ward.</td>
<td>Taped ward rounds and team meetings, ethnographic observations, patient records, routinely collected hospital information. Content/thematic analysis.</td>
<td>Treatment/ongoing care phase. Discharge planning</td>
</tr>
</tbody>
</table>

Table 1: an overview of the research projects within this report.

4. The original timetable and milestones and study progress

The original timetable is demonstrated below in table 2. Overall the study progressed according to the timetable with the exception of some delay with gaining ethics and governance approval, although the delay was not as severe as sometimes is the case with gaining these approvals.

The date of submission for the final report was moved back to the end of January 2009, whilst preparing a draft of the final report I was notified of the existence of report guidelines stating the final word count for the report as being in the region of 20,000 to 30,000 words and having sections which had previously not been expected (a discussion of my background, professional development and future plans). Whilst I regard the requirements as specified in the report guidelines as reasonable their late appearance caused considerable delay as my original final report (about 10,000 words which had been informally agreed) effectively had to be doubled.
<table>
<thead>
<tr>
<th>Date</th>
<th>Action and/or outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 2006</td>
<td>Start project – negotiate access and finalise proposal.</td>
</tr>
<tr>
<td>November 2006</td>
<td>Gain support of clinical areas.</td>
</tr>
<tr>
<td>January 2007</td>
<td>Gain ethical and Trust R&amp;D approval</td>
</tr>
<tr>
<td>Feb 2007</td>
<td>Start data collection phase 1</td>
</tr>
<tr>
<td>May 2007</td>
<td>Finalise transcription – early analysis phase 1</td>
</tr>
<tr>
<td>June 2007</td>
<td>Start data collection phase 2</td>
</tr>
<tr>
<td>September 2007</td>
<td>Finalise transcription – early analysis phase 2 End of year 1 report – findings to date, manage risks and opportunities.</td>
</tr>
<tr>
<td>October 2007</td>
<td>Start data collection phase 3</td>
</tr>
<tr>
<td>January 2008</td>
<td>Finalise transcription – early analysis phase 3</td>
</tr>
<tr>
<td>February – June 2008</td>
<td>Develop analysis of 3 phases of the project and revisit literature, develop interpretation of findings.</td>
</tr>
<tr>
<td>June - December 2008</td>
<td>Prepare overall final report for submission January 2009</td>
</tr>
</tbody>
</table>

Table 2: The original timetable for the study.

5. Ethical approval and governance issues

Ethical approval was gained from the Multi-Centre Research Ethics Committee for Wales (MREC). At the time of applying an updated version of the Integrated Research Application System was launched which caused some delays as more and different types of information were required under the newly launched system. There were further delays in booking the application into the system for it to be heard in Wales as the committee’s agenda was fuller than usual due to Christmas and New Year. The discovery of seasonal variations in demand and productivity of the MREC service could be seen as the first finding of the study!

The NHS R&D approval system was also a challenge as there was no unified approach across NHS Trusts in South Wales. Thus, separate application forms had to be completed although thankfully only one criminal records bureau (CRB) check was needed. The introduction of the research passport scheme in Wales promises to integrate the R&D approval scheme and cannot arrive early enough.
6. Executive summary

This study explores important points along the patient’s journey through hospital. The concept of the patient journey challenges the traditional view of hospital care as a series of isolated care episodes (e.g. admission, followed by treatment, followed by discharge), and instead characterises patient care as a continuum encompassing all aspects of care and treatment (National Assembly for Wales 2005). The overall study is divided into 3 projects looking at bed management, nursing admission of patients and multi-disciplinary team working and its effects on discharge planning.

The first project investigated the under-researched topic of bed management. Using a variety of qualitative data, the work of bed managers was seen to be directly affected by health care policy, in particular government targets on waiting times for unscheduled patients and delayed discharges. It was also seen that bed managers often experience difficult and ineffective working relationships with clinicians on wards. It is postulated here that the results of such poor interpersonal relationships could negatively impact on the placement of patients into hospital beds and their subsequent discharge out of hospital.

Secondly, several episodes of nurses admitting patients into hospital were recorded and analysed. The aim of this project is to explore nurse’s use of mundane technology (paper-based nursing record) during the admission process of patients into hospital and whether the use of such technology affects the extent of patient participation during the admission process. The process of admitting patients into hospital has been identified as one of the most important parts of a nurses working day. Furthermore, the admission process has been highlighted as an important context to determine a patient’s needs throughout their hospital journey, and especially important in planning discharge. What emerges from the analysis is a better understanding of the interactive and interdependent relationship within nursing assessment interviews between the spoken words of nurses, the written word of the
assessment document and the spoken words the patient’s contributions. The analysis will subsequently inform a discussion regarding nursing practice during admission interviews, as well as contribute to the debate regarding record keeping at a time of great change where hospital records, such as those used during the admission process, are soon to be completed in electronic format.

Finally, the third project reports on a qualitative evaluation of team working on a hospital ward. In an attempt to improve the quality of patient care attempts were made to improve communication and interpersonal working within a multidisciplinary team. As a result, clinicians reported an increase in the amount of trust between colleagues leading to closer team working. Staff reported how closer team working had not reduced professional autonomy and had led to a considerable improvement in areas of care such as discharge planning. Interesting observations were also made about positive changes in patient safety and staff well-being during the period of change.

Overall the 3 projects contribute insights into under-researched areas of service delivery within the NHS. Although focussing mostly on the work of nurses the projects also reveal much about inter as well as intra-professional working.
7. Project 1 – Walking the tightrope: A qualitative investigation of the work of bed management in an acute hospital

7.1 Introduction

Bed management is an area of nursing practice and management that has expanded considerably in the past decade, in line with a growing realization that effective bed management is fundamental to good quality inpatient care (Proudlove et al 2007b). Historically, bed management in nursing texts was largely discussed in terms of how effective nurses managed the physical appearance of the bed as well as the immediate area around the bed, often referred to as the “bed space”. Many a historical anecdote testifies to the perceived importance of managing the appearance of the bed, such as having the wheels of the bed all pointing in the same direction (down the ward) prior to matron’s or the consultant’s ward rounds in a UK hospital (Bacon 2009). Nursing textbooks from the 1940s in Australia contained detailed descriptions of how to make up to 15 different styles of beds (Heartfield 2005), whilst Olson’s study of nursing in a US hospital early in the 20th century reports that caring for individuals was barely mentioned, instead reference was often made to the importance of caring for inanimate objects such as “care of bed and bedding” (Olson 1997).

Although bed making and the effective management of the bed space still has its place in nursing, the term “bed management” (and the associated “bed manager”) now refers to the practice, usually undertaken by registered nurses, of ‘identifying empty hospital beds and allocating waiting patients to them’ (Proudlove et al 2007a, p.35). Although simply defined, the actual practice of bed management is an area of healthcare that has been identified in major reviews as complex and challenging (National Audit Office 2000, Audit Commission 2003).
Recent NHS improvement work has focussed on improving patient access to emergency and elective care, driven by government targets such as patients only waiting a maximum of 4 hours in A&E before being treated or discharged. At a time where emergency admissions are at an all time high and bed occupancy is often as high as 97% in adult and elderly medicine (Audit Commission 2003), such improvement targets have had a significant impact on the work of bed managers (amongst others) who have had to balance the increased demand for beds with little or no increase in bed capacity. Additionally, increasing delays in discharges of patients ready to move to the next stage of care has added further pressure on bed stocks.

For the purpose of this study bed management (BM) is taken to consist of the operational day-to-day allocation and management of beds with an acute hospital. This work is performed by nursing staff and this study considers their role in one NHS trust. The work of BMs in this study mostly concerns the placement of emergency admissions but also occasionally extends to organising or negotiating the placement of elective admissions since the two often depend upon or utilise the same resources.

Traditionally, a “bed” had been thought of as being something owned by a consultant and allocated by him/her as best thought fit (Boaden et al 1999). However, over time, some of the consultants’ control over hospital beds was steadily eroded and ‘staff were spending increasing time searching for beds and arguing about their relative rights to admit patients to them’ (Green and Armstrong, 1994, p. 20). As a result bed management emerged as a way of overseeing the process of matching up demand for beds with the supply of beds within hospitals. The exact point in time that a bed management team starts to oversee this process varies between hospital authorities although difficulties in managing the availability of hospital beds have long been identified (Hospital Economy Committee 1930). However the Audit Commission (1992) conceptualized bed management as being responsible for
overseeing bed availability and management during the four-stage process of the hospital inpatient’s journey consisting of

1. Hospital admission (elective/emergency)
2. Placement
3. Stay
4. Discharge

The day to day work of BM is mostly done by nurses who have to work with all other professional groups (e.g. porters, radiologists, nurses, doctors, cleaners) to effect smooth patient flow through the acute hospital system. The consequences of poor patient flow are most visible in terms of the weak performance of hospitals on emergency and elective admission access targets, but also result in lengths of stay which are longer than necessary. Poor patient flow is often argued to be detrimental to quality of patient care although evidence about this is not conclusive (Proudlove et al 2007a). Overall there is relatively little literature about the work of bed management, this is especially so when compared to other topics such as the management of emergency admissions or the management of waiting lists and this study seeks to address this gap in the literature.

7.2 The state of hospital beds – delays, blockages and patient flow.

Much of the debate regarding hospital effectiveness focuses on the occupancy of beds and the duration patients have to wait to either occupy or vacate a bed. Latterly the time patients have to wait before vacating a hospital bed has increasingly preoccupied the health service, particularly as waiting times for hospital treatment continue to decrease (Welsh Assembly Government 2009). In particular, delays in discharging patients from hospital who are ready to move to the next stage of care have recently dominated political debate in the UK. So called “Delayed transfers of care” (DToCs), more pejoratively known as “bed blocking”,

Exploring the patient’s journey
have been described as having a detrimental effect on both the people being delayed as well as an impact on wider service delivery and performance across the whole health and social care system (Wales Audit Office, 2007). Although DToCs have recently attracted the attention of the media, politicians and the Welsh Assembly Government (WAG) e.g. Hudson (1998); Glasby (2003); Scottish School of Primary Care (2004); Social Care Institute for Excellence (2006); and the Cochrane Collaboration (2007) attest to policy initiatives and academic studies discussing “bed blocking” dating back over thirty years.

Research findings from the UK and beyond relating to the causes for DToCs have been remarkably consistent over the last three decades. These have been summarised as:

- Poor service co-ordination;
- Lack of clarity over respective responsibilities;
- Lack of information-sharing;
- An inappropriate range of service models;
- Inadequate assessment and planning for discharge;
- Inadequate consultation with patients and their carers;
- Lack of notice of discharge; and
- Over-reliance on the contribution of family carers.

(Henwood 2006)

Delays in discharging patients from hospital continues to be a major concern due to the ongoing risk that “downstream” discharge delays at the end of a patient’s journey subsequently reduces bed availability, resulting in waiting or delays “upstream” for both planned and emergency admissions. Seen in this way patient journeys are best understood from a systems approach to organisations, in which input, throughput and output are essential features of organisational systems, and are often used as indices of production. For example, a lack of throughput is often identified with organisational failure, thus numbers of admissions, discharges, bed occupancy and lengths of stay are routinely recorded and made available for public inspection.

Although throughput itself says nothing about the quality of performance between input and output, the implicit identification of throughput with effectiveness has led to the
creation of an ideological rationale that focuses to extraordinary degrees upon beds and their effective management with sometimes little concern about patient and staff well-being (Di Biasio and McClelland 2001). Similarly, Heartfield (2005) describes how hospital the concept of a bed or hospital beds have been translated through the economic rationalisation of healthcare systems from locations of care to a politicised healthcare commodity. As a result of the rationalisation and politicisation of beds, when operations are cancelled and seasonal variations (such as the “winter bed crisis”) cause long delays in emergency departments, bed management in the NHS is often publicly criticised by politicians and influential public bodies such as the National Audit Office (Beecham 2000).

More recently, the NHS has shifted its attention away from focussing purely on the absolute number of beds, instead increased attention has been paid to the concept of patient flow. Much emphasis has been placed on understanding variation and mismatch in the flows of patient admission and discharge activity patterns over the course of the day and the week. As a result bed management now involves much more than the placement of patients into a bed. Instead bed managers are increasingly being asked to oversee key points of the patient’s journey, such as discharge planning, and are now often referred to as patient flow co-ordinators (or similar) (NHS National Library for Health 2006).

The evolution from bed management to patient flow management in some NHS Trusts sees an attempt to establish a group of staff who take an overview of the patient’s journey through hospital from start to end. Proudlove and Boaden (2005) describe how the new role of patient flow managers can be seen as a ‘logical extension’ (p.467) of national service improvement programmes such as the NHS Modernisation Agency flow improvement programme. Also the National Audit Office (2000) report into bed management found that there was ‘considerable scope to develop the bed manager role’ (p.42), concluding that
“To increase its value, the bed management function needs to evolve into a skilled, professional activity that is able to look beyond the immediate daily task of identifying spare beds’ (NAO 2000, p. 43).

Thus, policy initiatives and the recommendations of statutory bodies have both considerably shaped the role and function of bed management. Considering the attention paid to bed management issues elsewhere, it is somewhat surprising that the work of bed managers and bed management has largely been ignored by researchers.

7.4 The work of bed managers – a review of the literature

Numerous studies can be found that attempt to model bed capacity, bed utilisation or develop information systems that best predict and manage patient flow (Harper and Shahani 2002, Ham et al 2003, Proudlove et al 2007b). Whilst such studies tell us something of the difficulties inherent in managing demand on beds little attempt has been made to understand the day to day work of bed managers. Green and Armstrong (1993), Boaden et al (1999) and reports such as Lying in Wait (Audit Commission 1992, see also National Audit Office 2000) are exceptions as they describe the day to day realities of managing beds in acute hospitals. Glimpses of the work of bed managers are also present in studies such as Heartfield (2005), Harrop et al (2006) and Chaboyer (2009) whose research touches upon issues of bed management rather than focusing primarily on the area.

When reviewing the above literature a common theme to emerge is the uneasy relationship which exists between clinicians (especially nurses and doctors) and bed managers. Green and Armstrong (1993), in one of the first studies to focus on the interpersonal and social aspects of managing beds, observed heated exchanges between bed managers (BM) and clinicians whilst Boaden et al (1999) reported that interpersonal exchanges between BMs and hospital staff “could sometimes turn nasty” (p.244). Green and Armstrong over a decade ago describe the emergence of a “folklore of resistance” as hospital
staff resisted the increasing influence of BM. Interestingly more recent work from both within the UK (Doherty 2009) and outside the UK (Heartfield 2007) demonstrates a continuing resistance to, and a stigmatization of, the role of BM. For example, nurses interviewed by Doherty commented on how they perceived the demands imposed on them by bed managers as ultimately “disempowering” nurses on the wards by sending patients to wards that were ill-equipped or unskilled to deal with them, subsequently jeopardizing patient care. Others openly question whether the actions of bed managers indirectly contribute to a lack of humanity within the NHS (Toft 2000).

A possible behavioural manifestation of the “folklore of resistance” can be seen in uncooperative behaviour of staff when dealing with bed managers or issues of patient flow. For example, Heartfield (2007) discusses how nurses describe tasks associated with bed management as being of “limited importance” (p.24) and nurses joked how they were slow to report patient discharges to bed managers. Chaboyer (2009) reported resistance on a surgical ward to the introduction of a whiteboard designed to improve patient flow whilst Green and Armstrong (1993) reported on the “cheating and bed games being played” (p.346) by Consultants and hospital managers who misled BMs as to the numbers of discharges being planned and the availability of beds on their wards. Bed managers also experience great difficulty in accessing the information they require to work effectively (NAO 2000, OECD 2000, Proudlove and Boaden 2005) and often have to plan their work on “quick and dirty figures” leading to judgements amounting to little more than “wild eyed guestimation” (Clarke 2005).

It is therefore unsurprising that bed management has been variously described as a difficult job (Boaden et al 1999) and as frustrating, stressful and complex (Proudlove et al 2007). As well as experiencing the uncooperative behaviour of fellow workers bed management appears to be a job that has no beginning or end and thus difficult to know
whether bed managers are doing a good job or not (Boaden et al 1999, NAO 2000, Proudlove et al 2007b).

To summarise, the literature reviewed presents a picture of bed management as a troubled role. Bed managers are perceived negatively by fellow workers who resist and obstruct their work. Furthermore, bed management is described as a role that has to consistently adopt a fire-fighting stance, with little time to think whilst receiving minimal feedback on their effectiveness or value to the NHS. However, very little of the research has been undertaken directly looking at the work of bed managers. Many of the points discussed in this section have materialised out of research studies that happen to discuss bed management and bed managers as part of studies who have their main focus elsewhere. Overall, with the exception of studies such as Green and Armstrong (1993) and Boaden et al (1999) little is known about the work of bed managers and it is the intention of this study to address this gap in the literature.

7.5 The study aims

The literature described above confirms the demanding aspects of the work of bed managers and how bed management has been identified as an area of healthcare work in need of development (NAO 2000, Proudlove et al 2007). However, there has been little research in to the mundane work of bed managers and how bed managers negotiate and experience their labour on a daily basis. I aim to address this gap by examining the work of bed management and in so doing gain a better understanding of an often discussed but under-researched group of healthcare workers who are centrally important to effective patient journeys.
7.6 Method

In researching 2 bed management teams located in different hospitals within one NHS Trust I undertook a period of fieldwork spanning over 4 months. The data reported here are drawn from fieldnotes written during episodes of participant observation, focus groups and semi structured interviews undertaken during this time.

The field data resulting from participant observations were collected during a 6 week period during which the researcher was based with the bed management team. For the first week the researcher was based in the bed management office observing and enquiring about how emergency and elective patients from both the medical and surgical stream were allocated to a vacant bed. This period was important in establishing the daily routine of bed managers and how they interacted within the only space in the hospital that could be considered their own. The remainder of the time was spent shadowing bed managers as they went about their daily work, mainly walking the wards and attending the various daily “patient flow” meetings where each hospital’s and the overall Trust’s bed state were discussed. Handwritten fieldnotes were updated throughout the day whilst every 2 hours or so a summary of events, thoughts and feelings were written up. At the end of the day an overview of the day’s observations were typed up in the hospital library, as a result of which a journal of valuable data soon emerged.

Following the period of observation semi-structured interviews were undertaken with 6 members of staff working within bed management. The decision to do interviews following the period of observation was a deliberate one as I wanted to use the observations to shape the questions. Also I felt that by this time I would have established rapport with the BM team, something which textbooks frequently suggest as important for the interviewer to achieve with respondents (Bryman 2008).

The interviewees consisted of 6 bed managers whose job was to find and manage beds
within the hospital. The aim of the interview was to build an understanding of the work of bed managers from their own perspective as little research exists that directly interviews bed managers about the work they undertake.

Towards the end of the data collection period focus groups interviews were undertaken with two groups of 4 bed managers. Focus groups were arranged as bed management is as much a team or group endeavour as an individual one. BM staff work together to allocate and organise the hospital’s beds and I was interested in ways in which bed managers interacted, described and discussed the work that they do. Also in conventional one-to-one interviewing, interviewees are rarely challenged but in the context of a focus group individuals will often challenge each other’s views. As a result it is possible that focus groups may generate more realistic accounts of the work of bed managers as they are forced to revise or think more about their views (Bryman 2008). Furthermore, themes and issues first identified during individual interviews and periods of observation were further discussed and clarified during both focus groups.

Thematic and content analysis of fieldnotes, interviews and focus group transcripts occurred concurrent to data collection. Analysis proceeded in an inductive fashion starting with the local categories of the participants themselves. This process consisted of a pattern of reading and re-reading data, a method of analysis which eventually enabled the progressive understanding of interview and fieldwork data to interact with our own emergent thoughts (Atkinson and Coffey 1996). All data sources were initially analyzed individually before emerging themes and paradoxes were compared across sources.

Finally, the empirical findings were informed by existing literature, such as prior research which has commented upon the work of bed management. In particular the work of Boaden et al (1999) and Green and Armstrong (1994) had considerable resonance and pertinence as they used similar methodologies and findings were similar in certain ways. Peer
review of data analysis, undertaken by a group of academics unconnected with the project occurred at all stages, further adding to the overall rigour of the study. However, one limitation of the study is that data were collected from only one location, and in common with most qualitative studies no claims are made regarding generalisability.

7.7 Theoretical assumptions

During the study it became obvious that the work of bed managers involved the meshing of numerous tasks involving the efforts of various units of healthcare workers (both as individuals and departments). It was also obvious that the style and quality of interaction which occurred during and around the work of bed managers profoundly affected how the work was carried out. As a result it became compelling to see the work of bed managers as being produced through numerous processes of social interaction, in other words, the nurses have to “do” bed management with colleagues and departments.

During the analysis a set of related concepts forwarded by Corbin and Strauss (1993) proved to be an effective way of organizing and making sense of the data. For example, Corbin and Strauss’s work was useful in analysing the interactional mechanics of how work was carried out in the organization, and for analyzing the structural/organizational conditions that bear upon the work performance of bed managers. The analysis therefore centres around 4 main concepts: (a) articulation, (b) arrangements, (c) the process of working things out, and (d) stance. These concepts directly connect interaction and work and explain why performance often bogs down and breaks down.

Importantly, the conceptual work of Corbin and Strauss frame the division of labour within organizations in dynamic terms, where occupational roles are not self evident but have to be actively negotiated within a system of work. In so doing they build upon and extend the related work of Strauss (1985) and others such as Friedson (1976) who suggest the need for
an analytic framework that connects the study of work to the interaction process. For example, Strauss (1985) whilst conceptualizing the division of labour in terms of work describes how:

Another potentially useful concept is the collective styles of interaction, which evolve among workers when carrying out their respective tasks: examples being the collaborative and the harshly conflictual. Interactional styles seem not only to affect the precise dividing up of work-what and who-but how that is put into operation; including in relation to accountability and to the necessary articulation of tasks (p.2).

The interrelationship between the four main concepts will be briefly described here before a discussion of the actual findings. Articulation refers to the coordination (or the “joining up” in modern parlance) of lines of work accomplished by means of the working out and carrying through of work-related arrangements. Arrangements refer to the agreements established amongst various actors within and between organizational units (such as bed management and wards, other departments). At the most basic level the arrangement which exists between wards and bed managers is one which sees wards discharging patients in a timely manner (Trust guidelines stated that 50% of discharge should occur “by noon”) thus creating a supply of beds to meet the daily demand. In turn the same Trust guidelines state that bed management should seek “to place patients internally according to clinical need, gender, infection control, security requirements and clinical firm/specialty where possible”.

As will be demonstrated in the following sections, the work of bed management requires collective coordination because many different health professionals are doing many different types of work, all of which influences the timing of when a patient occupies and leaves a hospital bed. Therefore arrangements have to be in place about what work has to be done, during what time period and in what space for articulation to occur. Working things out
is described by Corbin and Strauss (p.82) as the interactional process through which working arrangements are established, maintained and revised. Among the interactional strategies involved in this process are: negotiating, discussing, educating, persuading and threatening. Stance denotes the position taken by each participant toward both the work and the working-out process. This position is taken in relationship to perceived power for gaining control over the broader structural and organizational conditions that bear upon the arrangements thus influencing what the arrangements consist of. In all of this, the carrying out of work rests upon interaction.

7.8 Findings

7.8.1 Removing blockages and working things out

Tens of thousands of patients across the UK are admitted into and discharged out of a hospital bed on an annual basis and on the whole most patients occupy a bed and are discharged from that bed without delay. The work of bed managers is directed towards maintaining the uninterrupted flow of patients into and out of hospital beds. Maintaining the flow of patients results in BMs undertaking a considerable amount of articulation described by Corbin and Strauss (1993 p.71) as the ‘co-ordination of lines of work’. If everything goes more or less according to expectation and the smooth flow of patients is maintained neither staff nor patients complain about a “lack of coordination” and BMs rarely do more than oversee the flow. When patient flow is non-problematic bed management seems to work automatically and the overall articulation work appears invisible or implicit.

Nonetheless, even such non-problematic cases usually involves several interactions before and after to articulate it with the other specific tasks on which it depends or which depend on it. For example when a patient is admitted into an acute medical bed via a referral from a GP a number of telephone calls and related tasks occur between the GP, bed
management, ambulance services, patient/relatives, porters, nurses, doctors and other health professionals on the admitting ward or related departments (e.g. radiology) including related patient services such as caterers and cleaners. A similar number of calls and tasks are associated with the discharge of a patient out of the hospital bed to which the admitting patient is destined.

Therefore accomplishing such a “problem free” exchange of patients requires the articulation or alignment of several workers actions.

However, it is only when patient flow becomes disrupted or problematic that the articulation (or lack of) becomes visible or explicit and the dimensional conditions at work can be seen. It is at this point that the work of bed management also becomes visible as bed managers switch from overseeing patient flow to being directly involved in problem solving issues that disrupt patient flow.

For example the following extract written following a morning shadowing a bed manager describes how a patient discharge due to occur before noon was being delayed.

**Data extract 1 Fieldnotes**

10:45am

BM visits a ward where she is checking that a bed is available for a patient currently waiting in the medical admissions unit. A patient on the ward is ready for discharge but may be delayed as they need a change of urinary catheter- but no size 16 urinary catheter with a 30ml balloon to be found anywhere. This apparently is not an “usual” catheter size (although there are sound clinical reasons for this catheter being used) which is apparently why this ward and no other seems to have one. The nurses describe how they have been unable to track a catheter down and that the patient’s discharge is likely to be delayed until tomorrow. Aware that a delay here will knock on elsewhere in the system the BM telephones several wards and people who she thinks may be able to help, including the hospital urinary nurse specialist and a sales rep from a “catheter firm” who the specialist had met earlier in the hospital. Finally the BM speaks to a “friend” in the hospital’s supplies department – BM gets a bleep 20 minutes later to say that he has found one (somewhere!). The catheter is delivered to the ward by a porter and the patient is discharged home at 13:30 and the patient waiting in the emergency department occupies the bed by 14:00.

Data extract 1 demonstrates that although most of the work related to the patient’s discharge
has been successfully articulated and aligned, the issue of the replacement catheter threatened to disrupt patient flow. Existing arrangements between wards and bed management do not usually see bed managers actually involved in discharge planning on the wards. Corbin and Strauss (1993) however describe that such adjustments are often made to arrangements within institutions ‘in response to fluctuating daily contingencies’ (p.72).

In his early work on articulation Strauss (1988 p.168) states that ‘as analysts we need to focus on the negotiation, persuasion, and other processes that usually become explicit after disruptions have threatened the articulation of the work flow’.

The bed manager’s response in this instance was to intervene in an attempt to preserve the flow of patients by telephoning a number of workers who the ward were yet, or possibly would not have thought, to contact. Whilst on this occasion the BM ultimately resolved the disruption by enlisting the help of a “friend”, BMs also used other strategies to main patient flow. For example, data extract 2 is taken from a focus group interview undertaken with BMs. The focus group interviewer/convener had asked for examples where bed managers directly intervened on ward beyond what they would normally do

**Data extract 2 – focus group 1**

**BM10** – Sometimes wards are very passive. They say we could go for discharge tomorrow but he’s waiting for an INR so I say you taking bloods? Oh no. Alright are you going to, oh alright then. You have to spoon feed some wards it’s a bit worrying really but on some wards you have to do that. A couple of times I’ve even taken blood myself because people have said we’re waiting for someone to take blood, have you bleeped anyone? The SHO is in clinic...so I do it (some quiet laughter)

**BM7** – mmh yes I had to get an envelope once so a patient could be moved to discharge lounge. The receptionist didn’t have an envelope with a window on the front you know for addresses yeh so the patient was sat there and she said she was too busy to get one. I went to ward 21 and got 6 for her. The patient went to the lounge and we got on with it.

Previous studies of bed management have characterised bed managers as “copers” who spent a lot of their shifts on “fire-fighting” aspects of the job (Audit Commission 1992, Boaden 1999). The above 2 extracts show how BMs cope with contingencies that threaten the flow of
patients. What is noticeable is that bed managers spent a great deal of time “working things out”, employing a series of strategies such as prompting (the nurse in extract 2 prompts the nurse to take blood) or taking the initiative (in extract 1 when the nurse phones a friend or extract 2 when the nurse decides to take the patient’s blood rather than wait for the Senior House Office – SHO, or when the nurse borrows envelopes). Thus when existing arrangements (e.g. between nurses and SHOs regarding taking blood) temporarily break down or contingencies arise that surpass existing arrangements (e.g. the demand for an unusually sized catheter) adjustments have to be made to maintain the articulation of work leading to a timely patient discharge.

However, even though the Hospital Trust formally documents their expectations and arrangements regarding timely patient discharge much of the articulation process and working out required to maintain timely discharge is dependent on bed mangers using a range of strategies and interactions with fellow professionals which don’t explicitly appear in hospital documentation or guidelines.

A notable aspect of the first two extracts is that the interventions of the bed managers in removing a blockage which threatened the timely discharge of patients appeared not to result in any of the interpersonal conflict often described in the literature as being a routine part of BM’s work (Boaden et al 1999, Proudlove et al 2003, 2007). The data suggests that nurses and bed managers discovered a way to “work things out” and the resolving actions seemed to work to the advantage of everybody. However, whilst it appears that ward nurses and BMs can between them resolve unforeseen contingencies there was also ample evidence in the data of a less productive relationship and a more strained working relationship between BMs and ward based personnel.

7.8.2 Collecting and validating bed state information
The preceding section showed how existing work arrangements can occasionally breakdown or be in need of adjustment requiring the intervention of the BM. At certain times however the breakdown of work arrangements were not so easily resolved and questions regarding how to resolve contingencies became more protracted and conflictive. In particular, a great deal of conflict emerged from difficulties experienced by BMs when attempting to update the bed state information (i.e. to get the number of beds unoccupied on wards and the numbers of unscheduled or emergency patients waiting for admission) or occurred when there was disagreement about the placement of patients into empty beds.

A key requirement for effective bed management is the collection of information about pending admissions to the bed pool and the amount of beds currently available. BM normally have a good understanding of the amount of elective admissions planned for the day, however gathering information about the numbers of unscheduled admissions which appear in the system over a 24 hour period appeared to be much more difficult. Others have previously noted the difficulties encountered by bed management when trying to collect “real time” information about unplaced patients and available beds (Green and Armstrong 1993, Audit Commission 2003, Harrop et al 2006).

Various strategies have been employed in an attempt to improve both the management and availability of information in this particular NHS Trust and across the NHS. Strategies include the introduction of computerised technology, the continued use of paper-based technologies, more meetings to discuss the bed state and disciplinary measures against staff who fail to provide information about bed availability in a timely fashion. A computerised system providing real-time bed state information was operational within the Trust, however bed managers discussions during focus group 2 suggested that the information appearing on ‘the PC’ was itself inaccurate at times.
Data extract 3 – focus group 2

BM14 - You can spend most of your time chasing up to see where patients are now and tracking patients through EU (emergency unit) and SAU (surgical admission unit) and that’s another problem that why when we go to a bed state meeting what EU say and what we say very rarely tally because whilst we are walking the wards we have little time to keep an eye on what exactly is going on and they don’t update the PC

BM13 - But even then the information on PC might not be right as this morning as the PC said that the patient was in the trolley bay I went down there and they said the patient was in surgical assessment, I went to SA and the patient wasn’t there I went back to trolley bay I said can you tell me where this patient is but they’d never heard of this patient they then said we’re not really sure so I said look I haven’t got time to do this and left them for a bit but then they rang me and said the patient has gone home

BM14 - Yes that happened to me last week and I just don’t go with what’s on the bed state system anymore you just have to check

BM13 - It probably took me about 10 minutes wandering around which doesn’t sound very much but when you’re very busy its a waste of time. You’re making such an effort to bed that patient but chasing around EU trying to find them only to find that they have gone but in the meantime you’ve phoned the ward and given that information to the ward which has been a waste of time and it feels like doubling our workload as well. I find that happens to me all the time and it makes you look incompetent when you’ve got to ring them every time and explain the patient wont be coming. They think it’s us that don’t know what we are doing they don’t think that it’s SAU or EU who haven’t updated the information or don’t where their patients are.

The effect of the computerised information system not being updated had major implications for the work of bed managers. Firstly, it led to differences appearing at “bed state” meetings; secondly it led to BM not trusting the information (I just don’t go with what’s on the bed state system anymore) appearing on the system which, in turn, led to BMs “wasting” their time double-checking the whereabouts of patients. Having inaccurate information also has consequences for BMs relationship with wards. BM13 describes how having to cancel beds booked on wards for patients who have already been discharged, but not logged on the computer system as such, makes them ‘look incompetent’.

BM13 lack of trust in the information which they worked with also became apparent elsewhere in the focus group data. The following extracts sees the BMs discuss how clinicians in the admission or emergency unit sometimes book a bed for a
patient before establishing that the patient needs to be admitted. Interestingly the bed managers explain that the decision by clinicians in the admission/emergency unit to book a bed before knowing whether a patient needs admission or not is a direct response to the pressure imposed on them by government policy to admit or discharge a patient within a set time (4 hours) or else be “in breach” of this policy. Hospitals in Wales are set a target that 95% of all new patients (including pediatrics) should spend no longer than 4 hours in a major A&E department from arrival until admission, transfer or discharge. Furthermore, 99% of patients should wait no longer than 8 hours for admission, discharge or transfer from other unscheduled care admission areas such as a Medical Admissions Unit (MAU). Hospital statistics regularly published by government demonstrate hospital performance against these targets.

Data extract 4 - focus group 1

Interviewer – breach times and the effect this had on clinicians in EU/MAU and booking beds was mentioned a few times during individual interviews could you expand a little on this for me here?

BM8 - They are concerned about breach times from their end so what often happens is that they book a bed well in advance and tell you the patient has already been reviewed but then when you get a bed and phone the admissions unit to transfer the patient they say the patient can’t be moved yet because they haven't been reviewed. Often the patient will be discharged anyway and wont need a bed but they book it just in case so if the patient does need admission following review they can get them off the unit before they breach and not have to wait for a bed

BM7 - they are basically told they have to get their patients through as quickly as possible because of breach times but they don’t realise the work then falls on us to get the bed, chase the patient etc just to find out that its been a waste of time. It creates mountains of work and makes the bed state information inaccurate

BM9- but you get to know a bit about who tries it on and I’m learning now to make sure if I have enough time in those cases that I have some proof that a patient has been reviewed and genuinely needs the bed before I do anything else

It appears that government policy aimed at reducing waiting times for admitting unscheduled patients has resulted in some clinicians requesting beds before establishing a patient’s genuine need for admission. Thus, upon review by the senior medical clinician if a patient requires admission a bed will be ready and the patient
can be transferred out of the emergency unit within the breach time. If a patient is not for admission the clinicians merely have to inform the BMs that they no longer require the bed regardless of the “mountains of work” the request for the bed has generated for the BM. It appears that some clinicians are more prone to this than others (you get to know a bit about who tries it on) and that BM3 now establishes “proof” that a patient “genuinely needs the bed” before securing a bed on a ward.

Gathering information from wards once the patient was admitted also proved to be difficult. One of the arrangements stipulated in trust documents is that wards and BM work together to gather and prepare information about the bed state in hospitals. Knowing the exact bed state of a hospital is extremely important for a variety of reasons. However regardless of the importance of knowing bed state and of the arrangements in place to collect such information BMs were continually frustrated in their attempts to gather bed state information from wards. During individual interviews BMs discussed how difficult it could be to locate a member of nursing staff that could give information about the ward’s bed state.

Data extract 5 – individual interviews – difficulties getting information

Fundamentally the biggest problem we have is that on a lot of wards no one nurse is in charge of the ward anymore. Its time consuming because on medicine there isn’t a nurse like in the old days that knows what’s going on on the ward you have to find out in each bit like the 4 bedder, sides and then the 9 bedder. People do know the information for their area, but no-one person overall does. On some of the surgical wards one person knows the entire ward whilst others don’t…it’s very individual. None of the medical ward (BM2)

If you wanted to make a cubicle available you phone one ward and they’ll give you a yes or no answer and you can be confident in that. If you phone another ward you’ll have to phone one end and the nurse will say “oh that’s not my patient” and the nurse who is actually looking after that patient is on the other end but at break. You phone the other end and you’ll never be a 100% confident even when you reached a “no” that that “no” was right (BM4)

You can ask 3 different people and get 3 different answers – ask in the 9 bedder and they’ll tell you about their patients ask them about the rest of the ward and you’ll have to find another nurse (BM1)
As well as the timeliness of gaining information BMs also reported difficulties with gaining accurate information. Data extract 6 (below) demonstrates the difficulty experienced by bed managers in extracting accurate information from ward based staff regarding potential discharges for the following day (similar findings reported by Audit Commission 1992, Commission for Health Improvement, 2002).

Data extract 6 – individual information accuracy and trusting information

when you are collecting information on discharges we are often in the fantasy realm. On the surgical admission ward you know damn well there’s going to be loads of admissions there the following day and you go there the night before and ask who’s going to be discharged tomorrow they just hum and harrh they mention 3 predicted discharges or something but you know that they may as well have small print “however this information is untrue” (BM1)

BM6 - I’d say at the moment that we are told about a maximum of 40-50% of the numbers that actually do go home that were predicted the day before. I’ll give you a prime example this morning urology had 2 predicted discharges from last night and ended up discharging 9 and that’s one of the better wards (Laughs).

Interviewer - How does that affect the way you work?

BM6 we don’t trust the information that we get then because they could say 4 discharges and half an hour later say none. But when we push for clarification we get a lot of attitude from wards because they think we’re on their backs so if we ask too many questions they get very defensive but sometimes I only have to ask what their bed state is and they kick off.

The final section of the above extract (I only have to ask what their bed state is and they kick off) links to the most common theme running through all of the data collected for this project, namely the repeated descriptions of the hostility that bed managers experience from clinicians based on wards and other departments. This will be discussed further in the final section of the findings.

7.8.3 Hostility towards bed managers and BM strategies to manage hostility.

Other authors have noted that the pressure to accommodate emergency and elective admissions has led to BM concentrating on bed-finding and firefighting in response to bed
shortages (Proudlove et al 2003, Proudlove et al 2007). Proudlove and colleagues also comment upon how organizational culture and pressures on medical and managerial staff can result in strained relationships with BMs over priorities for admission, outlying patients, discharges and quick turnaround of beds due to access-time targets for A&E and Admissions departments. Considerable discussion in individual and group interviews focussed on the amount of hostility and conflict BMs experience on a daily basis. What also emerged in the data was that BMs depended upon strategies of negotiation and sharing decisions as a way of managing or reducing the amount of hostility they experienced. Whilst others such as Proudlove et al, and to some extent Green and Armstrong, have previously written about the sometimes hostile working environment within which BMs work, no recent studies focussing on the analysis of data concerning this particular aspect of the work of BMs exists.

The following data extracts typically represent the numerous examples of hostility discussed by BMs during individual and group interviews.

**Data extract 7 – hostility towards bed managers**

*I got very upset on surgery recently it normally goes over our heads but the pressure got to the point where I got extremely upset it was like knocking your head against a brick wall you were doing one thing the ward seemed to do exactly the opposite ward management were telling you what they wanted and not listening to reason for the last month or so we have been very much at conflict and I was so glad to get away from that ward because it was quite traumatic (BM1)*

*They don’t want bed changes to be made and I go into an area and I’m virtually surrounded by a group of people on a ward at one stage and I got really screamed at and shouted in the end the ward manager came out and was shouting at me as well and I thought I’m not having that so I walked off (BM3)*

*This one nurse was really really aggressive and defensive and very you know look at my board these are the outliers so what are you going to do about it sort of attitude and I’m like hang on I’ve only said good morning but I think she realised they’re not going to change anything through screaming and shouting about their outliers (BM4)*

*They just blank me sometimes they say I’ve not got time to talk to you I get that a lot oh bed management again i’m busy find somebody else to talk to. I was literally chasing a ward sister down the ward the other day it was like a carry on film trying to get information and talking to her back because she was walking away from me. I feel like*
saying I’m a nurse as well I’m trying here to do a job please have a bit of respect and look at me face to face (Focus group 1 BM7)

I had to tell one of the ward managers I said don’t make a fool of me in front of your staff that’s not what I’m here for because all the staff were there and I asked if they had any predictions (discharge predictions) and she said (putting on funny voice) well it may be raining tomorrow and all the staff laughed so I told her and it had a good effect for a week or so (laughs) (Focus group 2 BM13)

That BM experience hostility has been reported previously in the literature, but seldom have such vivid accounts of the hostility experienced been published. It appears that BM experience a range of hostile interactions, from face to face arguments, to being ignored or mocked in front of others. The root of the hostility often resulted from wards attempting to protect their beds and patients from being used by BMs, possibly for use by patients who may not fit the clinical expertise of the ward.

Data extract 8 – wards protecting their beds
Wards are very territorial each ward doesn’t matter if its medicine or surgery. They expect you to consider just their needs. I have had a couple of stand up rows with managers and I told them we don’t have the luxury of looking at just urology or cardiology etc patients we have to look at every bugger and everyone is our priority. They are all important. Frank is our manager here but everyone on each ward is our boss, and if you don’t listen to them they will send it to someone more senior (BM5)

Yeh, everybody’s got their opinion on beds and bed management. One of the wards said this morning this is the most important ward in the hospital and don’t forget that (laughter) but she told me straight no alcoholics or outliers and I should always have my electives on time (Focus group 2 BM11)

In what appears to be an attempt to head off hostility BMs also discussed how they would try to involve the wards in the process of allocating patients to empty beds. In doing so BM appeared took a “negotiating” stance towards their discussions with ward staff whilst also inviting ward personnel to empathise with the work they had to undertake on a daily basis and the difficulties therein.

Data extract 9 – negotiating and working with wards
I’ve given them the book before now and said you can choose any patient from there if you can find one you actually want but they are all awful aren’t they. That works usually as they think thank God I haven’t got your job and take a patient, but it doesn’t last. (individual interview BM2)
Focus group 1
BM10 Wards know sometimes that when they have an empty bed and you walk onto a ward you’re going to give them an outlier, they have no choice but its just the way that you do it as you can go in and say I wasn’t going to give you that one or that one but I’m thinking of giving you that one, what do you think?
BM9 Yes. There’s a lot to be said about involving the wards, telling them they have five patients down stairs waiting for a bed and ask them which they would rather have

Another BM described how a more positive working relationship between BMs and wards was sometimes possible when one good deed seemed to lead to another.

Data extract 10 – an example of reciprocal working
BM6 I’ve repatriated patients back to a ward sometimes when someone’s got outliers and they say you’re good to us and they they’ll take a knock then sometimes because you’ve shown your not completely blind to the wards need

Interviewer: could you give me an example of what you mean
BM6 Well sometimes a ward will give me less of a hard time about taking a patient if I’ve done them a favour in the past.

Such descriptions of a positive working relationship were very rare within the data set, and overall wards largely displayed resistance to receiving patients from BMs, even when they had adequate bed capacity.

Data extract 11 – a ward’s resistance to receiving patients and rationale by BM
Friday I had 10 empty on one ward and 9 on the ward next I know its unusual….so I deliberately gave a patient to the one with 10 so they will have an equal number of empty beds at the end of it and they said, and I hadn’t given them a patient all day, and they said you do know they have empty beds next door and I said yes you’ve got 10 and they’ve got 9 so I’m keeping it equal and showed him the bed state numbers…they still moan when they have 10 empty beds (BM1)

In Green and Armstrong’s (1993 p.342) study bed managers stressed a desire to work by negotiation rather than authority over ward based clinicians with one BM describing ‘not wanting to be a dragon’ but instead wanting a ‘good relationship’ with wards. A similar desire to work with clinicians is seen in extracts 9 and 10 which show bed managers attempting to relay the rationale for their decisions to clinicians whilst also involving clinicians in difficult decisions. Thus communicating the rationale behind a decision (extracts
9 and 11) whilst also involving clinicians in decision making appear to be two strategies employed by BMs to manage the strains and stresses of managing beds.

7.9 Discussion and conclusion

It is has become convention during any discussion of the UK National Health Service (NHS), at almost any point in its history, to first point out that the service is undergoing “an intense period of change”. With the continual requirement for hospitals to meet challenging targets set by policy makers this truism is as relevant for bed managers as any other group of professionals operating within the NHS. However, even though the types of pressure and demands out upon bed managers has changed over the last few years e.g. through the introduction of minimum waiting times for unscheduled patients to be admitted or targets to reduce the amount of delayed discharges (DTOC), this study has revealed that many aspects of the day to day working of bed management have remained the same.

For example a report by the Audit Commission (2003) described how bed managers experienced real difficulty in gathering information about availability and occupancy of hospital beds. This study has also shown how difficulties with the collection and accuracy of information persist which raise questions regarding the planning and delivery of patient care. For example, bed managers described how conflicting and misleading information would appear at a bed planning meeting. Also BMs discussed how a lack of trust in the information being collected led to a process of double-checking which created delays in the daily working schedule. Whilst we can only speculate about other consequences it is ironic to note that in an organisation so fixated on timeliness and reducing delays that staff still have to spend their time double-checking information for accuracy. We also know that the consequences for patients of being placed on a ward that does not specialise in their clinical need can include longer hospital stays and slower recovery rates.
A further finding of this study that was previously reported in the literature concerned the extent of hostility which BMs have to deal with. Although BMs have been described before as “copers” the amount of conflict they have to deal with leads to frustration and stress. There was an element of stoicism about the BMs, especially when together in the focus group or in team meetings, but this appeared to subside somewhat when working alone and was not so apparent during individual interviews. Whilst BMs frequently coped admirably the stress of constantly fire-fighting and often being in conflict with clinicians would regularly appear.

Bed managers are typically expected to manage the extraordinarily difficult task of attempting to place increasing amounts of patients into a decreasing number of beds. In so doing they frequently have to face clinicians who vent their frustration about the placement of outliers in “their beds”, “bed blockers” or cancelling elective patients, even though the root causes of these issues are far from the scope of BMs to resolve. The practice of bed management is therefore akin to attempting to walk a tightrope and consists of an ambiguous nursing role. For example, clinicians are involved in direct patient care whilst nurse managers oversee the care of patients and staff, however little of the experiences of being a clinician or a manager can prepare the nurse for the demands of bed management.

It was noticeable that much of the hostility experienced by BMs resulted out of attempts to meet the needs of the organisation (i.e. the timely placement of patients) which conflicted with individual wards’ requirements e.g. the desire to admit their own speciality patients into an empty bed. Rather than taking sides, either with the organisation or the ward, BMs would often attempt to share the burdensome decision with clinicians of where to place patients. For example, in an earlier extract we saw how bed managers negotiated with wards in an attempt to reach a decision about the placement of patients that met (as closely as possible) the needs or expectations of both parties. Negotiation was therefore used as a
resource by BMs in an attempt to manage to balance the organisation’s need for maintaining patient flow and the more individual concerns of wards.

The process of negotiation and discussion which BMs undertook with wards evoked the work of Corbin and Strauss (1993 p.73) who discuss how employees within large organisations make use of interaction to “Work out”, keep going and revise work-based arrangements.

This process consists of a series of interactional strategies and counter strategies taken by participants, in response to what is said or done by others during the process of making of arrangements both before and after the actual work begins. Strategies include negotiating, making compromises, discussing, educating, convincing, lobbying, domineering, threatening, and coercing.

However, Corbin and Strauss also insist that where employees have an equal voice in working out the arrangements for patient care, they are more likely to carry out the desired plan of medical care. Further studies would be required to establish whether the negotiation and discussion between BMs and clinicians resulted in clinicians being more likely to “carry out” the desired plan of care, however the data collected here suggests that BMs were, at times, utilising a negotiating stance with success.

As also discussed by Corbin and Strauss, when BM and ward based staff were unable to “work things out” this resulted in conflict and an inability to articulate work. In these instances workers tend to resort to strategies including: blowing off steam, giving false information or holding back on important information or simply ignoring agreed working arrangements (Corbin and Strauss 1993, p.79). Whilst failure to “work thing out” does not necessarily mean that the articulation of work will entirely collapse the performance of workers is likely to become less efficient and effective and there may be more errors, accidents and dissatisfaction with work. Whilst again the data collected here failed short of establishing the direct consequences of BMs and staff not being able to resolve differences.
there is evidence in the data collected and in previously published work that ineffective working between BMs and wards resulted in disruptions to patient flow (increase waiting time for admission, delayed discharges) and low staff morale (Boaden et al 1999, Proudlove et al 2007b).

To conclude, ensuring uninterrupted patient flow and timely admission into, and discharge from hospitals, requires the collective coordination of several key tasks. Bed managers play an important role in overseeing the coordination of such key tasks linked to admission and discharge of patients, thus understanding the work they undertake is important if a thoughtful debate is to occur about some of the problems encountered in Wales and beyond in ensuring satisfactory patient flow. This study shows that a vast amount of bed management work rests upon interaction and that negotiation, coercion and argument combine to affect the decisions made about where and when patients are admitted and discharged from a hospital bed. Additionally, policy initiatives focussing on reducing both waiting times for unscheduled admissions and delays in discharging patients creates a context for the work of bed managers characterised by BMs constantly having to manage one crisis after another.
8. Project 2 – An examination of patient participation at the interface between nurse-patient talk and organisational documents.

Abstract

Strongly worded directives regarding the need for increased patient participation during nursing interaction with patients have recently appeared in a range of ‘best practice’ documents. This paper focuses on one area of nurse-patient communication, the hospital admission interview, which has been forwarded as an ideal arena for increased patient participation. It uses data from a total of twenty-seven admission interviews, extensive periods of participant observation and analysis of nursing records to examine how hospital admission interviews are performed by nurses and patients. Analysis shows that topics discussed during admission closely follow the layout of the admission document which nurses complete during the interview. Whilst it is tempting to describe the admission document as a “super technological power” to influencing the interaction and restricting patient participation, this analysis attempts a more rounded reading of the data. Findings demonstrate that whilst opportunities for patient participation were rare, admission interviews are complex interactional episodes that often belie simplistic or prescriptive guidance regarding interaction between nurses and patients. In particular, issue is taken with the lack of contextual and conceptual clarity with which best-practice guidelines are written.
8.1 Introduction
Over 13 million patients were admitted to hospital for in-patient care within the National Health Service (NHS) in England and Wales during 2006-07 (HES 2007) and each patient had their care needs assessed by a registered nurse (RN) or student nurse. These “nursing admission assessments” therefore form a significant part of nurses’ routine daily work pattern in hospitals. Nursing assessments usually take place at the patient’s bedside forming one part of a hectic admission process which sees patients also undergo a medical assessment and various interventions such as blood pressure measuring, height and weight recording and blood taking.

In this section of the project I explore the work of nurses when initially assessing the health and social care needs of adults undergoing admission into hospital. The simultaneity of the patient’s entry into hospital with the need for nurses to gather assessment information regarding the individual, has led to the synonymous use of multiple terms to describe these activities. Nurses during this study, for example, stated that they were “admitting a patient”, “assessing a patient”, “taking the history”, “interviewing a patient” - with each term relating to the same activity.

Nursing literature is unequivocal regarding the significance of admission process for the nurse-patient relationship being forwarded as the important area of nursing work to be performed when a patient enters hospital (Latimer 2000). In particular, practitioners have been encouraged to view admission and discharge processes as “joined-up” or “seamless” stages of care. Over 2 decades ago it was stated that discharge planning should commence at the time of a patient’s admission to hospital (Waters 1987), or more recently in the case of elective hospital care discharge planning should start before patients enter hospital (NHS Scotland 2009).
Furthermore, the assessment interview has long been identified by nurses as an opportunity to encourage patients to participate in their care (King 1971, Crawford and Brown 2004). For example, Sully and Dallas (2005: 74) refer to the admission interaction as a phase of nursing work which offers opportunities ‘to develop a partnership’ with patients (Sully and Dallas 2005: 74). Similarly, Tutton’s (2005) interview study reported that nurses viewed history taking as fundamental ‘to the process of participation’ (149) creating an opportunity ‘for knowing what was important to them’ (148).

The above descriptions of the admission interview are typical of those found in the nursing literature which largely focuses on verbal communication during the admission interaction. However, nursing in general, and the admission process in particular, sees nurses routinely writing in and reading a variety of patient records and other kinds of documents. Systematic reviews of nurses’ record keeping and recording systems (Moloney and Maggs 1999, Currell and Urquhart 2004) report there to be a lack of credible research which examine the interactional practices of nurses and patients when records are being consulted or filled. Similarly, Heath et al (2003) and Timmermans and Berg (2003) draw attention to the disregard in sociological research for the ways in which people, in ordinary, everyday circumstances, use tools and technologies, objects and artefacts, to accomplish social action and interaction.

Recently authors such as Ventres (2006), Kaner et al (2007) and McGrath et al (2007) have explored the effects of medical records on the interaction of physicians and patients. However, few studies examine the use of seemingly mundane technologies such as paper-based or electronic patient records (EPR) and their detailed effects on healthcare talk and interaction. The lack of studies that attempt fine-grained analysis of talk is prevalent in non-primary care contexts where interaction involves nurses.
8.2 Study aims

The data presented here provides a rare glimpse into the interactions of nurses and patients during episodes of acute hospital care. The aim of this paper is to explore nurse’s use of mundane technology (paper-based nursing record) during the admission process of patients into hospital and whether the use of such technology affects the extent of patient participation during the admission process. What emerges from the analysis is a better understanding of the interactive and interdependent relationship within nursing assessment interviews between the spoken words of nurses, the written word of the assessment document and the spoken words the patient’s contributions. The analysis will subsequently inform a discussion regarding nursing practice during admission interviews, as well as contribute to the debate regarding record keeping at a time of great change where hospital records, such as those used during the admission process, are soon to be completed in electronic format.

8.3 Background - patient participation

The image of the consumer stands at the heart of attempts by policy makers to reform health systems to meet the demands of a “modern” world in which citizens are assumed to have greater involvement and confidence in challenging clinician authority (Newman and Vidler 2006). In the UK and beyond such a conception has been a central feature of the increasing value placed on patient participation (and patient involvement and partnership) at all levels of healthcare delivery. For example, patient participation has been prioritized in a plethora of supra-national (WHO 2005) national (NHS Executive 1996) and sub-national (Welsh Assembly Government 2003) government policy documents.

Professional bodies and regulators of nursing practice in the UK have also identified patient participation and involvement as central to good nursing practice. For example, Royal College of Nursing (2003: 3) identifies a ‘commitment to partnership’ with patients as one of
its six defining characteristics of nursing. The Nursing and Midwifery Code of Professional Conduct (NMC 2008: 2) recommend nurses should uphold ‘people's rights to be fully involved in decisions about their care’. However, despite the many writers and policy documents advocating patient participation within the context of nursing care, there is little consensus about what participation means.

Fieldwork for my study was undertaken at hospitals using Dougherty and Lister’s (2004: 36) manual of clinical nursing procedures as a “best-practice” guide. The manual offers guidelines on various aspects of nursing practice including “communication and assessment”. For example, page 30 state that the assessment interview ‘should progress logically, ensuring meaning for the participants’ whilst also providing nurses with an opportunity to ‘gain an understanding of the patient’s priorities for care’. Overall, the procedure manual characterises the initial interview as an interaction which enables the gathering of patient information whilst also facilitating the establishment of a therapeutic nurse-patient relationship. Whilst patient participation during initial assessment is not explicitly mentioned, the manual does state that effective assessment ‘should be a process in which the patient ideally plays an active role’ (p.25).

The procedure manual therefore avoids presenting guidelines to nurses about participation during patients’ admission (or any other phase of care). In so doing, the manual reflects a wider trend in nursing literature and policy documents which encourages patient involvement during the admission phase but avoids offering specific guidance. The lack of specific guidelines is probably indicative of the potentially complex nature of participation and care giving in practice settings. For example, hospital wards, such as those recruited into this study, admit adult patients suffering from a wide variety and severity of illness which result in varying opportunities for patient participation. Such potential complexity would quickly make redundant specific guidelines for use on acute medical wards for example.
What remain therefore are literature and policy documents that exhort nurses to involve patients. Sahlsten et al’s (2008: 9) in depth analysis of the patient participation literature describes the defining attributes of patient participation as including interaction where ‘The nurse displays genuine interest and empathy’ and ‘where the patient volunteers information without being asked or is invited to do so by means of open questions’. Sahlsten and colleagues’ defining attributes neatly captures how nursing literature has traditionally portrayed patient participation as being dependent on a command of relevant communication skills (interest and empathy, the use of open questions, etc.). As such it provides a useful conceptual “baseline” for further exploration in this study.

Peräkylä and Vehvilainen (2003) have called on conversation analysts to explore the relationship between professional-client interaction and organized knowledge (referred to as “stocks of interactional knowledge” or SIKs) that are found in textbooks and policy documents. In particular they propose that conversation analysis (CA) findings can provide a more detailed picture of practice than that described in SIKs. In doing so, CA can add a new dimension to the understanding of practices described within abstract or general documents. The intention in this paper therefore is to create a dialogue between nursing SIKs which describe patient participation and the actual practices of nurses in the hope of adding a new dimension to the understanding of practices described by an SIK.

8.4 Methods

Sample and recruitment

The setting for this study was 3 acute hospital sites in the UK with data being collected from 5 hospital wards in total (two medical wards and one ward from general surgery, neurology, cardiology). All patients recruited were classified as “unscheduled admissions”, having been admitted to the wards via a referral that day from a primary care practitioner or the accident and emergency unit. The initial admission interviews were carried out by registered nurses
within 2 hours of the patient arriving on the ward. It is inevitable that nurses also assessed patients during subsequent interactions but the study’s attention was maintained purely on the initial admission interview which, as discussed earlier, has been presented in the literature as a prominent and important event within which information is gathered and rapport with the patient established.

The method used is conversation analysis (CA) as applied to the study of institutional interaction (see Drew and Heritage 1992). Twenty-seven admission interviews were observed, audio-taped (621 minutes of talk) and transcribed, whilst 25 nursing documents produced as a result of these interviews were photocopied and analysed; no nurse or patient was recorded/observed more than once. There were no explicit inclusion/exclusion criteria adopted for recruitment to this study, and a purposive sampling approach was undertaken, with the researcher choosing cases that illustrated the process under scrutiny (Silverman 2005). Relevant ethical approval for the study was granted and data anonymised before publication.

Prior to audio recording a total of 45 admission interviews were observed during 175 hours of participant observation on the wards. The need for a period of field-work became clear during preliminary visits to clinical areas. Particularly apparent during these visits was the complexity of activities undertaken during assessment interview and the range of distributed activities which feature, sometimes only momentarily, in the accomplishment of the work in question. Therefore, a variety of data was collected using ‘field methods’ (ten Have 2004: 127). Observations, note taking, documents which were perused and copied, all helped to sketch the overall features of the setting, while the audio recordings were collected to identify the spoken strategies used to actually “do” the assessment interview.

Notes were taken during the admission process (e.g. “nurse writing in notes”, “patient points to left side of head”) and a summary report of each admission was written up
immediately at its completion. The report was a particularly useful record of the interaction between nurse and patient, allowing more detail to be added to the notes taken during the admission and leading to a fuller consideration of nurses and patients conduct.

My observations built upon previous studies that had utilised observational data to better understand doctor-patient work in primary care settings (Heath 1986, Ruusuvuori 2001). These studies reveal how participants coordinate tasks with the actions of others, how they monitor each other’s conduct and its relevance, and how attending to the medical record shapes and constrains interpersonal communication. During the course of this study it became apparent that nurse-patient interaction was similarly influenced on occasion through nurses attending to or reading the admission record during the admission interview. In particular, the close working of nurses with the assessment document, appears at times, to limit the patient’s voice and restrict opportunities for patient participation.

Analysis

Analysis involved repeatedly listening to the tapes and reading through the transcriptions, based on Jefferson’s (1984) orthography, which were produced as soon as possible following recording. The analysis of talk was augmented by the field-data detailed above. For example, photocopies of the nursing notes gave an insight into what nurses wrote during the admission. Timing the admission interview with a digital stopwatch enabled handwritten fieldnotes regarding gestures, laughter or nurses’ reading the notes to be co-ordinated with the transcripts at a later stage. For example a fieldnote entry such as “NW 3.12” was subsequently translated into “nurse writing in the notes at 3 minutes and 12 seconds” of the admission interview. The overview of the admission, which I wrote at its completion, also enabled me to access useful supplementary information during analysis. Such additional data proved invaluable in the absence of video-recording, the use of which proved impractical for a variety of reasons associated with the acute-care nature of the settings.
8.5 Findings

Topical organisation of talk.

One feature of the admission interaction was the extent to which the topics discussed during admission followed the sequence of topics as they appeared on the admission document being completed by the nurse at the time of the interview.

Extract 1 SB1 – 3 minutes into assessment of surgical patient admitted for “observation re. abdominal pain/distension”

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>25</td>
<td>n</td>
<td>any problems with your boweil or w]aterworks</td>
</tr>
<tr>
<td>26</td>
<td>p</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>(6.0)</td>
<td>((nurse writing in notes))</td>
</tr>
<tr>
<td>28</td>
<td>n</td>
<td>and you manage to wash and dress yourself</td>
</tr>
<tr>
<td>29</td>
<td>p</td>
<td>yeh yeh</td>
</tr>
<tr>
<td>30</td>
<td>(8.0)</td>
<td>(( nurse writing in notes, patient looking through window))</td>
</tr>
<tr>
<td>31</td>
<td>n</td>
<td>and you’re walking about ok [you] don’t get short of breath [walki]ng</td>
</tr>
<tr>
<td>32</td>
<td>p</td>
<td>yeh [no-no]</td>
</tr>
<tr>
<td>33</td>
<td>n</td>
<td>walking around or anything</td>
</tr>
<tr>
<td>34</td>
<td>(7.0)</td>
<td>((nurse writing in notes))</td>
</tr>
<tr>
<td>35</td>
<td>n</td>
<td>sleeping what you’re like with your=</td>
</tr>
<tr>
<td>36</td>
<td>p</td>
<td>=well you know its off and on you know not good not bad ((short</td>
</tr>
<tr>
<td>38</td>
<td>laugh))</td>
<td>you know we both sleep for about three to four hours and then</td>
</tr>
<tr>
<td>39</td>
<td></td>
<td>we’re awake you know so:::</td>
</tr>
<tr>
<td>40</td>
<td>(4.0)</td>
<td>((nurse writing in notes “sleeps 3-4 hours”))</td>
</tr>
<tr>
<td>41</td>
<td>n</td>
<td>(do you do anything?) with religion or anything</td>
</tr>
<tr>
<td>42</td>
<td>p</td>
<td>uh:: &gt;&gt;&gt;no&lt;&lt;</td>
</tr>
</tbody>
</table>

When reading extract 1 with figure 1 (below), we can see how the nurse asks the patient questions concerning bowels/waterworks and hygiene “and you manage to wash and dress yourself” (line 28 relating to “Personal cleansing and dressing” on the document) before moving on to the unconnected topics “and you’re walking about ok” (line 31 – “Mobilising” on the document), sleeping (line 35) and religion (line 41).
As was noticeable across the data-set, the nurse’s action of reading and writing in the admission document (extract 1 lines 27, 30, 34, 40) seemed to influence topic-ordering during the assessment interview. However, this is not to suggest that the document “controlled” the interaction, as figure 1 also shows that the nurse chooses to skip certain topics (e.g. “controlling body temperature” is not discussed before “mobilising”) and covers some topics out of the order presented on the assessment form. It is therefore worth noting that the choice of how to specifically question patients regarding these topics is at the discretion of individual nurses. The assessment form merely reminds the nurse of the details that might be noted during admission and lists them in a prefixed order, but does not dictate the practical shape the gathering of the patient information might take. Indeed, the topic headings merely
mapped out the topic areas for discussion as nurses rarely followed the exact order of the topics as written on the assessment sheet.

Concerns have previously been noted about how nurses’ and physicians’ use of paper or computerised templates tend to “crowd out” the patients’ voice (Berg and Bowker 1997, Harris et al 1998, Rhodes et al 2006). These concerns have led to guidelines recommending that nurses should not follow assessment frameworks too rigidly as they may prevent nurses from critically thinking about the significance and type of information they are gathering from patients (Dougherty and Lister 2008). It is evident from the data presented in this section that, on the whole, topic selection during the admission interview is guided by the admission framework, rather than being rigidly followed to by nurses. However, in the next section data is explored which suggests that nurses, on occasion, follow the admission framework more rigidly. It will be shown that a more rigid adherence to the admission template has implications both for the type of information that is gathered from patients and for the patient’s voice within the interaction.

**Delaying patient descriptions of their illness history to fit with corresponding areas of the nursing record.**

The previous section discusses how the assessment document functions as an informal prompt sheet for the topics to be covered during the patient’s admission and that the patients’ “activities of daily living” were assessed as a series of single, unconnected topic areas (bowels, hygiene, walking). However, patients rarely experience symptoms of illnesses or problems with daily living activities as single events or as clearly defined topic areas. Regardless of this nurses repeatedly directed the interaction according to the particular area of the paperwork (and the one topic) that was being completed at that time. The focus on one topic at a time was problematic for patients as seen in the following extract, where a nurse is admitting a patient onto the neurology ward for investigations into recurring headaches.
Extract 2 Mb2 - Delayed discussion of headaches, 11 minutes into the admission.

176 n YOU DO a lot round the house then to help is it-
177 p well (. ) mu::muck in- with the daughters come in=
178 n =do they oh ok
179 p wu since April I can’t (. ) bloody do much cos I (. )=
180 n =alrigh
181 p because these headaches come straight away-
182 n °right °
183 (0.8)
184 n what type of accommodation do you live in↑
185 p we’ve gorra council house

2 minutes later, following discussion/recording of patient's occupational status (retired) and confirmation of his General Practitioner’s details.

208 n right (. ) reason for admission
209 (1.6)
210 p hu:headac[hes]
211 n [hu] (. ) headaches right how long have you been having these
212 p headaches?
213 n uhm since last April

In extract 2, the nurse whilst completing the “Social factors” part of the form asks the patient a question regarding his house cleaning arrangements. In the course of answering the patient discusses needing assistance with the house work (‘I can’t bloody do much’ – line 179) in relation to his reasons for being admitted (‘these headaches’ - line 181). Therefore, the patient clearly introduces “headaches” at this point as a relevant consideration which limits his ability to “do much”. However, in this case it paves the way for a further question on “social factors” concerning “accommodation”. Previous CA studies reveal that acknowledgement tokens, such as the nurse’s “right” (line 182) and subsequent pause (line 183) are ‘closure implicative’ (Jefferson 1972: 317) and pave the way for the introduction of another topic, however in this case a topic is re-introduced namely the discussion of “social factors” such as “accommodation” (line 184).

However, the subject of headaches is re-introduced later in the admission as the nurses asks ‘reason for admission’ (line 208 – corresponding to the box “Reason for admssision/referral”). Interestingly, the question is met with a considerable silence (1.6 seconds) suggesting that the patient experiences some difficulty with the preceding talk.
(Pomerantz 1984). Furthermore, field-notes written immediately afterwards noted how “exasperated” the patient appeared during this stage of the admission.

One possible reason for the difficulty is that the patient had already clarified that “headaches” were a major concern and constituted the reason for admission. The pause may also display the patient’s expectation that the nurse takes into account what was said beforehand, an expectation related to the notion of “recipient design”. Boyd and Heritage (2006) note that the principle of recipient design is critical to the achievement of rapport in healthcare interaction, as questioning patients in a way that is orientated to their responses to previous questions ‘will generally tend to be heard as sensitive, concerned, and caring’ (164).

Extract 3 demonstrates a similar occurrence featuring a different interview and nurse on the neurology ward, where a patient is being admitted for “investigations into prolapse disc”.

**Extract 3 VG432- 9 minutes into admission - delayed discussion of sleep**

211  n  are you able to sleep with the pain
212  p  oh:: I’m no good sleeping like (. ) I’m up at 3
213  n  have you been taking tablets to help with the sleep
214  p  the GP wouldn’t give me sleeping tablets and when I go to bed
215  n  = right you’ve come in for tests into pain in your back
216  (9.0) ((nurse writing in notes))
217  n  right have you had any falls at all

**6 minutes later following discussion of mobility, hygiene, diet and elimination**

499  n  how are you with sleeping
500  (2.0)
501  p  I::: uh I’ll go to sleep (. ) wake up (. ) for a bit like
502  n  =mmhuh↑

Whilst discussing “reason for admission” (back pain) the nurse asks the patient ‘are you able to sleep with the pain’ (line 211). The patient proceeds to explain that sleeping is difficult (line 212), adding that the GP refused to prescribe sleeping tablets (line 214). However, the discussion of sleep/bed time is terminated by the nurse stating the reason for admission (line 215) and withdrawing eye contact via the act of writing “admitted for investigation re. back
pam” in the notes. Six minutes later the nurse re-introduces the topic of sleep (line 499), resulting in a delay component of 2 seconds before the patient hesitantly begins to answer.

Patients therefore display difficulties when previously disclosed information is revisited during the assessment interview. As they never see a copy of the assessment form, patients have no way of knowing that earlier discussion of “headaches” or “sleep” are re-introduced by nurses in an attempt to co-ordinate talk to the sequence of topics appearing on the paperwork. Fieldnotes suggest that this feature of the assessment interview proved irritating to the patients, and it may well be that patients expect nurses to be sensitive to earlier answers. Interestingly, critics of standardised research interviews have similarly found that a lack of recipient design during interviews produces awkward interactions (Maynard and Schaeffer, 2006; Woofitt and Widdicombe 2006).

The influence of reading and writing in the notes on patient interaction.

As already noted, the assessment was frequently punctuated by nurses writing in the patient’s admission documents. For example, extract 4 (below) sees the nurse and patient discussing the patient’s previous medical history before the nurse’s gaze moves towards the notes placed on the table in front of her where she writes in the “previous admissions” box “Hysterectomy 24 years ago”.

Extract 4 VR206 – 4 minutes in, patient admitted to medical ward for shortness of breath

51 p I had a hysterectomy
52 n when was that
53 p hu::: twenty four years ago now twenty five
54 n “oh alright” ok
55 n (10) ((writing in notes))
56 n any other medical problems
57 p uhm (.) yeh my ( ) (on-going?) problems (swelling?)
58 n your ankles still swell do they
59 p yeh and my blood pressure is quite high my blood pressure
60 n (4.0) ((writing in notes))
Following the 10 seconds it takes for the nurse to write in the notes (line 55) supplementary questions on the related theme of “other medical problems” are introduced followed by the patient’s answers which are immediately written in the notes. Although none of the nurses explained to patients that periods of interaction would sometimes be followed by periods of writing, the patients’ conduct was sensitive to nurses’ interactions with the notes as they rarely interrupted or questioned nurses whilst they wrote. Therefore, nurses’ re-direction of gaze (away from the patient) when writing in the notes had significant consequences for the production of patient talk. However rather than assuming that the use of nursing notes remain stable throughout interactions, Heath & Hindmarsh (2002: 118) recommend that the use of objects such as nursing records be examined to understand how they ‘come to gain their particular significance at specific moments within courses of action’. With this in mind, the following extracts demonstrate specific moments where the nursing records achieve particular significance during the admission interview.

**Extract 5 TDJ034 – opening turns of admission to medical ward, the patient being interviewed by the nurse following assessment by the doctor.**

1 p what’s this for now↑
2 n we’re just going to admit you
3 ((nurse shuffles the forms and bangs them on the desk))
4 (1.5) ((nurse reading the notes))
5 p [you shouldn’t have to]
6 n [you remem-member]=
7 n mmh
8 p =shouldnt have to readmit me ther-the Dr came to clerk me this morning
9 n “ahh”
10 (10) ((nurse reading through notes and organising the paper work))
11 n “right” (.) can I have your telephone number
12 p zero two three

The patient mistakenly reports there to be no need for the nurse to repeat the admission process as she has already been admitted by the ward doctor (see line 8). Whilst joint medical-nursing admissions do occur in some hospitals, it was not the case here. The nurse’s hushed utterance (ahh – line 9) is followed by his engagement with the notes in such a way that is influential within the interaction. For example, the patient’s behaviour is sensitive to
the re-direction of the nurse’s gaze (line 10) as no further discussion of the need to “readmit” occurs whilst the notes are consulted. The silence which accompanies the nurse’s reading is only broken when the nurse asks for the patient’s telephone number” (line 11), an utterance that simultaneously starts the disputed admission interview and silences the patient’s queries about the need for “re-admission”. Overlooking the opportunity to explain the separate nursing and medical admission processes, the nurse then proceeds with a full assessment of the patient from this point onwards.

Extract 6 also demonstrates how reading the notes alters the course of the interaction, this time when a patient attempts a discussion of his cancer and treatment options.

**Extract 6 DWA95 – 6 minutes into admission to a surgical ward for ongoing cancer treatment**

47 n did he get you to sign a consent form
48 p no=
49 n =sorry about that
50 p not yet (.) so I think this is uh::m (.)“I can’t” this is ( ) cancer in
51 the uh colon I had removed a tumour [remo]ved
52 n [muh]
53 p about uh >>twelve months ago<< by Mr Y and he’s passed me on now
to Mr X so I don’t know whether its all related with the cancer in the uhm (.)
55 oesophagus:
56 n oesophagus
57 p oesophagus yeh (.) so they’re trying to burn it away now
58 n rightly ho
59 10 ((seconds nurse reading/looking at notes))
60 p I don’t know whether I’ve got much to worry about at my age (laughs
61 a bit) I think they’re anxious for me to get a telegram from the Queen
62 ((patient laughs for 1.2 seconds))
63 ((nurse laughs for 1.5 seconds)
65 (4.0) ((nurse looking at notes))
66 n so you’ve had a right hemicolectomy in the past didn you
67 p yes

Towards the end of an explanation of recent hospital treatment which begins on line 53, the patient appears to “probe” for more information towards the end of this turn, stating ‘I don’t know whether it’s all related with the cancer…’ (lines 54-55). The nurse does not “hear” this as a probe, for example by responding to or exploring the patient’s concerns, instead she helps with the pronouncement of terminology (line 56). The patient continues describing his treatment ‘they’re trying to burn it away now’ (line 57) followed by the nurse’s response.
‘righty ho’ (line 58), an idiom associated with attempts to close interaction (Beach and Dixson 2001), and disengagement of eye contact to read the notes (line 59).

However, a deviation from the norm occurs as the patient breaks the silence accompanying the nurses’ reading by repeating an earlier theme of uncertainty, stating ‘I don’t know if I’ve got much to worry about at my age’ (line 60). The patient continues by speculating that his imminent treatment is motivated by others’ (‘they’) desire for him to ‘get a telegram from the Queen’. Both laugh at this point, with the nurse’s laugh marginally outlasting the patient’s before trailing off into another 4 seconds of silence as the nurse reads the notes. This short period of reading leads to the re-starting of the interview with an unrelated point ‘so you’ve had a right hemicolectomy....’ (line 65). The word ‘so’ can be heard as a direct effect of the nurse reading the notes, and has the immediate effect of orientating the interaction to what was just read (Beach & Dixson 2001) in contrast to what was just discussed and laughed about (cancer and prognosis). Further talk about cancer treatment and prognosis remained unvoiced during the remainder of the interview.

Extract 6 sees the patient offer an account of his previous hospital experience which is unrelated to a question. Such “off-topic” departures can be used by patients to accomplish a range of ancillary tasks, for example they can be used to introduce features of the patient’s life-world which are matters of significance or preoccupation. Heritage and Stivers (1999) propose that departures exist in defiance of the restrictive agenda of physicians’ questioning providing insights into what was ‘on the patient's mind’ (165). The off-topic departure in extract 6 can be heard in the same way, with the talk, temporarily at least, being focussed on the patients own preoccupations and topics rather than the nurse’s.

Patient initiated departures have the potential to offer nurses different interactional possibilities where patients lead the discussion. Yet what is emerging is that the initial assessment constitutes an environment in which patient-led talk is most often curtailed. As a
result, what was “on the patient’s mind” is not responded to during the admission, which according to nursing literature and policy at least, appears to be the ideal forum for such discussion. One possible reason for this could be related to a question of relevance. Off-topic expansions neither respond to a prior question nor offer clarification of an earlier response, therefore as the nurses’ actions suggest have little relevance to the form-filling task at hand.

**Documentation reduces patient participation.**

In this section I compare the entries written into the nursing record with the ‘raw material’ (Hak 1992: 145) of the actual spoken interaction used to produce the record. In particular, the comparison will show how patients’ utterances are transformed into a written “nursing history”. Guidelines produced by the UK nursing regulatory body specifies that the nursing record should demonstrate a full account of the patient’s assessment in addition to being factual, accurate and ‘recorded in terms that the patient/client can understand’ (Nursing and Midwifery Council 2007: 2).

With this in mind, extract 7 provides a typical stretch of interaction where the nurse and patient are discussing the topic of sleep.

**Extract 7 EGH 239 – 14 minutes into admission to a cardiology ward for investigations into chest pain**

| 247 n: | How-how long do you sleep (.) for↑ |
| 248 | (3.2) |
| 249 p: | ° Uh:: I wake quite early uhm:: ° |
| 250 n: | How many hours do you sleep at night? |
| 251 p: | Well I try and get 8 hours but its not- its not always 11 o’clock umh |
| 252 | (0.6) |
| 253 n: | Broken sleep is it↑ |
| 254 p: | I sleep til seven probably yeh yeh |
| 255 | (0.5) |
| 256 n: | How many hours a night rough::ly↑ |
| 257 p: | (0.5) Say seven um I think |
| 258 | (7.8) ((n writes in notes)) |
| 259 n: | Righty ho (.) so you’re a retired gentleman |

Of interest here is that the above interaction about the patient’s sleep is written onto the assessment sheet by the nurse as “Sleeps 7hrs a night”. Looking at the transcript and listening to the tape it is clear that the written version of the patient’s sleep (entered into the “Sleeping”
section of the form) does not capture the nuance of the verbal description of the patient’s sleep pattern. The transcript shows a series of qualifiers (“probably” line 254, “I think” line 257) which together with the pauses between questions (lines 248, 252) and equivocation (line 249) suggest that the patient may regard the nurse’s questions as problematic. Indeed the patient appears to reject the original premise of the question (How long....) by attempting an answer that initially avoids any quantification of the length of sleep.

However, the question of how long the patient sleeps is repeated a further two times (lines 250 and 256). Each repeat of the question follows a response by the patient which draws upon personal experience to describe a night’s sleep (lines 249 and 251), answers which are declined until a more objective quantification of time is produced (7 hours line 257). What becomes apparent is that the repeating of the question is due to the nurse pursuing a category of answer (number of hours) which is different to the category of answer (quality of sleep pattern) actually given by the patient. The initial question regarding how duration of sleep is repeated until this category of answer is provided.

A review of the “Sleeping” section of the assessment documents collected during this study showed that all documents contained a quantification of sleep rather than a description of sleep pattern. However, it is important to note that the discussion of quantity rather than the quality of patients’ sleep in extract 7 is not “caused” by the assessment tool, it is instead the result of the way nurses choose to implement the record at this particular time. Whilst other nursing records specifically determine the type of content allowable (certain sections of a fluid chart can only be filled using metric numerical data e.g. 20mls) the assessment sheet only pre-structures broad topic areas rather than the exact type of information to be collected. In this way the assessment sheet can be seen as a mediating rather than a determining presence during the interaction.
As already touched upon, the information about “sleeping” that is finally recorded in the patient’s notes is not a direct reflection of the patient’s utterance but the outcome of the nurse’s interpretation of the nature of a permissible response and her pursuit of such a response. While the statement “sleeps 7 hours a night” may be technically correct the patient’s actual experience, which he tried to volunteer, was lost. A comparable restriction of patient histories is noted in Berg’s (1996) study of doctor-patient consultation. Berg noted that writing down one line summaries which of complex medical and social issues produced a particular rendering of patients’ histories that appear more manageable on paper than when communicated verbally by the patient.

8.6 Discussion

Assessing the impact of paper-based technology on nurse-patient interaction is timely as the UK health service moves towards the use of EPRs. Policy makers have favourably contrasted EPRs to current paper-based records which they describe as antiquated, inefficient and a threat to patient safety (WAG 2003). However, nurses have consistently adopted a negative stance towards EPR, with a particularly enduring concern being that electronic systems restrict the patient’s voice and individuality (Rodrigues 2001, Darbyshire, 2004, Kirshbaum 2004, Lee 2006, Rhodes et al 2006). For example, Rhodes et al (2006: 374) state that moves towards the use of computerized templates in nursing ‘risk emphasizing diagnostics over therapeutics and diminish the patient to a minor supporting role’. Somewhat ironically therefore, this study shows that nursing practice using “old” paper-based technology limits patient participation and the patient’s voice in similar ways as those attributed to “new” electronic technologies.

Therefore, an alternative consideration of the use of technology in nursing and in other areas of healthcare practice is required, one which follows on from Timmerman and Berg’s (2003) plea to neither over or under-estimate the role of technology in healthcare and
which focusses not only on templates (computerised or paper), but on the practitioners who use them. Ventres et al (2006) provides a fine example of one such study that considers the practitioner more fully than most. Their recent ethnographic findings discuss how “physician style” was a major determinant of how EPR technology was used in encounters with patients. For example, those doctors with an “interpersonal style” were more led by patient narratives than those with an “informationally focussed” style who positioned themselves at the computer-monitor and asked computer-guided questions.

Borrowing Ventres terminology, the nurses in this study utilised an “information focused” style of interaction asking “template-guided” questions. It is impossible in this study to categorically state why the nurses utilised a “template guided” style of interaction with patients which appears at odds with best-practice guidelines for the assessment. In these busy and “time scarce” clinical environments, nurses’ use of the admission template certainly aided in managing the recurring task of taking a patient’s history.

An easy answer would be to cite the admission document template itself, a position that would reverse the historical tendency that sees nurses view such technologies as neutral objects which have little tangible effect on actual care-giving (Barnard 2002). For example, one could point to the way in which the interaction follows the overall shape of the template, and the way in which detailed answers given by patients were sometimes reduced to a few words and figures that fitted into, for example, the “Sleeping” box. In other words, one could claim the document controlled the interaction. Yet, at other times nurses could be seen to skip or change the sequence of topics appearing on the document (as shown in figure 1) and the template makes no practical recommendations about how nurses should interact with patients during its completion. Overall, the admission document could not function without the nurses working with it, the implication of which is that no one thing is in control, nurses, patients or the assessment template.
Viewing the assessment documents as only one of many factors that influences interaction between nurses and patients is an alternative to the somewhat naive notion that technologies such as paper documents act with ‘super technological powers’ to control the actions of all others (Timmermans and Berg 2003: 100). Yet, such technological determinism is still evident in literatures and policy documents concerning management and information technologies. For example, the case for introduction of the Electronic Patient Record in Wales is partially made by policy makers who describe how ‘antiquated paper-based systems’ frustrate ‘effective record keeping and potentially threaten the quality of care and patient safety’ (Welsh Assembly Government 2003: 59). Explanations of how exactly the use of paper-based systems linearly exert these effects (potentially or otherwise) is left out of such discussion.

What the data does show is that the initial assessment interview, which has been forwarded as an important area of nurse-patient interaction within which patients are supposed to be active participants, sees patients largely take the role of passive responders. However there is little consensus about what patient participation is (Collins et al 2007) at the same time there is mounting evidence that whilst some patients expect greater involvement during healthcare, others want little (Barratt 2005). Regardless of this patient participation at key points of the patient’s journey such as discharge planning continues to be presented as necessary and desirable (Petersson et al 2009).

Furthermore, the characterisation of assessment as a routinised list of questions raises doubts about the information gathered about the patient. As the assessment of patients is the first step of the nursing process, seamlessly followed by planning, implementation and evaluation of the care the lack of patient centred information gathered during hospital assessment has obvious implications for the ensuing steps of the nursing process and of the patient’s journey through hospital.
The kinds of guidance that nurses are given regarding communication with patients during initial admission interviews and how to provide opportunities for their participation should therefore be more informed by a better understanding of the interactional dynamics of, and the contextual influences on, nurse-patient encounters. For example, evidence suggests that many health professionals lack the requisite skills and that the contexts of care delivery (including socio-economic influences and work pressures) bring their own constraints (Collins et al 2007), all of which are important factors which textbooks and policy documents do not currently address. Therefore, in any nurse-patient encounter, the particular constraints that govern how patients are involved and the extent of their influence on interaction are likely to shift from one moment to the next. Making this point clear in “best practice” guidelines would better highlight the potential for patient participation regardless of the presence of electronic or paper-based templates, the constraints of time, and so on.

8.7 Conclusion

Most hospital nurses in the UK still operate with paper rather than electronic technology, thus the data provides a timely insight into current nursing practices. The imminent introduction of EPRs into hospitals provide a challenge to all health professionals and nurses have raised concerns regarding the introduction of EPRs on the grounds that electronic records will “crowd out” the patient’s agenda resulting in the ‘de-individualisation of care’ (Lee 2005: 345). However, on the evidence of this study nurses’ decision to shape the assessment interview around the structure and layout of the assessment document serves to suppress the expression of patient concerns whilst minimising patient participation.

Berg’s (1997) work on medical interaction suggested over a decade ago that instead of focusing on either the tool or the work practice it is their interrelation that is central. The analysis here similarly suggests that other factors need further consideration rather than merely focussing on the technology which accompanies the interaction. Nurses’ use of paper-
based or electronic records need to be seen by nurse managers, researchers and policy makers as a social action embedded within a larger system of activity. This socio-technical view of nursing work therefore undermines the previously rationalist, technology-centred writing so pervasive within the nursing literature. A more balanced approach towards technology and its effects on nursing work suggests further research is needed into how nurses learn to use and then apply their understanding of paper-based (and electronic technology) to their daily practice. Such work would provide an invaluable adjunct to the current plethora of studies which focus on nurses’ attitudes and perceptions regarding the introduction of specific information management technology.
9. Project 3 – “It’s like a fish trying to describe water”: A qualitative evaluation of multi-disciplinary team-working on a hospital ward

ABSTRACT
This study was performed to examine the extent of multi-disciplinary team (MDT) working on a medical rehabilitation ward for older people following the introduction of a service improvement programme designed to promote better team working. A 12 month qualitative study consisted of collecting participant observations, semi-structured interviews, data from staff workshops and routinely collected data e.g. staff sickness and absence reports and patient safety incident reporting. Research participants included all members of the MDT e.g. nurses, doctors, physiotherapists, social worker, occupational therapists. The results of the study suggest that staff perceived that MDT working had improved over the 12 month period. Four themes emerged from the data which offer insights into the development and effects of better MDT working; (1) the emergence of collegial trust within the team, (2) the importance of team meetings and participative safety (3) the role of shared objectives in conflict management (4) the value of autonomy within the MDT. Interestingly, reductions to staff sickness/absence levels and in catastrophic/major patient safety incidents were also detected following the introduction of the service improvement programme. The study adds robust qualitative insights into the development of team-working in a hospital context.
9.1 Introduction

Effective interprofessional teamwork and collaboration has been identified as being critically important in delivering high quality organisational performance in healthcare (Suter et al 2009). Among the benefits claimed for effective teamwork are higher quality of patient care, better patient flow and throughput, improved staff morale and increased patient safety (Firth-Cozens 2004, CHSRF 2006). These claims have led to policy-led reforms which attempt to reverse previous trends toward isolation and specialization which traditionally characterise western healthcare delivery (Becker 1961, Atkinson 1995). For example, recent health policy in the UK has strongly endorsed more effective team-working as a means of improving care for older people across a range of contexts (Welsh Assembly Government 2006). This policy document identifies effective multidisciplinary team-working as a significant factor in delivering improved hospital-based care, in particular recommending the introduction of regular multidisciplinary meetings, shared record keeping and multidisciplinary goal setting.

Whilst team-working is a term that frequently appears in healthcare policy and literature, it has been described as a complex concept that is often taken for granted in the workplace. For example, Enderby (2002) describes how individual health professionals are often expected to work as clinical teams with no explicit detail of the team's purpose, management structure, corporate role or even clarity about its membership. Others comment on the paucity of research regarding how team-working impacts on patient care (McCallin 2001, Baxter and Brumfitt 2008).

However, several studies report how a positive “team climate” can lead to better healthcare and healthcare outcomes (Poulton 1993, Wagner 2000, Shortell et al 2005). The concept of team climate has been defined as the shared perception of behaviours, practices and procedures, both formal and informal, within a team, “the way things are done around here” as perceived by team members (Thylefors 2005, NPSA 2008).
Few qualitative studies have explored inductively the underlying beliefs and values that guide attitudes and behaviours of professionals within teams, leading to calls for more qualitative work in this area (Bowers et al 2003). Instead, instruments such as the Team Climate Inventory (TCI) has emerged as a favoured survey tool by researchers interested in understanding interprofessional team-working across a range of healthcare contexts (Ouwens 2008). The use of qualitative research methods could be particularly useful for exploring complex issues, eliciting opinions and identifying interprofessional relationships and structures which are difficult to identify through questionnaires such as the TCI (Bowers et al 2003). A strong case exists therefore for more qualitative studies to enhance the excellent work that others have already undertaken in this area.

This article reports upon a qualitative study which evaluated the effects of a service improvement programme designed to improve interprofessional team-working on a hospital ward in the UK. The data, subsequent analysis and discussion contribute a much needed understanding on the emergence of team-working as it occurs in practice.

9.2 Background to the study

In April 2007 personnel on one ward (anonymised to ”ward G”) in a large teaching hospital underwent a service improvement programme designed to encourage better team-working. The programme was initiated by a multidisciplinary project group (consultant geriatricians, nurses, occupational therapist, physiotherapist, social worker, dietician, human resources manager) following concerns raised by ward staff about the negative impact that a lack of team working was having on the quality of care experienced by patients. The multidisciplinary project group was tasked with set about trying to improve team working via:
1. **Reconfiguring therapies workforce and social work services to be ward-based.** As a rule, occupational therapists, physiotherapists, dieticians and social workers were based in departments elsewhere in the hospital and visited ward G on a largely *ad hoc* basis. The decision to locate therapists on ward G was based upon the assumption that closer physical proximity of staff would encourage better team-working and more patient-centred care. The only additional staff resource provided was the provision of a full-time (as opposed to the usual part-time) social worker.

2. **Consultant-led daily ward rounds and weekly MDT (multi-disciplinary team) meetings.** The customary working pattern consisted of daily ward rounds that were infrequently attended by consultants and *ad hoc* MDT meetings. The extent of consultant involvement was identified as problematic by the project group as treatment decisions, which could have been taken during early morning ward rounds for example, would often be delayed until later in the day/week. The decision to schedule more consultant led ward rounds and MDT meetings was based on the assumption that more timely decision making would be possible if consultants were present during meetings.

3. **Encouraging a team problem solving approach and an ethos of patient-centred care within the ward.** The uncoordinated nature of team-working, as partially highlighted in points 1 and 2, had resulted in a “silo mentality” where professions largely worked in isolation to each other. In an attempt to encourage co-ordinated working and problem solving a series of staff workshops were scheduled before and during the change period with the aim of encouraging ward staff to explore and establish the contextual factors that would best enable the desired change in working practices.

The overall objective of this article is to present a qualitative evaluation of the first 12 months of this service improvement programme. In particular there were 2 specific aim of this study:
1. To investigate the extent to which MDT working had been integrated into the everyday working on the ward.

2. If MDT working was occurring, what were the effects of team-working on staff members and on patient care.

9.3 Methods

Ward G is a 34 bedded medical rehabilitation ward for older patients within a large teaching hospital of 800 beds. Patients are referred for medical rehabilitation to the ward from other wards in the hospital. The ward accepts patients undergoing medical treatment but does not admit patients who require stroke-related rehabilitation as these are met elsewhere in the service. The bed occupancy rate constantly exceeds 90% with beds divided between 4 consultant geriatricians.

The study was granted ethical approval by a National Health Service research ethics committee and all data are fully anonymised.

Data collection

A variety of qualitative data were collected over a period of 12 months, namely:

May 2007 – January 2008: Fieldnotes and audio-recordings were collected during participant observation of the newly established consultant-led ward rounds and weekly MDT meetings. Observations focused in particular on the extent to which ward rounds and MDT meetings met the programme’s original aims. For example, better organized and more regular MDT meetings were identified as a medium through which more timely, team-based decisions were to be made and the observer attempted to document data that would assist to explore whether
this was happening. The meetings and ward rounds were audio-recorded using a hand-held
digital Dictaphone and a multi-directional lapel microphone. In an attempt to avoid recall
errors, fieldnotes were written up immediately following the ward rounds and MDT
meetings. The audio recordings were of great assistance during this process.

**December 2007 – March 2008:** Semi-structured interviews with 12 staff members (1
consultant, 5 nurses, 3 physiotherapists, 2 occupational therapist, 1 social worker) – average
length of interview 43 minutes (range 25-56 minutes). In order to access a range of
professional views a decision was made to use a purposive sampling approach at this stage of
data collection. The aim of the interview was an exploration of the participants’ views
regarding the degree to which the project’s initial aims were being met. Therefore, questions
were partially structured to explore the view of staff regarding the extent of team-working on
the ward and any subsequent change in their working practices in the weeks and months since
the project’s initiation. However, the interview style was sufficiently loose for participants to
discuss a broader range of issues related to the project should they choose to.

**May 2007 – February 2008:** Observational and documentary data (e.g. writing on flipcharts)
gathered during 4 staff workshops held between April 2007 and February 2008. The
workshops were designed to involve ward staff in the change process and latterly to evaluate
changes. The staff workshops were attended by a total of 40 staff representing all healthcare
professions associated with the ward. During the workshop staff were divided into mixed-
professional groups and asked, for example, to evaluate the changes occurring on the ward
and to identify working practices that could be improved. Observational data collected at this
stage included the extent to which members of staff participated in the workshops as well as
noting verbal comments made by staff that was not captured on the flipchart. For example,
"better communication" was written as an evaluative comment on a flipchart by one group and the accompanying verbal description of "better communication" was noted by the observer.

Silverman (2005) considers that some qualitative researchers erroneously collect multiple data sources in the hope of accessing some illusory overall “truth”. Silverman’s is a valid point, however, we considered the collection of multiple data sources as an important step in establishing rigour within the study. For example, as well as observing and audio-recording team meetings, the topic of “team meetings” was further explored individually during interviews and collectively during workshops. Thus, collecting multiple data sources facilitated an in-depth understanding of the phenomena of “team meeting” which was faithful both to the meanings and actions of those involved.

Data analysis

Thematic and content analysis of fieldnotes and interview transcripts occurred concurrent to data collection. Data analysis was partially foreshadowed by the original aims of the research, however analysis largely proceeded in an inductive fashion starting with the local categories of the participants themselves. This process consisted of a pattern of reading and re-reading data, a method of analysis which eventually enabled the progressive understanding of interview and fieldwork data to interact with our own emergent thoughts (Atkinson and Coffey 1996).

All data sources were initially analyzed individually before emerging themes and paradoxes were compared across sources. Finally, the empirical findings were informed by existing literature, such as prior research on teamwork within medical and other contexts. At the culmination of this process of data reduction and re-ordering a total of 4 themes were identified. The themes are presented here as offering ‘mechanical arguments’ which aim to
‘explain how and sometimes why social phenomena work, often in relation to other phenomena’ (Mason 2002 p.175), rather than presenting causal arguments based on cause-effect relationship existing between the variables indentified.

Peer review of data analysis, undertaken by a group of academics unconnected with the improvement programme, occurred at all stages, further adding to the overall rigour of the study. However, one limitation of the study is that data were collected from only one location, and in common with most qualitative studies no claims are made regarding generalisability.

9.4 Findings

The findings of data analysis strongly suggested that MDT working on ward G had improved since the inception of the programme. The extent to which MDT working had been integrated into the everyday working on the ward and the effects of team-working will be discussed under 4 themes, namely:

1. The emergence of collegial trust within the team.
2. Team meetings, participative safety and patient safety
3. Conflict and the mediating effect of shared objectives and trust.
4. Autonomy within the MDT

There is a degree of overlap between the themes identified. For example, the concept of collegial trust was a recurring issue of importance which was “nested” (Atkinson and Coffey 1996) or embedded in all of the other themes. The themes did not emerge in neatly bounded packages, in fact it was often the case that topics intersected and overlapped. Separating the findings into themes therefore serves merely to ease the process of presenting research findings.
The emergence of collegial trust within the team.

Interviews and staff workshops enabled the opportunity to ask the staff the question “Is MDT working on ward G the same, better or worse since the project started?” All participants indicated that they considered there to be better team-working on the ward. Several interviewees discussed that the project had led to positive changes in working practices and increased collegial trust between professions. Follow up questions during the interview asked for examples of improved working practices/team-working, a sample of typical answers are provided below:

Meeting more frequently together means that, as an example the ward manager gets to trust that the physiotherapist is going to do what they say. That’s why this has been a success, trust does make a difference you develop friendships then as well (Interviewee 11)

What has improved is the way that we work because you have a lot closer relationships whereas previously the physios, OT and social worker would be just coming on the ward doing their bit and going. So you build up hopefully a better relationship so that you can all interact better, we do communicate and I think at the end of the day we are communicating and obviously there has to be that trust between interprofessions (Interviewee 3)

We’ve achieved better discharge because we are now able to make decisions as a group as a team and we trust in one another’s judgment as well. When you work in a good team its difficult to describe it its like a fish trying to describe water its difficult to put your finger on what it is. Its symbiotic you work with one another (Interviewee 4)

Collegial trust has been described as being essential to a productive and safe work environment and refers to the expectations within a team that colleagues behave professionally and do the things they say they are going to do (Jackson 2008). The extract from interview 11 neatly captures the development of collegial trust amongst the staff through “meeting more frequently”, also echoing Jackson’s point that staff “get to trust” each other when they realise that colleagues are “going to do what they say”. Similarly, the extract from interview 3 sees the participant discuss a sense of collegial trust emerging out of
the decision to place the therapies and the social worker on the ward, as opposed to their previously *ad hoc* appearances on the ward. The redeployment of these staff onto the ward resulted in individuals no longer merely “doing their bit and going”, with the prolonged inter-personal contact leading to better relationships and interaction and an improvement in the “way that we work”. Interviewee 4 also comments on more successful working practices, specifically identifying “better discharge” resulting from being “now able to make decisions as a group as a team and we trust in one another's judgement as well”.

Collegial trust on ward G therefore appears to be a factor that is not simply present or absent within the team, but is negotiative, co-constructed and contextually specific. An element of emotion is also present in the interview data, particularly apparent when staff associate team-working with feelings of friendship, closer relationships, trustworthiness and what it means to be a “good team”. Team-working in this setting is presented as more than a dispassionate managerial construct, instead it is discussed as an emotionalised by-product of working closer as a group.

These extracts provide valuable insights into the views of a range of health professions, especially as concepts such as good team-working in healthcare have traditionally been explained as implicit and difficult to describe (Fineman 2005, Jackson 2008). Although the range of professions recruited into this study were able to discuss aspects of team-working without much difficulty, interviewee 4 (above) reflects the literature when stating that working in a “good team” is not easy to describe and “difficult to put your finger on”. When considering the comments made about difficulties in describing good team-working it was interesting to note several interviewees mentioned the evolving and shifting nature of the team:

> The new set-up is constantly going through constant evolution, revolution and reinvention but having established that you have faith in each other when difficulties arise they can be managed as you know those people so much better *(Interviewee 5)*
Interviewee 5 describes the new team “set up” as continually experiencing “evolution, revolution and reinvention whilst interviewee 7 evokes a sense of how key elements of the team (“mutual respect and trust”) emerged “little by little over time”. A further example of how elements of the team emerge over time is provided by interviewee 11 (discussed earlier) who describes how a “ward manager gets to trust” and how “you develop friendships” (emphasis added by authors). These extracts illustrate how, at any one time, this team existed both as a static and a dynamic entity. The physical characteristics of the team were static (the team personnel and location of team-work did not change) but other aspects were dynamic (interpersonal aspects of trust, friendship and communication were evolving and time dependent). The constantly evolving nature of their work as described by the interviewees might explain why description of concepts such as “good team-work” and “trust” has in the past proved so difficult, eloquently expressed by interviewee 4 as akin to a “fish trying to describe water”. The qualitative interviews deliberately employed a “reverse funnel” (Stewart and Cash 1991) questioning strategy (specific questions leading to broad discussion) and this gave interviewees the opportunity to discuss in-depth issues of team-working which rarely appear in the literature.

**Team meetings, participative safety and patient safety**

Fieldnotes collected during observations of MDMs reported meetings where all members of staff actively contributed to the discussion of patient care. Fieldnotes also recorded that members of the team contributed ideas during the MDM which were indirectly related to patient care, such as commenting about possibilities regarding potential changes to existing ways of working.
Fieldnotes extract and audio-recording MDM 4

Social worker: When patients such as this come in (pause) you-you know in the future then we should all aim to pool our ideas as soon as possible regarding the UA* assessment paperwork and what needs to be sorted out.

General concurrence in the meeting, somebody says “its a good idea” but not sure who. It is agreed that the social worker will draft some guidelines re. “UA and complex discharges”. *UA = “unified assessment”

During the staff workshops several staff commented and wrote about “rapport” and “positive” working within the MDMs which had led to “better team-working” (flipchart workshop 3).

The introduction of regular MDMs offered an important meeting point for staff and a “positive” forum where staff forge closer working relationships. The personal contact afforded by the MDMs appeared to be intimately linked to the development of trust within the group, a point reflected in some of the comments described in section 1 (above) and which echoes discussions in the literature about the positive relationship in teams between “face time” (the amount of time team members spend together) and trust building (Cross and Prusak 2002, Firth-Cozens 2004).

Staff reporting “positive working” and rapport at MDMs are further evidence of a high level of trust within the team and what is described in the literature as participative safety.

Participative safety relates to a general climate of trust and participation within teams characterised by interpersonal warmth and information sharing without fear of recrimination from other team members (Williams and Laungani 1999, Bower et al 2003).

The emergence of innovative practice is also a symptom of participative safety within teams, as team members are more likely to take the risk of proposing new ways of working in a climate they see as non-threatening and supportive (West 2004). An example of ward G staff working in innovative ways was discussed in workshop 3 where occupational therapists and physiotherapists discussed how they were setting joint patient outcomes and and
shared teaching sessions. It is important to note that these were considered as “innovative” practices within the context of ward G, and it is duly recognised that such working practices have long existed in other contexts.

Although the link is far from definitive, increasing credence is attributed to suggestions that closer teamwork has an encouraging effect on patient safety (Alonso 2006, Oandasan 2007, The Health Foundation 2007). A review of patient safety incident reporting on ward G over the 12 month period coinciding with the promotion of closer MDT working shows an overall increase in incidents logged, but a marked reduction in the severity of incidents (table 1 below). Increases in the reporting of safety incidents has itself been identified as a possible indicator of growing trust within healthcare teams as staff ‘need to trust that the matter will be dealt with sensitively, sensibly, and fairly’ before they are reported (Firth-Cozens 2004 p.57).

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<tr>
<td><strong>Severity of incidents</strong></td>
<td><strong>No.</strong></td>
</tr>
<tr>
<td>Catastrophic</td>
<td>1</td>
</tr>
<tr>
<td>Major</td>
<td>2</td>
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<td>Moderate</td>
<td>2</td>
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<td>Minor</td>
<td>12</td>
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Table 1. Number and type of adverse safety incidents on ward G September 2006-September 2007

Table 1 shows that during the 6 months prior to the service improvement programme there
were 3 severe patient safety incidents, including 1 catastrophic incident involving the death of a patient, and 2 major adverse incidents resulting in severe injuries to patients. In the 6 months following the programme’s introduction there were no recurrences of catastrophic or major incidents. Due to the unavailability of longer term data the data presented in table 1 is limited and therefore presented merely to add context and amplify the qualitative findings.

**Conflict and the mediating effect of shared objectives and trust**

Intra-team conflicts occurs when team members hold discrepant views or have interpersonal incompatibilities (Weingart and Jehn 2004). Two general types of conflict are differentiated in the literature: task or non-task. Task conflict involves disagreements among team members on performance-related activities, such as a difference of opinion regarding the process of undertaking an actual task or the delegation of resources to complete the task. Non-task conflicts are disagreements and incompatibilities among group members about personal issues that are non-task related, such as relationship conflicts characterized by personal or interpersonal concerns (Simons and Peterson 2000). During observations it was clear that team members would sometimes hold discrepant views regarding the task of patient care, especially when discussing or reviewing a discharge date where, for example, differences of opinion would arise between professional groups in relation to the patient's or family's ability to self-care. Conflict or lack of agreement was only ever witnessed between professions and never within professions and was exclusively task, rather than non-task related. The extracts presented below gives some insight into differences and conflict within the team.

There were and sometimes are clashes regarding professional boundaries, its bound to happen but we move on from that *(Interviewee 1)*

Professionals always have their own views and the MDT do have different views and different aims to a degree...things can get fraught. *(Interviewee 6)*

There will always be some conflict but you'll always get that and better team working is the major thing *(Workshop 3)*
Interviewee 1 raises the issue of "clashes regarding professional boundaries". A similar point is made by interviewee 6 who notes that “professionals always have their own views” and that "things can get fraught". It was noticeable that interviewees did not isolate individual professional groups or individuals within groups, instead they all referred to the collective (e.g. professionals) rather than the singular (nurses, physiotherapists, Fred etc), and as such avoided overly personalising issues of conflict.

It has long been stated that the management of conflict within teams is often made easier when teams are working toward the attainment of shared objectives (Peters and Waterman 1982, Weingart and Jehn 2004). Interview and staff workshop data reinforces this point, with the extracts provided below demonstrating staff “being signed up to the aim” (interviewee 1), having a "sense of joint responsibility and consensus" (interviewee 5) and "knowing the objective" (interviewee 10).

I think they are united by the fact that they want this to work and I think they are fully signed up to the aim of the project and that they want this to work and they are not going to let pettiness, professional tribalism or rivalry get in the way of that. I think they see this as much bigger than that (Interviewee 1)

Knowing what we are all working towards has produced a sense of joint responsibility and consensus (Interviewee 5)

Everyone’s knows the objective, it’s a corporate approach. We don’t operate in silos its about the patient its function before form (Interviewee 10)

The relationship between team objectives and the mediation of conflict is best captured by interviewee 1 who states that “they are fully signed up to the aim of the project and that they want this to work and they are not going to let pettiness, professional tribalism or rivalry get in the way of that”. Interviewee 5 makes a related point when discussing how “Knowing what we are all working towards has produced a sense of joint responsibility”. Data from workshop 3 (see above) gives some insight into the overall when staff expressed that “better team-working is the major thing”.

Exploring the patient’s journey
Also noteworthy is the interviewees description of conflict as an inevitable consequence of working across professional boundaries (“bound to happen” - interview 1, “always be some conflict” - workshop 3). What is interesting is that workplace trust is often described in the literature as a fragile commodity which is seriously threatened by conflict (Firth-Cozens 2004, Jackson 2008). However conflict within the MDT, rather than undermining trust was actually moderated by intragroup trust or “faith in each other” as explained by interviewee 5:

having established that you have faith in each other when difficulties arise they can be managed as you know those people so much better.

reflecting a similar point made by interviewee 2:

Of course we don’t always see eye to eye on things, there are times when we disagree but we also sort things out (pause) we trust each other so when people raise problems it’s for a good reason and not point scoring,

**Autonomy within the MDT**

Although a strong team ethos was apparent when analysing the data it was also interesting to note that individual’s valued their professional autonomy.

Encroaching on each other’s territory is not a bad thing but we need to keep things separate and clear as well, I like my own identity within the team *(Interviewee 12)*

We’ve got some shared roles within the overall team which is fine but I still think you need to have your core expertise there because otherwise you’re just going to water down the expertise of the individual professions and the patients will suffer *(Interviewee 2)*

The data extracts juxtapose individuals as having concurrent commitment to the “overall team” whilst “keeping things separate and clear as well” (interviewee 12). The following extract highlights how a professional grouping (“therapists”) contribute to the team’s knowledge about patient care.

Its best to keep professional expertise working within the overall team. It’s like adding our little bit to the pot as therapists as opposed to nurses or doctors we see things the others don’t and it adds to the team *(Interviewee 9)*
The interviewee describes how therapists add their “little bit to the pot”, revealing aspects of the patient that “the others don’t”, a process which ultimately “adds to the team”. Group autonomy therefore adds value to the team through complimenting the approaches of different professional groups. Other studies have also suggested that high levels of autonomy within teams contribute to more effective teamwork, work satisfaction and prevention of burn-out (Rafferty et al 2001, CIHI 2005).

Interestingly, in light of the previous research linking high levels of autonomy with work satisfaction and reduced burn-out, there was a notable reduction in staff sickness/absence rates on Ward G during the 6 months following the move towards closer MDT working (see table 2).

The sickness/absence rates are represented as percentages of total staff time, with noticeable differences (e.g. a difference of between 8.5 and 10%) in the period August to October. However, caution is required when considering these figures for the same reasons as discussed in relation to the data presented in table 1.
9.5 Summary and conclusions

Inter-professional team-working is a commonly used term that has attracted the interest of health managers, practitioners, academics and policy-makers. However, it is a complex concept lacking in-depth qualitative research regarding the effects of team-working on staff and patient care (Baxter and Brumfitt 2008). This paper provides findings collected from multiple data sources over a 12 month period, which describe the effects of a programme aimed at better inter-professional team-working on one hospital ward. Findings demonstrated the importance of the emergence of trust within the team resulting in, for example, increased collegiality, participative safety and innovative working practices between disciplines. Encouraging changes also included reduced levels of staff sickness/absence and of adverse patient safety incidents.

Although closer team working was evident, staff maintained a clear sense of professional identity and valued their autonomy within the team. This study, amongst others, suggests that concurrent allegiance to a team and individual’s professional values strengthens rather than undermines teamwork, disputing the counter-view that autonomy should be sacrificed in the name of better teamwork (Clements et al 2007). This study also shows that intra-team trust and unanimity of purpose can moderate conflict within a team, a finding that forwards a more robust view of trust than discussed elsewhere (Firth-Cozens 2004, Jackson 2008).

The findings also clearly suggest that team members valued the clear sense of purpose and direction which the improvement programme instilled into a previously disparate group. Of particular importance in developing purpose and direction was the implementation of regular team meetings and staff workshops where face-to-face contact led to better understanding and trust amongst employees. Prolonged interpersonal contact was instrumental in converting a team of individuals into an individual team. This study
contributes important insights into the development of team-working in healthcare. It both confirms findings from previous studies in addition to providing new insights, for example into
10. Summary of the projects

It could be said that the 3 studies vary greatly, focussing as they do on the workings of a multi-disciplinary team, the work of a uni-disciplinary team and before finally undertaking a fine-grained analysis of talk occurring between a nurse and a patient. However, when taken as a whole the studies provide an interesting insight into some of the hugely complex interactions and work that underpins a patient’s journey through hospital. One theme that spans the whole project is that of communication and its importance within and between people. We see that good communication can serve to bind teams together, leading to more trust between practitioners and ultimately better patient care decisions. It has also been noted that an approach to practitioner-patient communication which does not listen to the patient’s voice risks alienating patients and reducing both patient participation in the interaction and the patient centeredness of the interaction.

Furthermore, the task of bed management is also hugely dependent on efficient lines of communication between health professionals. Poor lines of communication lead to delays and ineffective completion of tasks. These may lead in turn to poor decisions about the amount and type of resources (beds) available to the hospital at any one time which itself has consequences for patient attempting to access or seeking to leave hospital. However, we also see that adopting a style of communication which includes negotiation and joint decision making can make the stressful job of managing beds more manageable on occasion.

Much has been made about the modernisation of health service delivery including the rush towards introducing “technologies” to enhance patient care. What emerges throughout the study is that, regardless of technology or innovation, the quality of working relationships within the NHS remains as important as ever, contributing to the well being of staff and patients alike. Therefore, before the inevitable adoption of further technologies within the NHS (e.g. the implementation of the Electronic Patient Record) a more rounded
understanding of how “technology” is currently used is needed as well as a more thorough understanding of the impact of technology on inter-personal relationships and *vica versa*. For example, I have shown how the interactions between nurses and patients are influenced and shaped by a technology that is usually considered passive within interaction. It has also been demonstrated that the lack of timely and accurate updates to the computerised “bed state” information system have led bed managers to not trust the information on a system that has been designed to assist their work. As a result bed managers spend valuable time double checking information on the computerised system to the point where clinicians are weary of what they consider to be repetitive questioning about the beds available on the ward.

The implementation of a strategy to improve team working can itself be regarded as the intervention of “technology” in the broader sense of the word¹ (in this case the technology being M.D.T. team-working). The relative success of this intervention was marked by close interpersonal working and a sense of trust which transformed a team of individuals into an individual team. The beneficiaries included patients and staff evidenced by a reduction in patient safety incidents and a decrease in staff absenteeism.

**11. Fellow’s background**

I have worked in both mental health nursing and general nursing, undertaking training in both areas in Cardiff. Whilst practising as a senior staff nurse I undertook part 1 of the MSc Social Research Methods course at Cardiff University and enjoyed it greatly. I found learning about both qualitative and quantitative methods to be stimulating, however I was also greatly influenced by the world class teaching team (e.g Paul Atkinson, Sarah Delamont, Amanda Coffey, Mick Bloor) who were mostly qualitative researchers.

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¹ The NHS define “health technology” as all interventions used to promote health, prevent and treat disease, and improve rehabilitation and long-term care.
Towards the end of part 1 of the MSc course I was offered a Tutor (Nursing) job at the School of Health Science, Swansea University. This was my first taste of teaching and working in higher education (HE) and although initially I was unsure whether I would remain in HE as adapting from clinical life was a major challenge, I soon realised that teaching in HE was the correct career choice. In particular, I found the prospect of working on research projects to be very attractive and soon got interested and involved with research within the School. I was also fortunate enough to be offered a place to study a part-time PhD via the School of Health Science staff bursary scheme, thus instead of submitting a dissertation for part 2 of the MSc Social Research Methods course I opted to leave with a Diploma and enrol for the PhD.

Following completion of the PhD in 2006 I have been fortunate enough to be involved in a variety of research projects within the School of Health Science and as a collaborator on projects with the School of Medicine in Swansea. I look forward to forging a post-doctoral research career and becoming a principal investigator in my own right.

12. RCBC fellowship professional development.

The fellowship has offered me several opportunities to develop professionally via the “in-house” study days organised for the community of scholars study days. The study days provided a range of speakers discussing issues of relevance to post-doctoral researchers – including sessions on funding mechanisms and financing projects, research governance, writing skills, leadership and influencing policy makers. Over the 2 years these sessions greatly enhanced my understanding of key areas in research which resulted in my having a better, more in-depth understanding of the issues that confront those wishing to develop a career as a principal investigator.
My professional development as a researcher was also greatly enhanced as a result of having the time to pursue a research project of my own design over a period of 2 years. As a result I learnt how to organise and run a research project gaining insights into areas such as managing a research budget, negotiating access to clinical areas, ethics and governance. Although I had some experience of what is now commonly termed “research governance” through doing my PhD, the fellowship enabled me to extend my understanding of ethics/governance and how to forge collaboration with key clinicians in the NHS.

One of my objectives for the fellowship period was to develop more of an international profile as a researcher. Again the protected time of the fellowship enabled me to invest quite a bit of effort into networking with international researchers. For example, I had existing contact with Dr Angela Chan (School of Nursing, Hong Kong Polytechnic University - HKPU) but as a result of the fellowship I networked more closely and built a “critical friendship” where we would support each other by commenting on paper’s being prepared or research ideas that were being honed for submission to funding panels. This culminated in me visiting HKPU and presenting some of the work undertaken during my fellowship (from project 3). As a result of this trip I am now collaborating in a study of nursing work funded by HKPU with the aim of attracting further funding in the future.

13. Community of Scholars.

Being a researcher, either as a PhD student or post-doctoral fellow, is often associated with a certain amount of loneliness or isolation. “Solo” researchers, as opposed to those working within a team can suffer from a lack of support and a lack of opportunity to discuss emerging issues, ideas or developments within their projects. Forming the community of scholars (CoS) therefore was an extremely insightful and useful idea which provided an antidote to the potential perils associated with being a solo researcher. Although potentially a mix of
doctoral and post-doctoral fellows could have been problematic due to differences in levels of experience or expectations, the CoS proved to be a very useful and supportive environment. Members instead of being divided by their differences were instead bonded by the common aim of undertaking a research project and all that goes with that. The bonds that have been made during the course of the fellowship between researchers are likely to be maintained well into the future.


Jones A “It's like a fish trying to describe water": A qualitative evaluation of multi-disciplinary team-working on a hospital ward. Currently under review with Journal of Interprofessional Care.

15. Other dissemination carried out and planned.

Conference presentations:


May 2008 International Network for Studies Concerning Older Adults (INSCOA) conference, Swansea Title of paper: Innovation or reinvention? Evaluating a service improvement programme designed to increase the timely discharge of older people from acute hospital beds.

Nov 2008 Pan-Pacific nursing conference – Hong Kong University, Title of paper: Trust, teamwork and improving patient safety on a rehabilitation ward

Planned dissemination:

I aim to publish finding from project 1 (Bed management) either in a journal such as Journal of Advanced Nursing or Journal of Clinical Nursing or a social science journal such as Sociology of Health and Illness or Social Science and Medicine.
16. External funding gained.

None as yet

17. Future plans.

To gain funding to revisit some of the areas touched upon during the course of the 3 projects. In particular, I am keen to undertake more research on the relationship between team working and issues of patient safety and discharge planning. Patients unnecessarily staying in a hospital bed due to for example, poor discharge planning, presents a major safety concern as prolonged length of stay has been associated with increased morbidity. As a result of my interest in patient safety I am one of a team who have submitted a bid for a Patient Safety and Quality of Care R&D Network to the newly formed NISCHR (National Institute of Social Care and Health Research) which will hopefully provide an arena to forge alliances with similar minded colleagues.
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