



Swansea University  
Prifysgol Abertawe



## Swansea University E-Theses

---

# Nursing patients in transition: An ethnography of the role of the nurse on an acute medical admissions unit.

Griffiths, Pauline

### How to cite:

---

Griffiths, Pauline (2007) *Nursing patients in transition: An ethnography of the role of the nurse on an acute medical admissions unit.* thesis, Swansea University.  
<http://cronfa.swan.ac.uk/Record/cronfa42820>

### Use policy:

---

This item is brought to you by Swansea University. Any person downloading material is agreeing to abide by the terms of the repository licence: copies of full text items may be used or reproduced in any format or medium, without prior permission for personal research or study, educational or non-commercial purposes only. The copyright for any work remains with the original author unless otherwise specified. The full-text must not be sold in any format or medium without the formal permission of the copyright holder. Permission for multiple reproductions should be obtained from the original author.

Authors are personally responsible for adhering to copyright and publisher restrictions when uploading content to the repository.

Please link to the metadata record in the Swansea University repository, Cronfa (link given in the citation reference above.)

<http://www.swansea.ac.uk/library/researchsupport/ris-support/>

**Title of thesis:** Nursing patients in transition: an ethnography of the role of the nurse on an acute medical admissions unit.

Pauline Griffiths

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

Swansea University

2007

ProQuest Number: 10821207

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



ProQuest 10821207

Published by ProQuest LLC (2018). Copyright of the Dissertation is held by the Author.

All rights reserved.

This work is protected against unauthorized copying under Title 17, United States Code  
Microform Edition © ProQuest LLC.

ProQuest LLC.  
789 East Eisenhower Parkway  
P.O. Box 1346  
Ann Arbor, MI 48106 – 1346





## Abstract

This thesis explores the role of the nurse on an Acute Medical Admissions Unit (AMAU). AMAUs provide a dedicated area for the assessment, treatment, and subsequent transfer or discharge of patients who are medical emergencies. Despite increasing numbers of AMAUs across the UK they are an under researched area and, in particular, there is limited research that has explored the role of the nurse in the AMAU setting.

Data were generated through the use of ethnography that entailed participant observation over an eighteen-month period, semi-structured interviews with a purposive sample of doctors, nurses, paramedics, and patients ( $n=19$ ), and examination of documentary evidence. Drawing on the concept of communities of practice (Wenger 1998) and the demand-control-social support model of occupational stress (Baker *et al.*, 1996) the key themes of the study were identified as: *The AMAU nurse's role in co-ordinating patients' transition*; *Professional skills and attributes of the AMAU nurse*; *'I love the buzz': the AMAU nurses' work place stresses and balances*; and *Organisational constraints and practice boundaries for AMAU nursing*

The findings from the study indicate that a key aspect of the AMAU nurse's role was the facilitation of rapid patient transition. In addition the study has identified the distinctive and locally negotiated working practices developed by the nurses to coordinate this transition. Another important claim arising from this study was the identification of this nursing role as an evolved construction within a community of practice.

This study makes a significant contribution to the limited body of knowledge regarding AMAU nursing practice by aiding understanding of the complexity of this nursing role. Additionally, the application of the concept of community of practice provides a unique perspective and insight into this under explored role. Recommendations are offered for practice, education, management and future research.

DECLARATION

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

Signed ..... (candidate)

Date ..... 22. 7. 07 .....

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Where correction services have been used, the extent and nature of the correction is clearly marked in a footnote(s).

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed ..... (candidate)

Date ..... 22. 5. 07 .....

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed ..... (candidate)

Date ..... 22. 17. 07 .....

**NB:** *Candidates on whose behalf a bar on access has been approved by the University (see Note 9), should use the following version of Statement 2:*

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loans **after expiry of a bar on access approved by the University of Wales Swansea.**

Signed ..... (candidate)

Date .....

## Contents Page

List of Appendices .....	i
Lists of Tables and Figure .....	ii
Acknowledgements .....	iii
Literary Conventions Used Within the Thesis .....	iv

### CHAPTER ONE

<b>INTRODUCTION TO THE THESIS .....</b>	<b>1-22</b>
<b>1.1 Introduction .....</b>	<b>1</b>
<b>1.2 Context of the study.....</b>	<b>1</b>
<b>1.3 Research aim and questions .....</b>	<b>3</b>
<b>1.4 The Study .....</b>	<b>4</b>
1.4.1 Reflexivity .....	6
1.4.2 Overview of the research conduct.....	7
<b>1.5 The concept of role .....</b>	<b>8</b>
<b>1.6 The Acute Medical Admission Unit (AMAU):The study site .....</b>	<b>13</b>
1.6.1 The setting and organisation of the AMAU.....	14
<b>1.7 Structure of the thesis .....</b>	<b>20</b>
<b>1.8 Summary .....</b>	<b>22</b>

### CHAPTER TWO

<b>LITERATURE REVIEW.....</b>	<b>23-62</b>
<b>2.1 Introduction .....</b>	<b>23</b>
2.1.1 Literature search strategy.....	23
<b>2.2 Defining Nursing.....</b>	<b>24</b>
2.2.1 Professional and theoretical considerations of the role of the nurse ...	25
2.2.2 Nursing theory .....	28
2.2.3 Care and caring.....	31
2.2.4 'New Nursing'.....	34
2.2.5 Working in a team: the nurse's role.....	37
<b>2.3 The development of AMAUs.....</b>	<b>44</b>
2.3.1 Organising acute medical admissions.....	45
<b>2.4 The role of the nurse in AMAUs .....</b>	<b>50</b>
2.4.1 Triage and admission.....	50
2.4.2 Preparation for the role .....	52
2.4.3 Communication with patients.....	56
2.4.4 Care of the elderly .....	58
2.4.5 Patients with mental health related needs.....	59
<b>2.5 Summary .....</b>	<b>61</b>

## **CHAPTER THREE**

<b>METHODOLOGY</b> .....	<b>63-117</b>
<b>3.1 Introduction</b> .....	<b>63</b>
3.1.1 The research aim and questions.....	63
<b>3.2 A qualitative approach</b> .....	<b>65</b>
3.2.1 Ethnography .....	68
<b>3.3 Location and access</b> .....	<b>73</b>
3.3.1 Obtaining permission from the Trust .....	75
3.3.2 Gaining approval from the Local Research Ethics Committee .....	75
<b>3.4 Sampling strategy</b> .....	<b>78</b>
3.4.1 Sampling during participant observation .....	78
3.4.2 Participants selected for semi-structured interviews .....	79
3.4.2.1 Inclusion criteria .....	79
3.4.3 Sampling of documentary evidence.....	83
<b>3.5 Methods of data collection</b> .....	<b>84</b>
3.5.1 Participant observation .....	84
3.5.2 Semi-structured interviews .....	89
3.5.3 Use of a modified critical incident technique .....	95
3.5.4 Documentary evidence .....	96
3.5.5 Field notes.....	97
<b>3.6 Ethical considerations</b> .....	<b>99</b>
3.6.1 Autonomy and privacy.....	99
3.6.2 Confidentiality .....	103
<b>3.7 Data handling</b> .....	<b>105</b>
<b>3.8 Data analysis</b> .....	<b>106</b>
3.8.1 The process of analysis.....	107
<b>3.9 Evaluating qualitative research</b> .....	<b>111</b>
3.9.1 Validity .....	112
3.9.1.1 Disputed strategies to enhance validity.....	113
3.9.2 Relevance.....	115
<b>3.10 Summary</b> .....	<b>116</b>

## **CHAPTER FOUR**

<b>INTRODUCTION TO ANALYSIS</b> .....	<b>118-134</b>
<b>4.1 Introduction</b> .....	<b>118</b>
<b>4.2 Communities of practice</b> .....	<b>118</b>
4.2.1 Defining communities of practice.....	119
4.2.2 Application of the concept.....	122
<b>4.3 The Demand-Control-Social Support (D-C-S)</b> <b>model of occupational stress</b> .....	<b>130</b>
4.3.1 Theoretical understandings of the D-C-S model .....	130
<b>4.4 Key themes of the study</b> .....	<b>133</b>
<b>4.5 Characteristics of the interview participants</b> .....	<b>134</b>
<b>4.6 Summary</b> .....	<b>134</b>

<b>CHAPTER FIVE</b>	
<b>THE AMAU NURSES' ROLE IN CO-ORDINATING PATIENTS' TRANSITION .....</b>	<b>135-172</b>
<b>5.1 Introduction .....</b>	<b>135</b>
<b>5.2 'First responders': Managing beds .....</b>	<b>135</b>
5.2.1 'Taking the call' .....	138
5.2.2 'Making a Bed' .....	142
<b>5.3 'Doing the board' .....</b>	<b>149</b>
5.3.1 'Stacking patients' .....	151
<b>5.4 Organising work: Valuing continuity of care .....</b>	<b>156</b>
5.4.1 The handover .....	159
5.4.2 Nurse-patient allocation.....	167
<b>5.5 Summary .....</b>	<b>172</b>

<b>CHAPTER SIX</b>	
<b>PROFESSIONAL SKILLS: THE ATTRIBUTES OF AN AMAU NURSE.....</b>	<b>173-208</b>
<b>6.1 Introduction .....</b>	<b>173</b>
<b>6.2 Effective communicator.....</b>	<b>173</b>
6.2.1 'Time to talk to patients' .....	176
6.2.2 Brief communication: trusting and 'clicking'.....	183
<b>6.3 'Knowing your stuff': Professional credibility.....</b>	<b>190</b>
6.3.1 Collaborative competence .....	197
6.3.2 Dealing with critical situations .....	201
6.3.3 'You are always learning': acquiring knowledge .....	203
<b>6.4 Summary.....</b>	<b>207</b>

<b>CHAPTER SEVEN</b>	
<b>'I LOVE THE BUZZ': THE AMAU NURSES' WORK PLACE STRESSES AND BALANCES .....</b>	<b>209-244</b>
<b>7.1 Introduction.....</b>	<b>209</b>
<b>7.2 Work place demands .....</b>	<b>209</b>
7.2.1 'Sort of give the impression': emotional labour .....	214
7.2.2 Dealing with death .....	217
7.2.3 'Thriving on stress': considering burnout .....	220
<b>7.3 Contested areas of control .....</b>	<b>228</b>
7.3.1 Working with hospital doctors .....	228
7.3.2 'Doing the writing': meeting managerial demands.....	235
<b>7.4 'Supporting each other' .....</b>	<b>238</b>
<b>7.5 Summary .....</b>	<b>244</b>

<b>CHAPTER EIGHT</b>	
<b>ORGANISATIONAL CONSTRAINTS AND PRACTICE BOUNDARIES FOR AMAU NURSING .....</b>	<b>245-280</b>
<b>8.1 Introduction .....</b>	<b>245</b>
<b>8.2 Institutional influences on the role of the AMAU nurse .....</b>	<b>245</b>
8.2.1 Caring or caretaking .....	254
<b>8.3 Boundaries of medicine and nursing .....</b>	<b>260</b>
8.3.1 Working with general practitioners.....	261
8.3.2 Caring for patients with mental health needs .....	264
8.3.3 Sharing documentation and team leadership.....	270
<b>8.4 Future developments of the AMAU nurses' role .....</b>	<b>275</b>
<b>8.5 Summary .....</b>	<b>280</b>
<b>CHAPTER NINE</b>	
<b>EVALUATION AND CONCLUSION.....</b>	<b>281-304</b>
<b>9.1 Introduction.....</b>	<b>281</b>
<b>9.2 Validity of the study .....</b>	<b>281</b>
9.2.1 Limitations of the study.....	282
9.2.2 Evaluating the study's validity .....	284
<b>9.3 Claims made by the study .....</b>	<b>287</b>
9.3.1 Managing rapid patients transition: the AMAU nurse's role.....	287
9.3.2 Development of an evolved role for the AMAU nurse .....	293
<b>9.4 Relevance of the findings .....</b>	<b>296</b>
9.4.1 Relevance for patients admitted to AMAUs.....	297
9.4.2 Relevance and recommendations for nurses and other health professionals .....	298
9.4.3 Relevance and recommendations for nurse educators and managers.....	300
9.4.4 Relevance and recommendations for the research community.....	301
<b>APPENDICES .....</b>	<b>305-348</b>
<b>REFERENCES .....</b>	<b>349-377</b>

## Appendices

	Page Numbers
<b>Appendix 1.</b> Diagram of the AMAU (not to scale).....	305
<b>Appendix 2.</b> Welsh Assembly Government innovations in care. Emergency pressures: Assessment units and admission wards. Information held on February 2002.....	306
<b>Appendix 3.</b> Routes of admission to the AMAU.....	307
<b>Appendix 4.</b> Information sheet (GPs).....	308
<b>Appendix 5.</b> AMAU nurses' role set.....	309
<b>Appendix 6.</b> Initial approach letter to patient participants (English).....	310
<b>Appendix 7.</b> Initial approach letter to patient participants (Welsh).....	311
<b>Appendix 8.</b> Information sheet for potential patient participants (English)...	312
<b>Appendix 9.</b> Information sheet for potential patient participants (Welsh)....	314
<b>Appendix 10.</b> Consent form (English).....	316
<b>Appendix 11.</b> Consent form (Welsh).....	317
<b>Appendix 12.</b> Letter to a health professional requesting participation (English).....	318
<b>Appendix 13.</b> Letter to a health professional requesting participation (Welsh).....	319
<b>Appendix 14.</b> Facsimile of a nurse-nurse handover sheet.....	320
<b>Appendix 15.</b> Modified Manchester Triage Score.....	322
<b>Appendix 16.</b> Patient Care Record.....	323
<b>Appendix 17.</b> Letter to AMAU staff at the commencement of data collection.....	335
<b>Appendix 18.</b> Interview schedules.....	336
<b>Appendix 19.</b> 'Social admissions'. Notice over phone.....	344
<b>Appendix 20.</b> Example of a letter that confirmed an interview appointment with a health professional.....	345
<b>Appendix 21.</b> Example of Free Node Coding Summary from a Patient Interview using N6 that Aided the Literal Reading Stage of Data Analysis.....	347
<b>Appendix 22.</b> Example of a Thematic Development.....	348

## **List of Tables**

- Table 1.** Patient activity and other performance data for the AMAU for 6 years up to and including 2002/03. Page 15
- Table 2.** Nurse staffing establishment on the AMAU compared to the general medical wards Page 18

## **List of Figures**

- Figure 1.** Roles that the researcher can adopt whilst collecting data using observation.(Adapted from Gold 1958.) Page 85
- Figure 2.** Early analytical theme ‘knowing the nurses’ plus data extracts Page 108



## **Acknowledgements**

I would like to thank my employers for the opportunity to undertake this research and for the support and encouragement that I have received. I am most indebted to Professor Joy Merrell for her unfailing hard work when offering supervision and her sustained interest in this research. Special thanks also to Professor Anne Williams who was influential at the start of this research and her continued interest and support.

I also offer my sincere thanks to the NHS Trust that enabled me to enter one of its wards and whose senior staff provided help and encouragement. I am grateful to all of the participants who contributed to the study and gave so generously of their time.

I would also like to thank Dr Fiona Murphy and Dr Sue Philpin for their continued friendship and support throughout all of the stages of this study. To my husband Geraint special thanks for the emotional support and the practical help that I receive in everything that I do and without which this study would never have been completed.

## LITERARY CONVENTIONS USED WITHIN THE THESIS

This section presents the conventions used within this ethnography to provide a comprehensive and readable account whilst respecting the anonymity of participants and the research setting. The actual words of the participants and the observations made during participant observation were considered to be key elements of the ethnography thus when using these data I use the same font as the interpretative narrative. When using data from participant observation I note these as ‘field notes’ and indent with single spacing. When using interview extracts I preface my questions with ‘PG’ and identify participants’ extracts by their workplace title and the interview number and likewise single space, indent, and use quotation marks. An italic font is used when using direct quotes from the literature, which are then indented and the italic font is also used when adding clarifying notations within square brackets in data extracts, thus [*intravenous infusion*]. The ellipsis is used when data extracts have been moved from the presented data. If the participant had paused, laughed or changed their tone of voice or speed of delivery then this is noted to help convey meanings that might otherwise have been lost. If the participant gave particular emphasis to a phrase within a dialogue extract I have then underlined that segment.

All interview extracts are verbatim transcriptions and extracts from field notes are drawn from observations recorded contemporaneously. All data have been edited to preserve anonymity and all names of people and places are pseudonyms. Throughout this thesis when using the term ‘nurse’ I refer to those persons who are on the nurses’ register held with the Nursing and Midwifery Council. To promote individual participants’ confidentiality when using interview excerpts I adopted the convention of terming registered nurses as ‘staff nurses’ and the AMAU’s senior staff nurses and the unit’s nursing manager (or ‘ward sister’) as ‘senior nurses’. There were no State Enrolled Nurses working on the AMAU. When referring to nurses who interacted with the AMAU nurses but did not work on the AMAU the job title of the nurse is used. Those medical staff interviewed are likewise referred to by their job title, such as senior registrar, and, again to maintain confidentiality, only an interview number distinguishes the two paramedics interviewed. When referring to patients interviewed formally I have given them fictitious names, all of these are first names as all patient participants requested that they were referred to by their first name. In some of the

field notes names of people, wards, or hospitals are sometimes used however all of these names were pseudonyms and were used merely to improve the dialogue flow. With these data extracts I have not given the dates the field notes were collected as I considered that potential harm and breaches of confidentiality might occur if by looking at off-duty sheets individuals could be identified. The ethically correct balance between maintaining confidentiality and rigour was a constant element of concern and reflection. As one clinical setting was used anybody that knew that the study had been conducted may be able to identify individual participants unless extreme care was taken. To this end I have also deselected certain interesting data if it would identify the participant and this was of particular concern if its content held the potential for the participant to suffer harm or embarrassment if identified (Hammersley & Atkinson 1995). During fieldwork when it was clear that participants had forgotten that I was a researcher and spoke indiscreetly I have not used such data verbatim but such discussion fed into my quest to gain an interpretative understanding of the role of the AMAU nurse.

# CHAPTER ONE

## INTRODUCTION TO THE THESIS

### 1.1 Introduction

The purpose of this study was to describe and explain the role of the nurse in an Acute Medical Admissions Unit (AMAU). As there is limited research that has considered this role, a qualitative and exploratory methodology was deemed appropriate. It was thus decided that the most appropriate research approach to achieve this aim was ethnography. As will be detailed later in this chapter the understanding of role utilised in this study drew on symbolic interactionism, from an ontological perspective that considered meaning to be socially constructed. Further, as my position as a researcher was constructed by my presence as part of the field (Aamodt 1982) and the interpretations offered are mine, I therefore use the first person throughout this study. This chapter will present the specific research questions and then will explore and justify the understanding of the concept of role utilised in the study. An introduction to the research setting is then given and finally an overview of the structure of the thesis is presented. Firstly, an overview of the context of the study is presented.

### 1.2 Context of the Study

AMAUs are located within National Health Service (NHS) district general hospitals (DGHs) across the United Kingdom (UK). These units are designated to accept all unscheduled adult emergency medical admissions, i.e. not surgical or trauma emergency admissions, apart from those medical patients going directly to critical care settings. Wood (2000a: 197) defines AMAUs, also named Emergency Medical Units (EMUs) or Medical Assessment Units (MAUs), as:

*A hospital facility for the assessment and initial treatment of acutely ill medical patients referred by their General Practitioner, local A&E [accident & emergency] department or emergency ambulance.*

Prior to the development of AMAUs patients were admitted directly to the ward of the on-call physician, or if a bed was not available on this ward to wherever there was a free bed elsewhere in the hospital (Mather 1998). In response to political demands for shorter waiting times in accident and emergency (A&E)

departments and improved efficiency in the admission and treatment of acute medical admissions (Wood 2000a; NHS Modernisation Agency 2001) AMAUs first appeared in DGHs approximately twelve years ago. Since then these units are evident increasingly in DGHs in the UK and are considered an auditable measure of good hospital management (Alberti 2003).

In Wales, AMAU development has been encouraged with these units seen initially as a component of the NHS Wales's response to winter bed scarcity and were considered in *A Plan for the NHS with its Partners. Improving Health in Wales* (National Assembly for Wales (NAW) 2001a). However, the NHS in Wales had limited understanding of the local organisation of these units and thus 'a review of best practice in managing emergency admissions and discharge planning across Wales and production of a guide to good practice' was deemed necessary (NAW 2001b: 11). Following consultation with relevant stakeholders, including Local Health Groups, NHS Trusts and social services the *Emergency Pressures Planning Guidance* (NAW 2001c) document was published. Within this publication it was noted that bed pressures and shortages were problematic issues throughout the year, not only during the winter months and that a longer-term strategy was required. In particular there had been an 'historic rise in medical admissions...' (NAW 2001c:EP1). One strategy that held the potential to utilise beds more effectively was to establish AMAUs in all DGHs in Wales (NAW 2001c). In 2002 there were fifteen AMAUs recorded in Wales out of a potential of nineteen sites (personal correspondence with NAW 2002). (Appendix 2 provides further detail.) The AMAU initiative was therefore valued and encouraged by devolved and national policy as a strategic development to manage acute medical admissions and bed usage in a more effective manner.

The nurse's role in the AMAU care setting however, as will be discussed in detail in Chapter two, has been under explored and there is a paucity of related literature that has considered this role. The literature identified consisted mainly of anecdotal accounts from clinical nurses, for instance Mayled (1998); Cameron *et al.* (2000); and Jervis (2000). Medically-lead research and governmental publications related to the AMAU initiative either ignored the role of the nurse or

noted that nurses had an important contribution to make by taking on delegated medical tasks (Clinical Services Advisory Group (CSAG) 1995; NAW 2001c; Alberti 2003). However, patients admitted to AMAUs are medical emergencies and providing care for patients who arrive acutely ill and undiagnosed is a challenging environment in which to work (Harrison & Daly 2001). It seemed probable then that the role expectations of the AMAU nurse would have particular, and indeed possibly unique, elements. If there were elements that were distinctive about this mode of care delivery from a nursing perspective then I wanted to understand what they were. All such endeavours are nonetheless, in essence, merely contributions to the potential that such insights could have to improve patient care on these units. This study provides a unique contribution to understanding this nursing role and by dissemination of study findings will contribute to the limited existing practice knowledge of AMAU nursing. The research aim of the study and the questions asked to achieve this aim are detailed next.

### **1.3 Research Aim and Questions**

The aim of the study was to describe and explain the role of the AMAU nurse.

The research questions posed to achieve this aim were:

- What are the perceptions of AMAU nurses as to their role?
- What are the knowledge, skills, and attitudes that are needed to work effectively as an AMAU nurse? Further, how are these abilities developed and what preparation do AMAU nurses have for this role?
- What are the perceptions of patients as to the role of the AMAU nurse?
- What are the perceptions of medical staff as to the role of the AMAU nurse?

During participant observation it became evident that paramedics affected the role of the nurse as the nurse would receive patients for admission from paramedics. Paramedics could potentially, it was decided, offer useful insights into the role of the AMAU nurse so an extra research question was framed:

- What are the perceptions of paramedics as to the role of the AMAU nurse?

Further objectives of this study were to commence the sharing of good practice and the potential for improvements in patient care by detailing nursing practice in an AMAU setting.

An inductive approach was utilised that sought understanding from data obtained in practice, from practitioners and patients who had experience of the AMAU and who had interacted with the AMAU nurses. Therefore, a philosophical armchair account of what nurses might, or should, do was not the goal of the study but rather an understanding that was grounded in the actual practice of nursing care delivery. Having provided a validation for the study and indicated the research aim and questions asked, the research methodology used is now discussed and justified.

#### **1.4 The Study**

A research methodology was sought that would enable access to participants who could provide information to achieve the aim of the study and answer the particular research questions as noted above. Further, I wished to immerse myself in the practice of AMAU nursing and to use the AMAU setting as a data source by gaining ‘first-hand experience’ (Mason 2002:55) of its culture. To this end I required a research strategy that valued discourse and observational data. An ethnographic approach provided this. Ethnography enabled an insider, or emic understanding of the cultural and social meanings that the AMAU nurses had negotiated to guide their practice. As will be developed in Chapter three the development of ethnography has been influenced strongly by the theoretical position of symbolic interactionism that guides much sociological research (Vidich & Lyman 2003). This provides another justification for the choice of ethnography as this offers ontological and epistemological congruence with the understanding of role accepted for this study, which is discussed later in this chapter. Hammersley & Atkinson’s (1995:1) definition of ethnography was accepted to guide the conduct of the research:

*[Ethnography is]...a particular method or set of methods. In its most characteristic form it involves the ethnographer participating, overtly or covertly, in people’s daily lives for an extended period of time, watching what happens, listening to what is said, asking questions –in fact, collecting*

*whatever data are available to throw light on the issues that are the focus of the research.*

As this definition demonstrates when using ethnography the researcher is the key data collector. However, this then causes a tension between seeking to collect data whilst acknowledging the ontological position of the researcher (Hammersley & Atkinson 1995; Mason 2002). My ontological stance was that of subtle realism (Hammersley 1992) and this will be developed further in Chapters three and nine. Ethnographic approaches can range from naturalism that seeks to study the social world in a natural state undisturbed by the researcher, a position of realism to a stance of anti-realism (Hammersley & Atkinson 1995). Anti-realist perspectives value the constructions that individuals make about their worlds through their interpretations of it (Hammersley & Atkinson 1995). This theoretical stance recognises heterogeneity and thus assumes that people will interpret the world in different, and often incongruent, ways to the interpretation of others (Porter 1998). This approach is encapsulated in the post-modern view of plurality of thought and perspective and the challenging of aspects of realities that have been taken for granted (Cheek 2000). Such post-modern thinking has influenced society generally and has resonance with my worldviews. However the stance of subtle realism, as argued by Hammersley (1992), offers a position between naïve realism and anti-realism and so provides a pragmatic mode of considering the credibility of research.

From a subtle realist perspective research findings and subsequent claims are constructed from what we are reasonably confident as being true. Hammersley (1998) contends that what we study exists independently of our claims about them, and that the social reality described represents rather than reproduces reality. Additionally, as Hammersley & Atkinson (1995) suggest social research cannot ignore the effect that the researcher has on the social world being studied. Further, the whole research process, from identification of questions to analysis and findings will be shaped by the researcher's 'socio-historical locations' (Hammersley & Atkinson 1995: 16). Insights into such personal orientations can be identified, explored, and monitored by reflexivity (Aull-Davies 1999) and will be discussed next.



#### *1.4.1 Reflexivity*

I held a particular role as an ethnographer in that the research was undertaken in the area of my professional expertise (nursing), within a speciality that held similarities to my own clinical experience, and within a study site that was a familiar clinical area. Acute medicine and critical care nursing were my main clinical backgrounds, having worked previously in neuro-surgery in a tertiary unit as a senior staff nurse, and then as a night sister and a medical ward sister in a district general hospital. Although I had been a higher education lecturer for over twelve years I had maintained links with medical wards and critical care units as a higher education provider's representative. This role included undertaking educational audits so that pre-registration nursing students could be allocated to those wards and units for clinical placements and the visiting of students whilst they were on placements. I was also the mentors' contact if they had concerns related to a student on placement. The AMAU studied was one of the clinical areas for which I was responsible and as will be developed in subsequent chapters there were issues that required resolution related to my pre-existing familiarity with the work of nurses and with the actual clinical setting.

I have had therefore a varied and enduring clinical background with my praxis expertise grounded in acute care provision. The AMAU system of providing care was thus interesting for me, as it was different from the previous (and long standing) system of admitting acutely ill medical patients to general medical wards that had been my experience when in clinical practice. The ethnographer is therefore a nurse and throughout seeks understanding of a nursing culture. Moreover, as the sole researcher I acknowledge that my personal experiences, my particular disciplinary background, and the wider sociocultural context of my life will influence my interpretations and constructions (Aull Davies 1999). Reflexivity was therefore regarded as an important activity throughout the conduct of the study and Mezirow's (1998) guidance for critical reflection was drawn on to aid this process. An overview of the conduct of the research is presented next.

#### 1.4.2. *Overview of the research conduct*

One AMAU in Wales was the site of investigation. The setting reflects a community of nursing practice and a particular form of meso-social setting that Blaikie (2000: 189) defines as ‘ a form of social organisation in which either space or common interests are the defining characteristics’. The goal of the research was to produce ‘a coherent and illuminating description of and perspective on a situation that is based on, and consistent with detailed study of that situation’ (Schofield 1993:202) rather than to produce a replicatable set of results. Therefore, I did not seek, following a qualitative stance, to offer generalisation other than what can be made by comparison to existing literature. Nonetheless, it is suggested that if nurses or others read this thesis and find within it issues that they recognise and deem significant, what Sandleowski (1986) names fittingness or Hammersley (1992) calls relevance, then a useful contribution to nursing scholarship will have been made.

Data were collected from 2001-2004 by participant observation undertaken for a period of eighteen months part-time (200 hours), by semi-structured interviews ( $n=19$ ) with nurses, doctors, patients, and paramedics, and from documentary evidence, both formal and informal. The research commenced without a theoretical framework as, following a qualitative stance, I sought findings that would emerge inductively from the data rather than seeking to fit findings to an existing framework. So whilst findings are discussed thematically the insights to interpretative understanding from the conceptualisation of situated learning (Lave & Wenger 1991), communities of practice (Wenger 1998) and work place stress (Baker *et al.* 1996) are drawn on in the interpretative quest. The capacity for the AMAU nurses to demonstrate a unique contribution to care delivery was discovered. Literature that considers New Nursing (Salvage 1992) and extended or expanded nursing roles (Hunt & Wainwright 1994) was also drawn on.

The goal of an AMAU is the provision of care for acutely ill medical patients (Wood 2000a; NHS Modernisation Agency 2002). Surprisingly, therefore the voice of the patient was silent in the literature that was identified. This thesis presented patients with an opportunity to discuss their experiences whilst

contributing to an understanding of the AMAU nurse's role. This is neither a sociological thesis nor an anthropological one, although elements from these disciplines are drawn upon. It is a nursing thesis that uses an ethnographic methodological approach in an eclectic manner by drawing upon alternative disciplinary knowledge rather than a rigid adherence to particular disciplines and their paradigmatic knowledge bases. However, I acknowledge the influences of my academic preparation, which is nursing, teaching, and health care law. These elements, together with my clinical experience and my role as a lecturer in higher education, must offer a distinctive perspective to the understanding of the role of the AMAU nurse presented. In the following section an operational understanding of the concept of role as utilised in this study is discussed.

### **1.5 The Concept of Role**

This section discusses the concept of role and how it was understood and applied to this research for as Clifford (1996) has noted, research that seeks to investigate the role of a professional group should detail the understanding of the concept utilised. Defining role is however a rather difficult endeavour for as Handy (1999) notes there has been little agreement on a precise definition. However, Handy (1999) suggests roles are associated with behaviour, or expected behaviour, in positions within organisations and involve interactions and relationships. Constructs of role, such as role overload and role conflict, that offer a vocabulary to describe social constructions (Clifford 1996; Handy 1999) will be utilised within the findings and definitions offered when used.

Biddle & Thomas (1966) discuss the development of the academic study of the concept of role and suggest that the evolution of such study can be categorised into three traditions, these being sociology, psychology, and anthropology. My understanding of role has been influenced by these three disciplines however I would consider the strongest influence to be that of sociology, in particular, symbolic interactionism. Early work in the 1930s by the sociologist George Mead gave the impetus to the main ideas of symbolic interactionism with its assumption that human conduct differs greatly from animal reaction, and further that human action is different from the stimulus-response based understanding of

human behaviour (Bond & Bond 1994). From a symbolic interactionist perspective the person, even within certain bureaucratic constraints, will develop a personal perspective on their role(s). Human action (or agency) acknowledges that humans plan their own actions and, importantly, reflect upon their experiences and are able to see themselves as others do. This picture of oneself is constructed by the individual's experience of the different meaning that s/he holds for others and how one is responded or reacted to (Bond & Bond 1994). The meanings of all objects are understood from the social interaction and subsequent interpretation that the person has with other members of society. Further, this perspective on social reality recognises that individuals have the ability to renegotiate meaning of the social world and its constructions (Aldridge 1991). That meaning is found in collective negotiation in the contexts of everyday experiences (Benton & Craib 2001). Mead developed the notion of self and considered that the individual or the self is influenced by social interaction and the individual's ability to examine and evaluate their own thought processes (Porter 1998). Riehl's theory of nursing was influenced by symbolic interactionism (Riehl & Roy 1980). Riehl developed the 'I' and 'me' concepts from the work of Mead and suggests that 'I' relates to self-concept that reflects the person's total behavioural perspective that provides a summation of their roles whereas the 'me' is the role taker. Riehl suggests that insights into another person can be gained by empathic understanding of the other's role (Riehl & Roy 1980). Goffman (1959) developed understanding of the self as created and understood by social interaction with the use of the dramaturgical metaphor in which the individual, by engaging in impression management, acts to portray a particular identity. Goffman (1959: 81) has noted:

*A status, a position, a social place is not a material thing, to be possessed and then displayed; it is a pattern of appropriate conduct, coherent, embellished, and well articulated. Performed with ease or clumsiness, awareness or not, guile or good faith, it is none the less something that must be realized.*

Another sociological approach to understanding the concept of role is the structural-functionalist perspective as espoused by Talcott Parsons (Porter 1998). From this perspective each section of society functions to support the other parts of the society and that society as a whole has needs that must be met if the society is to survive (Benton & Craib 2001). The concept of role, understood

from this perspective, becomes a combination of normative expectations of rights and duties placed on an individual. When roles are accepted by a large number of people they then become institutionalised (Porter 1998). Parsons, for instance, viewed illness as an interference with an individual's ability to perform their normal social roles. The person's exemption from their normal roles when taking on the sick role required them, to allay charges of social deviance, to be seen to take suitable help and to be trying to get better as quickly as possible (Alaszewski 1995). Interestingly Parsons offered a dichotomy of values that underlie any role; these are termed expressive or instrumental actions. Expressive actions are performed for their own sake whereas instrumental actions are goal orientated with an identified end (Porter 1998). This dichotomy has been utilised in nursing literature to describe aspects of the nurse's caring role, for instance Dunlop (1986) and Clifford (1995).

Criticism of this functionalist approach includes arguments that the attributing of such needs to a particular society cannot be proved as being necessary. Benton & Craib (2001: 90) suggest that the use of the term 'conditions of existence', which indicates that such conditions do not cause something to appear but rather provided conditions for the occurrence and that the occurrence will have been affected by multiple other processes as well. The functionalist perspective is therefore criticised by those who view institutional dominance as creating and sustaining oppression (Alaszewski 1995; Porter 1998).

Psychological scholars have also developed understanding of the concept of role. Peplau's (1992) nursing theory draws on the author's experience of psychiatric nursing and knowledge of psychology and is defined as psychodynamic nursing. Peplau (1992) defines six nursing roles within the nurse-patient relationship, that develop by extended engagement, that of stranger, resource person, teacher, leader, surrogate, and counsellor. Another nursing theorist who added to the understanding of the concept of role was Roy (1984) who developed a conceptual model for nursing that drew on adaptation theory. Within this nursing model role was conceptualised as drawing on a set of expectations towards one another (Roy 1984). A person's role performance is then conceptualised as

having three levels: a primary role, such as adult female and secondary roles that branch off from this primary role, such as wife, mother, and finally tertiary roles such as a member of a school council (Blue *et al.* 1994). It should be noted however that Roy used this role understanding as part of the nurse's holistic assessment of the needs of the patient and to raise the nurse's awareness of the various roles that the individual patient may have to perform. Clifford (1996: 1140) applied this understanding to the roles held by nurse teachers with a secondary role being 'nurse' and a tertiary role being a 'nurse teacher'. Burkitt *et al.* (2001) suggest that the nurse's sense of identity must operate within an institutional infrastructure that is controlled by outside forces that emit from managerial drivers. Nurses therefore hold their identity as a nurse in a generic sense but also hold self-determined specialisms that are 'both powerful professional identities and highly defended personal identities' (Burkitt *et al.* 2001: 38).

I take as my understanding of the concept of role as being influenced by both structural and situated influences (Wenger 1998). However, predominantly that a person's role in any situation will be occupied in relation to other people and that performance in that role is influenced by characteristics such as personality, personal attributes and skills (Clifford 1996; Handy 1999). March & Simon (1993:22) have noted that:

*Roles in organisations, as contrasted with many of the other roles that individuals fill, tend to be highly elaborated, relatively stable, and defined to a considerable extent in explicit and even written terms.*

However, as Biddle & Thomas (1966) argue, even though a person has a given role, for instance as a nurse, within the role there will likely be specialist activities or component parts that will differ from situation to situation. This supports symbolic interactionism as an aid to understanding the interaction dynamics that occur between people rather than by examining social structures only (Porter 1998). Clifford (1996) related this discussion to the role of the nurse teacher, a role within which there may be different degrees of specialization. Likewise, Hughes (1971:304) cautions when using the term social role that it 'is useful only to the extent that it facilitates analysis of the parts played by

individuals in the interaction that makes up some of the social whole'. An individual's work, despite differences in tasks and accomplishments, will contribute by social interaction to then become part of the whole product. The study of social role and division of labour must therefore consider interactional systems, such as teacher-pupil; physician-patient; nurse-patient, and as Hughes (1971: 309) notes:

*Certainly in some occupations there is some basic relation such as these; a relationship, which is partly reality, partly stereotype, partly ideal nostalgically attributed to a better past or sought after in a better future.*

Hughes (1971) notes that the role of the nurse, like that of other professionals, suffers from differing conceptions of what the role should be and understanding of what are proper rewards, and indeed responsibilities for the professional. Hughes (1971) suggests that any view of role-definitions as merely acceptance of what is handed down from above will be flawed. Understanding of role and development of role will emerge from communication between colleagues and others with whom they interact and so build up ways of working. So to understand the division of labour and subsequent roles requires the 'points of view of all kinds of people involved in it, whether their position be high or low, whether they are at the centre or near the periphery of the system' (Hughes 1971:310). Guided by this advice the themes and main claims of this study were identified following cross case analysis (Huberman & Miles 1998) of data gained from participant observation, documentary evidence, and semi structured interviews with doctors, nurses, paramedics, and patients. These multiple viewpoints were sought for as Handy (1999) notes the definition of a person's role will be a combination of the role expectations that interested others have of the focal person. Therefore data gathered from participants who have role expectations of the AMAU nurse were considered as a coherent strategy. Thus, the nurse has role definitions that arise from professional expectations and from society's perception of a nurse. Taking a social constructive view of the AMAU as a social organisation the role of nurse in the unit has been viewed as dynamic and changing: something tentative and creative rather than yet another mode of ensuring conformity (Buckley 1967).

In the following section an orientation to the research setting is provided to provide a backdrop to the social organisational culture of the AMAU nurses' practice. To help to preserve the anonymity of the setting and the research participants identifying elements of the setting have been omitted from this account.

### **1.6 The Acute Medical Admissions Unit (AMAU): The Study Site**

The DGH where the AMAU was located was one of five hospitals (two DGHs and three community hospitals) within an NHS Trust in Wales. The hospital provided services for a large catchment area that was mainly rural with its inhabitants living in market towns, small villages, and farms. The Trust was divided into clinical directorates (or units of management) and at the start of the research the two DGHs of the Trust had separate medical directorates on the two sites. During the research period the clinical directorates were reorganised across sites and the AMAU was then incorporated into a Trust wide medical directorate. The head of the management team of the directorate was a medical consultant and this leadership was rotated yearly. A senior nurse was part of this management team but never the head, despite the clinical directorate concept being offered initially as a chance for any health professional to take leadership (Mark 1991).

The AMAU was set up in 1996 with fourteen beds. Its function was to accept all unscheduled adult emergency medical admissions apart from those patients destined for the Coronary Care Unit (CCU), Intensive Care Unit (ICU), or High Dependency Unit (HDU). The planning team that had guided the commissioning of the unit included the medical directorate's administrative manager, the directorate's nursing manager, consultant physicians, and the ward sister who was to manage the unit. The ward sister and two senior staff nurses spent one day visiting an AMAU in another Welsh hospital to gain insights into AMAU organisation. Local general practitioners (GPs) were not included in the planning team and had no prior knowledge that the unit was being planned. GPs' first knowledge of the AMAU was when they received a letter the week before the unit opened containing a new contact telephone number to use when seeking to



admit a patient. Having introduced the study site an overview of the AMAU's setting and organisation is now provided.

### **1.6.1 *The setting and organisation of the AMAU***

The AMAU was on the third floor of what was known as 'the medical block'. Access to the block was by the main connecting hospital corridor and there was a choice of two lifts or a staircase to reach the third floor. There was a locked entrance for the sole use of ambulance staff next to one of the lifts. Staff often remarked that the AMAU's location was not ideal because of the need for patients to be transferred in the lift. The consensus was that the unit would be better located on the ground floor and next to the A&E department and to the X-Ray department. The unit was modern in its appearance and in good repair throughout. In appendix 1 a diagram of the AMAU (not to scale) is provided indicating the spatial layout of the unit and the positions of the unit's fourteen beds. Each bed area was supplied with oxygen and suction and on the wall in each room there was an ophthalmoscope and a patella hammer with which to conduct neurological examinations. The only major difference, compared to other medical wards in the hospital was that there were no bedside lockers on the AMAU but rather patients' belongings were kept in large plastic boxes. This was to expedite admission and subsequent transfer as the patient's belongings were moved in the box and did not need to move in and out of a bedside locker. Other elements of the spatial layout and organisation of the AMAU will be developed as they relate to the findings discussed in subsequent chapters. The unit was placed on one half of an existing general medical ward and next to the CCU and at the time of opening it was a relatively new and innovative development (Trust Data 2003). The operational policy for the unit stated that:

*The aim of the AMAU is to provide a dedicated area for the rapid completion of assessment, initial diagnosis and treatment of patients to facilitate early discharge or transfer to an appropriate ward within twenty-four hours of admission. The unit is staffed and equipped to deal with these groups of patients (Trust Data 2004:1).*

The admission criteria for the unit were that the patient was an acute medical (i.e. non-surgical or trauma) admission, requiring medical care and not social care, and aged over 16 years of age (Trust Data 2004). The numbers of admissions to the AMAU, like the UK pattern generally (Armitage & Flanagan 2001), had been

increasing year by year and bed pressures were a continuous problem as the figures in Table 1 demonstrate.

**Table 1. Patient activity and other performance data for the AMAU from 1997-2003**

	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
<i>Occupied day beds</i>	2651	2641	3132	3631	4986	4004
<i>Total discharges</i>	704	687	773	748	687	841
<i>Total ward episodes.</i>	3878	4002	3964	3904	3719	3814
<i>Average % Bed occupancy</i>	51.88	51.68	61.12	71.07	97.57	78
<i>Av/length of stay-ward episode(% of a day)</i>	0.68	0.66	0.79	0.93	1.44	1.05
<i>Day Cases</i>	16	16	6	38	44	43

Source: Adapted from Trust Data (2004)

As can be evidenced in Table 1 the number of total *ward episodes* (patients admitted and discharged or transferred from the unit) reached a peak in 1998/1999 and figures for the last year noted (2002/2003) were actually 188 episodes less. However, this apparent reduction in numbers of patients admitted is related to the increased numbers of patients who had to stay on the AMAU due to lack of beds elsewhere in the hospital to move them to: known as ‘access block’ (Fatovich 2002: 958). As the figures for *average length of stay-ward episodes* demonstrate there is a tendency for this figure to lengthen year by year, despite the requirement for early discharge or transfer from the unit noted in the unit’s operational policy. The year 2001/2 was particularly problematic as demonstrated by the *average % bed occupancy* that displays a general upward tendency but reached a high in 2001/2 of 97.57%. Armitage & Flanagan (2001), whilst discussing the increase in hospital bed usage, note that prior to internal market policies it was considered that bed usage was maintained effectively at a usage rate of 85%. Hospitals are now required to maintain bed occupancy at 95-98% and this higher figure restricts hospitals’ ability to respond to increases in demand due to limited flexibility at the margins of the system (Armitage & Flanagan 2001). Additionally, the data presented in Table 1 must be considered

carefully so as not to present a misleading picture. From the inception of the AMAU there had been no actual reduction in demand rather there were increasing difficulties in discharging or transferring AMAU patients. The Trust's 2004 review of the operation and effectiveness of the AMAU noted:

*There was a universally held view that the AMAU became ineffective on those occasions when beds on the unit became blocked by patients who were unable to be transferred to the appropriate specialised area because of a shortage of beds elsewhere within the Medical Unit (Trust Data 2004:2).*

The percentage increase in bed occupancy was alongside a parallel increase in the frequency with which admissions to the AMAU were deferred due to unavailability of beds, for instance during April-December 2002 a total of 423 patients had their admission deferred (Trust Data 2004). These patients were then admitted to another hospital, sent to the A&E department to wait for a bed and admitted after some delay, or managed within primary care. GPs once they knew that the hospital was full would reduce the number of requests for admission and this resulted in the figures demonstrating a more positive appearance than the reality of the situation warranted (Trust Data 2004).

Further, there is potential for misleading assumptions to be made from these statistics due to the format and collection of data. The figures for the *occupied day beds* statistic relied on data that were collected as a snapshot of the bed state each night at 12-midnight and thus provides rather misleading information. Patients who had been admitted and transferred during the day (which was the goal of the AMAU) but were not on the AMAU at midnight were not recorded as admissions. Some of these patients were however recorded as *day cases*. The number of *day cases* noted on the AMAU related to patients who had been admitted during the previous 24 hours and transferred onto another ward. They were not day cases in the accepted understanding of patients who attend for a specific treatment and then go home. Medical day case patients are often well known to ward staff and do not require a full admission procedure or acute treatment. The day cases recorded on the AMAU's figures were in fact not day cases but acutely ill medical admissions, patients who required complex nursing and medical assessments and treatments.

During the week commencing 20/03/04 there were between 4 and 14 admissions every day. So on this fourteen-bedded unit there were, on average, 8.4 admissions every day and on one day there were 14 admissions (Trust Data 2004). It must be noted that the busiest time for admissions on the AMAU tended to be between 3pm and 6pm, which was after GPs had done their house calls following morning surgery. Therefore, as GPs were the main source of patient referral most of the patients for admission would come to the AMAU within a three-hour period. All this activity was conducted using only 14 beds and in surroundings that had no specific physical adaptation for this volume of admissions and the poor health status of those admitted.

One adaptation made however was that the AMAU nursing staff establishment was higher than on the other medical wards in the directorate (and is illustrated in Table 2 on page 18). However, to understand Table 2 an explanation of the descriptors that were used for staff at the time of data collection is required. During the period of data collection the nurses on the AMAU, whilst still using such titles as sister, junior sister, senior staff nurse or staff nurse, were also alluded to by their pay grade, and subsequent responsibilities, with the use of a nationally agreed pay scale that ranged from A-I. On the AMAU under study there were *D* grades, newly qualified or inexperienced nurses; *E* grades who were staff nurses with experience; *F* grades who were junior sisters or charge nurses, also called senior staff nurses; and *G* grades, the ward sister or charge nurse also known as the ward manager. *H* or *I* grades were senior sisters/charge nurses who held responsibility for several wards and were not ward based. The directorate nurse was an *I* grade and the bed managers were *F-H* grades. Despite health care support workers, health care assistants (HCAs) and ward clerks, also having such pay related grades (from *A-C*) they, unlike the registered nurses, were not referred to by these grades. A new pay grading was introduced for NHS staff following *Agenda for Change* (DoH 2004a) so the *A-I* grading referred to in the thesis is now an historical artefact. Table 2 details a comparison of nurse staffing establishment on the AMAU compared to other wards within the medical

directorate and in particular it can be noted there was a higher ratio of experienced to inexperienced nurses than on the general medical wards.

**Table 2: Nurse staffing establishment on the AMAU compared to general medical wards**

<b>WARD</b>	<b>AMAU</b>	<b>WARD 1</b>	<b>WARD 2</b>	<b>WARD 3</b>	<b>WARD 3</b>
<i>Whole Time Equivalents (WTE)</i>	29.13	22.6	21.90	21.60	17.90
<i>Numbers of Beds</i>	14 beds	20 beds	20 beds	20 beds	14 beds
<i>G Grade (WTE)</i>	1	1	1	1	1
<i>F Grade (WTE)</i>	2	1	1	1	1
<i>E Grade (WTE)</i>	7.60	6	5.6	5.52	5
<i>D Grade (WTE)</i>	8.33	5.44	5.53	5.46	4.80
<i>A Grade (HCAs/ward clerks)(WTE)</i>	10.20	9.16	8.77	8.62	6.10

Source: Trust Data (2005)

Newly qualified nurses were not allocated to the AMAU, as the unit's sister considered (and supported by the rest of the nursing team) that a nurse would need to have at least six months experience before working on the unit. HCAs were part of the AMAU's staffing establishment however during data collection there was much movement of the HCAs around the medical directorate to cover sickness, maternity leave, and general staff shortages. HCAs are nursing auxiliaries who were given extra training to provide the shortfall in staffing following the introduction of Project 2000 nurse education. This change resulted in the removal of student nurses from the work force of the Trust as students were given supernumerary status (Allen 2001). Student nurses from the local university were allocated to the AMAU during their pre-registration higher education diploma or undergraduate nursing degree programme and the AMAU nurses acted as mentors and clinical assessors for the student nurses. The AMAU also provided a placement and assessment area for adaptation programme nurses who had qualified abroad. These nurses were required to follow a specific programme of preparation before gaining UK registration and whilst they waited

for this they were employed by the Trust as HCAs. After gaining their UK registration they were employed initially as junior staff nurses. Part of the nursing establishment budget provided two ward clerks who provided cover from eight am to eight pm Monday to Friday and eight am until midday on Saturdays.

The directorate senior nurse was the overall manager of the nurses on the AMAU however this role involved mainly personnel and strategic issues and did not affect directly the day-to-day delivery of nursing care on the unit. Other senior nurses with whom the AMAU nurses interacted were the bed managers. Bed managers were experienced nurses (F grade or above) who were responsible for collating information on bed availability throughout the hospital and were also involved at times in providing replacements for nursing staff who were off sick or if wards or units required extra help. Likewise they did not influence care delivery directly as their role was as a staffing and bed space resource manager.

Medical cover for the unit was dependent upon the medical consultant team on call. Within the hospital there were five such teams and an on-call rota was operationalised. Within a team there would be the consultant, registrar or senior registrar, senior house officer (SHO), and pre-registration house officer. The SHO or more commonly the house officer would carry out patient assessments on admission. Difficult cases were referred to the registrar for advice and very infrequently, and only in extreme situations, the consultant was called on when it was 'out of hours' (working hours were nominally between 9am and 5pm for consultants) for advice. The on-call medical team would also provide the core of the resuscitation team, together with an anaesthetist and an operating department practitioner. The medical team on-call would undertake a 'post-take' ward round of the AMAU patients twice a day at 8.30am and 5pm. During these rounds the consultant reviewed the on-going treatment for the patients and decided which patients were to be transferred or, infrequently, discharged directly from the AMAU.

Other members of the multidisciplinary team were not part of the day to day working of the AMAU due to the patients' short length of stay on the unit but

referrals would be sent to such professionals as social workers and physiotherapists. These health and social care professionals would however generally see the patient when on the transfer ward. Paramedics were commonly on the AMAU bringing in new admissions. Having orientated the reader to the study site the layout and structure of the thesis will now be discussed.

### **1.7 Structure of the Thesis**

In Chapter two a critical review of the literature regarding the role of the AMAU nurse is provided. Firstly, literature is reviewed to give an overview of the role of the nurse from a generic perspective. Literature that considers the AMAU setting specifically is then explored and it is noted that the majority of the research has been conducted from political, medical, or organisational perspectives only. The literature from an AMAU nursing perspective was sparse and, in the main, was not research based. Nonetheless this literature is reviewed in its entirety. Due to the paucity of literature related specifically to the role of the nurse in the AMAU, parallel literature was also reviewed from the A&E setting to develop understanding of the role of the AMAU nurse.

In Chapter three the methodology of the study is justified and detailed. During data collection my roles as a nurse, a lecturer, a researcher, and a friend overlapped and these issues are discussed and modes of resolution explained. Ethical considerations are fully explored.

Chapter four introduces the reader to the analysis of the findings by an overview of the most significant theoretical perspectives that were identified to aid understanding of the data. Firstly, Wenger's (1998) concept of communities of practice is reviewed and critiqued and so provides a grounding for the interpretation of the AMAU nurse's role as developed in the study. In addition, the demand-control- social support model of workplace stress (Baker *et al.* 1996) that offered a theoretical structure to organise and aid understanding of the effects of occupational stress and balances on the AMAU nurse's role is also examined. Finally the four key themes emerging from the study are outlined and the characteristics of the interview participants are presented.

The findings of the study and the related discussion are presented in Chapters five to eight. Chapter five explores the AMAU nurse's co-ordinating role in managing patients' rapid transition into and through the AMAU. The organisational culture of nursing care on the AMAU and the nurses' function in the management of the patients' journey into and through the AMAU is discussed. Additionally, the locally negotiated and distinct working practices that the nurses had evolved to promote coordination and continuity of care for patients are examined.

Considering the professional skills of the AMAU nurse and the role attributes required for this role of managing patient transition are discussed in Chapter six. Approaches to promote effective communication in a time-short care environment are explored in the context of practice reality. Theories of situated learning and communities of practice (Lave & Wenger 1991; Wenger 1998) are drawn upon to aid understanding of the processes by which nurses learn to become AMAU nurses.

The role stresses and modifiers to work place stress experienced by the nurses and their practice responses are explored in Chapter seven. The nurses' expressed preference for working on the AMAU, despite frequent incidents of work overload, was aligned closely with the high levels of decision authority and social support that they experienced. An organising structure for this chapter that reflected the inductively developed themes was that of the Demand-Control-Social Support (DCS) model of work place stress (Baker *et al.* 1996).

The final findings and discussion chapter is Chapter eight, which explores the organisational constraints and practice boundaries that affect the AMAU nurse's role. Discussion of the competing role demands and role conflicts that the nurses experienced, together with the practical and psychological adaptations that had evolved to resolve these differences are considered. The nurses' interactions with medical staff are discussed drawing on Wenger's (1998) conceptualisation of



boundary working. Finally the future role of the AMAU nurse is examined and a construction of an evolving role for this nursing role is offered.

Chapter nine concludes the thesis. Limitations to the research are acknowledged and an appraisal of the methodological approach drawing on Hammersley's (1992) concepts of validity and relevance is provided. Finally, the study's main claims are presented and a discussion of their relevance and resultant recommendations are then offered.

### **1.8 Summary**

In this chapter the research aim of seeking to describe and explain the role of the nurse on an AMAU was presented and the ethnographic approach utilised has been introduced. The conceptual understanding of role utilised in the study was explored and a symbolic interactionism perspective was considered congruent with the study's aim and supported the use of ethnography. It was noted that disciplines such as anthropology, sociology, and psychology were drawn eclectically on whilst considering that I sought a nursing perspective predominantly. An introduction to the research site was provided and information on its operation and personnel was offered. Finally an overview of the structure of the thesis was presented.

The next chapter presents a critical literature review that underpins the study's aim and subsequent conduct.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Introduction

In this chapter professional, clinical, and political literature is reviewed critically to provide a theoretical background to the research aim of describing and explaining the role of the nurse in an acute medical admissions unit (AMAU). This review drew on both theoretical and empirical literature and is structured by thematic separation into three major categories. The first category of *Defining Nursing* considers generic conceptualisations of the nurse's role as provided in the nursing literature. Secondly within *The Development of AMAUs* the background to the AMAU initiative is discussed and literature reviewed that investigates and offers commentary on the organisation of AMAUs. The third category concentrates on *The Role of the Nurse in AMAUs* and the limited literature that considers the nurse's role within these units is reviewed. As there was paucity of literature that related specifically to the role of the AMAU nurse selected literature that considered the parallel setting of accident and emergency nursing was also drawn on. The chapter concludes with a summary synthesis of the literature reviewed and justification for the research study and its conduct. The strategy utilised to conduct the literature search will be discussed next.

##### 2.1.1 Literature search strategy

The literature reviewed was obtained in variety of ways. Initially electronic database searching (including CINAHL, ASSIA, MEDLINE, and RCN) was conducted using key words/phrases such as role and nurse, AMAU, acute medical admissions, acute medical care, and nurse and acute medicine. There was no restriction on the country of origin of the literature reviewed but only literature presented in the English language was accessed. For the literature related to the role of the nurse and the AMAU literature there were no time limits on search parameters, however the latter's time span was self-limiting due to the relatively recent development of these units. UK literature was drawn on predominantly. However, as the literature obtained relating to AMAUs, in particular the nurse's role, from these sources was limited, this electronic searching was supplemented by hand searching and searching electronically

within appropriate journals (health service, nursing, medical, and sociological journals) and governmental publications. Once a useful source was found cited references from the article or book were obtained. Internet searching yielded results that the electronic database searching had not, including governmental (central and devolved) publications and links to articles published in peer-reviewed journals. Literature was obtained throughout the period of the conduct of the research by journal contents alert systems, following up suggestions and serendipitous insights following conversations with colleagues, feed-back after papers presented and attended at conferences, and regular re-searching of electronic databases and paper sources.

References were recorded using the reference database computer programme 'Endnote' and 1012 references were recorded in total. Often the literature obtained would be utilised for different categories within the review and this programme enabled searching of the references using key words. Another useful facility was the ease of locating literature, especially journal articles and governmental documents, as the file in which the paper copy was being stored could also be noted within *Endnote*. Literature reviewed was structured into content themes that enabled the combining of theoretical literature and empirical literature (Carnwell & Daly 2001). As this study seeks to gain an interpretative understanding of the role of the nurse in an AMAU this literature review commences with a generic overview of the role of the nurse.

## **2.2 Defining Nursing**

Conceptualisations of the role of the nurse have been influenced directly by developments in medical technology, societal norms and, in particular, the status of women in society (Wicks 1998). Holloway (1992) identifies five female stereotypes in nursing, these being an angel, a handmaiden, a nonentity, a sex symbol, or a battle-axe. Meerabeau (2004), in a discussion of the concept of the educated nurse, notes that none of these stereotypes are educated and the only one with positional power was the battle-axe. This power came from a bullying style, age, and seniority rather than by her expertise. The nurse's role has also been constructed as that of maintaining the ward space to prepare and present

patients for the medical gaze (Latimer 2000). The subsequent doctor-nurse-patient relationship has been compared to the father-mother-child triad of the Victorian home (Meerbeau 2004). However, Gamarnikow (1978) has argued that any consideration of sexual division of labour that was based on biological determinism should be replaced with an understanding of the social constructions of such gender implicit roles. In nursing's quest to define its distinctive role, separate from such stereotypical understandings, professional bodies both national and international, have attempted to present formal definitions of nursing. The attempt to define what nursing is reflects the moves towards the professionalism of nursing and developments in the role and function of the nurse (Davies 1995). Within this category literature that defines nursing is organised and critiqued within five sub- categories, which are: *Professional and theoretical considerations of the role of the nurse; Nursing theory; Care and caring; 'New Nursing'; and Nurses working in a team*. Firstly, literature that offers professional and theoretical definitions of nursing is reviewed.

### *2.2.1 Professional and theoretical considerations of the role of the nurse*

Virginia Henderson's definition of nursing first used in a published form in 1955 (Harmer & Henderson 1955), and adopted by the International Council of Nurses (ICN) in 1960, was a seminal influence on the discipline of nursing to define itself:

*The unique function of the nurse is to assist the individual, sick or well in the performance of those activities contributing to health or its recovery, (or to a peaceful death), that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible (Henderson 1966:15).*

This definition was significant as it was a pioneering attempt to detail an independent function for the nurse rather than as a doctor's aid. Henderson (1966) however, also noted that the nurse carries out therapeutic plans as initiated by the physician and works as a member of a team. Henderson's definition and the fourteen basic needs of the patient, that Henderson argued encompassed all of the components of nursing care, were significant in nursing theory development (De Meester *et al.* 1994) and had an enduring influence on more recent attempts to define nursing (Halloran 1996). For instance, The Royal

College of Nursing (RCN) conducted a wide-ranging consultation exercise and from this contends that:

*Nursing is use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, or death (RCN 2003: 3).*

The RCN's (2003) definition is qualified by six defining characteristics: the particular purpose of the nurse, the particular mode of intervention, specific domain related to people's unique responses to health, nursing the whole person, a particular value base, and a commitment to partnership. Apart from the term 'clinical judgement' this definition can be seen as a précised version of Henderson's definition. Further, it reflects movements to identify a unique role for nurses by their exercise of autonomous judgements in clinical decision-making (Clark & Lang 1992; Pesut & Herman 1999). Henderson's definition likewise guided The International Council of Nurses' (ICN) (2004: 1) when they suggest that:

*Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy, and patient and health systems management, and education are also key nursing roles.*

The ICN cautions that national nursing organisations must seek to define nursing and nursing roles in a manner consistent with accepted international definitions whilst maintaining relevance for the health care needs of the nation (ICN 2004a). The RCN's definition portrays a role for the nurse in a rather limited manner, whereas the ICN definition places the nurse as a participant in collaborative working, in shaping health care policy, and in developing health care systems. The ICN's definition constructs the nurse's role in areas not identified by the RCN definition such as health policy and research and so may be seen as contributing more to nursing's professionalising agenda. Further, a definition of nursing that is in line with UK and devolved political views on the future of health care (DoH 1999; NAW 1999 and 2001a). However, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (1999), the former professional regulatory body for nursing in the UK, cautioned that a

definition of nursing might actually prove to be too restricting for the profession. Additionally, the RCN (2003: 2) itself contends that 'definitions of nursing, like nursing itself, are dynamic; nursing is constantly evolving to meet new needs and take account of new knowledge'. Whilst theoretical considerations offer useful insights research that explores what it is that nurses actually do can provide evidence as to the true nature of the nurse's role.

In the late 1960s a large research project, entitled the '*The Study of Nursing Care*' was instigated by the Ministry of Health to develop strategies to measure the quality of nursing care (McFarlane 1970). The project leader Jean Kennedy McFarlane, later Baroness McFarlane, in the first monograph from the project noted rather tautologically that 'the unique function of the nurse is to give nursing care' (McFarlane 1970: 12). The nurse's function was further classified into basic, technical, and administrative nursing care however the defining characteristics of these classifications are not provided. McFarlane (1970) nonetheless suggests insightfully the still relevant observation that closer working and training of health professionals was recommended as 'this approach seems essential where different actors have different goals and have different criteria of care with differing validity' (McFarlane 1970: 40). The findings of this pioneering research still resonate today. The criteria to measure quality in nursing care are still confounding, for what is good care in one area, for example, total care in a critical care setting, might be judged as poor in another such as rehabilitation (Reed & Bond 1991). Squires (2004) in a review of international literature sought to identify the role enactment processes that could be identified as being part of the acute care nurse's role (the setting where most of the world's estimated 11 million nurses work). Twenty-eight articles from 1995 and 2002 were selected for dimensional analysis guided by grounded theory methodology. From this Squires (2004) contends that role enactment of the acute care nurse will vary from country to country for causes such as cultural demands, social expectations, and historical reasons. However, seven common core dimensions of the acute care nurses' role were identified: (a) care delivery, (b) autonomy, (c) culture management, (d) information management, (e) leadership, (f) psychological management, and (g) task-focused care delivery (Squires 2004). The largest dimension identified was that of task-focused care delivery. Despite

the reviewed article's country of origin care delivery was indicated as the major focus of work in the acute nursing role. Squires (2004) acknowledges that the article selection may have a Western bias and that developing countries have particular issues related to economic and social development that was not captured. Nonetheless Squires (2004) contends that these dimensions are worthy of further investigation, as they offer specific and measurable factors when seeking to define the nurse's role. Nursing scholarship and nursing theory has also contributed to defining the role of the nurse by describing, and indeed prescribing, what nurses do and will be discussed next.

### *2.2.2 Nursing theory*

Articulation of nursing's claims for professional status and therefore professional autonomy (Davies 1995) was seen in the development in the 1960s and 1970s of nursing models (Roper *et al.* 1996). Also termed conceptual models, they provide structures of concepts and propositions with which to understand the nurse's role (Marriner-Tomey 1994). Nursing models and the subsequent mid-range theory development that they encouraged were offered as strategies to develop nursing knowledge, practice, teaching, and research (Fawcett 1995). They were conceptual tools that held the potential to demonstrate nursing's unique knowledge base rather than 'merely eclectic borrowings from other disciplines' (Baly 1980:419). Used in conjunction with the nursing process nursing models were to guide individualised care in an efficient and yet non-routine bound manner by gathering and organising patient data in a systematic and consistent manner (McFarlane & Castledine 1982; Alfaro 1990).

Meleis (1991: 265) suggests that 'nursing theories offer a beginning articulation of what nursing is and what roles nurses play.' Additionally, Fawcett (1992) proposes that nursing models and clinical practice could be developed by their reciprocal relationship. Draper (1993) critiqued Fawcett's discussion of model development by suggesting it came from a confused positivist position. However, Kahn & Fawcett (1995) countered this critique and argued that a conceptual model's credibility can be judged with the criteria of social utility, social congruence, and social significance. Further that examination of publications by

the model's author, and those who have used the model, aids claims for its utility. Draper (1993) nonetheless asserts that nursing models were flawed as they cause practitioners to experience feelings of guilt when they are unable to meet the ideals of the nursing models. Additionally, Arbon (2004) argues that it is ironic that nurse theorists have emphasised the uniqueness of the individual patient whilst failing to recognise that the individual practitioner should also be viewed holistically and their uniqueness or particularity considered. Further, Arbon (2004: 153) asserts that:

*Nursing theorists have sought to define nursing practice in ways that have tended to deny the individual and situational facets of practice and the educational practices of nursing has reinforced this view.*

Allmark (1995) provides further criticism of nursing models by arguing that they do not offer theory but are merely normative suggestions about what nursing should be like. Tierney (1998) counters such criticism by suggesting that problems with the effective use of nursing models in practice may be related to poor preparation and understanding. Nonetheless, Wimpenny (2002: 346) argues that nursing models have 'lost the momentum and challenge that they promised the profession'. Such arguments would seem to be supported by the lack of the use of nursing models in practice as evidenced by the dearth of recent literature on the topic. Reed (1995) has debated the tensions between modernist and post-modernist perspectives on nursing models and disagrees that nursing has matured and no longer has any need for such models for knowledge development and practice. Nursing models must continue to evolve Reed (1995:81) contends 'lest they move from being extant to becoming extinct'. Additionally, more recently Fawcett (2003) has argued for a return to the study of nursing theory rather than merely applying theories from other disciplines to nursing practice. However, Pang *et al.* (2004) suggest that the main nursing models have a Western orientation that is not completely suitable for nursing development worldwide. Pang *et al.* (2004), drawing on their own cultural experience, contend that Chinese nursing needs to account for epistemic concerns grounded in Eastern ideologies and traditional Chinese medicine and philosophies. Nonetheless, nursing models do seek to distinguish a unique function for the nurse's role as opposed to following a medically lead approach to care.



The medical model, McKenna (1997) argues values cure and a Cartesian reductionist philosophy that separates the mind from the body. Nurses' practice had been influenced traditionally by 'the medical perspective [that] was inculcated in nurses' minds' (McKenna 1997:87). Movement away from nursing practice guided by the medical model and towards a coherent purpose of nursing practice was a key aim of nursing's theoretical development (Fawcett 1995). The nursing process was seen as an aid to defining nursing's distinctiveness by its function as a form of documentation, a method of work organisation, an educational tool, and a philosophy of professionalising (Allen 2001). However, Johns (1994: 51) criticises the nursing process as 'having no intrinsic value as a means for individualizing care despite the rhetoric that surrounded its introduction'. Benner (1984) also critiques the nursing process and demonstrated that nurses' clinical decision-making was more complex than the linear problem solving that the nursing process modelled. Additionally, Reed & Bond (1991) note that it is futile to introduce practices, like the nursing process documentation, if it is at variance with the nurses' existing value systems and levels of functioning.

Porter & Ryan's (1996) critical ethnography of a general medical ward sought understanding of the theory-practice gap as evidenced by the use of nursing process documentation. Using a single case study approach one general medical ward was studied and data were collected using semi-structured interviews of nurses of various grades ( $n= 10$ ) and overt participant observation of 16 nurses for a period of three months. Porter & Ryan (1996) offer structural arguments to explain why the nurses they studied failed to use care planning, as the nursing process would require them to. These authors suggest a theory-practice gap was present, not due to different class positions as had been suggested by Cooke (1993), but by the effects of social policy. Porter & Ryan (1996) argue that governmental attempts to minimise health costs had led to a general impoverishment of health care provision. The theory-practice gap was caused by the 'social structure of capitalism' that has constrained the actions of nurses (Porter & Ryan 1996: 419). Further, such external constraints exert a profound influence upon effective nursing care guided by nursing models and the nursing

process and should be considered alongside the theory gap between theorists and practitioners. The concept of care was an area of nursing theory development that sought to explain and to prescribe the distinctive role of the nurse and will be discussed next.

### 2.2.3 Care and caring

Watson (1985) offers an existential theory of caring that conceptualises caring as the moral ideal of nursing that can aid the enrichment and protection of human dignity. Watson stresses that caring will lead to an interpersonal relationship and to therapeutic interventions. Benner (1984) using the Dreyfuss model of skill acquisition described five stages of nurses' skill acquisition, which are novice, complete beginner, competent, proficient, and expert. The influences of authors such as Benner (1984) and Watson (1985) have seen the caring role of the nurse as a means of defining the role of the nurse. Additionally, the conceptualisation of nursing as a humanistic endeavour and as both an art and a science has held great influence on nursing scholarship following the work of Carper (1978: 12) who contends that:

*Caring as a professional and personal value, is of central importance in providing a normative standard which governs our actions and our attitudes toward those for whom we care.*

Furthermore, the caring of nurses has been conceptualised as being either instrumental or expressive caring (Dunlop 1986; Clifford 1995). Instrumental caring refers to what the practitioner does to or for the patient whereas expressive caring incorporates an emotional element and a commitment to values and respect for the individual (Clifford 1995). Sadler (1997) sought to define the professional caring of nurses working in the Mid West of the USA with data collected from triangulated sources. Firstly nursing literature (no older than 5 years) was searched using the term 'caring' which provided 1801 selections from which a 20% sample was randomly selected ( $n=341$ ). Using Schwartz-Barcott & Kim's (1986) hybrid model for concept development merged with Rodgers's (1989) evolutionary model of concept development, the selected literature was coded into themes of concept attributes, antecedents, consequences, and references. Semi-structured interviews with practicing medical-surgical nurses

(n=20) were then conducted during which the nurses were asked to define caring (the explicit questions asked were not provided). This data was analysed structured by the themes identified by the first stage of the study. Comparison of both sets of data for agreement and differences was conducted from which a refined definition of professional caring was constructed which contends that:

*Caring is an individually and socially defined creative process of using nursing presence, described by practicing nurses as multidimensional work, where a holistic connection is made with a person to meet a recognised need.*  
(Sadler 1997:16)

To support this definition non-participant observation of nurses on a 50 bed medical-surgical ward, total of 60 hours, was conducted using Schatzman & Strauss's (1973) guidelines for observations and field notes to understand the characteristics of caring observable in nursing practice. However, Sadler (1997:18) noted that in practice:

*...the idea that caring is invisible work and frequently conspicuous in its absence was supported. Although characteristics of caring were observed, frequently when one would have expected to observe caring, such characteristics were notably absent.*

It can be argued that Sadler has misunderstood the concept of the invisible work of nurses as described by Wolf (1989) as relating to important, usually emotional, work that was done but was unrecognised as work. Nonetheless, Sadler (1997) warns that the concept of caring should not be accepted as the only focus for the discipline of nursing as definitions of caring vary according to practice settings with different patient populations. Morse *et al.* (1991) analysed 35 authors' definitions of nurses' caring. From this caring was described as: a human trait; a moral imperative; an emotional and compassionate involvement; an interpersonal relationship; and a therapeutic intervention that is patient centred and action orientated. However, Morse *et al.* (1991) call for inductive research to understand the patients' concept of caring rather than the views of nurses solely. Likewise, Webb (1996) argues that patients should inform the care-cure debate and further that an inclusion of the concept of coping would articulate the needs and perspectives of the patient. Clifford (1995:40) offers a pragmatic view of caring as 'formalized caring' and suggests this would 'acknowledge the reality of practice as a formal social role rather than an ideal which sees caring in practice

as altruistic rather than functional'. Echoing Porter & Ryan's (1996) conclusions noted earlier Clifford (1995) asks that the societal and organisational effects that influence the nurse's role should be considered when analysing caring in nursing. Likewise Squires (2004) contends that a nurse's role enactment is dependent on multi-faceted influences, such as organisational and personal cultures. Buller & Butterworth (2001) in a qualitative research project that drew on ethnographic principles explored the skilled nursing practice of a range of nurses from different clinical areas. The authors suggest that their methodological approach is ethnographic as they sought to learn from the narratives of people rather than studying people and to gain 'understandings of clinical practice within this culture' (p.407). Data were collected using interviews, or 'semi-structured conversations' (p.408) with 22 expert nurses participants and 14 'non-expert' nurses ( $n=36$ ). An expert nurse was defined as having a minimum of five years clinical experience, was involved in clinical practice, and had undertaken recognised post-basic or postgraduate training. What was a 'recognised training' (p.407) was not specified nor why the term 'training' was used as opposed to 'education' was not specified. Analysis led to the development of an understanding of skilled nursing practice that encompassed caring, intuition, ordinariness (making skilled practice seem unremarkable), and role modelling.

Four domains from the narratives of skilled nursing practice contributed to this understanding of skilled practice were identified: being professional; relating and communicating; doing the job; and managing and facilitating. A common theme running throughout the domains and sub-domains of the study was that of confidence (being; giving; conveying; and providing confidence) however this was not highlighted within the paper's discussion. The concept of confidence can be related to the construction of role and the presentation of face (Goffman 1959) and would be useful to develop when considering the nurse's role. As Buller & Butterworth (2001) suggest qualitative studies of nursing have a role in representing nursing identities developed from representational discourses and can offer constructions of nursing identities and further note that:

*It is possible to ask fundamental questions about what nurses do, how they know about what they do, how they come to do what they do, and how they come to know about what they do (Buller & Butterworth 2001: 415).*

However, as Buller & Butterworth (2001) obtained data solely from nurses at interview they cannot then offer information on what the nurses actually did in their practice. Therefore evidence of these worthy themes being translated into practice, or not, was not evidenced whereas participant observation could have provided such data. The perspective of the patient as the recipient of care is also missing and so we cannot judge if patients valued what the nurses valued, or if indeed the patients had priorities that were different or the same as the nurses. From this study Buller & Butterworth (2001:413) contend that the theme of 'caring' was considered by participants 'as a primary feature of skilled nursing care' and thus important to understanding skilled nursing. However, it may be argued, from these findings that the term caring was used as an umbrella term for many elements of the nurse's role without actually defining what the role of the nurse is. With increasing demands on the role of the nurse, in particular the expectation that nurses take on tasks that are delegated by medical staff, there is a potential for nurses to be increasingly distanced from a more traditional bedside caring role especially when such delegated tasks often hold higher status (Snelgrove & Hughes 2002). Additionally, it has been argued that moves to professionalism and the preparation of student nurses to degree level may lead to student nurse applicants who are motivated solely by the academic qualification and do not seek to care (Woodward 1997). Whilst discussing the delegation of caring interventions to health care support workers Clifford (1995) warns that such proxy working may lead to nurses having difficulty in claiming for themselves the unique function of caring. Thus the use of the concept of care to define nursing is limited however the literature reviewed indicated that for care to be possible a nurse-patient relationship was required that included instrumental caring, expressive caring, and indeed moral caring. The nursing philosophy called the *New Nursing* sought to reclaim caring and care delivery as the role of the registered nurse and is discussed next.

#### 2.2.4 'New Nursing'

The '*New Nursing*' philosophy espoused humanistic approaches to nursing care delivery by valuing the patient's individuality and holistic care delivery (Salvage 1992; Johns 1994). Care, was to be delivered by a primary nurse who planned

and held professional accountability for the patient's nursing care throughout her/his stay in hospital. (Salvage 1992). Nursing development units were set up to deliver care guided by *New Nursing* tenets (Pearson 1988). This movement sought to move the nurse back into the traditional nursing role of caregiver whilst also promoting professional autonomy within a non-hierarchical working organisation (Pearson 1988: Johns 1994). However, an ethnography of nursing care delivery on two wards, one a primary nursing ward and the other a more traditionally organised ward, observed little difference in the quality of nurse – patient relationships (Savage 1995). Although nursing development units over time were closed down the influence of *New Nursing* and primary nursing filtered out to nursing delivery across the UK (Savage 1995).

Adams *et al.* (1998) undertook a hierarchical cluster analysis related to ward nursing practice using a postal survey with a nationally representative sample of 74 acute UK hospital wards. Their findings describe three types of clinical nursing organisation, which they termed devolved, two-tier, and centralised. The nurses working in a devolved system of working cared for their allocated patients, gave their patients' handovers at end of shift, and attended the medical ward round to discuss their patients. Nurses working in this system, which has similarities to primary nursing, expressed the greatest job satisfaction. The system of working described as being two-tier (Adams *et al.* 1998), which was the most common method of work organisation, was similar to team nursing. In this system despite caring for a defined group of patients the ward sister/charge nurse retained a high degree of control and authority. Those nurses working in a two-tier system reported the greatest stress levels related directly to a lack of clarity about lines of responsibility. This two-tier system lead to confusion whereas the use of a centralised system, where the ward manager was responsible for all key decision making, was less confusing for the nurses who knew exactly what their responsibilities were (Adams *et al.* 1998). The work satisfaction that devolved (or primary) nursing work organisation systems evidence supports socio-technical systems theory that values a balance between technical and social systems to promote the psychological needs of individuals for teamwork, multi-

skilling, and self management in the division of labour (Hatch & Cuncliffe 2006).

Allen's (2001) ethnography sought understanding of the role of nurses in the hospital division of labour. Data were collected on a medical ward and a surgical ward in a large UK hospital by participant observation (final number of hours not provided) and 57 interviews with ward nurses ( $n=29$ ), doctors ( $n=8$ ), nursing auxiliaries ( $n=3$ ), healthcare assistants ( $n=3$ ), and clinical managers ( $n=11$ ). An omission in this sample was the voices of the patients, the recipients of care, and their experiences of being cared for within the divisions of labour that Allen describes. Allen (2001) suggests that although some of the elements of *New Nursing* were evident in the patient care delivery observed there still remained tensions between ward nurses and senior nurses that reflected conflicts between professional and management discourses. However, although Allen was a nurse the participant role adopted (non-participant observation and running messages) excluded any caring work behind the screens as 'I felt without a caring purpose it was illegitimate for me to intrude into patients' privacy' (Allen 2001: 53). Therefore, missing from Allen's otherwise insightful and thorough ethnography was the understandings that experiencing direct care delivery to patients, and interactions with patients at this point, could have afforded than rather objective reporting of observed occurrences. Additionally, rather than just using the wards and ward staff as data collection opportunities a role could have been constructed of participant observation (Gold 1958) for as Johnson (1997:42) notes 'true participants have an opportunity to bargain for data, that is, they have something to offer respondents which is worth having'.

Latimer's (2000) ethnography of the bedside of older patients admitted to an acute medical unit cited medical hegemony as another structural impediment to the operationalisation of the tenets of the *New Nursing*. Observation was conducted of the admission, and subsequent care, of 20 patients aged over seventy-five years old admitted to two medical wards as well as nursing handovers, doctors' rounds, multidisciplinary rounds, and domiciliary visits prior to discharge. Latimer (2000) sought patients' versions of their experiences and

their relationships with practitioners and interviewed the patients who were observed (n=20) as well as the registered nurses (n=6) so as to extend understanding of the conduct of the nurses' practice. Latimer (2000) describes the work of the nurses as being effaced by the medical ward round and that the work of nursing was kept separate from pure clinical (medical) work and that these structures maintained nursing work as being supplementary rather than complementary. Therefore, from the literature reviewed adhering to *New Nursing* philosophies of humanism, individualism of care, and increased professional autonomy when working alongside the powerful professional discourses of managerial demands and of medicine provides contested areas of control. Consideration of collegial working and literature that considers the nurse's role within the health care team is discussed next.

#### **2.2.5 Working in a team: the nurse's role**

Health professionals in the UK, following governmental policy drivers such as *The NHS Plan* (DoH 2000a), *A health service of all the talents* (DoH 2000b), and *Modernising nursing careers. Setting the direction* (DoH 2006), are encouraged to move away from traditional professional working roles and restrictive professional boundaries. Nurses in particular have been encouraged to develop their roles so that 'decisions on who can provide care should start from the patient's needs not professional background and training' (DoH 2000b: 29). The nurses' then professional regulatory body the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting gave early sanction to this stance with the publication of the *Scope of Professional Practice* (UKCC 1992). Nurses were encouraged by this guidance to develop their practice responsive to a 'context of continuing change and development based on principles of practice rather than certificates for tasks' (UKCC 1992:1). This encouragement of flexibility at the boundaries of the work of the nurse were, it should be noted, presented at the same time as the doctors' 'New Deal' was agreed. The 'New Deal' is the title given to the UK's implementation of the European Working Time Directive that demanded a limiting of the working hours of doctors in training (Pearce 2003). This initiative has led to a reduced working week for doctors in training with nurses nominated to compensate for the potential



shortfalls in care delivery due to junior medical staff unavailability (Roughton & Severs 1996; Armitage & Flanagan 2001). This has led to 'the training of nurse practitioners to undertake many of the repetitive tasks previously undertaken by junior doctors' (Armitage & Davidson 2001: 537). The use of experienced nurses in 'repetitive tasks' is however an ineffective use of these nurses' skills, especially with job opportunities such as NHS Direct and nurse consultant posts now available as career choices. Further, this will not help workforce difficulties across the NHS and in healthcare delivery generally as there are problems currently in recruiting nurses in the UK. Large numbers of nurses are recruited from across the world and often from countries that then suffer from staff shortages (Clifford 2000). Nonetheless, nurses and doctors do work closely together and provide complementary connections in care delivery (Allen 2001). It is important however that the distinct contributions that the two professions provide to the overall care of the patient when working collaboratively are recognised and indeed respected (Carpentio 1997; McKenna 1997).

Collaborative partnerships in patient management can impact positively on patients' outcomes (Kenny 2002) and enhance job satisfaction (Stapleton 1998; Anderson *et al.* 2000). Snelgrove & Hughes (2000) sought understanding of the interpersonal relationships between nurses and doctors by an interview study of nursing staff ( $n=39$ ) and medical staff ( $n=20$ ) conducted in three district hospitals in south Wales. Findings indicate that nurses and doctors describe their roles in traditional terms. Doctors claim the key role in care delivery due to their legal and organisational responsibility and nurses suggest that a central element of their role was their knowledge of the social and emotional needs of patients. Traditional role boundaries were however being blurred in areas in response to work pressures and other contingencies. Snelgrove & Hughes (2000) discuss how the differing locales of work affected role blurring with nurses in specialist areas placing higher value on medical-technical tasks compared to nurses in general medical wards who were reluctant to take on medical tasks if they detracted from nursing roles. The effects of health policies, in particular the New Deal, were noted to be drivers to nurses taking on doctor-devolved work. In seeming contrast to this acquiescing acceptance of delegated medical tasks the

nurses discussed their role in terms of being the patient's advocate that required their willingness to challenge doctors' decisions (Snelgrove & Hughes 2000). Snelgrove & Hughes (2002) warn that team working is not always experienced as collegial and equal and can be plagued with the micro-political struggles of team members. Strauss *et al.* (1963) offers the concept of negotiated order to discuss the reconstituting of the social order in formal organisations by processes of social interaction. Friedson (1976) supports this argument and contends that the division of labour is established through the social interaction of the participants. Svensson (1996) develops this further with a study of the interplay between nurses and doctors on medical and surgical wards in five Swedish hospitals. The study however is rather limited by interviews being conducted solely with nurses ( $n=45$ ) so the doctors' perspectives were not heard. Nonetheless, Svensson (1996) suggests that the relationship between doctors and nurses have become more collegial due to the increase in chronic illness and the social dimension of care that have given nurses an enhanced role. Additionally, the effects of moving from task allocation to team nursing affected the nurse-doctor relationship and provided situations where the nurses and doctors discuss patients in a forum where the nurses' contributions are valued (Svensson 1996). However, it can be argued, that just because doctors and nurses talk this does not prove that the contributions of the nurses are valued. As Svensson's (1996) study only explores the perspective of nurses therefore the value that medical staff attribute to the contributions of the nurses cannot be judged. Such insights are nonetheless valuable as working relationships can demonstrate an explicit lack of appreciation of other professional viewpoints and contributions as illustrated by the following study.

Coombs & Ersser (2004) used an ethnographic approach to examine the role of the nurse in the clinical decision-making process in three intensive care units in the UK. Using a two-stage fieldwork approach six months were spent initially gaining orientation to the field and this was followed up by fieldwork over three months. This second fieldwork phase enabled follow-up data collection and verification of themes. In total 18 'ethnographic' interviews were conducted, 62 documents were collected and 200 hours of participant observation carried out.

Two core categories emerged following analysis using grounded theory strategies: knowledge for clinical decision-making and roles in clinical decision-making. Coombs & Ersser (2004) argue that the clinical decision-making relationships studied were demonstrating medical hegemony. Their findings suggest that the knowledge gained from the biomedical model of health and illness was the dominant knowledge paradigm in the interprofessional discourse. Medical staff sought scientific rational information and criticised nursing staff for their inability to defend their arguments on medical rounds. Coombs & Ersser (2004: 248) describe the doctors' strong belief in the hierarchical power relationship of the doctor over the nurse with doctors content to 'bequeath' care issues that they considered 'clinically superficial' to the nursing staff. This research reflects Porter's (1991) view of the dominant position of medical knowledge in defining illness and treatment in health care and Latimer's (2000) description of medical hegemony. However, Sweet & Norman (1995) argue that the stereotypical pattern of nurse doctor interaction, the so-called doctor-nurse game (Stein 1967), is now less common in clinical practice. Yet Coombs & Ersser's (2004) study demonstrates that issues of medical dominance are still pervasive, with an enduring problem being the differing expectations that the two professions have of one another. The nurses' inability to discuss patient related issues with confidence led to the medical staff not necessarily being able to make sense of what it was that the nurse was endeavouring to communicate (Coombs & Ersser 2004). This understanding is supported by Willis & Parish (1997), both nurses, who argue that if nurses wish to collaborate effectively with medical colleagues they need to develop integrated nursing and medical knowledge and the ability to communicate this effectively.

So despite nurses working closely and collegially with medical staff their role development remains linked closely to medical power. Changes in nurse education with moves to the higher education setting (UKCC 1987) and to an all-graduate profession (UKCC 1999; NAW 1999) sought to provide nurses with the knowledge, skills, and attitudes to function in equal partnerships with all members of the health care team. This team includes fellow professionals, patients and families, and the voluntary sector. However, professional barriers

can cause team members to insist on working from their own disciplinary philosophy and failing to engage in full participation with other professionals (Snelgrove & Hughes 2002). Multiplicity of effort, especially with assessment, is then the outcome that is inefficient and inconvenient for the patient. This multidisciplinary model of team working encourages competition between professions for dominance, sometimes with two professions allied against a third (Griffiths 2003). Commonly one discipline is acknowledged to be the one bestowed with the power, authority, and responsibility to make a final decision (Anderson *et al.* 2000). Additionally, as Allen (1997) notes, health professionals, such as physiotherapists are not allowed to provide their expertise for the patient (in a hospital setting) unless requested to do so by a doctor.

However, nurses have more professional autonomy than do allied health professionals, such as physiotherapists, as there are interventions, identified following a nursing diagnosis that the nurse provides without the permission or order of medical staff (Carpentio 1997). Additionally, *The Scope of Professional Practice* (UKCC 1992) cancelled existing guidance for nurses taking on extended (medically delegated) roles and encouraged nurses, by giving them freedom to expand their roles whilst accepting their own professional accountability. However, Fawcett (2003: 230) has suggested that ‘if the knowledge underpinning an activity cannot be traced to a conceptual model of nursing, nurses should not perform that activity’. Tasks or skills that are delegated to nurses by medical staff are considered to extend the nurse’s role, whereas an expansion of the nurse’s role contributes to an advanced level of nursing knowledge and skills to satisfy patient needs (Hunt & Wainwright 1994). An expanded role for the nurse therefore develops the unique nursing contribution within a health care team and so encourages interdisciplinary working.

An interdisciplinary model of practice promotes collaboration across disciplines as each practitioner enters into an interdependent working relationship (Anderson *et al.* 2000). Consensus building and group decision-making is more likely than in the multidisciplinary model and is valued by governmental policies such as

*Realising the Potential. A strategic framework for nursing, midwifery, and health visiting in Wales into the 21<sup>st</sup> century* (NAW 1999) and *A Health Service of all the Talents: Developing the NHS workforce* (DoH 2000b). The interdisciplinary model still however results in each discipline implementing their individual professional plans of care from their own disciplinary perspective. This leads to the care provision remaining fragmented because ‘continuity of care is not reinforced, nor is cohesiveness within the team valued as a therapeutic strategy that serves the best interest of the patient and the family’ (Anderson *et al.* 2000: 199). In a transdisciplinary model of practice all members are considered to be equal partners and individual attributes and experiences, as well as professional expertise are valued (Anderson *et al.* 2000). The team moves towards a common conceptual framework that demonstrates a shared philosophical perspective, with the exploration of varied theories, concepts and approaches to find what is the best plan for the patient, the family, and the community. Such a plan can then, by the redefining and diffusing of disciplinary power, ‘achieve a better understanding of the whole human enterprise involved in providing comprehensive and meaningful patient- and family-centred services’ (Anderson *et al.* 2000: 199). Such working can improve team working, promote flexible working practice, and remove barriers between professions, as discussed in *A Health Service of All the Talents* (DoH 2000b). Barriers to team working therefore are worthy of special consideration as they impact on the role of the nurse and are discussed next.

Barriers that impede the nurse functioning as a collegial member of the healthcare team remain issues of concern, as they are potential obstructions to effective care delivery and to the development of the nurse’s role. Anderson *et al.* (2000) discuss the importance of contextualising oppression, adding gender to other matrices of subordination such as class, race, sexual orientation, or physical (dis) ability that have been raised by feminist writers. Insights gained from the long battles against gender-based oppression can contribute to attempts of other groups to balance power in social institutions (Willis 1989; Wicks 1998). Anderson *et al.* (2000: 192) note that the nursing profession is very conscious of the contribution that gender has made to the ‘devaluation of the profession

internationally in comparison with its predominately male brother-discipline of medicine'. Since the 1960s and 1970s nurses have assumed responsibilities for complex machine technology. This development was offered as a strategy to make the nurse's role more scientific, to improve the reliability of their observations, and to strengthen the nurse-physician relationship (Anderson *et al.* 2000). However, this change in responsibilities may not be such a valuable development for nursing for as Sandelowski (1997: 171) argues:

*The transfer of technology from medicine to nursing reinforced the subordination of nursing to medicine and impeded the development of nursing as a valued province of knowledge and practice.*

Anderson *et al.* (2000) discuss how the differing epistemological and ontological presuppositions of nursing and medicine lead to conflicting paradigms of knowing as nursing's discourse is framed through the perspective of a holistic human context. If medicine's practice paradigm values rationalism and objectivity as being pre-eminent this can then cause disharmony with nursing's belief in holistic practice: if medicine is then the dominant group it can silence the voice of the non-dominant group, which is nursing (Lupton 1995). The nurse may adopt medical model thinking in practice so as to survive in hierarchical practice settings that privilege physicians (Wicks 1998). This technical-rationale approach that emphasises empirical knowledge can contribute to the nurse neglecting aesthetic, personal, ethical and moral ways of knowing (Carper 1978). So despite theoretical and research-based maturity in the articulation of distinct nursing approaches to care the medical model of cure can be valued over a caring nursing role (Davies 1995). However, guided by professional and political initiatives the role of the nurse is developing and so providing, potentially, an increasingly important contribution to health care provision as will be discussed next.

Nurses are taking on new roles such as nurse practitioner, clinical nurse specialist, advanced nurse practitioner, and nurse consultant (Barton 2006). However at present there is still some confusion as what these terms mean and a lack of consensus as to the level of practice such terms indicate (Sakr *et al.* 2003; DoH 2006). Barton (2006) discusses the proposals for regulation of advanced

level of nursing practice by the Nursing & Midwifery Council and links this discussion to the competency-based framework that now regulates pay frameworks within the NHS following *Agenda for Change* (DoH 2004a) and its accompanying *Knowledge and Skills Framework* (DoH 2004b). Therefore, the role of the nurse is currently under review. The Royal College of Nursing has stated that the future for nurses' role development should be positive with evidence that nurses make a positive and financially sound contribution to care (RCN 2004a). Understanding of the nurse's role can help nurses control future demands so that any new expectations of their role harmonise with what nurses consider to be enhancing of patient care.

In summary the quest to offer a universal definition of the role of the nurse is a challenging goal. Whilst definitions of the role of the nurse can be informed by guidance from professional bodies, nursing theory, understanding of the concept of care, and New Nursing a universal element of the role of the nurse was the need to be responsive to the individual patient's needs. However understanding the nurse's role must also reflect the changing social and cultural world in which the nurse practices and the potential constraints of hegemony. Following this overview of the literature that considers the role of the nurse from a generic perspective literature that relates specifically to AMAUs will be examined before considering the role of the nurse in AMAU practice.

### **2.3 The Development of AMAUs**

AMAU development was a political and strategic response to pressures on bed capacity in NHS medical wards (Capewell 1996; Hampton & Gray 1998). As Kendrick (1996) notes, as at least 80% of medical admissions are emergency admissions this issue was a major challenge facing the NHS. In a retrospective analysis of patients admitted to a medical receiving ward in a Scottish hospital in 1993, with a review four years later, an increase in average daily admissions from a mean of 17.0 patients a day to a mean of 25.6 patients a day was evidenced (Duffy *et al.* 1998). Duffy *et al.* (1998) discuss the increase in patients admitted in the later time (1997) sample that had not been referred by their GP, with many patients self-referring to A&E departments. Duffy *et al.*

(1997) extrapolate from this that GPs have a vital gate-keeping function within the NHS as they have more expertise in dealing with undifferentiated patient problems and living with uncertainty. Secondary care doctors, who are often junior, are more likely to admit a patient due to lack of such experience (Duffy *et al.* 1998). Additionally, Donaghy *et al.* (1997) suggest that there is a lower threshold to the seeking of admission generally related to GPs' fear of litigation, patients demanding the facilities of an acute hospital and more interventionist care models, as opposed to the more conservative treatments that might be provided at home. Kendrick (1996) suggests that the ageing population, readmissions and increases in specific chronic diseases, such as asthma, have contributed to this increase. Wanklyn *et al.* (1997) agree that the growing elderly population is a likely factor but also that the public now have a greater expectation for hospital treatment despite reductions in emergency hospital beds. A critical literature review of acute medical admissions claimed that there was an estimated 25% loss of hospital beds available for acute admissions in the UK between 1982 and 1992 (The New Zealand Health Technology Assessment Clearing House (NZHTA) (1998). This reduction in beds occurred whilst there was an increase in numbers of patients treated from 4,709, 000 cases treated per bed to 5, 989, 000 cases, or an increase of 65% (NZHTA 1998). Nonetheless, all of these pressures were to be managed alongside the reduction in the permitted working hours that doctors who were in training could work following the *New Deal* and to comply with European Working Time Directives (Roughton & Severs 1996). To set the establishment and organisation of AMAUs within its context, the system for the admission of acute medical patients is discussed next.

### **2.3.1 Organising acute medical admissions**

Hospital organisation of emergency medical admissions involves consultant physicians in an 'on-take' rota. The consultant's team of doctors then take all of the emergency medical admissions during this on-take period, usually a 24-hour period during the week or for the whole weekend (Green & Armstrong 1993; Donaghy *et al.* 1997). Prior to the advent of AMAUs the consultant lead medical team and the nursing team on the consultant's ward had to ensure that there were empty beds on the ward for their 'on-take' day. This was achieved by not discharging patients from the consultant's ward until it was the 'on-take' day for



that consultant's team of doctors (Green & Armstrong 1993). Latimer's (2000) ethnography discussed earlier describes nurses being more territorial in preserving of beds for their on-take days than were the medical team so as to maintain the area for the movement and flow of 'good medical materials' (p.70) rather than for patients with social needs. If the on-take team's ward was full then other beds had to be found, ideally on other medical wards but in practice wherever there was an empty bed in the hospital (Green & Armstrong 1993; Foster *et al.* 1996). Difficulties organising clinical care might then occur if patients were placed on inappropriate and geographically distant wards (Houghton and Hopkins 1996). Such misplaced patients could then cause short-notice cancellation of elective surgery and lead to increased complaints and longer waiting lists (Foster *et al.* 1996). This system was described as an inefficient use of hospital beds (Audit Commission 1992).

From a nursing management perspective this system was problematic as it was difficult to judge how busy any ward would be and patients, often seriously ill, would be admitted to an already busy ward (Green & Armstrong 1993). GPs seeking a patient's admission would contact the on-call admitting doctor but often this doctor then had no idea where the available empty beds were and so lead to the wasting of the GPs' and the hospital doctor's time (NHS Trust Federation 1995; Kendrick 1996). Additionally GPs reported difficulties in contacting the junior doctor on call (Houghton & Hopkins 1996). The Audit Commission (1992) recommended that beds be removed from the traditional system of consultant ownership and that a more efficient organisational approach would be to pool beds with a central management of all beds. The Clinical Standards Advisory Group (CSAG 1995) conducted a study of non-scheduled medical admissions commissioned by the Department of Health. All urgent and emergency admissions over seven consecutive days were reviewed from a stratified random sample representative of 27 health districts (from a potential of 215 health districts) in England, Wales, Scotland, and Northern Ireland (CSAG 1995). From this study it was concluded that:

*Admission wards were generally seen to have the major advantage of concentrating diagnostic and therapeutic activity on new arrivals in one place with higher nurse staffing levels and with appropriate equipment for treatment*

*of seriously or critically ill patients. This allows housemen on admitting teams, particularly those in major specialities, to spend all (or most) of their 'on take' day in one area. It also has advantages for the principal diagnostic services if most of the urgent requests come from and return to a centralised admissions ward (CSAG 1995: 54).*

Therefore, this study supported the usefulness of such initiatives as AMAUs by their ability to concentrate emergency admissions, medical and nursing staff, and equipment in one area. The CSAG (1995) further argues that bed managers, provided that they were given the necessary authority and were available 24 hours a day, would aid efficient beds usage. The Department of Health notes that bed bureau and bed management are linked and are crucial to the effective functioning of AMAUs (Alberti 2003). However, individual AMAUs across the UK were organised dependent upon local needs and circumstances as there were no nationally agreed guidance for the organisation and running of AMAUs (Alberti 2003). The Department of Health, several years after the first AMAUs were established offered a checklist for emergency assessment units, which provided key principles without which an AMAU would be unlikely to be successful. These principles are:

- *Early senior clinical assessment and decision-making*
- *Maintenance of the flow of patients out of the unit*
- *Relatively high level of direct discharge*
- *The process in the EAU must add value to the emergency care of the patient*
- *It must not duplicate processes occurring elsewhere*
- *It must not be used as a holding area for admissions.*

(Alberti 2003: 3)

[EAU or Emergency Assessment Unit is another name for an AMAU] .

However, AMAUs, in whatever form, cannot act as a substitute for a properly designed whole-system (Royal College of Physicians of Edinburgh 1998). Additionally, such new innovations are not a panacea for the problems related to acute medical admissions (NHS Trust Federation 1995). AMAUs will not work as a simple add-on to existing, unchanging systems: there must be commitment to changed working systems to improve the acceptance, or refusal, of medical emergency admissions (Alberti 2003). More recently 'A *guide to emergency medical and surgical admissions* was published by the Department of Health (Alberti *et al.* 2005). This guidance outlines the basic principles of treatment for

emergency care as the assessment of a patient once only, the use of strategies to quickly and accurately find out what is wrong, and the prompt management of patients so as to have the right treatment in the right place the 'first time round' (Alberti *et al.* 2005: 2). Cooke *et al.* (2003) note that there is no evidence to support that an AMAU is better than the A&E in conducting initial assessments, however they contend that an AMAU is able to offer better medical observation and so:

*They may result in benefit because the person is admitted to an area where the usual practice is to observe and then discharge and hence they are not mixed with cases where a longer stay is usual (Cooke et al. 2003:141).*

However this is not a universal experience in all AMAUs. Wood (2000a), a lecturer in nursing, conducted a scoping exercise via a telephone interview survey of nurse managers and clinical nurse specialists on 12 AMAUs, selected purposively from a potential of 22 AMAUs in the West Midlands. The aim of the study was to gain information about AMAU organisation and the types of roles undertaken by nurses on the units. The lack of universality in the terminology lead to problems as each hospital used a different name for their unit. However, Wood (2000a) from this study describes two types of AMAUs.

Firstly there were assessment units where patients were referred by their GP, the A&E department, or sometimes directly by emergency ambulances. Once on the unit patients were triaged (assessed for seriousness of their condition), initial investigations performed and treatment given. Only after this rapid assessment a decision to admit or not was made. If the patient was to be admitted then s/he was moved to a general medical ward. Length of stay on the assessment unit was between 2 to 12 hours and the patient remained on a trolley during this time. The second type was an admission ward, which was similar to assessment units apart from the generally longer length of stay, and that the patient was cared for on a bed not a trolley (Wood 2000a). Many patients stayed on the admission ward for their whole hospital stay unless they were to have a long hospital stay. Staff interviewed indicated that patients and relatives assumed that the patient would be staying in hospital if placed in a bed, whereas the placing of the patient on a trolley did not lead to the same perception. Some units did not have senior

medical staff leadership and nurses in these units reported difficulties in managerial decision-making (Wood 2000a). Wood (2000a) acknowledges the small-scale nature of the study and that findings cannot be generalised to other AMAUs. However Wood's study is useful as it is, from discovered literature, unique in its approach and makes a useful contribution to the very sparse body of empirical literature that considers nursing in an AMAU setting.

Reference in the literature to the disadvantages of AMAUs is limited. Mayled (1998) suggests that nursing staff stress levels maybe heightened due to the high turnover of patients, many of whom are seriously ill, and the high incidence of abusive and violent incidents. Additionally ward nursing staff are potentially at risk of losing their skills when caring for acutely ill emergency admissions, as the acute episode will have been dealt with before the patient reaches the medical ward (Jervis 2000; Wood 2000b). Cooke *et al.* (2003) note that for AMAUs to be effective managerial and clinical systems must be in place together with appropriate staffing and facilities. The general indication however from the literature is that AMAUs are a positive innovation and the limited criticism identified was related to the potential de-skilling of ward nurses and the increased stress for AMAU nurses. Literature related to the needs of the patient in the AMAU setting was not discovered. Foster *et al.* (1996) suggest that patients have benefited from the AMAU system, as there are reductions in diversions to other hospitals, less cancellation of elective surgery as beds have not been taken by emergency medical cases, and that promptness in assessment and treatment 'must also have an impact in clinical outcomes' (p.25). However, no data are provided to support these contentions. In summary, the literature that considers AMAUs is limited and, in general, describes the usefulness of these units and ways to improve the service that they deliver. In the following section the sparse literature that considers the role of the nurse in an AMAU setting is reviewed.

## **2.4 The Role of the Nurse in AMAUs**

Within this category the limited literature that considers the role of the AMAU nurse is reviewed using the five sub-categories of *Triage and admission*; *Preparation for the role*; *Communication with patients*; *Care of the elderly*; and *Patients with mental health related needs*. The discussion is supplemented with literature drawn on from the A&E nursing literature due to the paucity of literature that considers the role of the AMAU nurse. Firstly, the AMAU nurse's role in the triage and admission of patients is discussed.

### **2.4.1 Triage and admission**

Conducting triage, a word developed from the French verb 'trier' meaning to 'assort', is an important component of clinical decision-making in emergency settings to prioritise patients by their medical needs and the risk of death or grave outcomes that they face (Andersson *et al.* 2006). Jervis (2000) provides an account of the organisation of nursing work on an AMAU in North Staffordshire where she is a staff nurse. Patients admitted to this AMAU are described as being triaged by the nurses by an assessment and a prioritising of their needs, and further that:

*The high levels of clinical knowledge enable the AMAU nurse to act as an advocate for the patient, balancing the patient's need for immediate physical interventions with their emotional needs (Jervis 2000: 43).*

Similarly, in Wood's telephone survey of AMAUs in the West Midlands, discussed earlier, the participants described the AMAU nurse's role as 'based around the need to assess patients' immediate needs, prioritise their care and provide immediate treatment' (Wood 2000a: 199). Andersson *et al.* (2006) in a qualitative study of Swedish emergency department nurses' triage decision-making collected data by non-participant observation followed by short interviews ( $n=19$ ) in which the nurses reflected upon their decision-making skills. The nurses' abilities to triage were identified as being affected by the nurses' skills and personal capacity (internal factors) and the work environment (external factors). The numbers of participants provided a small sample size, which the authors note as a limitation. A limitation not considered was the short

period of observation (only ten minutes per nurse) that may have restricted the potential for understanding the practice of these nurses that longer engagement might have provided. Further, longer engagement and utilising participant observation may, by valuing active and reflexive engagement in the field (Mason 2002), have lead to a deeper understanding of this nursing culture. As the authors have espoused a qualitative approach the limitation that the authors identified, that of the potential 'Hawthorne Effect' that their observation conduct may have occasioned, relates more to quantitative concerns for internal and external validity (Bowling 2002) than a qualitative interpretation. Nonetheless, despite these limitations, and that the study was confined to one clinical area, the findings are interesting and may prove to have resonance with the experiences of AMAU nurses. External demands that can interfere with the provision of suitable care reflects a potential area of common interest as the working environment of the AMAU has many commonalities with the A&E setting. Interestingly this study did not discuss the role of the medical staff in the unit studied or how the nurses handed over the patient for medical intervention, or indeed if the doctors would reassess the patients.

Jervis (2000) contends that when nurses and doctors conduct separate patient assessments this is an impediment to efficient care provision and duplicates effort. As the Audit Commission (1995) reported doctors and nurses spend up to 25% of their time collecting information including much repetition of collected data. This has particular implications for patients and relatives in acute setting such as an AMAU as patients are acutely ill and distressed and therefore the repeating of information should be kept to a minimum. More recently Alberti *et al.* (2005: 9), within '*A guide to emergency medical and surgical admissions*', recommend that duplication of data collection and entry is avoided and that integrated records should be provided so that a patient has one form only. Dyer *et al.* (1998) report an audit of an initiative to reduce the time spent collecting patients' information on an AMAU in Oldham NHS Trust. A baseline audit of 15 sets of patients' notes was conducted which established that nurses on the unit spent, on average, 46 minutes per patient assessment. Using a multidisciplinary approach new documentation was developed that was interdisciplinary and made access to all information on one patient easier. It was estimated that the nurses

had saved an average of 26 minutes per assessment as a result of the new documentation. Dyer *et al.* (1998) estimate that in total 60 hours a week had been saved by the new documentation and that the information collected was more meaningful and complete and subsequently improved multidisciplinary communication. Dyer *et al.* (1998:51) suggest that the reduction in duplication of paperwork enabled nurses to 'spend more time working in enhanced roles such as holistic care, and reducing the pressure on junior doctors'. What was this 'holistic care' is unclear other than 'nurses are now free to spend extra time promoting better patient care'. However it was apparent that value was given to taking on more extended roles with this freed up time as the nurses had been 'trained to take blood samples, cannulate, and record electrocardiograms' (Dyer *et al.* 1998:51). There is lack of articulation by Dyer *et al.* (1998) as to what an expansion of the nursing role in an AMAU could permit but rather their account provided an emphasis on the undertaking of more extended roles. There was no strategy to enhance or develop the nursing contribution with this extra time. A similar emphasis was voiced by Foster *et al.* (1996) who describe the organisation of an AMAU in the East Glamorgan hospital in South Wales that was set up in 1994 in response to a 30% increase in acute medical admissions over the preceding two and a half years. The role of the nurse in this account is described as contributing to the patients' initial assessment and notes that the nurses were 'appropriately trained' (Foster *et al.* 1996:24). What this training comprised of is not specified apart from noting that the nurses received extended skills training in venesection and cannulation, which were all medically delegated tasks. As Castledine (2005) has warned the perceived higher status of taking on roles that include medical interventions can cause nurses to neglect nursing interventions. Next, literature is discussed that considers how AMAU nurses have been prepared for their role and the concepts of an extended or an expanded role for the nurse are drawn on.

#### **2.4.2 Preparation for the role**

The past clinical experience of the AMAU nurses surveyed by Wood (2000a) was, in the main, in general medicine or A&E nursing, unfortunately specific information on numbers was not provided in the paper. Many of the nurses with A&E experience had undertaken the English National Board (ENB) 199 (A&E

nursing) course but few had undertaken specialist education related to nursing in AMAUs, such as (ENB) *A95-Nursing of persons in medical assessment units* (Wood 2000a) again no numbers were provided. Further information on this course was sought from the Nursing and Midwifery Council (NMC) but as this course was not one that the NMC set standards for they did not hold any information (Personal correspondence NMC 2/08/04). That there is currently no specific educational course for this nursing role is surprising as the nurses do have particular responsibilities. For instance the nurses in Wood's (2000a) survey acted as a source of information for junior doctors and on some of the units surveyed nursing staff would accept admissions from GPs. Some nurses Wood (2000a) noted had undertaken health assessment courses but in the main any training was provided by the Trust to cover such skills as advanced life support, venepuncture, and recording of electrocardiograms (as was also reported by Foster *et al.* 1996; & Dyer *et al.* 1998).

Wood (2000a) hypothesized that the differing ethos of the A&E nurse and of the general medical ward nurse may lead to different approaches to patient assessment and care. The nurses with the A&E background may have better skills in rapid assessment and decision making whereas the general ward nurses may have been more used to patients being admitted and then staying in their care until discharge (Wood 2000a). This is a lone opinion as other authors suggest that the skills of rapid assessment, treatment and providing rapid transfer are those of the AMAU nurse whatever the clinical background experiences (Foster *et al.* 1996; Jervis 2000). However, the acute and emergency nature of the patients' conditions when admitted requires rapid treatment interventions and these are most often initially acute medical interventions (Alberti *et al.* 2005). Armitage & Flanagan (2001:11) contend that 'a high skill mix is necessary on AMAUs so that the nursing staff can carry out a range of extended roles'. Such extension of the nurse's role would relate to undertaking tasks, such as cannulation, that were the previous province of the junior doctor as these guidelines for emergency admission units issued by the DoH note:

*Nursing: staff interested and preferably experienced in acute medicine should be recruited. There are great opportunities to extend nursing roles, e.g. clerking and requesting of investigations* (Alberti 2003: 5).



However, as Castledine (2005) argues that the move in the UK towards developing the nurse practitioner role so that the nurse can undertake a range of advanced skills has been in reality a way of doctors developing roles for nurses to provide a stopgap for medical staff shortages. Encouragingly in a later guide for emergency admissions Alberti *et al.* (2005) have suggested a more positive role development for nurses. Within this guide the need for specialist nursing teams who, following care pathways, can initiate early treatment and manage tertiary referrals and so demonstrate practice autonomy was emphasised. Additionally, Mayled (1998: 45) when discussing the development of an advanced nurse practitioner role on a medical admissions unit notes:

*Nurses in this role are also involved in the development of nursing as a profession as they share their wealth of experience with colleagues not only in nursing, but also with all other healthcare professionals allied to medicine.*

Mayled (1998) describes an advanced nurse practitioner role that was created initially to assist junior doctors when assessing newly admitted patients. However, Mayled (1998:47) notes that the evolving nature of biomedical expertise requires that the skills of the nurse 'progress alongside medicine, with the quality of care remaining paramount'. Although Mayled (1998) describes an advanced role for the AMAU nurse what the role requirements of the non-advanced practitioner AMAU nurse are not made clear apart from the need to be skilled and efficient and with a dedication to the smooth transition of the patient from admission to discharge. How the unit was organised and the role and function of the nurse within the unit is not detailed in this paper. This development appeared to concentrate on the ability of the advanced practitioner nurse to assist the doctor rather than offering a general AMAU nursing role development:

*The advanced nurse practitioner admits and clerks emergency medical admissions, assesses their individual needs and implements appropriate care. To further enhance quality care, the advanced nurse practitioner is routinely called for advice concerning particular aspects of patient management. Responsibility also includes attending all cardiac arrest calls while on duty, not only to assist with immediate clinical care of the patient, but also to ensure the procedure is run smoothly and to provide support and feedback for nursing and medical staff after the event (Mayled 1998: 46).*

Interestingly, Mayled describes a role that includes admitting and clerking patients that is at more advanced level than that of the A&E nurse practitioner who triages patients or who provides a minor injury service (Sakr *et al.* 2003). Charters *et al.* (2005) surveyed UK consultant nurses in accident and emergency care using semi-structured questionnaires, 44 consultant nurses were approached, and a response rate of 58% ( $n=25$ ) was achieved. Three quarters of the respondents reported that they had no specific preparation for the role of consultant nurse. Charters *et al.* (2005) acknowledge that the low response rate, the use of a self-administered questionnaire, and the lack of a comprehensive list of emergency consultants nurses are limitations to the study. Nonetheless, Charters *et al.* (2005) contend that there is need for a nationally agreed programme of preparation and a consultant emergency nurse competency framework to provide a uniform understanding of the knowledge and skills needed for this role. Likewise Mayled's (1998) description of the advanced nurse practitioner role cannot be compared to other advanced AMAU nurses' roles, as there is no national agreement on such competencies. Literature searching for this review discovered no other literature that discusses such a role, neither for the advanced AMAU nursing practitioner or indeed the ordinary AMAU nurse. Wood (2000a) suggests that nurses working in AMAUs are working in a particular branch of medicine and that AMAU nurses must develop their own professional identity, as have A&E nurses. This will include specialist educational support programmes, research activity, and a broad literature base to support care decisions. As the Royal College of Physicians of Edinburgh (1998:1) have noted:

*The accident and emergency department and the acute admissions departments in medicine and surgery are the shop windows of the hospital and are the points at which critical care, resuscitation, and frequently life-savings measures are taken.*

This quote draws the role and function of the A&E and the AMAU setting as offering similar care provisions. Of course then the roles of the health care workers would, logically, display comparable role expectations and experiences. One such common theme is communicating with patients in a care environment of rapid transfer and is discussed next.

### *2.4.3 Communication with patients*

Rapid patient turnover and assessment is a feature of the AMAUs' care provision (Jervis 2000; Wood 2000a). Jervis (2000) suggests that AMAU nurses require communication and assessment skills on a parallel with A&E staff and the skills necessary to receive patients, and their relatives, who are frightened and possibly confused. Byrne & Heyman (1997) using a grounded theory approach interviewed 21 nurses in two UK A&E departments to explore their perceptions of their work, patient communication needs, and how they dealt with patient anxieties. 'Almost all' (Byrne & Heyman 1997: 97) of the nurses interviewed expressed a marked preference for major trauma work and many had been attracted to A&E work because of this potential for exciting work. Such work provided the nurses with the opportunity to demonstrate their technical abilities whilst valuing the emotional component of the nurse-patient relationship. 'The major trauma patients therefore provided nurses with an opportunity to feel both technically expert and rewardingly useful' (Byrne & Heyman 1997:97). Although such major trauma provided a relatively small percentage of the nurses' work, the far more common 'minor injury' patients were considered far less interesting and were often noted as being boring and repetitive (Byrne & Heyman 1997). These attitudes and the organisational structures of the A&E departments, which placed greater emphasis on potential 'major trauma', impacted on the nurses' priorities and their approach to dealing with patients' anxieties (Byrne & Heyman 1997).

Minor injury patients were perceived as having less anxiety and the nurses restricted the time they spent with these patients. To achieve their aims the nurses described 'just popping' in to these 'minor' patients to deliver essential instrumental care and then leaving quickly to deter the patient from expressing any worries or making any demands on the nurse (Byrne & Heyman 1997). This would seem to support Menzies's (1960) observation that nurses will often block difficult conversations when they feel that they cannot offer solutions to the patient's problem. The nurses' actions demonstrated to the patient that they were obviously busy but that the patient had not been forgotten about. The nurses, although noting that psychological support was important, considered that getting

patients through the department was a more pressing aim (Byrne & Heyman 1997). Despite being a small study conducted in only two departments it nonetheless provides valuable insights into how these A&E nurses perceive their work and the value given to communication with patients. Baille (2005) using reflection on three case studies drawn on from personal experience reported that positive relationships between patients and nurses could be achieved in the A&E setting. Despite short interaction time frames as long as the nurses remain courteous and kind and accompany patient care with pleasantries then the patient will consider that they have had a positive relationship (Baille 2005). Short interaction times and acutely ill patients are factors that both A&E and AMAU nurse experience. Further, research that explores the needs of A&E patients can offer potential insights for AMAU nurses, in particular to understand the caring behaviours that patients seek.

The Caring Behaviour Tool, developed by Cronin & Harrison (1988) and based on Watson's (1985) theory of caring, was adapted by Baldursdottir & Jonsdottir (2002) for use with patients who had received care in an A&E unit in Iceland. A 61-item questionnaire was developed and circulated to 300 emergency department patients with a response rate of 60.7%. The primary caring behaviour that patients sought from the nurses was to 'know what they are doing'. Patients were noted to prioritise the clinical competence of the nurse and Baldursdottir & Jonsdottir (2002) contend that this supports Watson's notion of caring being manifest in actions for and on behalf of patients. Further that such caring actions result in the enrichment and protection of human dignity. This study's findings indicated that patients' responses to care aspects related to emotional and spiritual needs were of less importance to them than were those related to physical care and monitoring (Baldursdottir & Jonsdottir 2002). However, there is a risk that responding to the emotional needs of A&E patients may be neglected and this may be exacerbated by rapid patient turnover (Baillie 2005). Further, there is a risk of stereotyping and objectifying of people's bodies, as rapid identification of the acutely ill is a key responsibility of the A&E nurse (Malone 1996). Whilst there was no research literature discovered that addressed specifically communication in an AMAU setting understandings from the

literature of parallel settings, such as A&E nursing, may offer relevant insights into the role of the AMAU nurse. For instance, Baldursdottir & Jonsdottir (2002) describe elderly patients expressing greater needs for emotional support in the A&E setting than younger patients. Patients aged over 65 years old are the age group admitted most often to AMAUs (Capewell 1996; Kendrick 1996), and logically, would have specific needs when admitted as emergencies. The limited literature that considers this patient group will be discussed next.

#### **2.4.4 Care of the elderly**

Moving patients rapidly through the AMAU was emphasised by Cameron *et al.* (2000) who report on the effectiveness of a nurse led multidisciplinary team on the management of elderly patients with functional problems admitted to an AMAU. Data were collected over the first 16 months of the team's operation and 1065 patients' cases were reviewed, which was 29.9% of all acute admissions aged 65 years old or over admitted to the AMAU. The authors acknowledge that the research only provides descriptive information of the team's interventions. Nonetheless 24% of these frail, elderly patients were discharged home directly from the AMAU whereas previously many would have been admitted due to delays with intermediate care and social work referrals. Cameron *et al.* (2000: 514) conclude that 'a senior nurse with extensive geriatric experience is the individual with the best balance of skills to co-ordinate such a team'. Despite a high proportion of acute medical admissions being elderly people (Houghton & Hopkins 1996; Dorward 1997; Hampton & Gray 1998; Armitage & Davidson 2001) Cameron *et al.*'s (2000) study was only nursing literature identified that discussed the particular needs of elderly patients admitted to AMAUs. This is an area that requires better understanding so that the needs of the elderly can be addressed correctly. For instance, Baldursdottir & Jonsdottir (2002) note from their study of caring behaviours in an emergency room setting, as discussed earlier, the older the person the greater their expressed need for caring behaviours. This may be related, Baldursdottir & Jonsdottir (2002: 73) suggest, to elderly patients feeling generally more vulnerable and so having a greater need for 'attentive assistance'. There are parallels, for example short interactions and sudden acute illness, to the AMAU setting and another patient group admitted to

AMAUs, and who also do not comply with the acute medical profile of a treatable physical disease, are patients with mental health related needs.

#### *2.4.5 Patients with mental health related needs*

Hopkins (2002), a senior lecturer in mental health nursing, used an ethnographic approach to investigate what it means to AMAU nurses to have patients admitted who had self-harmed. Data were collected by participant observation (over one month), semi-structured interviews with four nurses, and the use of a reflexive fieldwork journal. Although the small sample size and lack of detail on time actually spent in participant observation are limitations to this study nevertheless it provides thought provoking findings. Further, it was the only qualitative study discovered that considered the AMAU setting. Hopkins (2002: 151) developed three themes that related to the busy-ness of the unit, how these patients were seen to 'slow down' the busy-ness of the unit, and the behaviours of the patients that self-harm when on the AMAU. These self-harming patients were seen to 'block up' the AMAU by hindering the flow of admissions and transfers through the AMAU, as they could not be discharged until seen by the psychiatric liaison team. The nurses' rules of efficiency were challenged by the patients' 'malignant behaviours' (Hopkins 2002:151) as they had caused the self-harm that required admission, they demonstrated violent behaviour, and were demanding of the nurses' time when they wanted to go outside to smoke as a nurse escort was required. Hopkins (2002) contends that although the AMAU nurses were reluctant to express their ambivalence towards these patients, their behaviour towards them indicated ambivalence, and indeed resentment. Supporting Felicity Stockwell's seminal study of *The Unpopular Patient* which sought understanding of nurses' relationships with patients in which Stockwell (1972:51) noted:

*Frustration and impatience were expressed about patients who grumble, moan or demand attention, also irritation about patients considered to be wasting their time. Psychiatric patients were overtly rejected or ridiculed.*

Findings from Hopkins's (2002) study suggest that support for and suitable attitudes to patients with mental health needs remain an enduring area of concern in general ward areas and emergency departments. Kerrison & Chapman (2007) using a qualitative methodology undertook a focus group with five emergency nurses and semi-structured interviews with subject experts ( $n=12$ ) in an West

Australian teaching hospital. Despite the small sample size the findings echo Hopkins (2002) in that despite developments in nurse education since Stockwell's research the preparation for nursing staff to deal with acute mental health problems in the emergency setting remains poorly addressed. Further that 'emergency staff held stereotyped mindsets and values to mental health often causing barriers to the patient's treatment' (Kerrison & Chapman 2007: 54). Hopkins's (2002) and Kerrison & Chapman's (2007) findings are supported by Mackay & Barrowclough's (2005) study that used four hypothetical scenarios, which described patients, admitted to an A & E department following deliberate self-harm. Participants were A&E medical and nursing staff ( $n=89$ ) from four A&E departments in Manchester, England. Participants expressed higher levels of irritation and less helpfulness towards those hypothetical patients who were seen to be potentially more in control of their situations. Mackay & Barrowclough (2005) call for detailed research into this area whilst Hopkins (2002) suggests a need for participatory research methods to help gain an understanding and development of care provision. Kerrison & Chapman (2007) describe an educational programme developed from their findings to address the learning need identified, this is positive use of research findings that adds to their study's claims for relevance. Hopkins (2002) contends that AMAU nurses must learn more about mental health problems and so gain confidence in dealing with patients with mental health problems and this work could also contribute to curriculum development.

Another area of related interest is dealing with aggressive patients. Jervis (2000) reports that AMAU nurses require similar skills to A&E nurses when dealing with violent and aggressive patients and factors such as lengthy waiting times, lack of personal space, and pathological aggression are features of both A&E and AMAU settings. Wells & Bowers (2002) following a systematic review of literature related to the prevalence of violence towards nurses working in general hospitals noted that 9.5% of nurses working in general hospitals are assaulted in any one-year and surprisingly most incidents occur in areas other than A&E departments. They call for better training, research and importantly the need to report all such incidences. Jervis (2000) notes that on the AMAU that she

describes the nurses attended a course on managing aggressive patients, including the use of physical restraint. Patient aggression has been reported as a main stressor for A&E staff following an investigation to measure if the characteristics of fatigue were significantly correlated to symptoms associated with burnout in A&E nurses (Walsh *et al.* 1998). A questionnaire developed using the Maslach Burnout Inventory (MBI) was distributed to a convenience sample of A&E nurses attending an RCN A&E Association Annual conference. 200 questionnaires were circulated with a response rate of 67% ( $n=134$ ). The Depersonalisation subscale of these nurses was reported at a mean of 12.05, (the MBI rates moderate depersonalisation at 7-12 and high depersonalisation at 13+). As Walsh *et al.* (1998) note this high level of depersonalisation was evidenced in a group of A&E nurses who were sufficiently interested in their work to attend a conference and to belong to a RCN interest group so the results that would be recorded in other A&E nurses is a concerning issue. From their findings Walsh *et al.* (1998) report that patient aggression contributed to high levels of stress in the work of the nurses studied compounded by short patient interaction times and a dominant medical model of care. In summary the literature indicates that dealing with mental illness and violence in the emergency setting is an area that requires further research and importantly improved educational preparation and support for nurses who work in these areas. In the following section a summary of the literature review is provided together with justification for the framing of the study's research questions.

## **2.5 Summary**

This literature review has provided an overview of definitions and theoretical perspectives that seek to articulate the role of the nurse. From the advent of nursing models and the nursing process to *New Nursing* and the more recent emphasis given to the concept of care understandings of the role of the nurse are tied enduringly with nursing's professionalising agenda. Nonetheless understanding the nurse's role in terms of 'formalised caring' (Clifford 1995: 40) rather than idealist wishful thinking when confronted with the realities of societal and organisational constraints have been highlighted by some authors, for instance Porter & Ryan (1996). This review also noted that the future for the role



of the nurse is linked increasingly to policy developments that would seek to extend the nurse's role to take on the delegated work of medical staff. Likewise, the limited literature that considered AMAU organisation seldom noted a role for the nurse apart from undertaking repetitive and low skill medical tasks. The sparse literature discovered that did consider the role of the AMAU nurse offered limited research-based understanding of the role. Rather anecdotal accounts of the role or discussions of the role of the nurse in terms of aiding the doctor by taking on extended roles were predominant. Nor was any literature discovered that provided insights into patients' perspectives of AMAU care provision or experiences of being nursed on an AMAU. This literature review has demonstrated that despite central and devolved policy rhetoric and support for the development of AMAUs they are under researched and poorly evaluated. And in particular the role of the AMAU nurse has not been specified or defined and the nursing culture within that setting has not been investigated. The predominate approach to understanding the nursing role in an AMAU setting is that of anecdotal accounts, with Hoskins's (2002) ethnography being the only qualitative study discovered.

Ethnographies that explored the role of the nurse and the culture of nursing have been reviewed within this chapter for instance, understanding of the theory-practice gap and use of nursing process documentation on a general medical ward (Porter & Ryan 1996), nursing assessment and care of elderly patients admitted to a Scottish teaching hospital (Latimer 2000), the nurse's role in the hospital's division of labour (Allen 2001), understanding skilled nursing practice (Buller & Butterworth 2001), nurses' attitudes to patients admitted to AMAUs who had self-harmed (Hopkins 2002), and nurses' clinical decision-making in a critical care setting (Coombes & Ersser 2004). Therefore to achieve the research aim of seeking to describe and explain the role of the AMAU nurse ethnography was considered to be an appropriate research approach. Ethnography provided a research methodology that was suitable to explore the culture of AMAU nursing and so to offer a starting point to understand this nursing role. The following chapter discusses the methodological approach of the study.

## CHAPTER THREE

### METHODOLOGY

#### 3.1 Introduction

This chapter discusses the rationale for adopting the qualitative research approach of ethnography to explain and describe the role of the AMAU nurse. An account of the methods used and the conduct of the study to achieve the research aim are provided. My role as the sole researcher is detailed together with considerations of access to the research field and the ethical considerations that the study raised are reported and discussed. In addition issues of rigour, including the reflexive approach adopted are examined. Firstly, the aim of the study and the research questions asked are provided.

##### 3.1.1 *The research aim and questions*

The aim of this study was to describe and explain the role of the AMAU nurse. To recapitulate from Chapter one the research questions posed were:

- What are the perceptions of AMAU nurses as to their role?
- What are the knowledge, skills, and attitudes that are needed to work effectively as an AMAU nurse? Further, how are these abilities developed and what preparation do AMAU nurses have for this role?
- What are the perceptions of patients as to the role of the AMAU nurse?
- What are the perceptions of medical staff as to the role of the AMAU nurse?

During participant observation it became evident that paramedics affected the role of the nurse as the nurse would receive patients for admission from paramedics. Paramedics could potentially, it was decided, offer useful insights into the role of the AMAU nurse so an extra research question was framed:

- What are the perceptions of paramedics as to the role of the AMAU nurse?

Further objectives of this study were to commence the sharing of good practice and the potential for improvements in patient care by detailing nursing practice in an AMAU setting. By developing this understanding to help inform nursing

educational and managerial programmes and to contribute to a research based body of knowledge into the nurse's role within the AMAU clinical setting and to stimulate further research outputs related to this area.

As demonstrated by the literature reviewed in Chapter two little is known about the role of the AMAU nurse this study required an exploratory approach (Hammersley & Atkinson 1995). An understanding of relationships, as well as the social processes involved in the construction of the role of the AMAU nurse was required. The theoretical paradigm selected was of qualitative interpretation that constructs understanding from multiple data collection sources to answer research questions (Denzin & Lincoln 1998). Interpretations, meanings, and understandings were to be gained from those who inhabit the field and were then the study's primary data source (Mason 2002). I sought the perceptions of participants as to their constructions of meaning: an insider or emic understanding rather than imposing my outsider view (Blaikie 2000). The research strategy that was considered most suitable to answer the research questions, and that also satisfied the ontological and epistemological perspectives on the nature of social reality held by the researcher, was that of a qualitative ethnographic approach (Mason 2002).

The AMAU was a development in care delivery that had not been researched from a qualitative perspective. There was no ready-made theoretical framework to develop hypotheses regarding the role of the AMAU nurse so the field was entered with an inquiring perspective seeking to understand the organisation of the AMAU and the role of the nurse within it. As Malinowski (1992: 9), a founding father of ethnography, commented:

*Preconceived ideas are pernicious in any scientific work, but foreshadowed problems are the main endowment of a scientific thinker, and these problems are first revealed to the observer by his theoretical studies.*

The foreshadowed problems that I commenced the research with were turned into a set of questions and developed further in the early stages of data collection (Hammersley & Atkinson 1995). I concur that there is a potential danger that if one commences data collection with a fixed and predetermined theoretical framework the mind of the researcher could then be closed to other emerging

insights (Hammersley & Atkinson 1995). Eisenhardt's (1989) suggestion that an initial definition of the research questions is required, even in very broad terms, to prevent becoming overwhelmed by the volume of data was accepted. The initial questions posed for this research gave focus to identification of the field to be studied and to data collection and subsequent analysis. The way that these questions were answered is addressed in the following section in which justification for the methodological approach taken and detail of the conduct of the research is discussed.

### **3.2 A Qualitative Approach**

The aim of this study was to describe and explain of the role of the AMAU nurse from the nurses' own perceptions and from others who interacted with the nurses, and this then included my own perceptions. The research questions were stimulated by an interest in acute medical admissions units and wanting to know more about the role of the nurse in such a unit. An understanding of the workings of complex social situations and relationships and subsequent social processes was sought (Denscombe 1998; Blaikie 2000) thus a qualitative approach was considered to be most suitable to achieve the research aim. Additionally as Silverman (2001) notes qualitative approaches are particularly suitable when we seek to understand a social situation about which we have limited understanding, as was the case in this study.

My ontological stance is within the qualitative research paradigm and with a perspective that considers that a researcher cannot hope to discover the reality that a positivist research approach would seek, rather I concur that individuals will offer multiple social constructions (Denscombe 1998). I agree that reality has a plurality that cannot be reduced or captured by grand or totalising theories and that this ethnography can only offer a partial representation of reality (Cheek 2000). I sought to learn about particular constructions of realities of AMAU nursing from research participants who are partners in the study. I am in agreement with Aull Davies (1999) when she argues that impartial impressions from the researcher are an illogical aim. Whilst, quantitative research approaches to knowledge generation have lead to improvements in health care nonetheless there are criticisms of the appropriateness of such designs to study the human

condition (Stoecker 1991). Seeking to find the truth that is accessible in a constant and measurable form has its origins in the philosophy of the Enlightenment (Rolfe *et al.* 2001; Burkitt *et al.* 2001). This modern world, a world of science and rationality, having once gained dominance and power, caused the relegation of interpretative, intuitive understanding to secondary importance (Cheek 2000). Weinberg (2002: 13) whilst arguing for a sociological understanding of scientific research methods notes:

*Qualitative social science is overwhelmingly predicated on the presumption that meaning and human practice merit scientific interest as genuine and significant phenomena in their own right.*

Qualitative research seeks naturalistic perspectives and the interpretative understanding of human experience (Denzin & Lincoln 2003) whilst acknowledging anti-realist challenges to assumptions that social phenomena can be presented in a literal fashion (Hammersley & Atkinson 1995). Qualitative researchers seek rich description of the social world and the emic understanding that can develop. Such understanding requires an emergent research design and the researcher's role as a *bricoleur*, or a maker of quilts, who draws on varied and creative strategies to seek understanding (Denzin & Lincoln 2003). Thus data collection methods in qualitative research are varied and can include observation, interviews, texts and documents, but can also include dance and poetry (Silverman 2001). The interpretative process to understand the practice of AMAU nursing thus sought understanding using the language of the participants and cultural artefacts of the culture rather than imposing concepts on the data (Blakie 2000). Guided by Hammersley & Atkinson (1995) I concur that the researcher plays a key role in qualitative data collection and that social researchers are a part of the social world that they study.

Other qualitative approaches were reviewed prior to commencing the study, in particular the use of grounded theory and the use of a phenomenological approach. Grounded theory seeks to identify basic social processes and develop explanatory models of human behaviour grounded in the context in which they occur: the explicit goal of grounded theory is to develop theory in the form of a core concept that is developed and its emergence detailed with its attendant theory (Glaser & Strauss 1967). This research approach was developed to

counter criticisms of qualitative research as demonstrating a lack of rigour (Glaser & Strauss 1967) and contains many elements that are common to qualitative research such as seeking to collect data in a natural setting and the use of a constant comparative approach to data analysis (Morse & Field 1996; Silverman 2001; Mason 2002). However the grounded theory approach requires a prescribed and structured method of data collection and analysis with the goal of the research being generation of an inductively derived theory (Bowling 2002), which was not the objective of this study. Further, as Johnson & Webb (1995b: 83) have cautioned the 'inflexible use of grounded theory concepts and excessive diagramming of relations between concepts can be as reductive as those survey methods which grounded theory was meant to supplant'. Nonetheless, within this study an adductive research approach was utilised that has similarities with grounded theory methodology, where 'theory, data generation, and data analysis are developed simultaneously in a dialectical progress' (Mason 2002: 180).

Another research approach used commonly by nurses is that of phenomenology (Dowling 2004). A research approach, and also a philosophy, that focuses on the lived experience, a perception of the individual's being in the world as a mode of inquiry that seeks to derive the essence of an experience (van Manen 1990). As this approach centres on seeking understanding of the meaning the essences of a particular human experience, it would not provide a research approach to answer the study's aim of seeking a cultural understanding of the role of the AMAU nurse. I accepted LeCompte & Schensul's (1999:21) description of culture as consisting of 'beliefs, behaviours, norms, attitudes, social arrangements, and forms of expression that form describable patterns in the lives of members of a community or institution'. Collective meanings were sought in this study that could only be accessed by prolonged engagement in the field (Mason 2002). Blaikie (2000) notes that the collection of data from a qualitative perspective will always seek to view the world from the viewpoints of the people studied, the discovering of their socially constructed reality and the meanings that they ascribe to their activities. Geertz (1993), developing Max Weber's notion of man as an animal suspended in webs of significance he himself has spun, describes

these webs as culture, and the analysis of these webs is an interpretative one that seeks meaning. Geertz (1993:20) contends that:

*Cultural analysis is, or should be, guessing at meaning, assessing the guesses, and drawing explanatory conclusions from the better guesses, not discovering the Continent of Meaning and mapping out its bodiless landscape.*

So social events, behaviours, institutions, or processes are part of the context of culture and interpretation can only be achieved by producing detailed description of the social setting (Blaikie 2000). After consideration of alternative approaches an ethnographic approach was considered to be appropriate for gaining an interpretative and emic understanding of the role of the AMAU nurse.

### **3.2.1 Ethnography**

Ethnography is both the research method and the written account of the culture investigated and has as its goal a desire to understand the cultural perspective of the group: a description of behaviours and offered insights into why the behaviour took place (Morse & Field 1996; Denscombe 1998; Brewer 2000). Blaikie (2000) contends that qualitative researchers view the social world as a process and not as a static event therefore the areas of interest are social processes rather than individual characteristics and the relationships between abstract concepts. Ethnography seeks insights into human phenomenon or human culture (Brink & Edgecombe 2003) and was considered a suitable approach to achieve the aim of this study. I drew on Hammersley & Atkinson's (1995:1) definition of ethnography as:

*...a particular method or set of methods. In its most characteristic form it involves the ethnographer participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions –in fact, collecting whatever data are available to throw light on the issues that are the focus of the research.*

Williams (1995) suggests that ethnography explores how people interpret their experiences of the world and is both a method of data collection and a theoretical or philosophical framework. However, Savage (2000) contends that there is a lack of a supporting epistemology underpinning ethnography and that there are different ideas regarding what is legitimate knowledge to develop the methodology. Savage (2000) concludes that there is a lack of a definitive

definition of ethnography but it is both a process and an outcome. Ethnography's strength is the role that the researcher plays in identifying cultural and social behaviours through participant observation and then questioning the meaning of the behaviour through interview: a detailed way of witnessing human events in the natural context in which they occurred (Hammersley & Atkinson 1995). Savage (2000) recommends ethnography when access is required to beliefs and practices in context. Such an approach is valuable therefore, in the modern NHS that considers the views and opinions of patients as central to policy development, for instance *A Statement of Healthcare Standards -Standards for NHS Care and Treatment in Wales* (Welsh Assembly Government (WAG) 2004) give emphasis to the inclusion of patients' wishes in care delivery policy.

Early ethnographical studies, as demonstrated in the work of Malinowski (1992), sought to understand unique and disappearing cultures by living with and experiencing the social life of the participants. From such studies explanations, classifications of rituals, and rich descriptions of the day-to-day social life of cultures were provided. Malinowski (1992:xvi), who commenced '*Argonauts of the Western Pacific*' in 1914, recognised that although at that time there were 'still a large number of native communities available for scientific study, within a generation or two, they or their cultures will have practically disappeared'. However, early ethnographers such as Malinowski adhered to the dominant modern positivist paradigm of the time and sought objectivity by studying 'other' cultures that were different from their own (Brewer 2000). Despite critiques of such early research as demonstrating a colonial and Christian centric worldview (Tedlock 2003) such pioneering work can help the researcher of today to understand the essence of ethnography and so guide the research process. For instance, Malinowski (1992: xvi) argued that:

*One of the first conditions of acceptable ethnographic work certainly is that it should deal with the totality of all social, cultural and psychological aspects of the community, for they are so interwoven that not one can be understood without taking into consideration all the others.*

Ethnography in the pre and post World War Two period, with the leadership of the Chicago School of Sociology, was influenced by symbolic interactionist and post-structural thinking (Brewer 2000). These scholars became more interested in



the ethnographies of cultures that were not distant geographically but 'exotic' in that the culture studied was completely novel to the researcher and often involved the study of 'deviant' cultures (Hammersley & Atkinson 1995). For example in Whyte's (1981) study of American-Italian street gangs '*Street Corner Society*' only by the use of a 'key informant', known as 'Doc', was Whyte able to gain access to the group without risking placing himself at risk. Therefore, the traditional aim of the early and immediate pre-and post World War Two ethnographers was to study cultures in socially exotic locations different from their own and to report upon their findings in an objective manner with data drawn from extended time spent in the field (Denzin & Lincoln 1998). However, these sociological scholars, for instance Becker *et al.*'s (1961) ethnography of medical students, were influenced strongly by symbolic interactionism and so developed the ethnographic approach to the study of more local and 'non-deviant' cultures. Ethnography is then a detailed way of witnessing human events in the context in which they occur that can investigate and solve problems that are not accessible to quantitative methods (Brewer 2000). However, the development of human rights in research studies following the atrocities of human experimentation as conducted by the Nazi regime during World War Two, has resulted in increased ethical questioning of research conduct (World Medical Association 2004).

Each modern generation of ethnographers has looked back upon earlier ethnographers and criticised them for their ethical approaches (Hammersley & Atkinson 1995). Frequently critiques of lack of informed consent and invasion of privacy are encountered with individuals being used to satisfy the researcher's end with little or no advantage in the enterprise for the 'subjects' (Brewer 2000). Studies have also utilised covert participant observation and have sought to justify this deception by claims that there were no other way because of restrictions on access or fear of reprisals. A controversial study was that of Humphreys' research '*Tearoom Trade* (Humphreys 1970). Humphreys used covert observation to collect data on men who were using public toilets for homosexual encounters and then approached these men at their homes to collect social data under a different guise. This research has been criticised by Humphreys' fellow academics for the invasion of privacy of the individuals

studied and the potential for those men studied to suffer harm (Aull Davies 1999; Brewer 2000). Extreme evidence of harm by misuse of ethnographic data was the use of French ethnographic studies that had been conducted in Vietnam that US military intelligence used to aid in the selection of bombing targets during the Vietnam War (Aull-Davies 1999). However, social scientists have argued that covert strategies may be the only way to present research that does not merely offer ‘a reproduction of the images that an elite groups may wish to present’ (Hoeyer *et al.* 2005: 1744).

Traditional modernist approaches to ethnography have also been challenged by critical ethnographies that draw on critical theory perspectives such as Marxism or feminism (Porter 1998). Critical ethnographers seek to provide individuals with the insights to identify sources of domination and repression (Porter 1998). Another influence on ethnography that develops critical theory has been post-modern thought that challenges reality and recognises ‘multiple voices, views and representations challenge the idea of a rational and unified subject that is at the core of modernists tenets’ (Cheek 2000:19). As introduced in Chapter one and will be developed later in this chapter I found congruence with Hammersley’s (1992:5) concept of ‘subtle realism’. Subtle realism is positioned between naive realism, a modern approach that claims that a truth has been found by objective methods, and critical realism, which claims that consideration of multiple and fractured narratives negate against claims for the discovery of a one and incontestable truth.

Hammersley & Atkinson (1995) argue that ethnography will always focus on understanding the perspectives of those studied, and that observation will take place in the participants’ every day life. Ethnography’s strength is the role that the researcher plays in identifying cultural and social behaviours through participant observation and then questioning the meaning of the behaviour through interviews: participant observation being the ‘signature of ethnography’ (Brink & Edgecombe 2003: 1028). However, some writers have viewed ethnography and participant observation as being the same, for instance Taxis & Barber (2003) conducted covert non-participant observation of nurses giving intravenous injections. However, whilst their findings gave a classification of

drug errors their approach gave no contextual information on the clinical setting or its culture and the potential influence that this would have on drug errors. So whilst being a useful study in a limited manner, notwithstanding the ethically problematic use of covert observation, it cannot be classified correctly as ethnography. Claiming to use an ethnographic approach without the use of participant observation is increasingly evident, for instance Ersser's (1997) ethnography sought understanding of nursing as a therapeutic enterprise with data collection obtained solely from interviewing. Such an approach negates against the contextual understanding that the use of participant observation would provide. However, it is increasingly acceptable for interpretative ethnographies to be conducted without using participant observation. In such studies the primary data source are people and their interpretations are gained through narratives obtained by strategies such as interviewing (Blaikie 2000). I however, concur with Brink & Edgecombe (2003: 1028-1029) who note:

*As any nurse can tell any researcher, spending time on a hospital ward observing what nurses do 24-7 and asking about what is being observed, while it is being observed, is a far more valid way to discover what nurses do than to create a focus group of nurses, or interview three of them, and ask them what they do when they are working...a culturally distinct population does not, in itself, make the research an ethnography.*

The ethnographic approach utilised for this study established involvement with the field under study for as Aamodt (1982) notes ethnography develops concepts for understanding human behaviour with the researcher an active participant in both data collection and analysis. Ethnography has been the research approach used in studies reviewed for this study into the role of the nurse within different settings such as Savage's (1995) ethnography of two medical wards using different nursing organisational systems, Allen's (2001) ethnography of the role of the nurse in the hospital division of labour, and Latimer's (2000) ethnography of the admission of older people to medical wards as were reviewed in Chapter two. In summary ethnography is increasingly being used in disciplines such as nursing and is a research strategy that is evolving and adapting. No longer does the ethnographer spend several years in the field collecting data as did the early anthropologists but more focussed ethnographies based on a single community or ward area are offered. Ethnography has been affected by changes in approaches to knowledge generation and the nature of knowledge from modern scientific-

rational thinking to post-modern thinking. Thus ontological and epistemological positions will influence the conduct of ethnographies (Cheek 2000). However, the value of ethnography is its underpinning and fundamental goal to understand a culture. This understanding is obtained by the study of people's behaviour in every day or natural small-scale settings, using data collection methods that are varied and flexible, and with analysis that seeks interpretative understanding of human actions and contexts (Hammersley & Atkinson 1995). Limitations and criticisms of the use of an ethnographic approach include a lack of scientific-objectivity, political problems (both of access and power differentials), and role conflict and the negotiation of role during field work (Johnson 1997). Arguments that counter the claim of a lack of scientific-rationality were presented within this chapter already. The other issues I will address during my discussion of the process of data collection and analysis detailed in the following section. Nonetheless, underpinning the study is my assertion that what is presented can only be considered as a construction of events. I acknowledge that my 'self' will have particular perceptions based on such considerations as my history, race, gender, and class (Aull Davies 1999) and additionally I can only offer the constructions of reality as presented to me by participants. Notwithstanding these caveats ethnography was a suitable methodology to gain an interpretative and emic understanding of the role of the AMAU nurse. The conduct of the research will be discussed next.

### **3.3 Location and Access**

The AMAU that provided the field of study is a 14-bedded unit in a district general hospital (DGH) in a rural Welsh town. Criteria for the selection of this AMAU included its geographical proximity; the Trust's familiarity to myself having worked there several years previously as a ward sister on a medical ward (so I had knowledge of the previous organisation of acute medical admissions in that hospital); existing collegial relationships as I was the higher education link lecturer for the unit; and the positive and encouraging attitudes to research held by senior nurses within the Trust. Hammersley & Atkinson (1995) have noted that often availability and accessibility will influence the selection of research fields. Further, as Stake (1994) contends accessibility and convenience enable prolonged periods of engagement in the field. The central selection criterion for

qualitative research should be where most learning can occur, and that whilst 'balance and variety are important, opportunity to learn is more important' (Stake 1994: 244).

However, such pragmatic considerations were not the sole criteria for selection. This AMAU also provided a unit that had been in existence for seven years at the commencement of the research and so had developed ways of working established over time. In appendix 2 the data on assessment units and admission units in Wales held by the Welsh Assembly Government (WAG) at February 2002 are summarised and, as Wood (2000a) has also noted, comparing like with like was impaired by different titles for the units and dissimilar organisational structures. In Wales at the commencement of the research, using this WAG data, there were nineteen sites (hospitals) accepting emergency admissions and fifteen had some form of admission unit that was not solely an accident and emergency unit. However, in 2002 in the five Welsh DGHs that I was familiar with there were no AMAUs, defined as a distinct clinical setting that accepted only acute medical admissions and aimed to transfer patients rapidly, despite these three hospitals being recorded on the WAG list as having an AMAU. By 2005 all five hospitals had AMAUs however at the time of the study there were limited numbers of AMAUs in existence in Wales.

The AMAU is located in a DGH that is representative of a typical hospital found in Wales as it is sited in a town but serving a predominantly rural catchment area. It also has a 'likely typicality' (Hammersley 1992: 93) in that it is a medium sized DGH with critical care units but no tertiary role. This aspect will be discussed later in this chapter as there are particular ethical considerations related to privacy when one unit is being studied (McKane & Tolson 2000). The AMAU selected provided 'a named setting in which phenomena occur that might be studied from a number of angles' (Hammersley & Atkinson 1995:41). The phenomenon that this research sought understanding of was the role of the AMAU nurse. The AMAU existed before and will continue to exist after the research has been completed and had not been created for the study. It is a naturally occurring phenomenon and so was studied in its natural setting with no attempt to influence individuals or social processes (Brewer 2000). The selection

of the site was therefore in part opportunistic but also purposive, or judgemental (Hammersley & Atkinson 1995) as the AMAU selected offered an established team of AMAU nurses in a setting that was accessible in a DGH that may be viewed as 'typical' in a Welsh context. Next I will discuss my journey to obtain the required authorisation from Trust managers and the Local Research Ethics Committee (LREC) to conduct this study in an NHS setting.

### *3.3.1 Obtaining permission from Trust managers*

Initially permission of local gatekeepers in the Trust was sought before the LREC was approached formally. The LREC required a letter from Trust managers confirming that they agreed in principle to patients and staff being approached for this research. The senior nurse in the Trust, the senior nurse of the medical directorate, the medical director of the unit, and the ward sister were all approached directly and by letter that included the research proposal. Ward meetings to explain the purpose of the study and the research approach were arranged following this correspondence. The chair of the Trust's R&D committee was also informed of the proposed research (this was in 2000 at the start of the research and before research governance gave Trust R&D committees a major role in vetting research carried out in NHS Trusts in Wales). All approached were helpful, accessible, and no barriers were presented. The conditions to be satisfied were that firstly, formal ethical approval was obtained and secondly, that participants were fully informed and aware that involvement was voluntary. Once this qualified agreement was in place the next stage was to approach the LREC.

### *3.3.2 Gaining Approval from the Local Research Ethics Committee (LREC)*

As NHS premises were to be accessed and human participants used I was required to present a research proposal for approval to the LREC (RCN 2004b). The proposal was approved and permission was given to begin data collection commencing with participant observation and collection of documentary evidence and to progress to formal semi-structured interviews. The research approach was an emergent design that sought refinement of research questions to aid the development of analysis: this analysis would expand in parallel with the continuing process of identifying and defining the issues to be studied

(Hammersley & Atkinson 1995). Therefore, the questions to be asked in the semi-structured interviews had not been developed when the proposal was presented to the committee however a key concern of the LREC was to review the patient interview schedule. Consequently there was one stipulation to ethical approval; this was that I return for second phase permission once the patients' interview schedule had been developed. These requirements were complied with but in the intervening time the LREC adapted their guidance to applicants to ensure that research proposals reflected the direction given in research governance publications (Department of Health (DoH) 2001; Wales Office of Research and Development for Health and Social Care (NAW 2001d). When I returned to the LREC with the patient interview schedules and intended approach to use with patients two extra issues arose, the use of the Welsh language and the *Data Protection Act 1998*.

Firstly, to conform to the requirements of the *Welsh Language Act 1993* potential research participants had to be offered the choice of information in English or Welsh. To concur with these requirements all information sheets and consent forms for participants were to be translated into Welsh so that this language choice could be offered. (Appendices 6-11 provide give examples of translated initial patient approach letters, information sheets, and translated consent forms, and appendices 12 & 13 provide examples of the bilingual approach used for health professionals.) My ability to use the Welsh language was too restricted to conduct an interview or to type or understand an interview transcript in Welsh. After considering various options in this rather uncharted water, and after consultation with my supervisors and advice from colleagues and the LREC's chair, I made it clear in the information to participants that I would not be able to conduct an interview through the medium of Welsh. Neither could I offer another interviewer to conduct, transcribe, or translate an interview in Welsh due to my intention to conduct all of the data collection and transcription myself. To have another's involvement would have changed the perspective of the research process that I sought to follow. However, in Wales there are people, mainly children under school age and some elderly people, who are monolingual Welsh speakers and consequently if research conducted in Wales does not provide provision for Welsh speakers to contribute then their voices will not be heard.

There are also many Welsh speakers who although can speak English wish to conduct their life through the medium of Welsh. The *Welsh Language Act 1993* and *The Welsh Language Scheme 1996* provide legislation that gives equal legal status to the Welsh and the English language. So whilst acknowledging the value of the requirement it caused me a delay of two months to satisfy this condition. In the event no one insisted on being interviewed in Welsh although one patient and one doctor wished to sign the Welsh language consent form. However, my rather limited ability to speak Welsh proved useful during data collection and analysis as will be developed later in the study.

The second issue that required resolution was the requirement by the LREC to adhere to the provisions of the *Data Protection Act 1998*. The *Data Protection Act 1998* provides legislation that protects an individual's right to privacy of any personal and sensitive data. Each Trust is required to appoint a 'Caldicott Guardian' who is responsible for the privacy of patient information in the Trust (NHS Executive 1999). It must be noted that this stage of the research occurred at an early phase in the understanding of research governance and the implications of the Act so there were no established systems in place for the researcher to follow. The nominated Caldicott Guardian in the Trust was a medical consultant with day-to-day issues being dealt with by the Trust's information technology (IT) team. A copy of the research proposal and the patient interview schedule were submitted and I was asked to meet with the senior IT officer. The *Data Protection Act 1998* considers the fact that a person is in hospital to be a matter of personal privacy. Therefore, as I was not providing care I had no right to know that individuals were in-patients, far less to have any right to approach these patients directly to ask if they would be interviewed. The compromise agreed was that a ward nurse would identify patients who had been on the AMAU and act as an intermediary by asking these patients if they would consent to being approached by myself. This issue is developed further when discussing participant recruitment later in this chapter. Gaining access was extremely time consuming and this was despite cooperation and helpfulness at every stage of the study. As I sought access to multiple data sources the sampling approach was a complex undertaking and an account of this is detailed next.



### 3.4 Sampling Strategy

The study was conducted in a single setting with the AMAU conceptualised as an open system whose boundaries shift by redefinition and negotiation constituted 'through cultural definition and social strategies' (Hammersley & Atkinson 1995: 41). Further acknowledging that influences from outside the physical boundaries of the unit affected the running of the unit and the work of the nurses. Only one AMAU was selected for study but as sampling strategies were not needed to offer generalisation but to gain an in-depth understanding (Brewer 2000), one unit was considered appropriate.

Sampling was not seen to be about numbers but rather about the quality of information obtained, as too much data would not allow for the deep analysis that a qualitative study required but too little would not provide enough information (Sandelowski 1995). The sampling approach utilised was purposive in that the field site and the cases sought were selected by their ability to give information to inform the research questions and to illustrate the features and processes of interest (Hammersley & Atkinson 1995; Silverman 2001). Purposive sampling seeks out data on events, incidents and experiences but not individuals *per se*; data were required that could give information about the particular phenomenon under study (Sandelowski 1996) which in this case was the role of the AMAU nurse. Sampling of those who populated the field, sampling of the time frame spent there, and sampling of the events, documents, and artefacts found in the field (Brewer 2000) was the sampling approach used. Firstly, data sampling during participant observation is discussed.

#### 3.4.1 *Sampling during participant observation*

Participant observation took place part-time over eighteen months from January 2001-July 2002. Guided by Brewer (2000) I sought time and events sampling to aid my understanding as well as participant sampling. AMAU care was provided twenty-four hours a day and the unit opened every day of the year. Therefore I conducted participant observation at various times of the day, of the week, and of the year. For instance, a key thrice-daily event on the AMAU was the intershift report or handover so I ensured that I witnessed handovers between all shifts, including night duty. Data was gained that reflected the effects of potential

fluctuations in numbers of admissions and therefore the workload for the nurses and other staff throughout the year

I noted in my field notes initially all events witnessed and endeavoured to record the mundane as well as the interesting (Becker *et al.* 1961) but as data collection progressed I utilised a more purposive approach as I sought development of particular insights. I utilised a participant observation role and this issue will be expanded later in the chapter. Participants who were observed during participant observation were those who were considered to be important to the purposes of the study from those who populated the field. During participant observation informal discussions with nurses, patients, relatives, doctors, paramedics and other health care workers that expanded my understanding also took place. Once the emerging topics of interest became clearer I then sought participants to be interviewed as will be discussed next.

### ***3.4.2 Participants selected for semi-structured interviews***

The sampling strategy for interview participants was purposive (Coyne 1997; Holloway & Fulbrook 2001) and guided by the analysis of data collected during participant observation. The research began with foreshadowed problems that were substantive, empirical, and had an exploratory orientation (Hammersley & Atkinson 1995) and as the study progressed issues of particular interest and relevance were identified and addressed with more precision. Participants were sought who would offer personal understanding of the AMAU and the role of the nurse. The participants were nurses working on the AMAU, together with doctors and paramedics who interacted with the AMAU nurses, and ex-patients of the AMAU. All were selected using judgement as to their ability to inform and share insights regarding the role of the AMAU nurse. The inclusion criteria utilised are discussed next.

#### **3.4.2.1 Inclusion criteria**

Nurses who were working, or had worked on the unit for more than six months were included as it was judged that they would have had sufficient time in which to understand their role. All of the unit's nurses had been interviewed informally during participant observation and all had indicated their willingness to be

interviewed formally. The nursing (registered nurse) establishment on the unit was 18.71 Whole Time Equivalents (WTE) with grades from G to D on the unit (as detailed in Table 2 on page 18). In order to gain differing perspectives nurses of varying seniority and with a variety of educational and clinical backgrounds were included. Therefore, whilst not seeking sample randomisation formally there was a form of pragmatic sampling coupled with simple randomisation based on availability. Those nurses interviewed were selected in part due to their, and my availability and this may then also enhance claims for non-bias in my selection. All of the nurses worked full time, apart from one E grade staff nurse who worked 30 hours a week. Seventeen nurses meet the inclusion criteria and seven nurses were selected for interview influenced by the issues discussed above. However the precise backgrounds of those interviewed are not identified in this section, or within the study's findings, in order to maintain confidentiality but are specified to a limited degree in Chapter four.

Whilst health care assistants (HCAs) might have been included in this sample I did not interview any formally however I did interact with and had discussions with HCAs during participant observation, as will be noted in the findings and discussion chapters. Access to this group was also difficult as despite the unit's establishment of HCAs being 10.20 WTE this included the ward clerks who were always busy and who declined to be interviewed formally. Also the HCAs were moved to and from other wards and would at times take on the ward clerk's role so a permanent work force of HCAs was not available to interview. Nor did I interview any bed managers or the directorate's senior nurse although again I did interact with and have discussion with them during participant observation and bed managers feature in data extracts from field notes. The bed managers and the directorate senior nurse, whilst interacting in their hospital bed management role and providing directorate leadership, their presence on the AMAU, and thus their ability to understand the day-to-day working of the AMAU nurses' community of practice, was restricted. However, both groups would have particular insights regarding the role of the AMAU nurse that further research could develop.

The hospital doctors included in the interview sample were selected purposively from the five teams of doctors. A team consisted of a consultant, a registrar or

senior registrar, one senior house officer, and one pre-registration house officer. Two consultants and two registrars/senior registrars were approached to be involved in the study (at the time of the study due to sickness the other three consultant posts and their registrar posts were being covered by locum staff who changed frequently). Two consultants and one registrar replied positively however due to the work-pressures of one of the consultants only one consultant and one senior registrar were interviewed. One of the doctors was female and the other male, also one was relatively new to the hospital and one had worked in the hospital for many years. The junior doctor interviewed was regularly on the AMAU and therefore had useful insights regarding the role of the AMAU nurse.

Ten local GPs were written to, requesting if they would consider being interviewed however despite enclosing a reply slip, a Freepost envelope, and a reminder letter two weeks after the initial letter only two replied. However, in the end due to sickness only one GP was interviewed. The large numbers of requests GPs receive to contribute to research projects requires them to be selective and pragmatic when agreeing to participate. The GP interviewed was very interested in medical admissions generally and brought to the interview a comprehensive list of related issues.

The inclusion criteria for paramedic participants were that they had experience of transporting patients into the AMAU under study. As this group was selected after the commencing interviewing they were strategically identified (Mason 2002) in that their contributions were drawn on to help my developing interpretations. Paramedics who brought patients to the unit were all employed by the Welsh Ambulance Service Trust and I obtained permission to access paramedics from their Trust's R&D committee. These participants were obtained using a form of snowballing sampling (Mason 2002) in that a paramedic colleague asked his colleagues if anyone would agree to be interviewed by me. Only two paramedics offered themselves and were interviewed. It is acknowledged that the paramedics volunteered themselves, and logically several others did not, so there may be a bias in their selection. Total number of paramedics who are involved with patients being admitted to the AMAU is

unknown but would include potentially all of the paramedics in the Welsh Ambulance Trust based in south, mid, and west Wales.

The patients' inclusion criteria were that they had been patients on the AMAU within the previous two months; otherwise issues of recall and memory loss may have affected their contributions. Further, that they were aware of their time on the unit and that they were willing to be included. When I went to the general medical wards to seek out potential patients to be interviewed it was at different times of the year and so recruited participants who had experienced the AMAU over a two-year period (from 2002-2004). Therefore patients were recruited before they left hospital and were accessed only after they had left the AMAU and were awaiting discharge on their transfer ward. Initially I did not intend to have the selection of patient participants influenced by nursing staff due to the risk that non-compliant or complaining patients would be de-selected and so provide a skewed impression of patients' views (Brewer 2000). However, the LREC and the Trust's Caldicott Guardian both required that the ward nurse should act as an intermediary and approach the patient in the first instance to seek permission to be contacted about the research. This potential bias (Redsell & Cheater 2001) was countered to some degree by framing my initial question to the ward nurse, as 'have you any patients who are scheduled to go home who were on the AMAU?' I would then ask for the approach to be made to a patient selected by myself from the list comprising of gender, age, medical consultant, and medical diagnosis (no names), given to me by the ward nurse.

It was considered important to include as wide a range of patients' views as possible so a mix of male and female patients of different ages and medical conditions were recruited. I recruited and interviewed four men. However, despite recruiting five female patient participants whilst inpatients once they were at home three declined to be interviewed. These three patients had indicated that they would have been happy to be interviewed on the ward when I first approached them but as this contravened my stated approach, as agreed by the LREC and Trust's Caldicott Guardian so I was not able to do so. Time constraints (I interviewed patients in the latter stages of data collection) impeded the recruitment of more women to the study. The approach to and conduct of the

interviews is discussed later in this chapter. None of the seven patients interviewed had been on the unit during my periods of participant observation.

One exclusion criterion was an absence of the medical consultant's express permission to approach patients in their care. I had gained a verbal 'blanket permission' from the directorate's senior physician who spoke for the consultants. However, I had also sought individual consultant's permission to approach patients in their care in the letter asking if they would agree to being interviewed and only approached patients who were under the care of those consultants who agreed. I did not approach patients if they were unable to give informed consent for whatever reason. All admissions to the unit were aged over sixteen years following Trust policy however patients aged from sixteen to twenty years were a low presence on the unit and the youngest participant interviewed was twenty-one years old.

The final sample was 19 (3 doctors, 7 nurses, 2 paramedics, and 7 patients) as participants were selected for their ability to contribute to an interpretative understanding of the role of the AMAU nurse rather than attempting causality related to variables such as age or gender (Mason 2002) the sample size was considered suitable. Seeking in-depth data from participants was the goal of interviewing and 19 interviews provided such data. More information on participants' characteristics is provided in Chapter four.

### *3.4.3 Sampling of documentary evidence*

Documentary data that was sampled for this study was done so purposively and drawn on to expand the scope of the data (Prior 2003) and included written documents, ward notices, and informal notes. The documentary sources, formal and informal, utilised existed independently of the study and were chosen for their ability inform the study's research aim (Hammersley & Atkinson 1995). A total of 35 documentary sources were reviewed. In the following section the conduct of data collection is discussed and rationale for approaches used offered.

### 3.5 Methods of Data Collection

This study used three methods of data collection. These were participant observation, formal semi-structured interviews, and within the interviews the use of a modified critical incident reporting technique, and collection and analysis of documentary evidence. Data collection commenced with participant observation in January 2001 and lasted for eighteen months on a part time basis. In total there were 30 episodes of participant observation with approximately 200 hours of contact. Participant observation was supplemented with 19 semi-structured interviews. Interviews were carried out over two years from January 2002 to January 2004.

In preparation for fieldwork I undertook manual handling and advanced life support training plus Trust updates on care of blood transfusions and intravenous drug administration. An honorary contract with the Trust was already part of my higher education contract. Data collection commenced with participant observation.

#### 3.5.1 Participant observation

Participant observation is a method of data collection that enabled immersion in the research setting and so enabled direct experience of the setting to be gained (Mason 2002). Goffman's (2002:149) insightful and eloquent definition of participant observation I judge to be closest to my own experiences:

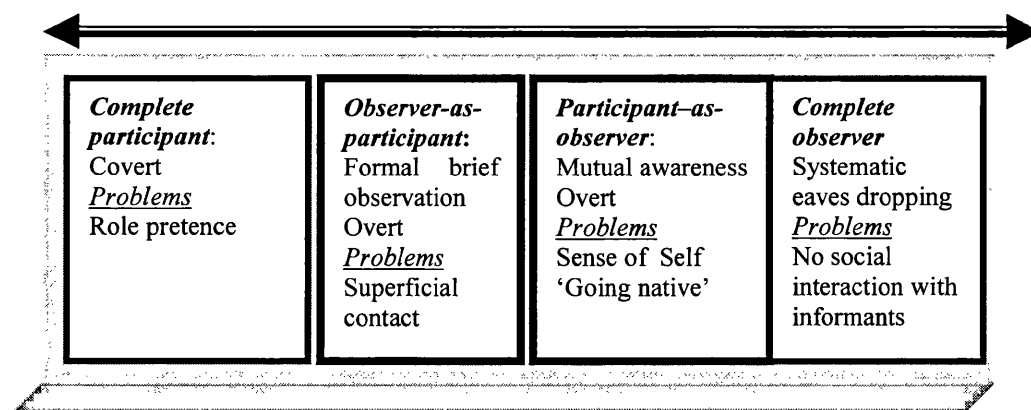
*It's one of getting data, it seems to me, by subjecting yourself, your own body and your own personality, and your own social situation, to the set of contingencies that play upon a set of individuals, so that you can physically and ecologically penetrate their circle or response to their social situation, or their work situation, or their ethnic situation or whatever.*

This total experience when conducting participant observation that involved self, body, personality, and social position identified by Goffman were relevant to my experience and will be related to and explored during my account of the study.

As I was familiar with the unit I did not need time to acquaint myself with the layout of the unit or the work of the unit. A goal of participant observation however was 'defamiliarization' (Thomas 1993:43), the need to reframe what I

saw, and maybe took for granted, into interpretations of cultural processes. The nurses on the unit were informed about the study and my intention to conduct participant observation at ward meetings and a general information letter was circulated to all nursing and medical staff on the unit (a copy of which is provided in appendix 17). There was no intention to act in a covert manner and it was made clear that the research sought to understand the culture of the unit and in particular the role of the nurse. The nurses and ward doctors were given the option to not be included in the participant observation; none indicated any objections and all gave their verbal consent. Conducting participant observation was found to be a complex undertaking and the roles I adopted in the field required consideration. A classic typology of observation roles has been presented by Gold (1958) and is summarised in Figure 1.

**Figure 1. Roles that the researcher can adopt whilst collecting data using observation.**



Source: Adapted from Gold (1958)

The role that I developed eventually was that of participant- as -observer however initially I acted as an observer- as- participant. This typology I found to be useful for as Gold (1958) noted I moved between roles. For instance, I was required to wear appropriate clothing for manual handling and to prevent cross infection and I decided to wear a staff nurse's uniform. This choice meant that I did not stand out as being different from any other staff nurse and so enabled me to 'fit in' and participate increasingly in care provision working alongside the nurses. However this uniform then contributed to a form of covert presence as I



looked and acted like a staff nurse. To counter this I wore a name badge with 'lecturer-researcher' identified and I introduced myself, when appropriate, as a higher education lecturer in nursing who was conducting research. As will be discussed later in this chapter, the ability to present myself correctly whilst holding the multiple roles of nurse, lecturer, and researcher caused me ethical concerns, especially when interacting with very ill patients. Another difficulty that arose was that medical staff, especially consultants, who came to the ward, saw my presentation as a staff nurse and would ask me questions about patients. At first this was terrifying but as time went on I was able to respond helpfully and so helped my relationship building with medical staff. Patients also saw a nurse when they saw me so I made it clear to patients that I held the role of researcher as well as a nurse providing care but ethical concerns arose when patients were too ill to be informed. Certainly as I regained my clinical confidence and became better able to understand the work of the nurses I moved from being an observer as participant and took on the role of participant as observer more effectively. As Gold (1958: 218) contends:

*Every field work role is at once a social interaction device for securing information for scientific purposes and a set of behaviours in which an observer's self is involved.*

Gold (1958) warns that the relationships that develop can cause the field worker tension between self and role. Friendships can arise that cause over-identification with participants leading to difficulties in maintaining a researcher role: the field worker may become over identified with the participants and so losing research perspective and are at risk of 'going native' (Hammersley & Atkinson 1995: 110). Gold (1958) notes that the sharing of intimate secrets between participant and field worker may be done so in the full awareness that the relationship is limited by the time in the field: an interaction of sociological strangers. If the relationship is deemed to be more important than the study then maintaining a field relationship may not be seen as important. Feminist writers, for example Williams (1995), have suggested that intimate and supportive relationships can be developed without sacrificing scientific rigour by using reflexivity.

I contend that to spend extended periods of time with people will lead, almost invariably, to the development of friendships. Understanding the participants'

world leads to identification with their goals and problems however, by acknowledging such engagement reflexively this need not be a cause for criticisms. Hammersley & Atkinson (1995:112) warn against over rapport with participants and suggest the researcher adopts 'a more or less marginal position' or adopting a role of a 'marginal native' that is located somewhere between a stranger and a friend. Such a role is difficult to maintain, as a human instinct is to make friends and to wish to 'fit in'. However, as the participant observation was not continuous and often several weeks would have passed between episodes of data collection I retained elements of being a stranger in the field. I was an occasional visitor and after a break from data collection would return to a field where I was known but where changes had occurred and the nurses and doctors had new stories to tell and the patient population was different. Such breaks also gave me time to reflect upon findings and to examine reflexively my role in the field aided by my reflexive diary. As a doctoral student I was also undertaking regular supervision and during these sessions I was able to explore tentative findings and issues related to my role in the field with my supervisor.

However, when in the field the conflict of role described by Gold (1958) seemed pertinent as I sought to be a colleague and one of the team whilst endeavouring to do so in a natural and convincing way while collecting data and developing interpretations. Goffman (1959) describes the staging of appearances and performances that a person takes on to demonstrate the correct 'face' for a particular setting by the use of impression management. I soon learnt that during participant observation that the nurses in particular recognised questions that were research led and those that were ordinary conversational ones. If I asked more than two questions during a relaxed or a patient specific situation I would receive a distrustful glance but if I asked similar questions during formal semi structured interviews then the response would be more positive and detailed. I learnt skills in reading the appropriateness of time and place to attempt expansion of my understanding. I was mindful also of the maintenance of on-going consent and I would remind participants frequently that I was conducting research. However as noted by Merrell & Williams (1994) this often seemed intrusive, and importantly even rather boring to the participants.

The researcher in participant observation requires skills in relationship building (Brewer 2000) and my role in the unit was a negotiated one. I took a constructivist view that values an inter-subjective construction so that the researcher and the researched shared understanding and rapport (de Laine 2000). The dilemma is the paradoxical imperative to see the setting as a stranger whilst interacting and immersing in the social setting. These can be seen as competing demands and can lead to challenges to the researcher's sense of self (de Laine 2000). As a nurse I experienced, despite having no clinical responsibility, worries about the work of the unit, the many admissions, and the very ill patients. The researcher role had to be put to one side on occasions when I just 'helped' in a nursing capacity as I considered that not to do have done so would have been a dereliction of my understanding of my sense of self. I agree with Gerrish (1997:27) who suggests that the nurse researcher can reduce the potential dissonance between the dual role of nurse and researcher by offering a positive contribution to care rather than being an 'exploitive interloper'.

Another role held whilst in the field was that of a higher education lecturer and often the expectation of my current knowledge and expertise was at odds with my very rusty ability to perform well in an acute medical area. I soon learnt to swallow my pride and acknowledge that I did not know. Naïve questions that I asked were not done so on purpose but because I really did not know. Some of the nurses took time to accept that I really would be asking a genuine question and not a research 'trick' question. I had been involved with the education of many of the nurses and at first they seemed to assume that I was knowledgeable about all aspects of care. As time went on I was accepted more and my role transformed into a rather friendly 'back to nursing' (returning to nursing after a gap in practice) nurse as regards clinical practice but my higher education abilities were often called on for career advice and to help with assignments.

Role conflict was an issue that caused myself tension when deciding at what time to intervene in care delivery and if this would be at the expense of data collection. As a registered nurse I had an enduring professional duty to act if unprofessional care should be witnessed (Baille 1995; NMC 2004). Throughout my fieldwork I did not witness any ethically problematic issues but what did

concern me was the constant need to provide care to large numbers of acutely ill patients with pressing and complex needs with limited staffing levels. I acknowledge that this workload demand is not unique to AMAU nursing and that this anxiety-provoking situation would be likely experienced by myself in any acute nursing setting.

I did not take on patient allocation, despite being offered ‘some patients’ many times at the end of the intershift handover. This would have taken up too much of my time and I was also concerned about my professional responsibilities having been out of clinical practice for many years. I did consider taking responsibility for a group of patients for a shift initially, as it certainly would have given a clear insider view of delivering care as a nurse on the unit, but decided not to. The insights would have been those of a higher education lecturer who had not taken responsibility for a patient’s care for over ten years and would not have given useful insights into the role of an AMAU nurse. However, I found that if I helped in the best way that I could, I was still gaining information and aiding understanding of the AMAU nurse’s role. Not to help whilst staying in the field would have been destructive to my relationships with the nurses and personally unacceptable. Importantly, observations and discussions whilst helping with the nurses’ work led to increasing understanding of the culture of nursing on the AMAU. From early insights interpretative understanding arose from participant observation, these were then tested and developed during the semi-structured interviews. Formal semi-structured interviews were commenced whilst participant observation was still being conducted. The emergent design of the research enabled a semi-structured interview schedule to be developed that explored issues identified from initial, and concurrent, participant observation (Morse & Field 1996). An account of the approach to conducting semi-structured interviews is provided next.

### **3.5.2 *Semi-structured interviews***

The aim of the interview was gain across case perceptions of the role of the AMAU nurse and for participants to give in-depth personal accounts of their experiences and opinions about the role of the AMAU nurse. Following participant observation insights and understandings of cultural meanings had

evolved that I sought to explore in more detail, and from differing perspectives (Denscombe 1998). The goal of interviewing was to gain greater understanding of the observations made and confirmation of understanding together with the flexibility to explore issues that were important to the participants (Blaikie 2000; Mason 2002). A semi-structured interview approach was chosen as it was deemed suitable for the exploration of perceptions and opinions on often complex and maybe sensitive issues (Mason 2002). The interviews were one-to-one and so appropriate for the information gathering that was sought, as it was possible to concentrate on the individual and their responses (Hammersley & Atkinson 1995).

Guided by Morse and Field (1996:84) who suggest that the use of questions in a focussed format should help prevent 'dross rate', that is information that is extraneous to the study, I developed semi-structured interview schedules. These interview schedules were developed from the emergent understandings gained from participant observation. The semi-structured interview schedules were refined and added to as the interviews progressed. Despite using an interview schedule probing questions were used to gain more information especially if given responses or perspectives were novel or deviant (Silverman 2001) or to clarify answers (Denscombe 1998). For example, all of the nurses interviewed expressed concern regarding those patients awaiting admission to the AMAU apart from one nurse. I was able to explore this deviant response and this opened up avenues of analysis related to workplace stress and the influence of clinical experience in the AMAU. As some participants were answering in their second language, the format of the semi-structured interview facilitated rewording of questions to enhance clarity (Denscombe 2002). The construction of the interview schedules followed the criteria of specification, division, and tacit assumption (Barriball and While 1994). Specification relates to focus of each question and division to the appropriate sequence and wording of the questions. The concept of tacit assumption enabled awareness of the variety in meaning that words and phrases had. The semi-structured interview format provided flexibility to validate the meaning of responses. The questions asked followed a loose structure based on the key topics with questions noted that were supported by possible prompts or areas to explore (Mason 2002). The interview schedules are

presented in appendix 18 but it must be noted that the questions were adjusted slightly after each interview for clarity and/or theoretical development. For instance, the first doctor interviewed noted that the role of the nurse was to work in a team, not however as the leader as that was the function of the senior doctor. This led to subsequent questioning on the nurse-doctor working relationship. Throughout the focus was maintained on the research aim, which was to describe and explain the role of the AMAU nurse. Letters and information sheets (copies of which are presented in appendices 8, 9, 12, & 13) were sent to participants emphasised the individual's right to withdraw consent at any time. The time between making the appointment and the actual interview provided a cooling off period when participants could reconsider their initial approval to be interviewed.

Brewer (2000) suggests that it is valuable to take notes during the interview, if this can be done in a way that does not impede the interview flow, so to record anchoring points and non-verbal responses. This was not done as I found this to be distracting to the one-one interactions that I sought but field notes were compiled as soon as I completed the interview, often in the hospital canteen or in my car before going home. The interviews were audiotaped following the consent of the participant. The interviews varied in length from thirty minutes to two hours. The longest interviews were those with patients in their homes. My coming to the patient's home was clearly an important event and tea or coffee and biscuits were always provided. All interviews were truly conversations with a purpose (Spradley 1979) with participants demonstrating trust in me by being very disclosing in their contributions.

A quiet room that was free from interruptions was always used and it was ensured that any conversation could not be overheard. Six of the nurse interviews were in the sister's office on the AMAU and one was in another ward office. As the unit was always so busy the fact that the nurses were being interviewed was not notable. The room used was off the ward and all the nurses were interviewed in their own time at the end of their shift or during their lunch break so were not obviously absent from the unit and so helped maintenance of anonymity. My presence was also an unremarkable issue as I was so often on the unit. The paramedic interviews and one patient interview were conducted in

rooms of my employing college and the doctors were interviewed in their own offices. All other patients were interviewed in their homes. When going to patients' homes I ensured my safety by travelling in daylight, by letting others know where I was going and by carrying a mobile phone. I always dressed smartly and arrived on time. I ensured that I was always well prepared, for instance ensuring that the batteries in the audiotape machine would not go flat. An appointment would have been made and confirmed by telephone the previous day. The participant would have been given my contact number if they wished to cancel the appointment.

A free-flowing interviewing style approach was sought that could be responsive to the information provided and the cues of the participant (Hughes 1992). Holloway and Fulbrook (2001) suggest that the use of self-disclosure by the interviewer can help build a genuine relationship with the participant whereas Hammersley & Atkinson (1995) urges caution with self-revelation especially if there are differences between the beliefs of the researcher and the participant. I was influenced with the arguments provided by Wilde (1992) who suggests that when interviewing participants and seeking critical incidents, self-disclosure can enhance the interview and the information gained. Wilde further contends, and my experience confirmed this, that it is a false hope to assume a purely researcher role when interviewing and that using experiences from other roles will benefit the interview. In fact it would be very difficult, if not impossible to put aside the style of interaction that has become internalised. To try to alter radically one's style of interaction can lead to an unnatural style of interviewing that is uncomfortable. Further, as I was known to many of the participants any unnaturalness would have been perceived as such by the participants. I was influenced by Lowenberg (1994) who contends that the aim of qualitative research is not objectivity on the contrary what is valued is mutual sharing of information and the exchange of ideas between the interviewer and the participant.

I was aware that during an interview sensitive topics might be raised so time to debrief was provided after the interview was completed. However, the role of the researcher is not to provide on-going support but to be able to offer suggestions

of other professionals that the participant can approach for support (Astedt-Kurki *et al.* 2001). However, this proved not to be an issue during this study. It seemed that the process of speaking about their experiences did not cause participants any problems. In fact, the interviews seemed to be a positive experience for the participants as they certainly were for me. I had acknowledged that my own personal identity could affect the interaction so whilst seeking to draw on my own experiences and perceptions reflexively I sought also to ensure that I was not imposing my own constructions inappropriately or without justification (Mason 2002). For instance when interviewing nurses the fact that I was a lecturer in nursing may have lead participants to give answers that they thought I expected to hear. This potential effect had been minimised by my rapport with the nurses and the relationships developed during my time in the field undertaking participant observation. As I developed my interviewing technique I gained the confidence to be able to present myself as being receptive in my responses rather than merely worrying about what to say next. If I considered that I was receiving ‘answers that parrot an official line or reflect cultural rhetoric’ (Thomas1993: 40) I would reframe the question or vary the slant of the approach to the topic.

Feminist writers, for example Williams (1995), recommend a non-hierarchical relationship between the interviewer and participant. Although gender maybe shared there are other differences, such as status, that may impede a non-hierarchical relationship from developing. Such a feminist approach leads to a shared understanding that enhances the interview and subsequently the data collected. The interviewer will learn about their own self as well as the experience of the participant. This approach suggests the need for a less neutral and distant approach to interviewing so that the researcher can display emotions and personal feelings. This view influenced me and as I gained experience in interviewing I developed my skills and, importantly, relaxed and so interviews became more conversations with a purpose rather than an exercise in data collection.

I utilised existing skills in interviewing gained from my experience as a nurse and a lecturer. Such tactics as use of prompts, remaining silent, repeating the



question, repeating the last few words of the participant, probes, and summarisation of responses to check understanding were utilised (Bowling 2002). The ethnographic approach used had allowed time to build up relationships with many of the participants, especially the nurses. Additionally, as a qualified nurse I was able to demonstrate respect for the professional function of participants by being familiar with their language and specific professional knowledge. The ability I had to understand clinically relevant language helped discussions to flow without having to stop and ask clarifying questions about common issues. I was however conscious that familiarity with content can lead to issues being missed or taken for granted. I attempted a stance of retaining a critical distance whilst being familiar with the context. My insider ability to understand medical and related language was also required when patients were recounting their experiences. This example related to a patient who had been admitted in the early stages of diabetic ketoacidosis:

**Patient:** "... then she (*the nurse*) said 'we will now take your blood every four hours and dependent on what the sugar is we will adjust the insulin', it is like a (*pause*), what do you call it?"

**PG:** "Sliding scale?"

**Patient:** "Sliding scale! That is the word. I heard it so many times when I was there!"

(*Dave. Interview 15:3*)

As a registered nurse with medical nursing experience I was able to understand the technical and professional language that the participants used and this aided my acceptance in the field. In addition the time spent undertaking participant observation had brought my nursing knowledge up to date. Understanding the terms and jargon that the health care team used demonstrated an immediate grasp of the situations discussed (Melia 2000). During early interviews it was noticed that a story was often told to answer a question and when the story was being told the participant seemed to relax and the data obtained were particularly rich and interesting. It was therefore decided to capture this insight and to encourage subsequent participants to respond with specific occurrences, namely critical incidents.

### *3.5.3 Use of a modified form of the critical incident technique*

I wanted participants to describe the role of the AMAU nurse by describing specific incidents as I considered that it was more likely that participants would offer their unique perspectives with this approach rather than being guided by a more formal interview schedule. I drew on Flanagan (1954) who described the critical incident technique (CIT) as a set of procedures for collecting direct observations of human behaviour by focussing on specific incidents that aid recall. Respondents can be aided to thus identify and clarify the feelings and meanings that they attach to these incidents. An incident is defined as ‘ any observable human activity that is sufficiently complete in itself to permit inferences and predictions about the person performing the action’ (Flanagan 1954: 335). The term critical refers to the fact that the behaviour described in the incident plays an important or critical role in determining an outcome. Flanagan (1954) identified five stages to a CIT study: formulating the general aim of the activity, setting plans and specifications, collecting the information, and reporting and interpretation of the findings. I however utilised the CIT in a modified form as will be discussed next.

Formulating the general aim of the activity is a prerequisite for the evaluation of specific behaviours as being positive (effective) or negative (ineffective) (Flanagan 1954). My general aim was to gain perceptions of the role of the AMAU nurse so I incorporated questions that probed effective and ineffective aspects of this role and its delivery. Observers or participants should be familiar with the activity and be able to make first-hand observations, either about themselves or others (Flanagan 1954). Even if using self-reports Woolsey (1986) suggests that it is useful to give the participants a copy of the statement of the aim and a list of interview questions before the interview to orientate themselves. When I sent participants information about their interview I included information about my intention to ask them about critical incidents. (Appendix 20 gives an example of a pre-interview letter that explains the intended use of the modified critical incident approach to a health professional.) However, this did not always work out smoothly as on some occasions the participants had not received or had not read their information sheets. Another issue identified was that the term

‘critical incident’ was also used within the Trust to refer to a clinical mishap or a near mishap so I changed the term to ‘an occasion’ and so rectified this problem. When using the CIT within the interview I was guided by the experiences of others who have used this approach as will be discussed next.

Kemppainen (2000) suggests that it is useful to commence the interview with a brief introduction describing the purpose or the aim of the study. Next to ask the respondent to recall a specific incident and once identified to ask the respondent specific questions related to the research aim. The aim is to collect a clear description of the events leading up to the incident, which can then enable an understanding of why certain actions were taken or were not taken (Kemppainen 2000). Grant & Bannatyne (1996) studied indicators of care in long-term facilities and asked the participants (residents and significant others) questions in terms of what kind of care did the participants like best or liked least. This Grant & Bannatyne (1996) contended reduced the tendency of respondents to answer in a positive manner and also avoided emotive terms such as ‘good’ or ‘bad’, which is supported by French (1981) who noted that respondents often would only recount positive aspects of a service. I followed this advice and attempted to structure my questions to avoid emotive terms. (See appendix 18 for examples of the interview schedules that asked for a critical incident). For instance I asked patients ‘Can you tell me about something that a nurse did that demonstrated care that you thought was effective?’ This lead, as suggested by Grant & Bannatyne (1996), to participants talking about nursing care, as they perceived it and what aspects were important to them. The modified CIT was used with all participants, although as noted earlier the first two nurse interviews presented a critical incident spontaneously, and provided rich and in-depth data. Whilst observation and interviewing were important data collection tools as I sought a cultural understanding of the nurse’s role documentary evidence was also drawn on and will be discussed next.

#### **3.5.4 *Documentary evidence***

Documentary evidence was gathered that helped understanding of the role of the nurse and the culture of their working practices. The documentary data drawn on was formal and informal and although data involved mainly the written word

diagrammatic data sources were also considered. For instance, the diagram of the AMAU provided in appendix 1 offers a visual dimension to understanding the culture of the AMAU. As Hammersley & Atkinson (1995) note early ethnography dealt with illiterate cultures where artefacts were then used to gain understanding of the culture. However, in such a literate setting as the AMAU the use of the written word has importance to gain understanding of the social setting. The evidence collected and analysed included the formal documents used within the AMAU that influenced the practice of the nurses, for example the Patient Care Record booklet, (a copy of which is provided in appendix 16), that was required to be completed for all admissions. Formal documents that were reviewed will be referred to in the findings of this study. Official statistical data made available related to prevalence of AMAUs in Wales, numbers of patient admissions, and patients' length of stay on the AMAU were also drawn on.

Documentary evidence that was informal and had been developed by the nurses was considered most relevant to an interpretative understanding of the nurse's role and social action (Prior 2003). For instance, the nurses wrote their own notes on a pre-printed sheet containing patient information during the nurse-nurse handover that then guided their care delivery during the shift (a facsimile of a nurse-nurse handover sheet is provided in appendix 14). This information was then compared to the nursing notes made in the Patient Care Record. Guided by Prior (2003) the cultural significance of the relationships between the production, consumption, and content of documentary evidence drawn on were reviewed during analysis. Additionally, throughout the research field notes were maintained and they provided a key source of data with which to develop understanding of the role of the AMAU nurse and are discussed next.

### **3.5.5 *Field notes***

Spradley (1980) reminds ethnographers that field notes should contain relatively concrete descriptions of social process and their context. Such notes should aim to preserve the integrity of the observation by recording where it took place, who was involved, what was going on, if there were physical objects present, what the individual acts that were taking place, what was the event or sets of related activities, what were the sequence of events, what was the goal of the process,

and what feelings were evoked. I took these suggestions to structure my field notes. Short field notes were completed in a pocket notebook at a suitable time during fieldwork or as soon as possible after leaving the field and these notes were then expanded (Silverman 2001) and entered into word processing files. These were factual records without comment or supposition.

I followed the advice of Becker *et al.* (1961) who suggest that it is a good idea at first to note down everything, the usual and the unusual, as it is only as the research progresses will what is actually important become clear. All data were recorded in an unambiguous manner and with only concrete detail so that when returning to them there was no doubt who was speaking and if the conversation was noted *verbatim* or as a memorised summary. Attention to careful recording of field notes was essential when analysing the data to provide context that was a true record. Becker *et al.* (1961) warn that field observations soon become normal and therefore at risk of being ignored or being dismissed as routine and leading to too much emphasis being given to the abnormal or idiosyncratic. Therefore at first notes were made of everything possible that may have related to the research questions and then particular aspects were honed in on as the research progressed. I sought to keep my own descriptive glosses clearly distinct from the actual factual recording (Aull Davies 1999). I maintained a reflexive journal also where I recorded any problems, ideas or insights; these recordings were my personal insights (Spradley 1979).

In summary the use of participant observation, semi-structured interviews, use of different participant groups, the use of a modified critical incident technique, and documentary evidence was a complex undertaking. However this multi-faceted approach enabled data to be generated that were rich and in-depth and so enabled an emergent development of understanding throughout the study. The conduct of ethnographic research in a health care setting raises many important ethical issues, in particular related to patients as research participants. The following section will discuss ethical considerations that arose and deliberations on the ethical approaches taken.

### **3.6 Ethical Considerations**

Issues related to participants' rights to personal autonomy including informed consent, rights to privacy, and rights to confidentiality, are explored in this section. The ethical imperative of non-maleficence is considered a fundamental concern for the researcher and this underpinned all ethical decisions made in the field. However, throughout the conduct of this study I became increasingly aware of the importance of ethical deliberations that required situational approaches related to the specific context of the incident and although restricted by word constraints I will attempt to explain the ethical reasoning that I applied during this study. Firstly autonomy and privacy are discussed.

#### **3.6.1 *Autonomy and privacy***

Privileging the person's right to personal autonomy was a guiding concern throughout the research. An important aspect of respecting personal autonomy is the gaining of informed consent from all participants. However as Mason (2002: 82) warns the issue of informed consent in qualitative research requires a duty for the researcher to engage in 'a reflexive and sensitive moral research practice'. Therefore when participants received information about the research it was presented in a non-technical and understandable manner so that participants were capable of comprehending the information and their right to choose whether or not to participate in the research (RCN 2004b). Aull-Davies (1999) suggests that informed consent must include an explanation that is full and presented in meaningful terms with the researcher identified and with clear identification of other agencies financing or supporting the research. I incorporated this advice into my consent approach.

Following initial contact and verbal agreement to be interviewed participants were given a letter elaborating on the research to which an information sheet was attached. This letter noted unambiguously that they would have the right to give or withhold consent. The information letters and information sheets were worded so as to be suitable for the participant (examples of which are provided in appendices 6, 8, 9, 12, and 13). Written consent, including permission for the interview to be audiotaped, was gained (the consent form used is reproduced in appendix 10 in English and in appendix 11 the Welsh version is provided). I was

aware that all participants, but patients in particular, might feel they were in a vulnerable position so extra care was taken to ensure that they did not consider themselves to be coerced into taking part (Brykczynska 1998; NAW 2001d). Potential participants to be interviewed were given a period of two weeks from initial agreement to be interviewed to the date of the interview during which time they could change their mind about participating. A letter was sent to participants during this time confirming the date and place for the interview, with my contact details (see appendix 20 for an example of such a letter). It was made clear to the participants that their right to withdraw their agreement to the interview could be exercised at any time without any negative consequences. With patient participants it was emphasised that refusal or withdrawal of consent would not lead to any negative effects on their care. Further that the research may not have any therapeutic or direct benefit for them personally (McKane & Tolson 2000). Any possible benefit would be from the greater understanding of the organisation of the AMAU and the role of the nurse that may lead to enhancement of care on the unit or could inform nursing practice more generally. However some of the patients interviewed enjoyed the opportunity to discuss the care they received on the AMAU. I was able also to answer, within suitable constraints, questions about their care in particular to clarify interventions or events that they did not understand. However, the gaining of informed consent during participant observation was also an issue requiring ethical deliberation as will be discussed next.

Verbal and on-going consent was sought from participants during participant observation because data collection required many visits to the unit. Pre-field entry information was given at a unit meeting to the AMAU's nurses and medical teams, which was supplemented by written information and a copy was placed on the staff notice board. (This written information is reproduced in appendix 17.) Patients approached during participant observation were usually informed of my multiple roles (Holloway & Wheeler 1995) as a nurse, a lecturer, and a researcher however this was not always a suitable way to proceed. Participant observation that claims to be overt requires permission from all those observed but I found this to be an unobtainable goal. As Punch (1986) has noted gaining consent from all who inhabit the field is not usually feasible as the field

population can change rapidly. I was guided by Johnson & Long's (2003:5) opinion noted in a preface to the Royal College of Nursing Research Society's research ethics guidance:

*One might further suggest that despite the researcher's best efforts, informed consent is almost impossible to achieve. It is often impractical to be completely clear to everyone who might appear in a study that they are subjects of research.*

The ethical considerations that this research raised were complex and I was frustrated, as Punch (1986) also notes, by published research that too frequently offers an inadequate discussion of contextual ethical dilemmas to help guide other researchers. Even within this study word constraint limits the provision of multiple examples of situations that were, for me, ethically ambiguous. However as an indication of my concerns I present this field note that concerned a young man who was very ill:

Staff Beth had asked me to do some 'obs'. I went into the sideward where there was a young man of about 30. I knew that he had been admitted with acute exacerbation of asthma, that he was poorly when he came in and was now 'a bit better' but he was still short of breath with problematic readings of oxygen saturations and general vital signs and needed 'an eye' kept on him. He looked afraid and all my intuitive systems were on edge so I stayed with him for a while and tidied up the room and got him an iced drink. After a while he pointed at the window ledge on which a dove had landed and asked me "well, what do you make of that then?" He looked at me and held my eye; he was obviously scared and scared of dying. I knew (and he knew that I knew) that was what he meant. (Field Notes)

I interacted with this young man and I believe I helped him and certainly provided instrumental and emotional care however I did not tell him that I was conducting research. I called patients such as this 'patients in the background' and wondered what ethical justification, if any, was there to omit identifying myself as a researcher. In this, and in comparable situations, I made a decision not to burden a patient who was ill or distressed with information about my researcher role. However I was then acting in a covert manner, which I had not intended to when I presented my research proposal for ethical scrutiny. Denscombe (2002) suggests that retrospective consent can be obtained in such cases however the short length of time that patients stayed on the unit and the large numbers of patients would have made this impractical and untenable. Following Hammersley & Atkinson's (1995) advice I made individual





judgements about the ethically correct approach when observing patients in the field that were influenced by the needs of the patient. I was guided by Gilligan's (1993) insights into the contextual nature of ethical decision-making, an ethic of care, and the situational nature (Sherwin 1992) or the practical ethics (Williams 1991) of ethical decision-making as opposed to unwavering reliance on deontological/rationalist ethical guidance for research. Such contextual approaches Christians (2003: 223) classifies as social ethics and notes:

*Rather than searching for neutral principles to which all parties can appeal, social ethics rests on a complex view of moral judgements as integrating into an organic whole, everyday experience, beliefs about the good, and feeling of approval and shame in terms of human relations and social structures.*

Guidance from ethical codes and from non-nurse ethnographers required my in-depth consideration from a professional health carer perspective. A nurse researcher brings to the field, as in my case, multiple roles that make the conduct of research more complex than for a non-health care professional. I was guided by the medico-ethical deontological principles of autonomy, non-maleficence, beneficence, and justice (Beauchamp & Childress 2001). However, these principles had to be tempered by the need to remain mindful of the situational, practical, and context specifics of data collection. Total reliance on deontological ethical principles can lead to decisions being made that inhibit the contextual understandings that should influence ethical decisions: this was the personal ethical insight that undertaking this study provided. Throughout the study I ensured that any action on my part would not detract from the patient's good and in fact any interaction would enhance the patient's experience. When noting such incidents in field notes I used the data gained from clinical situations involving patients too ill to consent to participation as part of my interpretation of the nurse's role rather than a source of in-depth information about the individual patient. Thus I attempted to act in a moral manner dependent upon the particulars of the situation faced (Lincoln & Guba 2003).

If particularly sensitive issues arose I would ask the participant, when appropriate, how or indeed if they wanted the issue presented (Hammersley and Atkinson 1995). There were occasions when in the field that I witnessed comments being made by health care workers that although not categorically

specified as being 'off the record' it was logical that the speaker would not wish their comments to be used. Nonetheless statements were at times challenged despite this being a somewhat controversial approach as such challenges may affect the researcher's field relationships (Brewer 2000). However, I agreed with Kleinman & Copp (1993) who argue that it is dishonest to ignore such situations or appear to concur only to report them later negatively. Further that the expression of disagreement can lead to otherwise unobtainable insights and better analysis. Problematic issues arose most frequently in backstage settings, such as in the shared changing room. These data were not reported directly but elements of these discussions helped guide subsequent data collection and analysis. However, disclosures of a personal nature for instance related to a nurse's family or home, were treated as being confidential. My commitment to maintaining participants' confidentiality was a problematic issue potentially as only one AMAU was studied and is discussed next.

### 3.6.2 Confidentiality

Protecting the anonymity of participants was a paramount concern. Written and computer entries were rendered anonymous and pseudonyms always used (DoH 2001; RCN 2004b). A word-processing programme (WORD) and a data management software programme *Non-numerical Unstructured Data Indexing & Theorizing* (Nu\*dist now named N6) (QSR 1997) was used to store and manage data. Computer entries were on my code-worded restricted access personal computer. Data were coded to ensure confidentiality, with only myself knowing the codes and entering data. On the participant information sheets, (for example see appendix 8), and on the consent forms, (for example see appendix 10), the steps taken to ensure confidentiality of any collected data were made clear to the participant. The RCN (2004b) recommends that the signed consent form includes consent to the anonymous publication and dissemination of results and this advice was heeded. When interviewing it was ensured that participants gave written consent to the actual research contribution that they would be making to the doctoral thesis and to future publications. The interview audiotapes were identified by number and not by name and were stored securely in a locked filing cabinet with access restricted to myself. When transcribing the use of headphones ensured that no one else could hear the audio taped interview. An

undertaking was given to participants that the audiotapes would be destroyed after the research was completed following the instruction of the LREC. Additionally, publications that will arise from the research will be presented in such a manner so as to ensure that participants and the location remain anonymous as much as possible. Special care was required because as one unit was used many people would know that the unit was being researched and so particular staff could be identified more easily (McKane & Tolson 2000). Pseudonyms were used when names were used, although for the health care workers interviews I used only an interview number and a job title to augment my goal of maintaining participants' confidentiality. Findings were presented in an aggregated manner when using selections of interview material or reports of observations in such a way so that they could not lead to the identification of a particular person. Additionally, documentary sources presented in this thesis, either in the main body or in appendices were likewise presented in an anonymous fashion.

Understanding the correct way to proceed ethically during this study was a complex journey that was helped by discussions with others and the helpful comments of audiences when presenting these concerns (and my tentative deliberations) at conferences. My journey has caused me to question the moral mantra (Sherwin 1992) of bio-medical ethics and stimulated an interest in contextual ethics and the insights of Carol Gilligan (1993) who described an ethic of care as opposed to the dominant ethic of justice and its application of abstract non-contextualised ethical principles.

The volume of data collected using an ethnographic research approach is large and varied and handling this large amount of data effectively was a significant issue so not to lose important information whilst maintaining its safe and protected storage. The following section discusses the approach taken to data handling.

### 3.7 Data Handling

The data collected, which included field notes, reflexive notes, analytic notes, interview transcripts, and documentary evidence, was extensive. All of this information required a system to enable ease of access and manipulation of data. Data were entered into a word processing file using pseudonyms for participants and removing any identifying information. Data audio taped during semi-structured interviews was transcribed into word-processed files and all data were protected by entry-restricted codes. Annotations were included during transcription to indicate such events as a pause or change of tone or laughter. During participant observation my limited ability in Welsh was useful and as will be noted sometimes the meaning of a conversation cannot be translated easily therefore notes have been added to reflect more accurately the nuances of the exchange. The interview data was stored in the word-processed file and a paper copy printed off of each interview and stored in ring folders for each participant grouping or case (nurse, doctor, patient or paramedic) in date order. I found it useful when entering data into the word processing programme to use the '*Insert Comment*' function to note memos, insights or reminders whilst transcribing. These insert comments were printed off as a separate file so to leave the data file uncontaminated. Other data included a diagram of the unit and which is presented in diagrammatic form using *SmartDraw 2007* (Version 8.05) a computer programme designed to aid the production of floor plan diagrams. Documents collected were stored as hard copies in a document box.

All data saved in Word files were eventually transferred to the qualitative data analysis software package '*N6*'. Once transferred this programme aided access to data and data coding manipulation. As Barry (1998) has noted the time acquiring the skills to use such a programme may deter researchers but I consider it to have been time well spent. I undertook one day's training, which gave me an insight to its use, but in the main its programme is logical when one has some experience of word processing programmes. Once familiar with '*N6*' its facilities were valuable for data access and management and when undertaking thematic coding across data sets. However, as well as using *N6*'s facilities hard copies of data were also used for reading and re-reading, undertaking factual coding, and

making analytical comments when merging coded data. Webb (1999) argues that programmes such as *N6* are not suitable for small-scale studies and their use may interfere with the novice researcher's ability to develop the intuitive aspects of qualitative analysis. This was an issue that I considered but ultimately my experience was that *N6* saved time when managing data and enhanced the difficult task of analysis by the ease of access to all of the data, the stages of analysis that it enabled, and the ability to search for words or themes. This programme enabled easy printing out of thematic categories, combining of categories, and also permitted extracts of data to be used in different categories. Importantly the use of *N6* eased the goal of coding all data for, as Silverman (2001:240) notes 'every piece of data has to be used until it is accounted for' and so aided the process of data analysis that will be discussed next.

### **3.8 Data Analysis**

Analysis began with the formulation and reformulating of the research questions (Hammersley & Atkinson 1995). Formal recording of analytic memos was commenced from the start of data collection and these were collected alongside the more informal ideas and hunches that I had recorded. These records, even the very early ones, proved valuable to the final analysis. It was discovered later on in the research process that these notes contained valuable comments or insights that would otherwise have been lost.

Analysis was concurrent with data collection and informed the research design and an iterative process was followed (Silverman 2001; Mason 2002). Early data analysis and emergent issues of interest guided subsequent data collection (Hammersley & Atkinson 1995). This dialectical process, as a part-time doctoral student was difficult to maintain in its purest form for as Hammersley & Atkinson (1995) have noted the demands of capturing the naturally occurring social world leaves little time for in-depth analysis whilst undertaking data collection. Kleinman & Copp (1993) have noted, and I agree, that often due to time constraints, much data analysis is undertaken after data collection has been completed. The on-going records of insights and emerging themes of interest that I maintained in analytic memos however informed the process of abductive analysis. However, I acknowledge that the accounts are the participants' accounts

of how they experienced, interpreted, and constructed their social world and such accounts cannot truly present the participants' perceptions, as I cannot have direct access to others' experiences (Barriball and While 1994). I merely represent the experience of the participants as reported to me and the ethnography developed subsequently is my interpretation of their social constructions.

### **3.8.1** *The process of analysis*

I sought to conduct data analysis with cross-sectional indexing in that I wanted to conduct thematic content analysis (Silverman 2001) across the whole of the data set (I included the modified critical incidents reported in the interview data and did not analyse them separately) rather than viewing and reporting cases individually (Mason 2002). I was guided by Mason's (2002) advice on the conduct of analysis by data reading that was literal, interpretative, and reflexive. Literal reading was carried out to gain familiarity with the data and to gain an understanding of 'what is there' (Mason 2002:149). During data collection early interpretative analysis was undertaken as a continuous process (Brewer 2000) and such interpretation guided subsequent data collection. When writing up participant observation data analytical memos were recorded and personal narrative accounts were recorded in my reflexive diary. Field notes were entered into a word processing programme and printed off with large right hand side margins in which literal reading coding was noted, for instance terms such as 'the handover', 'admitting patients', and 'patient transfer'. Interesting or surprising observations were highlighted (Hammersley & Atkinson 1995) together with commonly expressed ideas or opinions. The interview transcripts were likewise read and reread and literal coding utilised and after several readings the early literal coding of all data were read with an interpretative reading. Documentary evidence, including formal and informal documents and other artefacts such as the white board, used by the nurses as a tool to manage the unit's beds, were considered in the context of their use and so contributed to the cultural understanding of the AMAU nurse's role. I engaged in a process of collecting data, considering the data that then lead to ideas, which in turn lead to further data collection. Interpretative reading, Mason (2002) contends, involves a construction or a version of what the researcher thinks the data means or represents, and what can be inferred from the data. Thematic development was

conducted abductively and although I sought cross-case analysis I undertook early literal and interpretive analysis case by case. The following is a small example of an early coding notation on patient interviews:

**Figure 2. Early analytical theme: ‘Knowing the nurses’ plus data extracts**

<b>Knowing the nurses</b>	“There was a thing above the bed’ but didn’t meet the nurse as far as I know”. <b>Cled (113)</b>	“They all looked after me. No one sticks out” <b>Cled (231)</b>	“They were busy. I don’t remember any of them to be honest.” <b>Dave (154)</b>	Didn’t have a ‘named nurse’ noted above the bed “just whoever was on duty” <b>Eve (372)</b>	“Sister was in charge.” <b>Dave (100)</b>
---------------------------	--	---	--	---	---

By the time all the data had been collected *N6* was being used and all data were transferred into the programme. *N6* simplified the process of interpretative analysis as the use of ‘free nodes’ in the programme made coding easy and enabled limitless codes to be used for any one data segment. As the analysis progressed these categories were collapsed into sets of analytical categories (an example of a free node coded summary from a patient interview is provided in appendix 21). For instance, once data sets had been analysed literally then interpretative understandings that were common across cases started to emerge, one such theme was that of ‘communication’. Using *N6* all the free node coded data segments that related to communication were readily accessible and were collapsed using the ‘merge’ facility present within the programme. This analysis, which was aided by *N6*’s facilities, was conducted concurrently and interchangeably with analysis that used paper copies of data. An example is presented in appendix 22 of a thematic development that drew on this combined strategy.

The themes and categories identified were varied in their origins but were all arrived at inductively. Some arose ‘spontaneously’ from the participants themselves (Hammersley & Atkinson 1995:211) and were important in understanding the role of the AMAU nurses. For instance the analytical concept of ‘*making a bed*’ came from the *in vivo* term being used commonly by the nurses and doctors and indicated a key element of the nurses’ work and importantly how they defined their practice goals. Patients also described their admission to hospital by prefacing their story with an account of the difficulty

their GP had in finding them a bed which supports the importance of this category. Another key category was that of '*knowing your stuff*' this was an *in vivo* label that expressed a cross case understanding of a key element of the nurse's role. The following extract was from an interview with a medical consultant:

**PG.** "Can you think of something would seem to encapsulate really good nursing care taking place, maybe an incident in which you have been involved on the AMAU"

"There was a young diabetic came in over the week-end, a sixteen year old, with ketoacidosis [*a serious blood acid –base imbalance*] and the monitoring that he had the way the nurses organised this especially the insulin and they checked his urine regularly without being asked to do that. It is that sort of thing. It is knowing what is needed for monitoring a diabetic."

*(Consultant Physician. Interview 9:5)*

This extract was coded literally as 'doctor view on good nursing' and then fed into the interpretative understanding that the AMAU nurse required particular skills and abilities. This extract then was merged into the over arching category of '*knowing your stuff*'.

Other categories used were 'observer-identified' (Hammersley & Atkinson 1995) in which analytic concepts were used to describe a phenomenon or range of phenomena drawn from the researcher's own cognitive explanation or from adapting existing concepts from the literature (Hammersley & Atkinson 1995). Such an observer-identified category was '*professional credibility*' that was a classification scheme that was developed by personal insight. The demand – control-social support model of occupational stress (Baker *et al.* 1996), that structured the inductively derived categories of Chapter seven, was drawn on from the work-place stress literature. The use of such established theory that the researcher then links to new findings is a process of recontextualization (Morse & Field 1996) and places the findings in the context of established knowledge. Analysis was on going even when the writing up stage of the study was commenced as considering the content and structure of the findings' chapters was found to be part of the interpretative process. So I returned to the data and reread them all and made notations as to where data segments may inform chapter themes in a recursive process. A new view of the data was enabled, as



findings would take on new relevance due to emerging awareness that had not been considered previously. Being very familiar with the data was a noted aspect of the analysis and often I would search out a particular interview section to develop a theme or interpretation from my memory.

The analytic terms used were able to offer an analytic concept to draw together a particular interpretation. The categories developed were then used to systematically code all of the data. So a cycle developed of reading, literal coding, interpretative coding, and application of the stable set of categories to the whole data set. I sought, as Thomas (1993: 43) reminds us to ensure that interpretative explanation is more than creating a list of typological terms or labels: the goal of analysis is 'defamiliarization' of data. The process of translating what has been seen and recorded into something new, even if data viewed are commonplace or mundane. Throughout data collection the concept of reflexivity had been acknowledged. A reflexive reading of the data that explored my role in data collection and the influence of my personal perspectives on the generation and analysis of data were sought (Mason 2002). For instance, the acute nature of the nurses' work and the large numbers of critically ill patients became a major lens through which I recorded and analysed data. This emphasis was influenced by my past role as a medical ward sister and that I found the high workload on the AMAU to be personally demanding. This particular effect may be less affecting for a non-nurse researching the same area.

Analysis of the data was a process that is difficult to report as the development of themes and analytical understanding progressed in a spiral manner, and yet often in intuitive leaps. Countless hours were spent reading transcripts, reviewing and collapsing coding, and thinking and drawing mind maps to try and achieve conceptual ways to organise the data. Mitchell (1983:207) has contended that qualitative analysis is a social analysis and requires the use of an inferential process and further notes that:

*The validity of the extrapolation depends not on the typically or representativeness of the case but upon the cogency of the theoretical reasoning.*

However, there came a point when decisions on the key themes and how to present them had to be made however throughout I referred to the research questions to frame analysis. The following section will offer a discussion on the evaluation of the research approach utilised drawing on Hammersley's (1992) concepts of validity and relevance.

### **3.9 Evaluating Qualitative Research**

Qualitative research requires criteria on which to assess its validity and methodological rigour but as Hammersley (1992) and Sandelowski (1986) have noted lack of consensus on what qualitative research is, and the wide variety of approaches used finds this to be a problematic issue. Authors such as Lincoln & Guba (1985) contend that qualitative research should not be assessed using the constructs of reliability and validity, internal and external, from the quantitative paradigm. Lincoln & Guba (1985) offered alternative criteria for evaluating qualitative research; these were transferability, trustworthiness or credibility, dependability, and conformability. Guba & Lincoln (1989) have developed further their counter to quantitative criteria of research quality and have offered a further dimension of authenticity. Silverman (2001) suggests that quality should be satisfied in qualitative research by the criteria of conceptual depth, rigour, thoughtful research design, and practical relevance. However, as Burnard & Naiyapatana (2004: 758) argue:

*Although there is discussion in the literature, about the 'trustworthiness' of qualitative analysis, it is also acknowledged that analysis of such data is a subjective process and, in the end, the researcher has to stand by his or her own category system.*

Hammersley's (1992) discussion of the ontological and epistemological nature of qualitative research such as ethnography using the construct of subtle realism, positioned between anti-realism and the stance of naïve realism, I found to be compelling. This concept has similarities to 'analytic realism' described by Altheide & Johnson (1998: 284) that views the social world as an interpreted one and not a literal one. Hammersley (1992) identified three elements of subtle realism. Firstly truth can be better constructed as 'beliefs about which whose validity we are reasonably confident' (Hammersley 1992: 50). When judging claims we judge their compatibility with assumptions we hold about the world,

which we are accepting currently as beyond reasonable doubt. Secondly those phenomena exist independently of our claims about them. So any claims made may represent that reality accurately, or not, but such claims do not change that reality and so cannot be considered true or false. The third element is that social research represents rather than reproduces reality and that phenomena can be represented from multiple perspectives (Hammersley 1992). Hammersley's (1992) interpretation of the concepts of validity and relevance as criteria with which to evaluate qualitative research claims is now discussed.

### 3.9.1 *Validity*

Validity in Hammersley's (1992: 57) terms is defined as 'truth: interpreted as the extent to which an account accurately represents the social phenomena to which it refers.' The concept of subtle realism suggests that whilst there cannot be certainty about the truth of anything nonetheless from our knowledge of the world there are aspects about which we have a confidence as to their truth (Hammersley 1992). Authors, for example, Sandlelowski (1986) and Altheide & Johnson (1998), have argued that a clear description giving details of the process used to collect data, the processes used to code and categorise data and develop conclusions can enhance validity. If an external auditor can judge the trustworthiness of the data and the interpretative processes involved in the analysis this provides an audit trail (Lincoln & Guba 1985; Sandlelowski 1986) that aid judgements of validity. Sandelowski (1996) suggests that if the decision trail of the researcher can be clearly followed and another researcher could arrive at the same or comparable, but not contradictory conclusions given the researcher's data, perspective and situation then validity is increased. This requires that decisions reached about theoretical, methodological, and analytical choices are made explicit within the presentation of a study. Such decisions are made however by the researcher and are influenced by the researcher's personal worldview therefore reflexivity can help acknowledge these influences.

Hammersley & Atkinson (1995) call for qualitative researchers to acknowledge the concept of reflexivity, for when we study the social world we must be part of it: eliminating the presence or effect of the research process or the researcher is an unachievable goal. Qualitative research demonstrates its creditability by

awareness of personal prejudices (Gadamer, 1976). Prejudice is defined by as the established background of understanding that the researcher brings to the work, a form of linguistically mediated pre-understanding where the researcher is situated in history and time, and as such prejudice is a precondition of truth and not an obstacle (Gadamer 1976). A reflexive approach was used throughout the study from the formulation of the research questions to the writing up of the study. To encourage reflexive thinking I maintained a reflexive journal. This enabled recording of my reflexive insights, and the ways in which the products of the research may have been affected by my personal sociocultural background, plus my subjective experiences that were intrinsic to the research (Aull Davies 1999). It also served as a diary of my progress and thinking throughout the progress of the research plus analytical insights or ideas that I did not want to lose; this included importantly recognition of the values and *a priori* assumptions that shaped the research (Hammersley 1992). This journal proved invaluable by providing an outlet for my thinking and captured some valuable ideas that otherwise might have been lost. It also cheered me up when I was despondent and unhappy with my progress to remind me of what I had achieved. There are other disputed approaches that are claimed to enhance validity within qualitative research. These approaches are inter-rater reliability, respondent validation, and triangulation and are discussed next.

### **3.9.1.1 Disputed strategies to enhance validity**

When coding text reliability can be assessed by the degree of agreement amongst data coders so that claims of inter-rater reliability can be made, however this strategy relates to positivistic research designs (Mason 2002). Inter-rater reliability Bowling (2002) argues can enhance the creditability of research findings, however, such claims are contested as inter-rater reliability has its origins in the statistical analysis required in quantitative analysis (Mason 2002). Such concerns have limited relevance for qualitative research that seeks interpretative insights and that acknowledges reflexively that any narrative will have multiple interpretations (Hammersley 1998). Hammersley (1992 and 1998) does not discuss inter-rater reliability specifically but notes that ethnography describes and interprets human action and that the researcher's perspective and experiences will be influential in analysis. For even if inter-raters who are experts

in the field under study describe similar themes they may package the themes differently, for as Armstrong *et al.* (1997: 605) have argued:

*...all analysis is a form of interpretation and interpretation involves a dialogue between researcher and data in which the researchers' own views have important effects.*

I therefore did not draw on inter-rater reliability for the above reasons. The contextual nature of my analysis was informed by other aspects, such as my experiences during participant observation, rather than solely on the text presented as in an interview transcript.

Another strategy claimed to enhance validity is for participants to read, discuss and verify the interpretation drawn from the analysis (Robson 1993). Such respondent validation is established when participants discover in the study recognition of themselves (Cutcliffe & McKenna 2002). However such an undertaking is problematic due to such issues as rules of etiquette and polite behaviour that may lead to the socially expected responses of agreement (Bloor 1997). Such an undertaking can aid analysis but cannot be claimed as a tool to aid validity (Hammersley 1992). Further, issues of interest will vary dependent on the specific audience (Hammersley 1992; Bloor 1997). Respondent validation was not undertaken for the reasons above, and also returning with one's findings to participants is time consuming and not always possible as participants leave the setting. It is acknowledged however that broadening of analysis may have been aided by this strategy. One method used within this study was to ask participants' views on issues raised by previous participants. This enabled some degree of verification however this qualitative study was not seeking consensus agreement 'but rather to "map" a range of views and experiences' (Burnard & Naiyapatana 2004: 758). Prolonged engagement in the field and the development of rapport with healthcare staff enabled me to return to participants, or to events, to gain more complete understanding on developing themes and so enhances claims for validity (Morse & Field 1996).

Triangulation of data, it has been argued, will help increase construct validity, and if different data collection methods provide similar findings then validity can more readily be claimed (Eisenhardt 1989; Sandelowski 1995). Following the

philosophical underpinning of this research and drawing on Hammersley's (1992) notion of a subtle realism the goal of this research was not to seek a single truth. So I did not seek confirming data to prove or disprove hypotheses. In qualitative undertakings the use of multiple methods or data sources is a recognised approach to gain interpretative understanding, as was the case in this research. As Hammersley (1992: 71) noted 'where a claim is central, more convincing evidence will be required than where it is marginal' such evidence must then be judged in terms of its plausibility and credibility. However, on completion of the study I will return to the AMAU and feed back the study's findings to those participants who are still on the AMAU, as well as the wider dissemination that publication enables.

Therefore I do not claim validity based on the multi-method and across case approach used in this study from criteria that would support generalisability as emphasised by quantitative research, merely that such approaches add to the richness of data and a more complete understanding (Mason 2002). Validity was enhanced by gaining interview data from participants from four groups (doctors, nurses, patients, and paramedics), from prolonged participant observation and from documentary evidence. This enabled different perspectives to feed into the interpretation offered (Sandelowski 1986; Guba & Lincoln 1989). By seeking an interpretative understanding of the role of the AMAU nurse rather than generalisable themes I welcomed answers and sought out responses that were different or deviant to the majority of the answers (Morse & Field 1996). Any deviant responses or observations were considered to be important data and informed my analysis. Every piece of data was used which Silverman (2001: 240) terms 'comprehensive data treatment'. Deviant case analysis was sought within this study therefore by the adjustment of categories those data that did not fit with early emerging themes could also be included (Silverman 2001). The second criterion to evaluate research that Hammersley (1992) suggests is the criterion of relevance and this will be discussed next.

### **3.9.2. *Relevance***

Two characteristics of relevance have been identified by Hammersley (1992: 73) these are 'the importance of the topic' and 'the contribution to the literature'. A

judgement can be made as to the centrality or importance of the studied topic to the substantive field and its relevance to the values and needs of the wider society. Claims to generalisation in qualitative research are by theoretical inference (Hammersley 1992) or analytical generalisation (Silverman 2001) and not by statistical measures or probability. If findings and analytical insights or theoretical claims are found to have potential generalisability to fields beyond the field of study then a contribution to theory enhancement and to a cumulative body of knowledge may be claimed. Hammersley (1992) notes that the relevance of any research will be judged by the research's contribution to the literature and further argues that confirming what is already well known is of little value. Research should offer a significant contribution to what is established knowledge and thus judgements of its relevance may vary between audiences (Hammersley 1998). Hammersley (1992:73) contends that:

*...a piece of research may be judged relevant or irrelevant not only in terms of its relating to some topic of interest but also on the basis of its exemplification of some methodological or theoretical paradigm...while there is a role for judging research in terms of method exemplification, the primary emphasis should be on substantive relevance.*

I contend that if the findings of this research are shown to fit with contexts outside the study and with what the reader considers meaningful and applicable in terms of their own experience (Sandelowski 1995) then claims for relevance can be made. Lincoln & Guba (1985) suggest that the reader can judge the transferability of findings and if sufficient information is given similarities with comparable settings can be made. Throughout the reporting of findings detail as to the setting of data collection and findings are presented with data extracts so that the reader can judge the relevance of the interpretations offered. However, throughout a balance was sought between presenting in-depth data and protecting the anonymity of the setting and participants. The validity and relevance of this study are evaluated in Chapter nine.

### **3.10 Summary**

In this chapter the research approach utilised has been discussed and justification for decisions related to data collection, handling, and analysis made. The goal of the research was to describe and explain the role of the AMAU nurse and an

ethnographic approach supported this endeavour. Across case perspectives gained by interviewing and discussions in the field and the review of documentary evidence helped to provide rich descriptions of the nurse's role. Prolonged participant observation provided in-depth insights into the culture of AMAU nursing and the factors that enhanced and impeded the nurse's role within the unit. Judgements on claims for validity and relevance will be made by the contribution that this research makes to the health care literature and the degree to which those who read the thesis value the social constructions provided. The review of the powerful premises of deontological bio-medical ethics and the personal appreciation gained of contextual ethical decision-making were personal insights enabled by this study.

An introduction to the analysis of the study is provided in the following chapter. Two of the key theoretical insights that helped develop the study's findings and subsequent discussion are introduced. The four chapters that present the key themes of the study are also outlined and the characteristics of the interview participants detailed.



## CHAPTER FOUR

### INTRODUCTION TO ANALYSIS

#### 4.1 Introduction

In this chapter an introduction to the analysis of this study is presented. Firstly, overviews of the most significant theoretical perspectives identified during the study's latter stages of data analysis and thematic development to aid articulation of findings are reviewed. The two theoretical insights considered are those of communities of practice (Wenger 1998) and the demand-control-social support (D-C-S) model of occupational stress (Baker *et al.* 1996). These concepts are comprehensively explored as they were drawn on principally, but not exclusively, to aid analysis and understanding of the data and therefore the role of the AMAU nurse. My theoretical conceptualisation of role has been discussed previously in Chapter one. Hammersley (1992) suggests that an important aspect of demonstrating relevance in an ethnographic study is the potential contribution that findings make to theoretical development. Therefore the utilisation of these theoretical perspectives offered theoretical substance to the findings of the thesis but their use also aids the theoretical development of the concepts themselves. This discussion is followed by an introduction to the thesis's themes and finally the characteristics of the interview sample are outlined. Firstly the concept of community of practice (Wenger 1998) is considered.

#### 4.2 Communities of Practice

As will be expanded in subsequent chapters the AMAU nurses practiced in a unique setting unlike any other in the hospital: it was not a traditional general medical ward nor was it an accident and emergency (A&E) department. Understanding the role of the AMAU nurse and of AMAU nursing practice was aided by an understanding of the concept of community of practice (Wenger 1998). Within this section there are two sub-categories, which are *defining communities of practice* and *application of the concept*. Firstly, a critical review of the concept of community of practice is provided.

#### 4.2.1 *Defining communities of practice*

The concept of a community of practice relates to any group that is involved in joint activities and who reproduce the community over time with the induction of new participants to the community. Within a community of practice a shared practice is experienced and is not merely the sharing of an interest or simply being in a particular geographical location (Wenger 1998). The initial identification of the concept of communities of practice was by Lave & Wenger (1991) who both have an academic background in educational scholarship and research and in particular social learning. Lave & Wenger (1991) developed their understandings after reviewing studies of modern apprenticeships that included non-drinking alcoholics who attended Alcoholics Anonymous, US Navy quartermasters, supermarket butchers, and Yucatec midwives. These examples were drawn on to illustrate the premise that effective learning occurs when individuals develop social participation in a community of practice: this learning occurred by what Lave & Wenger (1991: 37) named as 'situated learning'. New participants in a community of practice are viewed as co-participants from the very beginning of their practice, even though functioning initially on the periphery of practice by their engagement in 'legitimate peripheral participation' (p.29). Such learning follows trajectories of participation with 'centripetal movement' towards full participation, and a new identity shaped by their 'changing knowledge, skill, and discourse' (p.122). The concept of situated learning has been used as a theoretical framework with which to explore the learning experiences of student nurses exposed to two very different pre-registration curricula (Cope *et al.* 2000).

Cope *et al.* (2000) explored the concept of situated learning in a comparative study of two pre-registration nursing student groups who had experienced different educational programmes (the 1982 scheme in schools of nursing and Project 2000 scheme in higher education). Interviews were conducted with students selected by random sampling ( $n=11$  from the 1982 scheme and  $n=19$  from the Project 2000 scheme). The interview questionnaire was developed to investigate potential areas of difference that students experienced following curriculum change. Data were analysed informed by the theoretical perspectives of situated learning (Lave & Wenger 1991). Students' responses from both

groups were noted to be similar however as Cope *et al.* (2000) note the research strategy utilised may not have been sensitive enough to distinguish fine-grained differences in the students' experiences. Disadvantage of such interviews guided by structured questionnaires include the assumption that questions asked would be understood in the same way by all participants and thus lack the comprehensiveness to gain alternative insights that an unstructured format allows (Bowling 2002). Nonetheless, all of the students stressed the importance of their clinical placements in their development as competent nurses and the divergence between their educational preparation and the practical components of their course. Cope *et al.* (2000) argue that preparation of mentors would be enhanced if the concept of situated learning and the utilisation of cognitive apprenticeship techniques were incorporated into this preparation. The interview questionnaire was not provided so the questions asked cannot be reviewed therefore challenges to suppositions within the questioning could not be made. Nonetheless Cope *et al.* (2000) argue that the common experiences of student nurses adds validity to the usefulness of the concept of situated learning when seeking to understand the elements of an effective learning environment. However, Cope *et al.* (2000) do not critique the concept or the underpinning philosophies of its authors.

Hammersley (2005) offers cautionary arguments against wholesale acceptance of the concept of situated learning as Lave & Wenger's (1991) position argues that formal education, as in a classroom setting, and academic educational research generally, has a limited positive effect on the learning of the student. Over-reliance on propositional knowledge and decontextualised knowledge has been highlighted as a concern for professional educators (Schon 1987). This Hammersley (2005: 6) concedes as being a valued argument and notes that 'effective practice depends on distributed learned capacities, rather than on the intellectual knowledge or skills of any single person'. Hammersley (2005) nonetheless cautions against accepting arguments that would discount the relevance of formal learning. Rather, as Nonaka (1994: 22) has argued knowledge development can be enlarged and enriched by an interactive movement between tacit and explicit knowledge and that:

*Individual knowledge is enlarged through this interaction between experience and rationality and crystallized into unique perspective original to an individual.*

Lave (1996) has developed her ideas and argues against the usefulness of formal teaching and the uniformity of propositional knowledge. However, Wenger's subsequent work developed the concept of community of practice, a concept that was alluded to but not then developed by Lave & Wenger (1991). Wenger (1998) however draws on situated learning as a conceptual underpinning to inform understanding of social learning rather than offering a polemic against formal teaching. Wenger's (1998) theoretical understanding of situated learning and communities of practice was developed following a longitudinal ethnography of medical insurance claims processors in a large USA medical insurance company in 1989-1990. Wenger (1998) describes his increasing appreciation of the social aspect of learning and the development of such learning and notes:

*Overtime this collective learning results in practices that reflect both the pursuit of our enterprises and the attendant social relations. These practices are thus the property of a kind of community created over time by the sustained pursuit of a shared enterprise. It makes sense, therefore to call these kinds of communities 'communities of practice' (Wenger 1998: 45).*

Wenger (1998) situates the concept of communities of practice as a social theory of learning that develops both structural and action (or agency) social theory. Duguid (2005) concurs and describes community of practice theory as a social theory inherently which can help illuminate tacit knowledge (Polanyi 1966) by emphasising the complementary nature of *knowing how* that can help to make *knowing that* actionable. Wenger (1998) argues that a community of practice will have three main dimensions that have developed through routines and repeated interaction, and not by rule or by design. Firstly, within a community of practice there is a *mutual engagement* that binds members into a social entity, developed by negotiation of the meaning of their practice that incorporates diversity. Doing things together, developing mutual relationships and community maintenance evidences this engagement. Participants are thus involved in a *joint enterprise* that is continually renegotiated by its members leading to the formation of a local code of practice and a regime of mutual accountability. And thirdly, the capacity that the community has produced is reified by the *shared repertoire* of communal

responses developed over time. This repertoire reflects the history of the mutual engagement but also the resources to produce new meaning (Wenger 1998). These resources include stories, historical events, routines, symbols, discourses, vocabulary, tools, and documents that then act to hold and to transmit the accumulated knowledge of the community and provide dynamic co-ordination. Wenger (1998) argues that a community of practice will result in 'a 'locally negotiated regime of competence' (p.137) and a 'shared history of learning' (p.86). A community of practice is more than the technical knowledge or skills that members learn and emphasis is given to the relationships that are built over time (Lave & Wenger 1991). Such communal enterprise develops in the members a sense of identity with the group. The shared repertoire of generated ideas, commitments, and memories then contributes to the effectiveness of the community of practice. The concept has been developed by academic discourse and research conducted by a wide variety of professional communities. Scholarly development of the concept of community of practice is discussed next.

#### *4.2.2 Application of the concept*

The concept of community of practice has been applied to various settings, including on-line learning (deLaat *et al.* 2000; McLure Wasko & Faraj 2000), inter-agency learning (Lathlean & Le May 2002; Gabby *et al.* 2003), nurses' learning (Burkitt *et al.* 2001), becoming a doctoral student (Hasrati 2005), power relationships in an anaesthetic setting (Goodwin *et al.* 2005), and the process of becoming a Wiccan (or witch) (Merriam *et al.* 2003). These research studies are explored and the concept's limited application to nursing is highlighted.

The concept of communities of practice has provided conceptual underpinnings to research into learning through participation. For instance, de Laat *et al.* (2000) undertook a pilot study of the use of computer supported collaborative learning in an organizational setting. Eight Dutch police officers participated in an on-line learning environment to discuss work related problems using *Web-Knowledge Forum* (a computer programme designed to support a web-based learning environment). This programme collates all on-line communication and provides a shared database that is available to all participants and aims to facilitate both cognitive and metacognitive activities. Following a two month period during

which time the participants worked together using the programme, the content of the written notes submitted were analysed for their content into three main headings: cognitive activities, metacognitive activities, and affective activities. Participants were also asked to complete a questionnaire about their experiences of working with *Web Knowledge Forum*. Overall the programme and the working of on-line communities of practice were found to be helpful. One problem noted was related to the unstructured nature of the process and a lack of a directed focus to the discussion, which could be remedied, de Laat *et al.* (2000) suggest, by the agreement of a learning agenda. de Laat *et al.* (2000) argue that this research supports the use of working in communities of practice in organisations and that such on-line group-ware holds a promising direction in which to share learning and develop shared problem solving. Lathlean & Le May (2002) and Gabbay *et al.* (2003), in a non-electronic setting, also describe difficulties in the development of an agreed approach to a joint enterprise when setting up a new community of practice.

Lathlean & Le May (2002) and Gabbay *et al.* (2003), whilst discussing the same studies, drew on the concept of community of practice to investigate multi-professional inter-agency working. Two action research projects were undertaken; one related to primary care, in particular care for older people, and the other related to outpatients' services for dermatology and ear, nose and throat provision, in which communities of practice were to be developed. Developing approaches to deal with issues identified by the community and drawing on the key concepts of communities of practice Lathlean & Le May (2002) highlight challenges to working in this way. These include agreement on who should be the leader of the group, for at first participants looked to the facilitators of the project for leadership. However, over time when the group assumed ownership for the project then reliance reduced. A particular challenge was the creation and maintenance of a shared purpose and this required the group to develop a consensus rather than being lead by one particular professional group. Lathlean & Le May (2002) suggest that studying the functioning of communities of practice provides a useful basis to gain understanding of decision-making and how knowledge and information occurs between different agencies. This echoes

the claim held for communities of practice that they enhance shared learning (Wenger 1998) that is supported by McLure Wasko & Faraj (2000).

In an on-line setting McLure Wasko & Faraj (2000) examined three *Usenet* newsgroups (Internet protocols that provide self-organizing electronic discussion where an issue in the newspaper/journal is discussed on-line in a public forum). Three technical communities all related to computer working were selected, as these areas are part of a rapidly changing and technical area it was considered that they would provide a dynamic environment. An invitation to contribute was sent by email and participants were asked why they participated in the forum and helped others. Content analysis of 531 responses, some participants gave multiple motivations, from 342 participants (information on total number of participants approached is not supplied) was conducted. Results indicated that the highest number of comments ( $n=213$ )(41.9%) related to the benefits that 'interaction with a community' provided (McLure Wasko & Faraj 2000:164). Barriers to the community included worries over lack of expertise, unwillingness to aid some contributors such as university students who had not done their background reading, and issues that arise in face-to-face groups such as dealing with big egos and perceived personal attacks.

McLure Wasko & Faraj (2000: 170) suggest that organisations rethink current management strategies based on knowledge markets and extrinsic reward systems and rather convince 'members that knowledge should be treated and valued as public good rather than a private good'. However, Peltonen & Lamsa (2004), whilst acknowledging the potential positive influence of the concept of community of practice on workplace innovation (cultural and social) and knowledge creation, argue that there is still work to do on the full social theory implications before its acceptance as a working theory of organisational knowledge creation and learning in the modern business enterprise. Peltonen & Lamsa (2004) contend that there is a risk (supported by Lave & Wenger 1991) that communities of practice could be over romanticized. A community of practice may not be a positive environment if the enduring culture is that of poor work practices or unequal power relationships (Goodwin *et al.* 2005). Further, that the value of the existing formal educational process must be respected as

over reliance on social learning has as yet uncertain results (Peltonen & Lamsa 2004). Wenger & Synder (2000) offer suggestions as to why the concept of community of practice may be greeted with reservation. They suggest that, as it is a fairly recent articulation of what is an old idea, there have been limited numbers of companies that have sought to nurture communities of practice. And finally, by their nature communities of practice have an 'organic, spontaneous, and informal nature' and so makes them 'resistant to supervision and interference' (Wenger & Synder 2000:140). This observation can help understand the problems when seeking to instigate a community of practice as noted earlier (deLaat *et al.* 2000; Lathlean & Le May 2002; Gabbay *et al.* 2003). For, it is the organic nature of social learning, rather than reliance on formally structured and explicit learning, that is the predominant conceptual insight into organisational learning provided by the concept of community of practice.

Amin & Cohendt (2000: 95) in a discussion of organisational learning describe communities of practice as '...vital sources of both routine and strategic learning through interaction and everyday actions bringing together tacit and formal knowledge'. These authors argue that learning in the firm, or organisational place of work, has been poorly understood as regards the chance discoveries, experimentation, and trial and error learning that takes place. Amin & Cohendt (2000: 107) further contend that:

*Every organisation is made up of many communities of practice in which learning is not a matter of conscious design or recognisable rationalities and cognitive frames, but a matter of new meanings and emergent structures arising out of common enterprises, experience and sociability-learning in doing.*

Learning-in doing was exemplified by Hasrati (2005) who utilised a constructivist grounded theory approach to understand the process of PhD supervision of Iranian students studying in five UK universities. This was part of larger project that sought understanding of the process of academic socialisation of these students. Thirteen Iranian PhD students were selected, eight who were in engineering faculties and five who were in social sciences faculties together with six of their supervisors (four from engineering and two from social sciences). Qualitative semi-structured interviewing was utilised and data analysed using



grounded theory principles. The four themes developed were: initiation; scaffolding; the supervisors' role in inter-student cooperation; and the supervisors' feed back on students' writing. Hasrati (2005) argues that most learning occurred through informal interactions with their supervisors and other PhD students. The students valued undertaking low skill tasks, such as basic laboratory work initially to build their confidence. In summary Hasrati (2005) describes these findings as supporting the theory of legitimate peripheral participation, and the legitimacy that the newcomers, i.e. the PhD students, were given by their supervisors' approach to research training that demonstrated apprenticeship-type approaches to models of supervision.

Belonging to a community of practice relates to a joint enterprise and mutual engagement and as such can be discovered in unusual places and not solely in formal educational settings or endeavours. Merriam *et al.* (2003) developed the concept of community of practice and legitimate peripheral participation by applying it to a marginalized group of Wiccans (or Witches). A purposeful sample of Wiccans ( $n=20$ ), eight men and twelve women were selected. Using a qualitative semi-structured interview format participants were asked how they became a Wiccan and what learning occurred during the process of becoming a Wiccan. Following analysis using the constant comparative method three themes supportive of Wenger's (1998) community of practice were identified: a trajectory of participation, learning in practice, and identity development. Merriam *et al.* (2003: 187) summarise from their research that:

*Although there is clearly a cognitive dimension to learning, this study points out the shared nature of the learning, the need for practice, freedom to make mistakes, and opportunities to discuss experiences and reflect on those experiences.*

Very similar findings were achieved following a study of UK nurses. Burkitt *et al.* (2001) in a study commissioned by the English National Board for Nursing, Midwifery and Health Visiting sought understanding of the knowledge and skills that nurses utilised in their practice. The study commenced with pilot focus groups that asked both students and qualified nurses (both clinically and educationally based) how they used cognitive and affective processes in their practice. The terms cognition and affective were soon identified as being poorly

understood by participants. The research approach was then modified to identify concepts that would emerge from the data, terms that nurses and educationists actually used and understood. The final study aim was to understand the 'construction of the identity of the nurse and account for the acquisition of key skills and competencies in nursing' and an ethnographic approach was utilised (Burkitt *et al.* 2001: 19). Participants were registered nurses ( $n= 15$ ) and student nurses ( $n=5$ ) who were shadowed for 4-6 days in a variety of clinical settings. Semi-structured interviews incorporating critical incidents were then conducted with these participants. Interviews were then conducted with nurses working in educational settings ( $n= 18$ ) and focus groups with participants attending seven post-registration educational programmes.

Initially two researchers, who had not been involved with the collection of data, carried out thematic analysis. The researchers noted that this approach enhanced the analysis but do not clarify why this is. Qualitative analysis of ethnographic data that does not have the interpretations of the data collector negates against the potential for drawing on personal experiences gained whilst in the field that can enhance understanding. As Hammersley & Atkinson (1995) note analysis in ethnography is not a distinct phase as it actually feeds into the research design and conduct of the research, including acknowledgments of reflexivity. A member of the team who had been involved in data collection conducted the final analysis drawing on the initial analysis to allow the 'existential component' of the data collection (Burkitt *et al.* 2001: 24). However, this was then offering insights onto an already structured analysis so, although not specified, this approach may have been for pragmatic reasons rather than a planned strategy to enhance qualitative analysis. Nonetheless the findings are interesting and hold resonance as Burkitt *et al.* (2001) developed the concept of community of practice and applied it to nursing practice as represented by a two-axis figure. The vertical axis is a subjective axis, defined through nursing identities and a social psychological sense of identity or a 'consciousness of kind' (p.37). The horizontal axis is an institutional axis that reflects the combination of the interaction of resources, power, space, and time in a specific setting. The nurse's sense of identity must operate, Burkitt *et al.* (2001) argue, within an institutional infrastructure that is controlled by outside forces that emit from managerial

drivers. Burkitt *et al.* (2001) argue that as the two axes interact this then affects the nurse's experience of being a nurse. Therefore, working in practice settings that are influenced predominantly by economic and external health care philosophies can lead to 'an alienation of the human essence of caring from the process of caring' (Burkitt *et al.* 2001:60). Benner (1984) drew on the articulation of tacit understanding to understand the caring of expert nurses within their area of clinical expertise. Benner (1984), who conceptualised the novice nurse gaining expert knowledge through the learning of structures of thought that are then applied to practice has been a seminal influence on understanding the development of nursing expertise. However, this contrasts to the social nature of learning that the concept of community of practice espouses (Burkitt *et al.* 2001). The application of knowledge as form of 'embodied practice' was identified as being valued by participants rather than 'the overly cognitive view of knowledge and practice found within nurse education' (Burkitt *et al.* 2001:97). Learning was viewed as embodied performances that involved 'engagement with the world and interaction with co-participants in joint practices' (Burkitt *et al.* 2001:27). Such construction of a social identity occurs, Wenger (1998) suggests, through participation in the community where new skills and knowledge are learnt and mastered in co-participation and subsequent reformulation of the participant's identity. However, from a nursing perspective the development of the role of the nurse can also be constrained by internal boundaries within the community of practice.

Goodwin *et al.* (2005) using an ethnographic approach sought to understand multi-professional anaesthetic expertise. Data were collected from observation of interventions in the anaesthetic room that included nurses, patients, operating department practitioners (ODPs), and doctors (anaesthetists and surgeons). This report was drawn from a larger study and the number of observations recorded was not reported. Wenger (1998) describes boundaries of practice occurring at the margins of communities of practice and when communities overlap. Goodwin *et al.* (2005) identified within the anaesthetic community of practice boundaries within the community that distinguish and contain members' professional development. These boundaries were conceptualised as being drawn on professional discipline lines and that there were enduring constraints on the

centripetal movement of nurses and ODPs due to the dominance of medical professional knowledge:

*Consequently, the nurses' and the ODPs' participation is capped limiting the resources they have to participate and influence the care of the patient*  
(Goodwin *et al.* 2005)

Further constraints on the development of the nurse's role can also be considered drawing on Burkitt *et al.*'s (2001) conceptualisation of a potential distinction between the generic sense of identity as a nurse, an *imagined community*, and the particular kind of nurse that reflects their practice 'I am an AMAU nurse' that Burkitt *et al.* (2001: 28) describe as an *actual community of practice*. The nurse can experience dilemmas when the demands of the imagined community, as in professional and academic drivers, seem to be contrary to the reality of the actual community where the nurse has to deliver clinical care. When a community of practice exists participants experience a sense of belonging and an allegiance to the community's common enterprise.

Wenger & Synder (2000) discuss the differences between communities of practice, formal work groups, teams, and informal networks. What distinguishes a community of practice from a formal work team Wenger & Synder (2000) suggest is a will to build and exchange knowledge and an evident self-section for inclusion in the group by members. Further a community of practice will exist for as long as the group seeks to maintain it, and the continued demonstration of 'a passion, commitment, and identification with the group's expertise' (Wenger & Synder 2000:142). In this study I argue that the praxis witnessed on the AMAU was an enhanced form of practice and articulation of its culture can be aided using the concept of community of practice. I will argue that the AMAU nurses' working culture was more than a formal work group that seeks merely to deliver a service with a manager's control required for its members to deliver the job's requirements. Additionally, the social construction of the AMAU nurses' learning was a clearly recognisable factor in their clinical development. The application of the concept of community of practice in aiding understanding of the role of the AMAU nurse will be evident in the findings of this thesis. However, whilst communities of practice provided a thread of understanding that ran throughout the thesis other theoretical insights were also utilised to develop

an in-depth understanding of findings. In particular, (as will be discussed in Chapter seven), the work place stresses and balances that the AMAU nurses experienced in their role were not explained comprehensively by drawing on the concept of communities of practice. The Demand-Control–Social Support model of occupational stress (Baker *et al.* 1996), a widely accepted and researched model of work-place stress that enhanced understanding of the AMAU nurse’s role will be discussed next.

### **4.3 The Demand-Control-Social Support Model of Occupational Stress**

The AMAU nurses faced constant demands related to the severity of the illnesses that patients presented with, the numbers of patients admitted, and the nurses’ responsibilities when managing the environment of the AMAU. I was interested in the apparent paradox of high demands and responsibilities, with the nurses often articulating worries over these issues, and the enjoyment of their work that was evidenced. Chapter seven explores this aspect of work place stress in the theme *‘I love the buzz’: the AMAU nurse’s stresses and balances*. The categories of this theme are organised using the demand, control, and social support (D-C-S) model of occupational stress (Baker *et al.* 1996; Tummers *et al.* 2002). Comparable themes had been developed inductively by data analysis and without conscious realisation that a formal model existed. Following a review of the literature the D-C-S model was considered a useful representation with which to structure findings related to the work place stressors and balances experienced in the role of an AMAU nurse. An overview of this model is presented next.

#### **4.3.1 Theoretical understandings of the D-C-S model**

The Demand-Control (DC) model, also known as the job-strain model, is a commonly utilised model to understand negative and positive effects of organisational work place stress levels (Baker *et al.* 1996; Tummers *et al.* 2002). This model relates to the combined effect of high job demands and low control leading to negative health outcomes. Baker *et al.* (1996) have discussed the problems with research that has attempted to validate the DC model due to lack of consistency in definitions of the terms demand and control.

Demand, it is suggested, (de Jonge *et al.* 1999), is a key source of job stress leading to negative psychological and physiological effects. Work place demands such as time pressures, high working pace, and difficult and mentally exacting work were enduring elements in the AMAU nurses' practice (de Jonge *et al.* 1999; Muncer *et al.* 2001). If increased work demands lead to health workers experiencing adverse affects on their mental and emotional health and well being this can lead to occupational burnout and job dissatisfaction (de Jonge *et al.* 1999). Baker *et al.* (1996) argue that increased workload demand, if coupled with decreased control leads to negative health effects. Better psychological effects related to life satisfaction are experienced if a person has an internal locus of control (Landau 1995), rather than experiencing an external locus of control. It is argued that an internal locus of control can have a moderating effect on job stress and health as those who can regard stressors as controllable will utilise problem focussed actions rather than reacting with emotional based actions (Schmitz *et al.* 2000; Mc Vicar 2003).

In a study of German nurses' job satisfaction and potential for burnout a self-report questionnaire was completed ( $n=185$ ) that had been developed using the recognised and tested scales of Life Satisfaction and the Oldenberg Burnout Inventory (OLBI) (Demerouti *et al.* 2000). Demerouti *et al.* (2000) describe burnout, demonstrated by exhaustion and disengagement, being influenced by excessive demands and inadequate resources. A particular finding was that nurses exposed to high work demands, although reporting high levels of exhaustion, did not always report disengagement. Those nurses experiencing high work demands but who were also confronted with a lack of resources, such as performance feedback and participation in decision-making, were more likely to report disengagement. Demerouti *et al.* (2000), developing Herzberg's two-factor theory of motivation (Herzberg *et al.* 1959), suggest that their findings support the contention that work satisfaction is enhanced by achievement, responsibility, and recognition. When such motivators are absent then employees cannot satisfy personal growth needs and 'develop a neutral and indifferent attitude towards their work' (Demerouti *et al.* 2000: 461). The lack of inclusion of any measurement of the social support that the participants experienced is a criticism of the research as increasingly research on work-place stress

acknowledges the value of social support in the work place. Additionally, the DC model has been criticised because it over simplifies the complexity of work by concentrating on job demands as the 'root cause of occupational stress' (Janssen *et al.* 1999:1361). Baker *et al.* (1996) offer an integrated model of occupational stress that builds on the DC model but which emphasises also the need to identify the level and type of social support. Further, Baker *et al.* (1996) suggest that research should assess separately the affect of these measures on job satisfaction and health rather than as a combined construct.

The concept of social support in the workplace has become an increasingly important topic in the study of work place stress as high social support has been shown to influence positively job satisfaction and an individual's health status (Tummers *et al.* 2002). Langford *et al.* (1997), from a concept analysis of the term social support, contend that social support is the assistance and protection that individuals give to others. Social support in the workplace can be developed by the values of the organisation, such as supporting a friendly working environment, which then contributes to employees' job satisfaction (Verplanken 2004). These contentions are supported by Shirey (2004: 313) who, following analysis of 15 research articles related to nurses' work place social support, argues that 'inherent to the conceptual definition of social support is the notion of reciprocity that involves exchanges of resources between at least two individuals'. Shirey (2004) contends that social support offers a buffering and mediating influence on workplace stress and its potential for negative sequels such as burnout, absenteeism, and intention to leave. A gap in the literature noted by Shirey (2004) related to the effect social support would have on patient outcomes, as it would seem logical that there would be a positive correlate to be found. The AMAU nurses faced high work demands, both physical and psychological and frustrating aspects of their work, such as numbers of admissions, over which they had limited control. However, paradoxically the nurses expressed their appreciation of the degree of control they had over their working environment. Additionally the importance of social support was evidenced in the practice of the nurses therefore the D-C-S model was a useful theoretical contribution to aid understanding of the role of the AMAU nurse.

Within this section I have introduced and reviewed the concepts of community of practice and the demand-control-social support model of occupational stress. The usefulness of these concepts for illuminating understanding of the role of the AMAU nurse will be evidenced in subsequent chapters. In the next section the themes of the thesis are introduced.

#### **4.4 Key Themes of the Study**

From analysis of the data four key themes emerged. In the first theme, which is developed initially in Chapter five, the AMAU nurse's role in managing patients' transition and the nurses' community of practice is introduced. The nurses' self-designed and self-managed role in the coordination of the acceptance of patients to the AMAU and the subsequent provision of care and rapid transfer or discharge of the patient is discussed. In the second theme developed in Chapter six the professional skills and attributes of the AMAU nurses are considered. It is argued that the AMAU nurses had developed skills and abilities related to communication and a professional credibility guided by their common enterprise within their community of practice. In Chapter seven the third theme, "I love the buzz": the AMAU nurses' workplace stress and balances', draws on the demand-control-social support model of occupational stress noting the particular and indeed unique demands that the nurses faced. It is argued that the high work place demands that were encountered were ameliorated by the degree of control that the nurses' exercised over their individual practice and the social support that they received from one another. The final theme of 'organisational constraints and practice boundaries for AMAU nursing' is discussed in Chapter eight. The institutional influences on the role of the AMAU are considered and evidence offered for an approach to care that had been modified to reflect their real world demands. The nurses' working relationships with other professionals are considered, in particular the working relationships with medical staff. The chapter concludes with a discussion of the potential future development of the AMAU nurse's role. The study's findings were based on the analysis of two years of part-time participant observation undertaken from January 2001 to January 2003, semi-structured interviews ( $n=19$ ), and documentary evidence. In the following section the characteristics of the participants who were selected for interview are described.



#### **4.5 Characteristics of the Interview Sample**

Seven nurses were recruited all of whom were female (there were no male nurses who were permanent staff on the AMAU) and their ages ranged from 25-47 years with an average age of 34 years. One ward sister (or G grade), three senior staff nurses (or F grade), two experienced staff nurses (or E grade), and one junior staff nurses (or D grade) were represented in the sample. All of the nurses worked full-time with the exception of one nurse who worked part-time. The selection reflected the range of the nurses' grades and the proportion of full to part-time nursing posts on the AMAU. The nurses had all worked on the AMAU for at least six months with three years being the average length of time on the AMAU. Six patients were recruited to the study, four male and two female. As has been discussed in Chapter three a further three female participants were recruited but withdrew their consent once they returned home. Patients' ages ranged from 20-75 years with an average age of 49 years. The medical diagnoses of the patient participants included transient ischaemic attacks; viral meningitis; unstable diabetes (hypoglycaemia); diabetic ketoacidosis; chronic obstructive pulmonary disease; and pneumothorax. The average time that the patients interviewed spent on the AMAU was 14 hours, which compares favourably with the average length of stay of patients on the AMAU of 12-14 hours (Trust Data 2004). Four doctors were recruited and the sample consisted of a consultant physician, a senior registrar, a general practitioner, and pre-registration house doctor. There was one doctor who was female and three who were male. Their ages ranged from 25-55 with an average age of 41 years. Two paramedics were recruited, one male and one female with an average age of 40 years.

#### **4.6 Summary**

In this chapter the two main theoretical concepts that were drawn on to describe and explain the role of the AMAU nurse within this study have been introduced. An overview of the four themes of the study was presented and the characteristics of the interview participants detailed. The following chapter commences the presentation of findings and discussion with the study's first theme, which is the AMAU nurses' role in co-ordinating patients' transition.

## CHAPTER FIVE

### THE AMAU NURSES' ROLE IN CO-ORDINATING PATIENTS' TRANSITION

#### 5.1 Introduction

This is the first of four chapters that presents and discusses the study's findings to realise the research aim of describing and explaining the role of the AMAU nurse. A core finding from the study was the identification of the AMAU nurses' role in the co-ordination of rapid patient transition into and through the AMAU. This chapter examines the AMAU nurses' working culture; a distinct way of working that had evolved to achieve this central aspect of their role. Theoretical insights were drawn on to aid understanding, these included in particular the concepts of primary nursing and New Nursing (Savage 1995), and communities of practice (Wenger 1998). Wenger (1998) notes that participants in a community of practice define and pursue their joint enterprise by a shared repertoire of locally negotiated resources such as tools, documents, routines, vocabulary and symbols that can carry the accumulated knowledge of the community. Therefore to situate the role of the AMAU nurse in its cultural context this chapter discusses the negotiated resources developed by the AMAU nursing team within the categories of: *'First responders': managing beds*; *'Doing the board'*; and *Organising work: valuing continuity of care*. As discussed earlier to protect nurse participants' anonymity a convention of identifying interview extracts by noting the unit's sister and the senior staff nurses as 'senior nurses' and the other registered nurses on the unit as 'staff nurses' has been adopted throughout the study. The AMAU nurse's key role in the facilitation of the admission of patients to the AMAU is discussed next.

#### 5.2 'First Responders': Managing Beds:

In this category the AMAU nurse's role in coordinating the use of the AMAU beds and the priority that the nurses gave to this aspect of their role is considered. A distinct aspect of the AMAU nurse's role was accepting patients for admission from, most commonly, GPs (Trust Data 2003) and this is discussed in the sub-category of *'taking the call'*. The focal role that the nurses played in managing

beds on the AMAU is then developed within the sub-category of *'making a bed'*, in which the skills to provide an empty bed for a new admission in situations of chronic bed shortage are discussed. Firstly, an introduction to the AMAU nurse's role in the admission of patients is presented.

Most AMAU patients were admitted either directly from home at a GP's request or from a GP's surgery (Trust Data 2003). However, patients were also admitted from the A & E department, outpatients' clinics within the hospital, tertiary hospitals, residential homes and nursing homes, both private and publicly funded, and mental health units. (A diagram to illustrate routes of admission to the AMAU is provided in Appendix 3.) However, patients could only be admitted if there were beds available and as will be developed throughout the study bed availability was an enduring problem for health care staff, and for patients. Yet, once admitted patients stayed on the AMAU, on average, for 12-14 hours only, sometimes less but only longer if bed shortages in the hospital impeded patient transfer from the AMAU (Trust Data 2001). The nurse's role on the AMAU was a complex one with distinct role expectations related to the management of beds:

**PG.** "What are the main responsibilities of the AMAU nurse?"

"I would say to manage beds efficiently, to liaise with all the wards so to transfer in and out, to get the patients in easily we need to get them out, and to be there to initiate and to care for the acutely ill. We are like 'first responders' so to speak."

*(Senior Nurse. Interview 4:1)*

This senior nurse's account of her main responsibilities related directly to the purpose of an AMAU, which is to admit, treat and transfer acutely ill medical patients (Jervis 2000; Wood 2000a; Mather & Connor 2002). The bed management role was a time consuming endeavour and a distinctive aspect of the AMAU nurse's role. It is of note that the nurse in the above extract indicated the bed management element of the role before considering the direct care needs of the patient. Interestingly, the term 'first responder' does not relate solely to the role of a first responder to a cardiac or respiratory resuscitation, which is the usual understanding of the term (Resuscitation Council 2003). The term 'first responder' was used by the nurse to encompass the AMAU nurses' unique

function which was to be the first point of contact when a doctor, usually a GP, wished to admit a patient as well as their role in the initial assessment and treatment of patients. As the following extract illustrates it was not only senior nurses who viewed bed management as an integral part of the AMAU nurse's role. The staff nurse in the following interview extract had worked on the AMAU for less than a year:

**PG.** "If someone asked you to describe what your job entails on this AMAU what would you say?"

"It is a bit of everything. I mean you have got the numbers of admissions, which you don't have on the ward. Taking the call from the GP and accepting the patient. You have got extras, which is the experience of the bed management. You have got more investigative work as well to do with the patient and dealing more closely, I feel, with the consultants because you provide information for them when the patient is first admitted."

*(Staff Nurse. Interview 4:3)*

As emphasised by the senior nurse in the interview extract discussed earlier this junior staff nurse also defines her role predominantly in terms of bed management and dealing with large numbers of admissions. This bed-managing role was an expected competence of all the AMAU nurses with no perception that there were different expectations in this role for the senior and the more junior staff. The AMAU nurses therefore required specific skills to manage beds so as to enable rapid transition of patients through the AMAU, as the more rapidly a patient was transferred the sooner there would be a bed free to accept another admission. However, this rapid throughput of patients did not restrict the development of the doctor-patient relationship as the medical consultant's team who had admitted the patient generally maintained medical responsibility for the patient after transfer. Yet, this was not the case for the AMAU nursing team and resulted in the nurses seldom knowing patients' outcomes:

"Here you are more involved with the patient initially and then once they are transferred out then *(pause)* well that is the only problem. Once they are transferred out you don't get a chance to follow them up."

*(Staff Nurse. Interview 4:8)*

Once transferred the patient ceased to be the professional concern of the AMAU nurses and the patient's outcome would not be known unless such information was sought out specifically:

PG. "Do you ever find out how your patients have got on after they have left the AMAU?"

"I sometimes phone to see how they are getting on but not very often."  
(*Staff Nurse. Interview 5:3*)

As will be developed throughout the study the short time that the nurses spent with an individual patient was a primary driver to their approach to care organisation and their tacitly developed philosophy of care within their community of practice. The first stage in the transition of patients into and through the AMAU was a doctor requesting an admission and as will be discussed next this gave the AMAU nurses a particular and unique aspect to their role.

### 5.2.1 'Taking the call'

A telephone call was usually the first indication that the nurses would have that a patient was to be admitted, with GPs and the A&E department utilising a direct telephone line reserved solely for this purpose. The telephone, which was bright red, was located on the wall near to the door in the doctors' office on the AMAU. This room was in a central position on the unit near to the nurses' bay and the telephone could be heard easily (a diagram of the AMAU setting is provided in appendix 1). The telephone had a distinctive ringing tone and it was a high priority to answer it quickly. It was a unique aspect of the AMAU nurse's role to accept patient referrals for admission, as nurses on the other wards within the Trust did not have this responsibility. Wood (2000a), from a telephone survey of AMAUs in the West Midlands, also reports AMAU nursing staff accepting admissions from GPs. Additionally, even if sitting in the room with the telephone, the doctors did not answer the red telephone as this was clearly the nurses' responsibility. However, this aspect of the nurse's role was accepted with a degree of scepticism rather than being considered a positive role development as this extract illustrates:

"They [*hospital management*] tried for a while to get the doctors to go back to taking calls as they thought that we were taking too many admissions. That didn't last long! We had saved the doctors so much hassle, which was soon realised. So back it came to us."  
(*Senior Nurse. Interview 7:5*)

Hearing the telephone ring usually provoked a groan or a 'here we go again' from the nurses. All of the nurses were expected to 'take the call', although this could be a daunting prospect for some junior staff and they were often seen glancing around quickly to see if there was someone else nearby who could take the call:

I noticed that Lara [*a staff nurse new to the unit*] was very reluctant to answer the GP phone. When I asked her later about answering the phone she said that she tried to avoid it as she felt it to be too much of a responsibility.

*(Field Notes)*

The accepting of an admission from the GP was a key departure from the usual role expectations of a nurse. The admitting procedure prior to the AMAU being set up was for the junior doctor on call to be contacted directly by the GP. As Kellett (1999) has noted this was also the procedure that was followed throughout the UK and in Ireland. The accepting of patients for admission by the AMAU nurses, rather than the GPs having to contact a junior doctor, was appreciated by the GP interviewed:

"It is much easier because you don't have to wait on the phone, because if you are in a patient's house it can be difficult sometimes. So you don't have to hang about on the phone as you usually get answered fairly quickly. It is a direct line so you don't have to go through switchboard whereas before you were hanging around for switchboard. Then the junior physician on-call might not be there as he might be doing something else, the phone might be going off, three other doctors might be using it. So it is a lot better."

*(General Practitioner. Interview 9:2)*

This GP noted the resolution of the problems that the previous admitting system had caused and an appreciation of the ease of access and acceptance of medical emergency patient referrals that the AMAU system provided. The GP's comments echoed the arguments for the instigation of AMAUs. Such arguments included the wasting of GPs' time contacting hospital doctors and the inefficient use of hospital doctors' time answering these calls and searching for beds (NHS Trust Federation 1995; Kendrick 1996).

A direct line that was dedicated for the sole use of GPs when seeking to admit emergency admissions was suggested by Houghton & Hopkins (1996) as being a recommended standard for emergency medical admissions. However, they further contend that a senior house officer or senior registrar should accept

admissions so as to avoid unnecessary admissions. On the AMAU studied the nurses answered all of the GPs calls and GP referrals were seldom refused. The nurses would only query the admission if it appeared that the patient could be more appropriately referred to the social services. Above the red telephone there was a notice that gave the nurses advice if this situation should arise (this notice is reproduced in appendix 19). However, in the vast majority of cases, accepting an admission by the nurse involved merely noting the patient's information onto a prepared sheet (a copy of this is presented in appendix 4) and/or giving the GP information on bed availability. However, acceptance of the preponderance of patients would likely still be the case even if it were a hospital doctor who took the GP's call:

“In the current climate of legality a person coming with a collapse, which is the most common presentation coming for admission, for what we can call an acute admission. A GP colleague having assessed and prioritised the patient at home it is therefore very difficult and risky to say well 'no' when a colleague is saying somebody needs to come in no matter how experienced you are. It is very difficult to not accept an admission that your colleague has contacted the AMAU for.”

*(Senior Registrar. Interview 8:4)*

Therefore, the acceptance of patients was a formality in the vast majority of cases and a delegated responsibility over which the nurses had no control, it was a task that saved another professional group's time. The nurse's role in accepting patients for admission to the AMAU was therefore that of an extended role (Hunt & Wainwright 1994) and did not enhance nursing care for the AMAU patients directly and rather detracted from nursing care delivery. This medically delegated role was time consuming and reduced further the limited time that the AMAU nurses had to interact with patients, as will be discussed in Chapters six and eight, and used the nurses' time in an undertaking what was previously viewed as a medical task. However, the nurses by undertaking this role did streamline the acceptance of patients for admission and therefore contributed to an improvement in patient care delivery by alleviating potential delays for patients waiting to be admitted. However, as the review of the literature demonstrated there is a dearth of research that has explored the impact of this

change in practice on the nursing care delivered to emergency patient admissions to AMAUs, especially at a time of nursing shortage.

Findings from this study indicate that the AMAU nurses played a key role in the transition of the patient from their pre-admission setting, usually their home, to a hospital bed. Meleis *et al.* (2000) note that when patients experience illness they undergo changes and demands in their lives, health, relationships, and environments and the nurse's role is to aid patients in through these transitions. Additionally, such transition times cause patients to experience vulnerability. Patients on the AMAU therefore experienced transition and vulnerability related to their acute illness but also when adapting to the environment of the AMAU where their illness was named and treated. Admission onto the AMAU was therefore a major transition stage in patients' continuum of care (McBryde-Foster & Allen 2005). The nurses aided patients' transition into the hospital care environment through their role in accepting admissions and, as will be developed later in this chapter, by managing beds. However, this start to the continuum of care, as a result of the development of AMAUs, had resulted in an extra transition stage in the patient's care journey. The previous system of emergency medical admissions, as reported by Green & Armstrong (1993), sought to admit the patient directly to the medical ward of the on-call physician or to a speciality ward, such as a cardiology ward. On the ward medical and nursing staff would then assess, implement and coordinate the patient's care to discharge. On the AMAU the nurses undertook a novel role by accepting new patients for admission, however as the goal of the AMAU was rapid transfer of patients the nurses did not then play an enduring role in the care of these patients.

Professional conceptualisations of nursing that relate to holistic care (Watson 1985; Sadler 1997) and time to develop a relationship based on an holistic understanding of the patient structured by a nursing model (Fawcett 1995) had to be reconceptualised in the AMAU setting. Nursing theorists such as Peplau (1987) describe the relationship between the nurse and the patient or client to be a critical aspect of the therapeutic process. Further, that the nurse-patient relationship should develop to enable mutual understanding of health goals and collaborative working to solve health problems. The continuum of the patient's



care to enable the development of a relationship between the nurse and the patient, as indicated by nursing theorists such as Peplau, was not feasible for nurses on the AMAU. However, the nurses had evolved their practice in response to these demands and an understanding of their role had been developed that led to the production of their joint enterprise. As Wenger (1998: 80) notes

*Because members produce a practice to deal with what they understand to be their enterprise, their practice as it unfolds belongs to their community in a fundamental sense.*

As will be developed throughout this chapter the nurse's role required involvement with the patient's transition through the AMAU to the next stage of the patient's continuum of care, which was usually to a transfer ward, or infrequently directly home. The AMAU nurses therefore dealt with a rapidly changing and transitory group of patients and they had adapted and developed their practice to facilitate this aspect of their role. An important feature of this role included the nurses' endeavours to provide empty beds for new admissions, which will be discussed next.

### **5.2.2 'Making a bed'**

The bed occupancy on the AMAU was 98% on average (Trust Data 2003) therefore providing empty beds for new admissions was a constant source of pressure within the hospital generally. The operational policy for the AMAU stated that 'The majority of patients will have a stay of twelve to twenty-four hours' (Trust Data 2001:2) thus short stays coupled with high bed occupancy resulted in high work activity in providing empty beds. Empty beds were made available by transferring patients to medical wards within the hospital. The on-call medical consultant undertook 'post-take' rounds on the AMAU at 8am and 5pm. On these rounds patients who were to be transferred to a general medical ward, and infrequently those patients who were to be discharged home directly, were identified. The AMAU nurses would then organise the transfer of patients using a list of available transfer beds provided by the bed manager. It was noted that the AMAU nurses exercised high decision authority regarding the order in which patients were transferred and their transfer destination. Sometime there would be a requirement for a transfer to a specific ward, for instance a cardiac patient to the cardiology ward however more usually the patients were just to be

moved out as soon as possible. Co-ordination of this transfer process was the nurses' responsibility:

PG. "Can you tell me about what happens when patients are transferred from the AMAU?"

"In my own experience I've not had any problems. I mean they're [*the nurses*] good at hand over, and in fairness often you put blood forms and X-Ray forms out for somebody and then a bed comes up, so they move and they always have it done. They are geared to hand over."

(*Junior Doctor. Interview 11: 4*)

In fact the nurses were seen as pivotal to the effective transfer of patients from the AMAU to the ward:

"Nurses are very good at handover [*laughs*]. Nurses are and doctors aren't!"

(*Consultant Physician 9:3*)

The nurses were acting as the coordinating agents for the medical process of care and transferring patients was the nurses' responsibility. The medical staff did not get involved with the patient's transfer and would see their patient again on the general medical transfer ward and so medical care was disrupted minimally. I had thought before data collection that patients would be unhappy to be transferred, as that had been my experience when a medical ward sister. This was not the case and patients accepted that they were to be moved as it was made clear, often by their GP prior to admission, that the stay on the AMAU would be a temporary one. Patients interviewed and met during participant observation indicated that they were pleased just to have been found a bed and to have received treatment. The following are some typical comments:

"The right place to have everything dealt with. Everything done quickly-no complaints."

(*Dave. Interview 15:5*)

"The AMAU checks you over and does what's needed and then you are ready for the other ward".

(*Bill. Interview 13:4*)

"They assess you and see to which ward to send you".

(*Cled. Interview 14 :6*)

Findings indicated that the most common reason that impeded patient transfer was hospital bed shortage. However, nurses on the transfer wards often tried to avoid accepting patients, even if they had beds, as they were already busy or

wished to avoid accepting patients who had demanding needs or did not fit with the ward's medical speciality. (This is developed in Chapter eight.) The move from bed ownership by consultants to a system with a central pool of beds can be impeded by medical staff resistance, either overt or couched in terms of particular speciality needs, and that such actions result in ineffective use of available beds (Green & Armstrong 1993). Nonetheless, as evidenced in this study the pressure on beds, and the subsequent difficulties in transferring patients, was related predominantly to institutional constraints associated with resource limitations. The continual shortage of beds on the AMAU was noted frequently in the narratives of the nurses and doctors:

The bed manager came to the unit at 9am with the hospital bed state. Apparently the hospital was nearly full and there was a risk that non-emergency admissions would have to be cancelled. She asked 'can you make a bed as there are two in casualty?' The staff nurse replied 'I can make one but you will have to find somewhere for him to go'

*(Field Notes)*

The freeing up of beds to accept admissions was also a key collective enterprise between nursing and medical staff and required a coordinated approach:

"When in these times, when we have so many constraints and the usage of beds if you like and the call for efficiency from every body, money is not lying around and each year we face the winter crisis and all those other crisis. So beds are short and we have to do our best and the nurses say to me 'we've been asked to make a bed. Can you come and okay a transfer?'"

*(Senior Registrar. Interview 8:3)*

'Making a bed' is used as a metaphor as nurses are neither carpenters, nor indeed magicians but their role included the responsibility to ensure beds were freed up rapidly so as to accept new patients. However, bed availability within the hospital, and therefore patients' transferability to other wards, was a factor not within the AMAU nurses' control. The metaphor of 'making beds' expresses the elements in this enterprise of creating a free bed when one was not there before. Doctors and bed managers would ask the nurses several times a day 'can you make a bed?' The use of this metaphor increased the pressures on the nurses with an impression given that the nurse could provide a bed if s/he had the skills (professional ability) to craft one. This moved the responsibility on to the nurse to work harder and to demonstrate that if that individual nurse was indeed

talented enough then an empty bed could be provided. During participant observation it was clear that this function of 'making beds' was time consuming for the nurses. I explored this during the nurses' interviews and the following extract is a typical response:

**PG.** "What proportion of your time is spent sorting out beds?"

"A very high proportion. We have got admissions to come in without beds at the moment so I am having to think ahead as to what beds I have got coming up and can I accommodate the ones that are outstanding."

*(Senior Nurse. Interview 3:5)*

So when there was not a bed free the nurse taking the call would inform the GP to send the patient in later in the day if there was a bed that was due to become vacant. The GP would be given a specific time to send the patient in or the nurse would agree to contact the GP, or the patient or carers directly, when a bed became free. If the GP was concerned that the patient was clinically unstable then the patient could be sent to wait for the AMAU bed in the A&E department; thus adding an extra transition point to the patient's care journey. A&E doctors seeking transfer of patients to the AMAU who had been admitted to A&E (rather being sent there to await a bed) or consultants wishing to admit patients from their clinics were likewise given a time for admission or told that the patient would have to wait until there was an available bed. However, delays in receiving details of the total bed state of the hospital from bed managers were identified as a major constraint to effective management by a directorate management team SWOT analysis (Trust Data 2003). This being a constant source of concern for the nurses:

**PG.** When do you get the bed state?

"Quite often we don't get a bed state until lunchtime and that's not good bed management. So they need to do something. Perhaps we could manage ourselves in the directorate and have someone who only considers bed management. The bed managers are expected to do too much in this Trust. You know it would be excellent if we could have bed state at regular times and we would then know where we could move our patients to."

*(Senior Nurse. Interview 3:5)*

These delays impeded the nurses' ability to transfer patients and therefore provide empty beds. The bed manager's role was also to keep the nurses informed of the status of other hospitals within a 40 miles radius so that GPs could be given helpful information about bed availability elsewhere. However, the bed managers within the Trust actually functioned as hospital nursing managers and therefore held multiple other responsibilities. Bed management is a key element in the effective use of an AMAU but to be efficient bed managers must have the time and the power to use beds from a whole hospital perspective (Green & Armstrong 1993; CSAG 1995; Alberti 2003). Therefore, transferring patients was a complex endeavour nonetheless beds had to be provided and this caused the nurses concern, as their role was central to the process of making beds available. This pressure to 'make beds' was time consuming and additionally the nurses worried about the patients they would transfer:

**PG.** "Can you tell me about the decisions that you make when deciding who to transfer?"

"Sometimes, I do feel that sometimes you make decisions in a rush and often it is the least wrong decision. I mean a patient could come in and they might perhaps not be as unstable or as poorly as the gentleman say came in before. So you have had two admissions in that last hour, one is more stable than the other. Now out of those two you have to decide, because all of your other patients who can be moved can't be moved due a lack of a suitable bed or they need a side ward. Of the two who can use the free bed on the transfer ward you have to decide then which one is best to be moved."

*(Staff Nurse. Interview 4:6)*

Thinking through the possibilities and ramifications of moving patients required complex judgements to be made, made more so when it was not clear who was the most suitable, or indeed the least unsuitable, patient to move. The AMAU nurses had to make the decision and then live with the consequences as the following critical incident illustrates:

**PG.** "Can you tell me about a situation when you were unhappy with the care that a patient was receiving, or wished that it could have been done differently?"

"We transferred a patient out who was 90% stable and he deteriorated within an hour of being transferred. You think 'oh God. I wish we had transferred someone else', as I should have seen that happening before he was transferred out. We have been trying to manage the beds, trying because you can only send certain patients to certain wards. [*Pause*] Also if we transfer patients

before they were fully stable and perhaps they become more poorly straight away when they get to the other ward than that is awful.”

*(Senior Nurse. Interview 2:7)*

The complexity of such decision-making, involving clinical knowledge and indeed ethical reasoning, would be difficult to model in a classroom setting. The skills required in this decision making process demonstrates expertise development that had been gained by the nurse's experience in the AMAU's community of practice (Wenger 1998). As this senior nurse notes there was often ambiguity in the decision-making related to transfer options, as often there was not a clear 'either or' judgement to be made. However, the nurses had to make a best choice given complex known variables and accept that sometimes there were unsatisfactory outcomes due to factors over which they had no control. However, refusing to transfer a patient was not an option, as the nurses' joint enterprise centred on 'making a bed'. Hanks (1991) suggests that learners do not just learn what the experts know rather they learn, by their increasing access to fuller participation, to play roles in the community of practice. The nurses' acquisition of the skills needed to practice as an AMAU nurse, and the nurses' valuing of learning by doing is developed in Chapter six. The AMAU nurses exercised distinct skills and abilities so as to 'create a practice to do what needs to be done' (Wenger 1998: 6) this practice involved the provision of empty beds and making difficult decisions about who to transfer, which were then key elements of their role.

Latimer (2000) has likewise argued that the role of the medical nurse includes the providing of a space for medicine to take place and to present patients for the medical gaze who are appropriate medical material. The AMAU nurses expressed a responsibility for, and exercised a major influence on, the management of the AMAU's environment to admit and treat acutely ill medical patients. They were key professionals in the co-ordination of the patient's admission and transfer. Further, the AMAU was only working efficiently if empty beds were being provided constantly so as to admit more acute medical admissions. Walton (1997) argues that each organisation develops its own culture that will affect the members of the organisation in particular by consensus agreement as to what is important and what is irrelevant to the culture. Key

elements that the nurses appeared to value as important to their work was the organisation of the AMAU to accept, treat and transfer patients rapidly. The AMAU nurses had constructed their role to achieve these shared goals in a setting of bed shortages. However, the problems with bed availability in the hospital and the increased demands that the AMAU faced were institutional factors over which the nurses had no control and were not unique to the hospital studied.

Armstrong (1998) discusses the decline in the number of hospital beds in the UK from a peak of 488, 013 beds in 1960 to only 255, 054 beds by 1990, and notes that this decline in beds continues yearly. During this time Armstrong (1998) argues that the hospital bed has changed from a place of safety and rest to a place of danger, related to hospital acquired infection and other risks of bed rest, that have lead to reduced hospital stays, and greater reliance on community care. I would argue that findings from this study suggest that the enduring problem of bed availability has given the hospital bed another stage in its history, that of a rare resource. The skill to use these resources effectively was an important part of the nurses' role as they managed the AMAU's environment of care. The coordination of the environment of care is an important element of all nurses' work with Fawcett (1995) noting that the environment is one of the four central concepts of the nursing metaparadigm. Environment, Fawcett (1995:7) contends is:

*... the person's significant others and physical surroundings, as well as the setting in which nursing occurs, which ranges from the person's home to clinical agencies to society as a whole*

The management of the clinical environment by nurses has been, from a theoretical perspective poorly addressed by the major nursing models that tend to relate environment to the individual patient's personal bio-physical-social environment (Fawcett 1995). However from the origins of nursing the ward or caring space has been the domain of nursing (Davies 1995). The coordination of the AMAU space by accepting patients for admission and the management of beds to ensure rapid throughput of patients were key elements of the AMAU nurses' role. In order to facilitate this coordinating role another strategy

developed by the AMAU nurses was the use of the whiteboard plan of the unit's beds known as 'the board' and will be discussed next.

### **5.3 'Doing the Board'**

To accept patients for admission efficiently when bed availability within the hospital was problematic required a system in place that ensured that the bed status of the AMAU was correct and available easily. Within this category the use of a white board bed plan of the unit and its function as a tool to facilitate the management of the AMAU's beds and patients' transition is discussed. A novel managerial concept of '*stacking patients*' that relates to the use of the board to co-ordinate the acceptance of patients who were waiting to be admitted to the AMAU is also discussed within this category.

The board was a 3 metre x 1.5 metre whiteboard that was attached to the wall in the centre of the unit near to the nurses' bay. This board offered a permanent diagrammatic representation of the beds on the unit and was divided into slots that corresponded to each of the AMAU's fourteen beds. In the bed slots reproduced on the board the patient's name was written using a non-permanent board marker. Other information that was noted within each of the bed space slots were: the name of the nurse caring for the patient for the shift; the admitting doctor's name; the medical consultant's initials; admission status (a designed box within the bed slot was shaded in when the patient arrived); the date of admission; and the time the patient arrived on the unit. A tick was used if the doctor had admitted, or 'clerked', the patient. If the patient was for transfer this was noted, including information noting where to and when. The colour of the board pen that the nurses used to write up patients' names and other information changed each day so that at glance it was clear when the patient had been admitted. Those patients expected, and for whom a bed had been allocated, also had their name on the board in a bed slot. Understanding and working with the board was a key element of the nurses' work. The following observation had been noted in early field notes:

The complexity of being the nurse in charge is incredible. The board is the ward's coordinating system. The nurse in charge stands and stares at the board often for several minutes getting an understanding of the bed situation, who can move and where, and the overall status of the shift. Other staff nurses



stand quietly by her side. It is almost a reverential respect whilst at the same time it minded me of a conductor just before the symphony begins. When the nurse in charge turns around the decisions have been made, actions decided on and everyone is ready to take their orders. *(Field notes)*

On every shift there would be a nominal nurse in charge of the unit whose responsibilities would include being responsible for coordinating the bed status of the AMAU: this person would 'do the board'. Those patients who had been identified, following the consultant's post- take round, for transfer would have this noted on the board next to their name together with such notes as 'bed free on Nightingale ward after 4pm'. I had noticed that a more junior nurse had 'done the board' and asked the senior nurse on duty if this was supposed to be the sole responsibility of the nurse in charge:

"You have got to allow other people to do the board [*pause*] I mean maybe technically I should be organising the beds but Sue does it, she does it well and she likes doing it so I think 'oh well let her do it' [*laughs*]. So I have got no problem with letting go of things on the ward."

*(Senior Nurse. Interview 1:3)*

As this senior nurse notes the coordination of the board and thus the bed management of the AMAU requires particular skills and importantly there must only be one person who does this. Too many nurses making decisions about patient transfers could have lead to confusion. So despite the valuing of autonomous and non-hierarchical practice by the AMAU nurses, (as will be developed later in this chapter), pragmatic constraints required that only one person undertook this function per shift. However, any of the nurses could take the responsibility for the board for the shift, as it was not essentially the function of the senior nurse.

If a patient was accepted for admission the nurse 'taking the call' wrote the patient's name straight away on the board after taking details from the GP, or more occasionally a hospital-based doctor. The significance of the board as a reification of the unit's bed status was held as an absolute by all staff. On returning from coffee, for instance, the nurses would ask 'is the board up to date?' just in case someone was on their way to write on the board. Not to have entered an accepted patient on the board would be a serious matter as another patient could be accepted but without a bed being available. The board system as

a unit management tool had developed in response to the needs of the nurses to have at a glance the current bed status of the AMAU. This system enabled a rapid response to requests to admit a patient and had become part of the unit's language by such phrases as 'what does the board look like?' Heartfield (2005:24), utilising a Foucauldian conceptualisation of power in regulating hospital use, has noted:

*The whiteboard though not recognised as a formal part of the hospital bed management program, was an immobile, material list, which acted as a type of informational panopticon through its representation of patients and bed spaces and their surveillance.*

The board as used on the AMAU was a 'relational location of surveillance' (Heartfield 2005:25) by its ability to transform the patient into a bed space occupier that was represented diagrammatically. The board enabled the nurses to manage the throughput of admissions, often ten a day, and the transfers and the discharges effectively, and at a glance, in an area that was distant from patients. The board had been developed as a tool to coordinate the AMAU and was a reification of this process. It had started out as a simple plan of the unit however it had gained 'a degree of autonomy from the occasion and purposes of its production' (Wenger 1998: 62). This was evidenced by the nurses' discourse that referred to patients by their effect on the board and the maintenance of fluid bed availability by 'doing the board'. When the unit was full patients had to wait, often at home or in the A & E department, until a bed was available. This led to the development of another created resource to aid patient transition, the 'stacking of patients' and is discussed next.

### **5.3.1 'Stacking patients'**

At the top of the board there was a space where the names of patients who were waiting to be admitted but were without allocated bed slots were recorded. These patients were then described as being 'stacked'. The names of the patients were put in the order of their acceptance together with any special instruction, such as 'call after 5pm'. This staff nurse explains the relevance of the stacked patient to her role:

"It is daunting to come on duty and have five or six stacked before you even start. It is usually difficult to move patients even if there are beds on the wards. We do try to move patients to the appropriate wards. But obviously if

there are beds becoming available on one ward you have just got to decide if it is a male or female bed and who you can move [*pause*]. If you have got six stacked on top of the board your existing patients have just got to be moved unless of course they need a cardiac monitor then you are more limited as to where they can go.”

*(Staff Nurse. Interview 5:6)*

The nurses and medical staff would talk in terms of ‘how many are on top of the board?’ or ‘how many stacked?’ The term ‘stacked’ was an interesting use of the word. The word stack means a ‘large built up pile’ (Chambers Dictionary 1998). This meaning of waiting in an arrangement seems to have been borrowed from a metaphor used by air traffic controllers where it refers to aircrafts waiting to land. This metaphor is effective as it conveys a complex concept simply, efficiently and is able ‘to draw together diverse domains’ (Hammersley & Atkinson 1995:247). It communicated the complex managerial issue of accepted yet waiting patients in a phrase. To carry the metaphor further the stacked up patients were in a dangerous predicament potentially, if they were not admitted (landed) safely. Moreover, once patients were ‘stacked up’ they became part of the nurses’ domain of responsibility. This is an example of a non-bed patient care space (Heartfield 2005) as these accepted patients were discussed as though they were present physically on the unit. They were reported on in the handover and an allocated nurse would have the responsibility to contact the GP, the A&E department, or the patient or carers directly when there was a bed free. This nurse would then put the patient’s name on the board bed slot to ‘book’ the space once the bed became vacant. This feeling of accountability for waiting patients, when the provision of a bed was beyond the nurses’ control, could have a stress inducing effect on the nurses, as this field note illustrates:

Molly [*an experienced staff nurse*] was concerned that they had six patient stacked up on the board. She said that she felt ‘responsible’ for them and felt a ‘strong pressure’ to make a bed for all of them as soon as possible. She said that she ‘would feel terrible if one deteriorated or died while waiting’.

*(Field Notes)*

However, one senior nurse was more detached and pragmatic:

PG. “Do you worry when there are patients ‘stacked up’?”

“No. Not at all. I have got 14 beds and no more. You can’t start thinking like that. If we are full then we are full and that is that.”

*(Senior nurse. Interview 7:5)*

This difference may relate to the second nurse's longer experience as an AMAU nurse and the acceptance of the fact that often patients have to wait. However, this was an isolated opinion as evidence from participant observation and interviews with the nurses indicated that large numbers of 'stacked' patients caused the nurses to experience anxiety. However, any such wait is also stressful for patients. Dave had self-diagnosed himself with diabetes mellitus using information from the Internet. He had a three-week history of boils and had been feeling unwell for longer than that. The GP agreed with Dave's self-diagnosis and wanted him admitted to hospital promptly:

"I know for a fact that there were no beds because the doctor, when I was in the surgery, was talking to different departments in the hospital, including the bed manager I think. What they did is, because of the situation that I was in, they guaranteed that I would get a bed in AMAU eventually; as that was the ward they considered I needed to go to."

*(Dave. Interview 15:2)*

The patients admitted to the AMAU were by definition acutely ill and as discussed it often took time for the prospective AMAU patient to have a bed made available for them. Often patients waited in the A&E department for a bed and this wait could take a long time. 'Access block' (Fatovich 2002: 958) is the official term for this inability to transfer patients out of an A&E department due to bed shortages within the hospital. *The NHS Plan* (DoH 2000a) identified that long waits for patients in A&E departments was unacceptable however such waits were the common experience of patients interviewed for this study. It was evidenced from participant observation and from patient interviews that this 'access block' added stress and concern to patients and their relatives at an already distressing time. Eve, a lady of 74 years with chronic lung disease was admitted with shortness of breath to wait in the A&E department for an AMAU bed. This took five hours and the long wait had been exhausting for Eve and her family plus she felt guilty that she was holding her family up. By the time she got to the AMAU she was tired, hungry, and thirsty:

**PG.** "You hadn't had anything to eat or drink while in casualty?"

"Nothing. I hadn't had a mouthful! And I asked twice if it would be possible for somebody to get me a drink of water you know but as I say they were so busy. The poor dabs they didn't know if they were on their heads or their feet. They are so busy you see. I don't know what happened. I think, I believe that

an accident had come I think, so it was all hands on deck there wasn't it then. The doctor came and said 'we are admitting you but I don't know where I am going to get a bed' 'Oh' I said 'that isn't up to me' that was his problem surely."  
(Eve. Interview 16:7)

Patients interviewed, and met during participant observation, were acutely aware of the shortage of beds in the hospital generally and considered that they were lucky to be getting a bed at all, even if it meant a wait. Patients were waiting in limbo in the A&E department although of course acute treatment was given quickly if needed. As The NHS Modernisation Agency (2001:8) noted waiting for a bed in A&E departments was 'a step that added no value to the patients' journey'. Findings from this study support Armitage & Flanagan (2001:10) who have suggested:

*Across the country bed availability is the most common difficulty in managing acute admissions resulting in unacceptable long waits for patients in accident and emergency departments and difficulties for the medical and nursing staff in managing patients in the best environment.*

Such delays in admission can also have negative effects on patients' health and well being generally (Houghton & Hopkins 1996). Further, patients who were GP referrals and were required to wait for an AMAU bed in the A&E department were not a high clinical priority for the A&E nurses and doctors. As Byrne & Heyman (1997) and Wiman & Wikblad (2004) have reported A&E nurses consider communication with patients, especially those with non-acute or life-threatening conditions, to be of limited importance. The patients waiting for a bed in A&E also caused extra work for A&E staff, in particular the nurses, who still had to provide care for their A&E admissions. This resulted in the AMAU nurses receiving frequent calls from the A&E department to ask if a bed was free but the AMAU nurses could not accept the patient waiting in the A&E department until there was a vacant bed.

The 'stacking of patients' is an area of practice that is under explored from an accountability perspective and is an interesting area for legal consideration. Although discussed by the AMAU nurses as an ethical or a professional worry in the future legal challenges could lead potentially to a clear legal responsibility. It is conceivable that a claim for harm due to negligence could be made against the Trust, which carries vicarious liability for the actions of its staff, by a patient who

was 'stacked up' and suffered harm due to delayed admission, especially if the nurse forgot or delayed calling when there was a bed free. Legal precedent (*Deacon v. McVicar and another* 7 January 1984 QBD) clarified that the decisions made by hospital staff as to their decisions about prioritising care can be considered in evidence in a negligence case. The tort of negligence seeks four criteria to be demonstrated: a duty of care; breach in the reasonable standard of care; causation; and harm (Mason & McCall Smith 1994). By accepting the patient and 'stacking' her or him the nurse has then accepted a duty of care, it could be argued, to the patient. This would be the aspect that would require a legal ruling. If the patient were to suffer harm due to failures in a reasonable standard of care then there is potential for a winnable negligence claim. This responsibility for the patient before admission was one of the distinctive role functions that the AMAU nurses held.

Additionally, the AMAU nurses had, by accepting the responsibility to telephone the GP, the patient or the carers when beds were available, incorporated a distinctive bed management element into their role. Organising the admission of patients had previously been the responsibility of the junior doctor in emergency admission situations and was another example of an extension to the AMAU nurses' role. By taking on this role the admission of patients to the AMAU was expedited and the nurses' community of practice valued the skills they developed to undertake this function. Therefore, the nurse's role in accepting and organising a patient's admission helped to achieve hospital targets and politically lead initiatives to reduce demands on junior doctors (CSAG 1995) and to decrease waiting time in A & E departments (Alberti 2003). Thus, the ability to provide the most efficient use of limited free beds to accept new admissions from GPs or the A&E department was a key function of the AMAU nurses' community of practice. However, the number of admissions and transfer bed availability were not within the control of the AMAU nurses. Nonetheless the nurses had, by developing negotiated responses that were evolved locally, enhanced bed availability and the speediness of admission acceptance. The role of the AMAU nurse involved responding to these demands whilst ensuring that patients were cared for in an individualistic manner following nursing's professional guidance

(NMC 2004). The organisation of nursing work that had evolved on the AMAU to enhance continuity of care is discussed next.

#### **5.4 Organising Work: Valuing Continuity of Care**

The distinctive approaches to organising nursing work evolved by the AMAU nurses that enhanced individualisation of care despite the rapid transition of patients are explored in this category. The underpinning value given to continuity of care evidenced by the nurses in their non-routine bound working are further explored within the two sub-categories of *the handover* and *nurse-patient allocation*. Firstly, the negotiated and flexible approach developed by the nurses to their work organisation is discussed.

The nurses were confronted every day with different challenges and their work was organised dependent on the daily situation. A constant issue for the nurses was the requirement to be able to care for newly admitted acutely ill patients whilst ensuring appropriate care for those patients who were already on the unit:

“Somebody has always got to be first or be last or what ever but you do work around that and I think the patients understand. You see on an ordinary ward I think patients can easily become institutionalised when they know that breakfast is at that time, dinner is then, and tea is then whereas here, if things are going on, we can have food at any time of the day. We have got to have a routine to an extent, there is a sort of a routine, but we do tend to bend the rules a little. We achieve the same things in a different way.”

*(Staff Nurse. Interview 4:2)*

This staff nurse describes a working system that was flexible for if ‘things are going on’ then the nurses must respond to the most pressing care need. The skills and knowledge of the nurses were geared to the acutely ill and they gained wide experience in such care. Nonetheless, the nurses had to provide care for a spectrum of patients from the critically ill admission to the patient who was frail or confused:

**PG.** How would you describe the AMAU?

“Well it is a cross between A&E and a normal ward because we have all these comings and goings yet we have to do drug rounds, do bed baths, and we have meal times and all that. I think some other places such as A&E don't allow for that.”

*(Staff Nurse. Interview 4:2)*

The nurses described flexibility in their approach to care whilst noting that there was ‘a sort of routine’ in that drugs were prescribed for certain times and there were interventions, such as personal care needs that had to be done. The nature of the AMAU’s work required a relatively higher establishment of registered nurse than on a general medical ward so as to undertake their role of admitting and caring for acutely ill medical admissions. (Staffing levels are detailed within Table 2 p.18.) The nurses therefore relied on the support of the health care assistants (HCAs) to aid the effective delivery of care and who worked alongside the nurses with minimal instruction. The HCAs (often still called auxiliaries within the hospital) on the AMAU undertook tasks that aided the registered nurses’ work specifically and worked closely with a registered nurse on a shift-by-shift allocation:

“...we have to maintain care for the patients here as well as prioritise the patients being admitted. The auxiliaries do ECGs [*electrocardiograms*] and I know that others in the hospital don’t. They will do the observations too. They are great and we all work together.

*(Senior Nurse. Interview 1:4)*

During participant observation it was evident that the HCAs on the AMAU, despite being a rather transient group as they were often moved to other wards and several left to become student nurses, were motivated and had close working relationship with the nurses:

I had asked Betty and Tony [*two HCAs*] if they liked working on the AMAU and how it compared to other medical wards. They both noted that they ‘loved it’ on the AMAU because the work was so acute and interesting. They both noted that they were learning all the time and felt that they really contributed to the work of the unit and that they were valued.

*(Field notes)*

The nurses maintained the jurisdiction over the boundaries of the HCAs’ work on the AMAU. The HCAs provided direct delivery of physical care to patients, such as personal care, but also the more technical care needs, such as taking blood pressures and 12-lead electrocardiograms (ECGs). The nurses provided care for their patients, supported by HCAs, following their own patterns of working that were not prescribed or interfered with:

“There is a sort of a routine. I have got my own routine that I generally follow but obviously it often goes haywire but I still try and be organised. I like to be very organised, and I like to know what is what.”

*(Senior Nurse. Interview 3:6)*



With the absence of a rigid routine on the unit the registered nurses were enabled to plan patients' care on an individual basis and were involved personally in the delivery of this care. Nonetheless, such work was to be completed as soon as possible:

I spoke to Kitty and Dawn [*staff nurses*] about the care needs of the patients on the unit. They explained that the 'routine care' in the morning was to be done 'as soon as possible' as 'you never knew what would come around the corner' so there was a need to complete washes etc as a matter of urgency, especially if there were empty beds at the start of the shift which should mean patients being admitted straight away. Kitty noted 'we need to clear the decks and be ready to accept whatever the day throws at us'.

(*Field Notes*)

As this excerpt illustrates the nurses' community of practice (Wenger 1998) sought always to be ready to accept new admissions and required such mutual engagement to achieve the shared goals of their joint enterprise. Other nursing work therefore was to be completed as soon as possible to enable this preparedness to admit acutely ill medical patients. Therefore the AMAU nurses' work organisation did not rely on routines to plan patients' care. The nurses' community of practice demonstrated an approach to care delivery that was sensitive to the needs of the individual patient, the personal style of the nurse, and to the demands of the unit generally. Johns (1994) notes that task orientated nursing is practiced as a series of tasks that are done to a patient following a strict time schedule rather being patient orientated. The practice of the nursing on the AMAU was not task orientated rather demonstrated autonomous behaviour in the organisation of the nurses' work and the flexibility to respond to patients' individual needs. The AMAU nurses' practice culture held similarities to the tenets of primary nursing but practiced within the constraints of the nurses' role in rapid patient transition: therefore their work organisation and practice can be termed flexible primary nursing.

Shifts could be very busy, especially if dealing with several critically ill patients, which would then leave a reduced work force to deal with all the other patients. However, despite an environment that had multiple demands there was no evidence that the AMAU nursing team sought comfort in routines to avoid emotional work (Menzies 1960) or used routines as a way to 'manage the

multiple demands of the ward environment' (Allen 2001: 95). The AMAU's organisation of care with its flexibility of working allowed more responsiveness to the needs of the individual patient. Such developments, or the shared repertoire, of resources that:

*...gain their coherence not in and of themselves as specific activities, symbols, or artefacts, but from the fact that they belong to the practice of a community pursuing an enterprise (Wenger 1998: 82).*

The planning of the AMAU nurses' work, and their flexible (and tacit) application of primary nursing, had to incorporate the certainty of new admissions, patients who were often critically ill, together with providing care for patients already admitted. Another developed strategy to enhance continuity of care was the nurse-nurse handover or the intershift report and will be discussed next.

#### **5.4.1 The handover**

The nurses worked four shifts to cover the AMAU day and night and a system of internal rotation (the nursing team would work both day and night shifts) was utilised. There was a two-pronged approach to enhance communication between the nurses when shifts changed over, firstly a sit down report followed by a bedside handover. The sit-down report was attended by all the nurses, HCAs, and student nurses coming on duty and was held in 'the clinical room', a room where the sterile dressings and the drug trolleys were located away from the patient area. Chairs were kept stacked in this room ready for this handover and the team coming on duty would each take a chair and make a seated semi-circle around the nurse who was giving the report. The nurses called this handover therefore the 'sit down report':

During the handover or the 'sit-down report' the nurse in charge gives the staff coming on duty an overview of the unit. The conduct of the handover of each patient followed a regular format. For example, 'In bed two there is Mrs Mary Smith aged 54 admitted this morning with shortness of breath. Query pulmonary embolism. She has been admitted [*i.e. by nurses and doctors*] and is waiting for a chest X-Ray'.

*(Field Notes)*

The nurse giving the handover would give a short report on all of the patients on the unit, the bed status of the unit, where transfer beds were available, and

information on patients scheduled for admission. This handover lasted between fifteen-twenty minutes and followed the same format. Firstly the bed number of the patient was noted, which located the patient in a physical space followed by the patient's name, age, and name of the medical consultant. The patient's status in transition through the system was always noted, with comments such as 'just in' or 'to be transferred after 2pm' used. The medical diagnosis and physically related problems, usually medical, were detailed during the handovers with little discussion about the patient's psychosocial background. Additionally, the nurses would use abbreviations understood by all, such as 'CABG' an acronym for coronary artery bypass graft. The information imparted was therefore related predominantly to the medical aspects of the patients' needs together with organisational information related to the bed status of the unit. Before leaving the room each patient would be allocated to a nurse who would then assume responsibility for that patient's care for the shift. The new nurse's name would be put on 'the board' in place of the nurse going off duty. This was a reification of responsibility as once the nurse's name changed on the board that nurse then assumed the clinical accountability for the patient's nursing care. This reflected the nursing management style on the AMAU that encouraged autonomous practice that I termed flexible primary nursing.

Nurses' knowledge of their patients, May (1992) suggests consists of foreground and background knowledge with body-centred information often given a foreground place in nursing handovers. Foreground knowledge relates to the patient's clinical definition that is medically constructed and this was the prominent discourse of the sit-down handover on the AMAU. Nurses obtain background knowledge, May (1992) contends, by their endeavours to construct the patient as a subject by such strategies as the Nursing Process and conversations with the patient. However, the sit-down report fulfilled other communication needs other than merely sharing foreground information. The sit-down report provided a space for the nurses where stories were shared related to particular clinical emergencies, difficulties with other health care professionals, amusing anecdotes or, as this extract illustrates, things that went wrong:

At the handover Fran talked about a patient who was transferred and that they had 'missed' the fact that a) he had telemetry on when they had transferred him to another ward and that b) he was an old case of 'MRSA' and that the transfer ward had called and 'were not a bit happy with us'. The group were good-humoured but still concerned about these errors and Penny noted ' I didn't see him really although he was my patient on the board. I got really busy with bed 3 and getting him off to the HDU. Sister took him over and she didn't say and the telemetry wasn't handed over in the morning from the night staff. They didn't say anything. Oh dear'. *(Field Note)*

The sit-down handover helped provide the nurses with a safe venue in which to discuss such issues without blame and as the extract illustrates the nurses experienced any such criticism levelled at any of the AMAU nurses as a shared experience. After the nurse giving the report had left the clinical room those nurses coming on duty would then talk about the report and reach a consensus about the approach that they would take to the work demands that they faced. The AMAU nurses appreciated the sit-down report as a way of orientating themselves to the unit for their shift:

"I hate it if I miss the handover. You never feel connected to the shift somehow. I need it to get my bearings."

*(Senior Nurse Interview 2:8)*

"It is good to know all the patients not only your own. Anything can happen so you need to understand, even if it is a bit superficially, what is wrong with them and any particular worries."

*(Staff Nurse. Interview 6:5)*

The sit-down handover therefore fulfilled a function of providing an understanding of the demands of the forthcoming shift rather than a detailed holistic understanding of individual patients' needs. To enhance continuity of care and to promote an appreciation of the needs of all of the patients another developed resource was that of the 'list'. The nursing team had developed a pre-printed pro-forma, or the 'list', onto which the ward clerk filled in the patient's name, age, medical diagnosis, and medical consultant's name prior to the sit-down handover. The nurses coming on duty each received one of these 'lists' from the ward clerk and filled in details related to the patient gleaned from information provided in the handover. (Appendix 14 has a facsimile of such a form.) HCAs and student nurses received 'the list' the same as the registered

nurses and made their own notes. These lists were referred to by the nurses throughout the shift and were greatly valued:

“I’m lost without my list. I have everything on it and it makes sure that I don’t forget anything. If I mislay it then I am lost.

*(Senior Nurse. Interview 1:5)*

The printed sheets were artefacts that helped give form to the experience of communication that the unit’s needs demanded and they helped translate the needs of the unit into a concrete form. The nurses carried their ‘list’ in their pockets so it was always at hand and would add information or tick off completed tasks throughout the shift. Importantly, not only did the list contain patients’ clinical information but also the patients’ transition status through the unit. Hardey *et al.* (2000: 208) have contended that nurses develop such information system on ‘scraps’ of paper or in personal notebooks as a response to their perception of ward documentation as being inadequate. Likewise, these ‘lists’ guided the AMAU nurses care delivery. The nurses expressed dissatisfaction frequently with the Patient Care Record (presented in appendix 16), which was the formal patient assessment and care planning record required by the Trust, as not being a suitable approach to guide patient assessment and care delivery on the AMAU. Therefore effective communication was not perceived as being serviced by the formal documentation of the Patient Care Record. (This aspect is discussed further in Chapter seven.) On the AMAU ‘the list’ was the major tool of communication and guide to care organisation and the sole source of information for the subsequent verbal handovers to the next shift.

The sit-down report provided the nurses and HCAs with an understanding of the demands that their shift would bring and an overview of all the patients. It was noted that the nurses receiving the report would seldom ask questions about the details of the individual patients’ nursing care plans, concentrating more on foreground knowledge (May 1992). This staff nurse explored her thinking regarding the sit-down handover and also summarised the accepted approach on the AMAU:

“I know some might say our handover is too medically orientated but let’s be realistic. We deal with acute medical admissions so if we don’t know what’s wrong with them then what’s the point of a report. Once I know say I have got

Mr Jones who is 65 years old with acute LVF [*left ventricular failure*] then I am able to know what his priority needs are.”

(*Staff Nurse. Interview 5:6*)

The nurses' past clinical experience permitted explicit and tacit understanding of the likely nursing needs once they were presented with a medical diagnosis that accessed a ready made collection of related information within a cognitive category (Hayes & Adams 2000). (The learning approaches of the AMAU nurses are developed in Chapter seven.)

Nursing handovers that impart information on all the patients on the ward or unit and is given to the entire on-coming shift have been described as a strategy that detracts from individualised care (Adams *et al.* 1998; Latimer 2000). A further critique is that it is indicative that the ward sister or charge nurse has not relinquished power (Johns 1994). However as noted the sit-down handover as witnessed on the AMAU appeared to enhance the effective organisation of nursing, despite the handover concentrating on medical problems and bed usage. It was a format to aid nurse-nurse communication that had been negotiated and developed by the nurses in response to the specific needs of the AMAU. It enhanced patient care in an AMAU setting by promoting understanding of patients' needs and the particular challenges that the shift would bring. Takase *et al.* (2006) suggest that nurses experience role discrepancy due to the incongruence between the idealised roles that they learn about in educational setting and the reality of the roles that they engage in at work. This May & Fleming (1997) have described as a theory-practice gap between professional ideas about what nursing ought to be about and what nursing actually is. Additionally, Burkitt *et al.* (2001) suggest that such incongruence results in nurses experiencing stress from the conflicting demands from an imagined community of practice, related to a shared professional identity, and their actual community of practice where they deliver care. Findings from this study support Burkitt *et al.* (2001) who argue that nurses develop an embedded identity in their area of clinical specialism. This then develops practice responses that are necessitated by the pragmatic need to deliver care in that setting rather than to satisfy the demands of a theoretical community of nursing.

The sit-down report promoted safe and efficient AMAU nursing practice. The AMAU nurses had developed their working practices to reflect their actual needs in a real practice setting that reflected their joint enterprise. Wenger (1998: 77) discusses the community coherence of the negotiation of a joint enterprise and notes '...it is their negotiated response to their situation and thus belongs to them in a profound sense, in spite of all the forces and influences that are beyond their control'. So despite potential criticisms of such a medically driven handover the AMAU nurses valued the information that the sit-down handover provided. Additionally, as Parker & Gardener (1992) have suggested the interaction of the handover is a valuable undertaking as it gives the group a sense of familiarity and the newcomer a sense of initiation into the group. Further it is a place where verbal portraits are constructed to enable the nurse coming on duty to feel familiar with the ward (Parker & Gardener 1992). The verbal portrait of the AMAU that the nurses obtained from the handover fulfilled their needs and promoted coordination of care.

The handover involving the whole shift can also fulfil a cultural role in that 'it would appear to be a way of ensuring social order is maintained within the group by enforcing cohesion and interaction' (Holland 1993: 1469). A more recent study (Lally 1999) explored the functions of nurses' communication at the handover using observation and the audiotaping of six handovers on one ward in a UK general hospital. Lally (1999) argues that the giving of information is not the only function of the handover other elements, which included teaching, team building and group cohesion, helped to construct a shared value system amongst the nurses. Although Lally's (1999) study is restricted to one ward it echoes earlier research (Griffiths 1998) and supports the findings of this study. The sit-down report helped the nurses shape their common identity as members of a community of practice and so enhanced their cultural identity. A distinct aspect of the nurses' work organisation was the use of two stages to the handovers. As noted the sit down report provided foreground knowledge (May 1992) and promoted a cultural cohesion. However following the sit-down report there was a bedside handover that enhanced the sharing of background knowledge (May 1992) and will be discussed next.

Following the sit-down report a handover then occurred at the patient's bedside between the nurse who had been caring for the patient and the nurse coming on duty who was taking over the patient's care. During the bedside handover, the nurse going off duty would entrust any care or other intervention (medical or nursing) that still required attention to the nurse coming on duty. This was the normal expectation on the AMAU:

“If you can't do it you pass it on to the next shift. You say ‘I am sorry but I haven't done it. Will you do it for me?’ It is all for the good of the patient.”  
*(Staff Nurse. Interview 6:5)*

This reflected the flexibility of working on the AMAU as the work demands were dealt with according to the particular demands of the shift. Demonstrating a non-task orientated working environment that evidenced autonomy in care delivery that was freed from hierarchical control. The specific content of these bedside handovers would vary from nurse to nurse and would also be dependent on the condition of the patient:

I joined a couple of bedside handovers today. They both used different formats. Katie offered information that was more related to pharmacology and the blood results whereas Joanna concentrated more on social-psychological issues. Both used their ‘lists’ to aid their memories and not the Patient Care Record. The patients were included and asked to confirm what the nurse was saying and they were asked how they were and if they wanted to add anything.

*(Field Notes)*

This observation was supported throughout data collection in that the nurses had their own style when delivering the bedside handover; this is in contrast to the very structured format of the sit-down report evidenced. The format of the bedside handover as practiced on the AMAU between two nurses and the patient did not risk breaches of confidentiality in the same way as a bedside handover that involved all the on-coming staff would. Intimate details could be discussed out of earshot of other patients when the two nurses engaged in quiet conversation with the patient. It was when background knowledge (May 1992) was shared. The medical diagnosis and other technical information had been discussed during the sit-down handover therefore, as Cahill (1998) has noted, patients did not have to get bored hearing the same information which had been shared in the sit-down report. The use of a bedside handover that includes the



patient is in keeping with the philosophy of primary nursing that encourages individualised patient care and patient participation in care (Johns 1994). The use of this two-pronged mode of handover satisfied the needs of communicating instrumental and expressive care needs (Clifford 1995). However, there is a risk that a bedside handover can maintain professional dominance if the patient is not involved in a manner that reflected the patient's wishes and delivered in an understandable manner (Cahill 1998). However, on the AMAU all bedside handovers observed fully involved the patient and/or relative provided that the patient's physical-psychological condition permitted such discussion.

The nursing staff going off duty would complete the formal written care plan in the Patient Care Record after they had given their handover but it was not the tool of communication for the hand-over. The AMAU nurses appeared to view the completion of the formal care plan as a legal and employer requirement rather than as a useful communication tool as has also been reported by other authors such as LeLean (1975); Griffiths (1998); & Kerr (2002). The nurses in this study, and as was echoed in the studies noted above, communicated by their narratives to one another. This may be an indication of the complexity of the care needs of individual patients and how they were attended to in a setting of other patients with their own particular needs. Also the linear format of the nursing process (Benner 1984; Johns 1994) that the written Patient Care Record required, reflected poorly the actual processes of clinical decision-making that the AMAU nurses utilised in their practice

The AMAU nurses' approach to the nurse-nurse intershift handover (sit-down and bed-side) was time consuming in a time short care environment. Despite this time factor the importance of effective information sharing and the social activity that enhanced shared understandings of meanings was valued. As Wenger (1998) notes by engaging in discourse with others, even those with whom we routinely spend much time with, we develop shared understandings and a negotiation of meaning, as it is a 'process by which we experience the world and our engagement in it as meaningful' (p. 53). The nurses had therefore developed particular formats for their handovers that were responsive to the demands of AMAU nursing. Another developed practice to enhance continuity of care was

the approach to nurse-patient allocation practiced on the AMAU, which will be discussed next.

#### **5.4.2 Nurse-patient allocation**

The allocation of a nurse to care for an individual patient for a shift was informed by the consideration of a number of factors including knowledge of the patient, the allocation of expected admissions, the expertise required for complex patient needs, plus balancing the existing workload on the unit. All of the nurses coming on-duty would be allocated to specific patients, this included the senior nurse on duty. This allocated nurse would then be the patient's primary nursing caregiver for the shift:

**PG.** "Do you think that there are any differences between a nurse on an ordinary medical ward and a nurse on the AMAU?"

"AMAU nurses have to use their own initiative far more. They haven't got to say 'can I change the care of this patient' [*pause*] as an AMAU nurse you are an individual practitioner"

*(Senior Nurse. Interview 7:3)*

A priority issue during the allocation was to ensure that if a nurse had admitted a patient then to maintain continuity of care she or he would take over that patient's care for the shift. It was recognized that the admitting nurse held special knowledge about the patient:

"We try and allocate ourselves to patients that we have admitted. You are more likely to know the patient well if you had admitted them. When you are assessing a patient, and especially if the family are there with them, then that is when you start building up a relationship and from there you can go a little bit further. If you haven't been involved in that process then I think it is more difficult sometimes to know them."

*(Senior Nurse. Interview 1:5)*

My involvement with patients' admissions during participant observation supported the verity of this contention. This was true particularly if the patient on admission to the AMAU was very ill and required critical interventions or resuscitation, in such cases the patient would stay as a vivid memory in one's mind:

I helped with the admission of an elderly man with terrible melaena [*passing blood in his stools, indicating a severe gastro-intestinal bleed*]. He was very poorly and very upset that he was soiling the bed' and kept say ' mae flin da fi nyrs' [*Welsh for 'I am sorry nurse'*]. No one else present could understand Welsh so I felt useful.

*(Reflexive Diary)*

The admission time was an anxious transition period for patients and their families, especially if the patient was seriously ill. During the admission period the nurse engaged with the family for the first time and information was sought related to the patient's psychological-social background and past medical history. The admission episode was therefore a key transition phase in the patient's care journey and as Meleis *et al.* (2000) note nurses are often the primary caregivers when patients are undergoing such health related transitions. Some patients admitted were at times readmissions so the nurses may have had an existing relationship with the patient; this was then another criterion for nurse-patient allocation:

“ At the handover with a readmission you can visualise the patient. If you know him from before and what he needs, you understand how poorly he might be at this time and with your knowledge from his previous admission you can start thinking about caring for him before even seeing him.”

*(Staff Nurse. Interview 6:4)*

As this nurse describes prior knowledge of a patient aids effective care, as the nurse would have an understanding of some of the patient's needs immediately. So whilst acknowledging the need for a thorough assessment on admission the nurses were able to, from their knowledge of the patient, identify deterioration in the patient's condition and further would have knowledge of the treatments administered previously. Importantly such prior knowledge may also hasten swift delivery of appropriate care for the patient. Malone's (2000) interpretative ethnography of frequent readmissions or 'frequent flyers' (p3) to emergency rooms in the USA notes that such patients' familiarity 'challenges the thin protection against existential vulnerability provided by rapid patient turnover' (p.3). This aspect was beyond the scope of this study to develop however the AMAU nurses' discourse did express particular concern for these patients that they knew and would an interesting area to develop.

During assessment the patient and nurse, or the relative and the nurse, talked and shared information. It was a time when the patient was refigured from an admission into an individual (Benner & Wrubel 1989). However, this critical stage in the patient's continuum of care was with nurses with whom the patient and the patient's family would not have an enduring relationship. I had noted that at admission there was a flood of information given from the patient and/or relatives or carers. At such an early stage in the patient's journey the relevance of much information was not yet clear. Nonetheless, the patient would be transferred usually within 12 hours, so despite the formal written records of this information any insights gained that were tacit or intuitive could not be built on. It can be suggested, and this would require research to confirm, that there is a disadvantage in the admitting nurse not having an on-going relationship with a patient and building on the first meeting and the understanding of the patient gained. Ideally a relationship commences at admission that is based on the mutual recognition of the patient's vulnerability and the patient's dependence, in varying degrees, on the nurse who will assist them with those activities that they would normally do themselves (Lawler 1991). Such a relationship is difficult to achieve in situations of rapid patient transition, as was the model of care on the AMAU.

Care, as has been discussed in this chapter, can be effective and valuing of the individual but long-term nurse-patient allocation was not possible within the AMAU system. Nonetheless, the nurse-patient allocation system practiced on the AMAU worked to enhance continuity of patient care within the constraints of AMAU practice. Allocation of nurse to patient on the AMAU was based on knowledge of the patient rather than by geographical allocation as in team nursing (Walsh & Ford 1989). Thus the nurse-patient allocation system utilised on the AMAU held similarities with primary nursing (Garbett 1994). Professionally orientated practice has been described as being predominately patient-concern orientated with the nurse engaging with the patient to offer care that is holistic and individualised (McKenna 1997). The nurses on the AMAU had evolved ways of working that demonstrated professionally orientated practice within the structural constraints that they experienced.

The AMAU nurses' approach to nurse-patient allocation demonstrated originality despite the high and demanding workload. A system of working had developed that valued continuity of care and centred on allocating a nurse to a patient based on the patient's needs rather than on geographical convenience for the nurse. The AMAU nurses had developed a form of flexible primary nursing despite the organisational constraints under which they worked. Such working promotes the individualising of patient care and as Johns (1990) suggests supports humanistic care. A negotiated meaning of their joint enterprise (Wenger 1998) had been developed in the AMAU's nursing organisation. New meanings and emergent structures had developed that had built on the tenets of primary nursing however the nurses did not express this view explicitly. It seemed that they were influenced tacitly by New Nursing ideas and had incorporated them into their practice. Maybe reflecting what Amin & Cohendt (2000: 108) when they note the praxis of innovation does not separate out the formal and informal... The role of the AMAU nurse demonstrated a flexible form of primary nursing in the development of an evolved strategy of nurse-patient allocation that enhanced continuity of care and autonomous practice. However, the AMAU patients were unaware of this strategy to promote individualisation and continuity of their care.

Those patients interviewed did not realise that that they had been allocated a nurse to care for them for each shift. Cled considered that all the nurses looked after him and that 'no-one sticks out'. Dave had vivid memories of the doctor who admitted him but did not remember any of the nurses on the AMAU:

"I don't remember the nurses from the AMAU. I think that would be because the first person that I really dealt with was Dr Pete [*junior doctor who admitted Dave*]. I do remember him. The nurses were probably not with me for as long as he was and they were doing standard checks like blood pressure and things like that [*long pause*]. So they were very busy, so I don't actually remember any of them to be honest."

(Dave. Interview 15:5).

Eve, noted that she did not have a nurse's name on the sign above her bed as only the medical consultant's name was noted but she did not find this a worry 'just whoever was on duty' looked after her:

PG. "Can you tell me about the nurses caring for you on the AMAU?"

“No. Not really. Normally they have had before [*when Eve was in hospital before*] behind your bed a sign with 'your allocated nurse is so and so' but that didn't happen this time. It was just who ever was on duty. So I suppose it was where the need was greatest, which end of the ward.”

*(Eve. Interview 16:7)*

The patients interviewed, and those with whom I spoke with during participant observation, did not realise that the nurses were aiming to make the nurse-patient allocation as continuous as possible. So despite every patient having a nurse who was responsible for them on every shift patients were unaware of this, in fact patients viewed the nurse-patient allocation on the AMAU as being a rather random occurrence. Therefore, the system of nurse-patient allocation that the nurses had developed to maintain continuity of care was invisible, unknown and therefore unappreciated by the patients. Jacques (1993) has warned that it is the visible tasks that the nurse does that are noticed and measured and that nurses often fail to articulate the invisible aspects of their work. As Hughes (1971: 308) noted over thirty years ago:

*Nurses' place in the division of labour is essentially that of doing in a responsible way whatever necessary things are in danger of not being done at all.*

Jacques (1993) contends that the connecting work of nurses, and the skills required to do this effectively, is under valued and underestimated in a climate of audit and measurable quality. Such work, often only noticed as such when it is not done, may seem to be common sense work, which is ill defined and happening naturally. Such work is often seen as women's work and it then remains as James (1989:16) noted 'undefined, unexplained and usually unrecorded'. Additionally, Wolf (1989: 464) describes nursing work as 'the glue' that keeps the hospital together. Much of the work of the AMAU nurses related to promoting co-ordination and continuity of care and they, by this work, provided the glue that enabled the AMAU to function. Liaschenko & Fisher (1999:32) argue that nurses need to understand scientific knowledge but also need to know 'how to get things done; they know how to move patients through a health care system and how to connect patients with resources'. These authors contend that nursing, like much other gendered work, is not credited as being work, that 'things just sort of happens' and that there is no knowledge in

arrangements that ‘just happen’ (Liaschenko & Fisher 1999: 32). However, the locally developed nursing strategies such the handovers (sit-down and bedside) and patient allocation developed by the AMAU nurses to promote continuity of care were only evident to the nurses, despite their importance in the maintenance of coordination and continuity of care. These strategies are examples of invisible and undervalued aspect of the nurse’s role that contributes to making the work of the AMAU nurses appear to just happen and so negates from an appreciation of the complexity of their locally evolved working systems.

### **5.5 Summary**

The negotiated responses discussed in this chapter had developed organically in response to the needs of the nurses’ joint enterprise of facilitating patients’ rapid transition. They demonstrated a community of practice (Wenger 1998) with a range of pragmatic and unique responses to external demands. The mutual engagement in their developed community of practice had led to the nurses working with a high degree of professional autonomy in their work organisation in particular related to the management of beds and the acceptance of patient admissions. I used the term flexible primary nursing to describe the AMAU nurses work organisation. However, there was a lack of articulation of these innovative strategies and of the tacitly developed shared identity and common enterprise of the nurses’ community of practice. This resulted in the nurses’ work being often invisible despite providing ‘the glue’ (Wolf 1989: 464) that ensured the coordination of the AMAU and of patients’ transition into and through its environment of care.

The following chapter provides a discussion of the distinct professional skills and attributes developed within the AMAU nurses’ community of practice. This local regime of competence then facilitated the nurses’ joint enterprise of managing rapid patient transition.

## CHAPTER SIX

### PROFESSIONAL SKILLS: THE ATTRIBUTES OF AN AMAU NURSE

#### 6.1 Introduction

The theme of this chapter relates to the AMAU nurses' professional expertise required for competency in their practice and the attributes necessary to exercise these skills as identified by this study. Two categories identified as being germane to the effective discharge of the role of an AMAU nurse were the professional skill of being an *Effective communicator* and the requirement of '*Knowing your stuff*': *professional credibility*. These abilities are arguably common to all nurses but I seek to demonstrate within the discussion that the AMAU nurses' role required particular skills and attributes and a distinct application. The meaning of attribute used relates to its literal meaning of ascribing, assigning, or considered as belonging, as a quality or property, or a virtue (Chambers Dictionary 1998). There is no intention to develop discussion related to attribution theory that seeks to understand and explain how people attribute causes to their, and to others, behaviour (Pennington *et al.* 1999). Firstly, the professional and human requirement for effective communication in the AMAU nurse's role is discussed.

#### 6.2 Effective Communicator

Developing the interpretation of the AMAU nurse's role commenced in Chapter five the abilities of the AMAU nurses to provide effective communication in a setting of rapid patient transition is discussed in this category. Firstly, the communication skills required for the nurse's role as the co-ordinator and manager of patients' transition are examined. This is followed by consideration of the nurses' interactions with patients, which is developed in the sub-category of '*time to talk to patients*'. The relationships that the nurses developed with their patients and the ability to foster trusting relationships, despite limited time for relationship building, is then considered in the sub-category of *brief communication: trusting and 'clicking'*. However, consideration of the distancing of the nurse from the patient due to time constraints and a developed culture of practice that accepted such disengagement as inevitable is also examined. Firstly,



the need for effective communication so as to undertake the role of coordinator of the AMAU care environment is examined.

The AMAU nurses interacted with a large range of personnel on the unit, exterior to the unit but within the hospital, and from outside of the hospital. (Appendix 5 presents a role set (Handy 1999) for the AMAU nurse.) As has been discussed in Chapter five the nurses communicated with these health care personnel and with patients and relatives in a busy and demanding care setting. All nurse participants identified the communication ability of the AMAU nurses as a central element of their role as this extract illustrates:

“Communication is very, very important everywhere but especially here because so much happens here and you have got to be on top and you have to remember who is doing what.”

*(Senior nurse. Interview 2: 3)*

Communication centred on patient care provision, which then necessitated effective interactions with other health professionals. Therefore, as this nurse indicates an important feature of the communication aspect of the AMAU nurse’s role related to the management of the AMAU. By noting a need to be ‘on top’ the nurse articulates the skill needed to connect the various strands of the unit’s organisation (events and people) and so to provide overall coordination. The exercise of these skills required more than simply knowing what to do, as it was imperative also to be able to communicate effectively in situations that required adaptability:

**PG.** “What are the skills that a nurse needs to work here?”

“Excellent communication skills would be top of my list. Being able to think on their feet, to be very adaptable and to be able to deal with people. To have good people skills I think that’s it and to have good basic nursing knowledge obviously. Yes, communication I think is the most important thing because everything changes so quickly here...”

*(Staff Nurse. Interview 4:4).*

These communication skills included the ability to deal with situations in a flexible manner because ‘everything changes so quickly here’ whilst having ‘good people skills’. Medical staff, who were the members of the multidisciplinary team with whom the nurses had the closest inter-professional relationship, likewise noted the need for effective communication skills:

PG. "What are the key skills that an AMAU nurse needs?"

"To work here you need someone committed to their job and able, but I think you've got to have as a nurse, and especially on the AMAU, a sort of social ability as well because they spend a great deal of time with very ill patients and the relatives, much more than we do. I mean obviously knowledge is very important, but equally, it's 50:50 with being able to communicate with patients."

*(Junior Doctor. Interview 11:2)*

PG. "What skills do the AMAU nurses need?"

"They should be good in communication skills. That is very important for an admissions unit, to be able to reassure patients, relatives. A patient being transferred to this ward or to that ward is being done so for a good reason and you need to tell them. Sometimes awkward things happen in the AMAU, like any other wards, they should be able to handle it."

*(Senior Registrar. Interview 8:4)*

The nurses thus required communication abilities that encompassed the dual needs of communication when managing the care of the individual patient and when coordinating the organisation of the unit. The social ability of the nurse was also noted for as well as being adaptable as things 'change quickly' they also had to be 'able to deal with people'. All participants noted the importance of effective communication as a central aspect of the role of the AMAU nurse. However, communication ability is a key skill for all nurses and is not unique to the AMAU nurse. The competencies required for a nurse to enter the Nursing and Midwifery Council (NMC) Register include the ability to form therapeutic relationships with patient/clients (NMC 2004). The nurses' code of professional conduct gives emphasis to the connecting aspect of communication that participants alluded to within this study:

*4.3 You must communicate effectively and share your knowledge, skill and expertise with other members of the team as required for the benefit of patients and clients.*  
(NMC 2004:8).

The relationship between a nurse and a patient is also emphasised throughout the Code of Conduct. The communication role described is one of protecting patients' preferences and choices by being an information sharer and an advocate for patients' rights and, in essence, to 'respect the patient as a individual' (NMC 2004:3). Additionally, the *NHS Knowledge and Skills Framework* (DoH 2004b),

that describes and defines the knowledge and skills needed by NHS staff to deliver quality services, has identified communication as its first Core Dimension and notes:

*Communication is a key aspect of all jobs in the NHS. This dimension underpins all the other dimensions in the KSF [Knowledge and Skills Framework] (DoH 2004b:51)*

Good communication skills are a universal requirement so as to deal effectively with individuals who are ill or needing health information to maintain health (Herzlich 1973; Leddy & Pepper 1989; Webb 1994; McCabe 2004; Squires 2004). The nurse's communication ability is a key aspect of nursing practice and is emphasised by nursing theorists, for instance Roper *et al.* (1996) who consider communication to be one of the twelve activities of living and Peplau (1992) who argues that communication is a fundamental aspect of nursing. Jacques (1993) develops the communication role of the nurse by arguing that a key role of the nurse is as a caring/connecting worker who assumes responsibility for conveying information between one part and another by a network of nursing communication. The AMAU nurses were noted similarly to have an important connecting role when managing the AMAU care environment whilst caring for acutely ill patients who stayed on the AMAU for a short time only. Therefore, these two role requirements resulted in a paradoxical situation. What made the need for effective communication particularly important, and also potentially restricted, on the AMAU was the speed of patient transition through the unit. The limited ability to foster nurse-patient relationships in this environment of time shortage is discussed next.

### **6.2.1 'Time to talk to patients'**

On the AMAU there were restricted opportunities for conversations between patients and nurses and thus patients had limited chances to talk to the nurses in a relaxed interaction. The nurses described this lack of time to talk to and to get to know the patient as a challenging aspect of their role:

“I like it when I can go home and know that I have done everything I am supposed to do and I have done it properly, I haven't cut corners you know and I have had time to have a chat. That's a nice feeling when you have had time to talk to patients.”

*(Senior nurse. Interview 2:6)*

This nurse explains that she would wish to talk to the patients but restricting this engagement was a feasible option and a way to 'cut corners' when the unit was busy. The nurses were thus pragmatic regarding their capacity to get to know a patient and a patient's family well in the time pressurised setting of the AMAU:

**PG.** "What are the key skills needed by an AMAU nurse?"

"Communication is important I would say. You see here you have to deal with bereavement and all sorts. I know that you have to deal with that anywhere but here it can be very sudden. You haven't built up a relationship with the patient or the family. You try and build up a rapport but you don't have the same rapport that you would if you knew the patient for a longer period of time. You just try and support them through the best you can."

*(Staff Nurse. Interview 5:7)*

When patients were admitted they had the full attention of the nurse and doctor and it was during this time that many questions were asked and information given. After this assessment stage the patient would be categorised by an informal classification of illness status used by both nurses and doctors: a continuum from critical, or 'very, very poorly', to 'okay'. If a patient were to be designated, as being 'okay' then the nurses would normally have limited one-to-one interaction beyond the patient's particular instrumental care needs. As this senior nurse noted:

"I mean a lot of patients go through here and I wouldn't know them from Adam".

*(Senior Nurse. Interview 1:4)*

The nurses' approach to patients who were 'okay' or considered to have non-critical problems was self-limiting either by the duration of an intervention or with questions being asked by the nurse whilst standing at the end of the bed. The nurses therefore used body postures that indicated that conversations with patients would not be long ones:

It was very busy on the unit today with everyone rushing around. When the nurses went into the side wards or into the bays they went in to 'do something'. As they did these things, like asking the patients things or doing a pump check, they would stand up and usually be writing while they spoke to the patient or with their pens in hand always looking ready to write.

*(Field Notes)*

The nurses were however under constant time pressure due to the number of acutely ill patients admitted and the requirements of existing in-patients together with the time spent ‘making beds’:

**PG** “Is there anything that you would change about the unit?”

“ *[Laughing]* More staff, which is obviously a problem, so we would have more time to spend with the patients that we have got; more beds; and the documentation because if we had less documentation we would have more time to spend with patients. That lack of time is what is most important thing to me I think, and that is probably what I would want to change.”

*(Staff Nurse Interview 5:4)*

As discussed in Chapter five the bed management aspect of the nurses’ role was time consuming and ultimately rather distracting from direct nursing care provision. Further, the need to provide sufficient staff with the distinct skills and abilities that the AMAU nurses exercised was difficult, as non-AMAU nurses would not have these skills. (This is developed later in this chapter.) Another aspect that restricted the nurses’ time to spend with patients, as noted in the previous interview extract, was the formal paperwork involved in their practice. (This is developed in Chapter seven.) Therefore the capacity of the nurses to communicate effectively with their patients was constrained by competing work demands and it was then often only those aspects that related to physiological or safety needs that could be met:

“ A situation that sticks in my mind was the time we had three arrests at the same time. During the consultant’s round the patient literally fell onto him. Then another patient arrested who was in the same four-bedder. The third one was in a side ward and she was quickly seen to and it was decided that she would go naturally. Everyone was running around like headless chickens.”

*(Senior nurse. Interview 6:9)*

The AMAU was a busy and bustling space. The day may have had quieter spells but only quieter by the AMAU’s terms of comparison. The nurses’ bay, the hub of the unit, was usually full of noise and discussions, with telephones and beeps going all the time. However, despite this busyness patients still sought interactions with the nurses. I had asked all of the patients who were interviewed ‘what are the attributes of a good AMAU nurse?’ and the two extracts detailed below were typical responses:

“The attributes of a good AMAU nurse, hmm, communication I would think would be one of the most important ones certainly from my point of view

[*pause*] it would be someone that communicates well and I think friendliness as well which I don't know whether if it is the right word but you do need to be able to put the patient at ease certainly..."

(*Eve. Interview 16: 3*)

"I suppose they [*the AMAU nurses*] must be able to communicate, as patients are people after all."

(*Cled. Interview 14:5*).

Additionally, those patients interviewed recognised that the nurses had rationed time to spend with them due to other demands on the nurses' time. The patient in the following extract was describing his arrival on the AMAU:

"When I came in the nurses at the bay said hello. I can't remember if possibly one of them came over and chatted to me before the doctor came but I think that it was more a case of them saying the doctor is going to come and see you to take some blood. I don't think that there was too much information there. I know that they were quite busy and I could hear that they were quite busy so I expected to wait longer than I did to be honest with you."

(*Dave. Interview 15:10*)

Patients interviewed indicated that they would like to have had more opportunity for interactions with the nurses:

"It is nice when somebody can come sit down on the bed and have a chat for five minutes and explain what is going on but on the AMAU there isn't time for much of that. I don't think it is realistic in actual fact."

(*Eve. Interview 16:7*)

All of the patients I interviewed used the same terminology by noting that the nurses were noted occasionally to 'have a chat', with an implicit understanding that such a chat was a short one:

"On the ordinary ward they are more relaxed, more inclined to chat during the day. There are more of them there. On the AMAU they are too busy so are less chatty because they can't have the time. Mind you if they have time they do have a chat for five minutes."

(*Bill. Interview 13:5*)

When using the terms 'a chat' or 'chatting' this would indicate that what patients looked for was a mode of communication that was easy or familiar in tone (Chambers Dictionary 1998): someone who 'chats' is acting in a friendly and equal manner with the other. However, even when perceived as chatting the nurses were usually carrying out their assessments or interventions during this

time. This may help explain a common finding from all of the patients interviewed which was they could not remember any individual nurse by name:

Everything was looking fine and working so there was nothing to worry about basically. One of the nurses came and did chat to me on the way down [*when transferred*] but I don't remember her name unfortunately but she was very nice. My experience with the nurses was that they were all very nice."

(Dave. Interview 15:6)

Nonetheless, all of the patients interviewed had keen recollections of the doctor who had admitted them:

PG. "Can you tell me about the nurses who were there when you were admitted? Who do you remember?"

"I think there about two or three of them and I saw the nurses before I saw Doctor Jones [*junior doctor*]. One was talking to me and one was helping the doctor. They were about my age; I don't think I saw them again."

(Adam. Interview 12:3)

Patients described brief yet satisfactory encounters with the AMAU nurses however none of the patients interviewed could remember any of the nurses who cared for them other than they were all 'very nice'. As long as the care provided resulted in the patient feeling safe and cared for then patients interviewed expressed satisfaction with their care. None of the patients interviewed offered any negative incidents related to communication with the nurses. Patients did not articulate the need for an in-depth relationship with an individual nurse and patients interviewed were keen to acknowledge that the nurses' busyness interfered with time for talking.

Morse (1991) describes four types of mutual relationships that develop between nurse and patient: clinical relationships; therapeutic nurse-patient relationships; connected relationships; and over-involved relationships. The nurse patient relationship that describes the norm on the AMAU was akin to a 'clinical relationship' described by Morse (1991: 458) as when:

*The patient has no expectation of the nurse beyond the care requested and received, and the nurse meets those needs quickly and efficiently as a professional. The interaction between the nurse and the patient is superficial, courteous, and by rote.*

In such relationships, affected by shift patterns and shorter lengths of hospital stays, neither the patient nor the nurse remember one another nonetheless patients express satisfaction with their care. However, patients do not then develop neither therapeutic nor indeed close relationships with the nurses providing their care and this Morse (1991: 467) warns leads to:

*From patients' perspectives, the clinical relationship means that nurses are invisible and interchangeable, rather like an excellent waiter, unnoticed and in the background, as long as one's needs are met.*

The findings from this study offer support for this categorisation. The AMAU nurses were comparable to the excellent waiter as described by Morse despite the nurses' attempts to maintain continuity of care with their work organisation system (discussed in Chapter five), which I named flexible primary nursing.

The nurses were conscious of a lack of communication with patients and despite the short time available the nurses worked hard at meeting the instrumental needs of the patients and managed to convey that any lack of communication was not intentional. The AMAU nurses often used the expression 'popping in' to describe the brief interactions with their patients who were clinically stable. The nurses had to ration their time so that the needs of the acutely ill patients were addressed effectively. Further, the nurses had to also attend to their responsibilities when maintaining the AMAU's provision of empty beds, as discussed in Chapter five. The term 'popping in' was also used by A&E nurses (Byrne & Heyman 1997) to describe their similar strategy of giving just enough care but without allowing time for a relationship to develop that would detract from their more esteemed roles of dealing with major trauma and moving patients through the department:

*Nurses often worked under considerable pressure and were faced with conflicting demands. Thus, at times when they were busy and unable to provide more substantial support, the act of 'popping in' may have served to reassure patients that they had not been forgotten (Byrne & Heyman 1997:99).*

Maslow's (1968) conceptualisation of a hierarchy of human needs can help understanding of this phenomenon of restricted communication in the care environment of the AMAU. The human being, Maslow suggested, must maintain the most basic (survival) biological needs, such as maintenance of an optimal



level of oxygen-carbon dioxide exchange, before considering more complex psychological motives that will only become important once the basic needs have been satisfied (Murray & Zentner 1989). Such higher level needs move from needs for safety, to belongingness and social needs, seeking ego needs related to self-esteem and feeling significant, and finally to reaching self-actualisation (realising the best of one's potential) (Hilgard *et al.* 1979). This model can be used to explain the approach to the instrumental level of communication that was evident on the AMAU. When busy the nurses' attendance to patients' basic biological and safety needs, such as giving medications and dealing with cardiac arrests, were the only meeting of needs that time constraints would allow. Short friendly interactions that mimicked the polite interactions of society generally were evidenced but development of in-depth and therapeutically driven interactions were not evidenced on the AMAU. Additionally such short friendly interactions were restricted and controlled by the nurses when workload demands were high.

Higher order communication needs to satisfy belongingness, love and acceptance needs were relegated to secondary importance: they were of reduced significance until basic needs could be met. Such a basic survival approach to patient care, and in particular to person-centred communication provision, had become the norm of the AMAU nurses' practice. However, Hallstrom & Elander (2001) report patients ranking communication needs highly and that medical patients' need for communication is higher than it is for surgical patients. As AMAU patients are all medical patients, and also acutely ill, so their information needs would be important to address. However time constraints and workload demands lead to 'clinical relationships' (Morse 1991: 458) being the standard nurse-patient relationship on the AMAU. Conversely, Morrison & Burnard (1997: 48) contend that the 'caring nurse always has time for people'. Whilst noting the difficulty in practice in meeting such a high standard the authors do not offer suggestions as to how the nurse comes to terms with not meeting such an exacting goal. It seems that it is exactly this time for communicating with patients that was the disposable option in AMAU nursing practice when time was short. Hewison (1995) from an observational study of nurse patient relationships in a small hospital for the care of the elderly reported:

*The institutional influences determine that interaction is largely routinized and task-orientated...nurses' interactions with patients were brief, confined to physical care, and almost invariably initiated by nurses (Hewison 1995: 79).*

Although it would appear that there was a wide gulf between nursing on a care of the elderly ward and on an AMAU nonetheless Hewison's findings held resonance with findings from this study. Hewison (1995) describe nurses being powerful in relation to patients who they controlled by the power of language. One sub-theme 'controlling the agenda' was identified in which nurses communicated with patients using a form of language that indicated that a certain action should be taken (Hewison 1995:79). However, there are limitations when attempting to interpret a social relationship by merely watching interactions, as was the case in Hewison's study, without seeking the interpretations of key actors. Nonetheless, in a similar fashion the AMAU nurses often controlled the nurse-patient relationship when they directed the conversation towards care needs solely. However, the AMAU nurses also managed to insert an element of friendliness into their limited interactions with patients and this ability is discussed next.

### **6.2.2 Brief communication: trusting and 'clicking'**

All of the patients interviewed noted that despite not seeing the nurses very much they were quite confident that the nurses were aware of their needs and were caring for them, albeit out of their sight. Patients explained that the AMAU nurses were not available as they were caring for ill patients elsewhere:

"...I had the impression that they were quite busy that day, but as soon as I pressed the bell someone came so I was okay."

*(Cled. Interview 14:5)*

"Well you see it is such a busy ward, no body had time they were so busy and the people that were there they were ill weren't they. They needed, you know, attention the whole time almost. I mean I was lucky because I didn't need that sort of one-to-one attention all the time. I could cope."

*(Eve. Interview 16:5)*

There may be elements of what Taylor & Benger (2004: 530) have termed the 'point of view paradox' in which patients' expectations regarding non-clinical service (emotional needs) decrease in direct relationship to the severity of their illness. The AMAU patients may experience this and once feeling better still

experience the effect by proxy for all of the other ill patients coming in. In fact all of the patients interviewed noted that they experienced a positive and welcoming interaction with the nurses when they were admitted, as this interview extract illustrates:

**PG.** “Did the nurse come to speak with you once you were in bed?”

“There were some nurses that came up and just started chatting for a bit and asking what brought me in. They were asking me what's my name and what do I do for a living, where am I living and stuff like that. Politely just like trying to get to know you and how to handle you like. That sort of thing.”

*(Adam. Interview 12:5)*

Patients, such as Adam, were noted to use their existing social knowledge to identify behaviours that they considered caring. Adam appreciated the nurses coming to him and that they ‘chatted for a bit’ and he saw them as being polite and interested in his life. Francis, an 18 year old who had been admitted with viral meningitis and required a lumbar puncture, described an episode of nursing care that had made a positive impact on her illness experience:

“I felt horrible. I had to sit up on the side of the bed and I was hugging this poor nurse to keep me sat up. She held me very firmly and smoothed my hair, which was nice and comforting, and told me what was happening. It was pretty quick then I lay down they gave me a drink of water and a tablet for my headache and I went to sleep.”

*(Francis. Interview 20:2)*

Francis demonstrates trust in the nurse’s knowledge and with the kindness demonstrated to her this then helped her to gain confidence and to feel that she was safe and cared for. As Morse (1991) notes when patients present themselves for care they assume that the nurse has the technical ability to provide this care. Francis received ‘one-to-one’ care due to the seriousness of her illness and her potential for clinical deterioration. Time was made to ensure that Francis was cared for in an unhurried manner as she was a priority case and potentially ‘very poorly’. The nurses interviewed acknowledged freely the limited time that they would spend communicating with patients who were not a clinical priority:

“Sometimes you hardly talk to a patient when it’s hectic.”

*(Senior Nurse 3:5)*

Nonetheless, it was possible to inject a friendly manner into the nurse-patient interaction whilst giving instrumental care:

Mary was changing an IVI and at the same time talked with the patient about the village where he was from and the fact that her aunt lived in the same village. Mary spoke Welsh with the patient and the other two patients in the four-bedder had joined in too. This friendly episode was conducted and the IVI changed all within five-ten minutes.

*(Field notes)*

The AMAU nurses had developed a particular style of interaction with patients whose clinical conditions were stable as is illustrated in the previous field note extract. The nurses also experienced 'leg pulling' by patients whilst conducting their work and always laughed at the patients' jokes or comments. In these short instrumental interactions the nurses would present a cheerful and friendly face. They would talk with the patients about lightweight news items, tell the patients a story about something going on in the ward or hospital, or demonstrated friendliness in other ways as this interview extract illustrates:

**PG.** "Was there any one nurse who sticks in your mind from the AMAU? That you thought looked after you well?"

"Well, they all did really; you know I have no complaints at all because they were patient and good workers. They was one old boy there, I don't know what had happened to him, because all they could get out of him was 'fxxxxxx hell', all the time! And I thought that they were really patient [*laughing*] with him because he couldn't speak, well he could speak that phrase all right. One of the nurses came into me and sat down and banged her head on my bed in frustration but then we both laughed".

*(Cled. Interview 3:7)*

This shared experience with the nurse, and the common frustration at the noisy patient, was for Cled a positive incident. The nurse responded genuinely to the situation and their common frustrations and so a connection was made between Cled and the nurse. Of course patients admitted to the AMAU were by definition acutely ill and besides the valuing of friendly social interactions they also needed to be cared for. Dave's admission was the first time that he had been in hospital and as he explained he was very anxious when admitted:

"One thing that I found though was that all the nurses that I dealt with both in the AMAU and in Cavell ward [*transfer ward*] seemed to me to be very kind

and that made me feel very good. It made me feel looked after which I think I probably wanted.”

*(Dave. Interview 15:4)*

Patients who were admitted to the AMAU had usually been taken ill suddenly and so were not expecting to come into hospital. However, patients appeared to trust the nurses to care for them and sought a combination of expertise with friendliness, as Dave noted he felt ‘looked after’. Bill, who had very unstable diabetes and so was admitted regularly to the A&E department or the AMAU, considered himself rather an expert on medical and nursing care in the hospital:

“Some you just click with, you trust them and build up a friendship. Mind you I get on well with all the nurses I am able to chat to all of them and approach them. They all know me, they say 'hello Bill, here again'. Even if I don't know them I soon get to know them.”

*(Bill. Interview 13: 5)*

Bill experienced his relationship with the nurses as impersonal trust as he gets on well with all the nurses but notes that some he ‘clicks’ with. Morse (1991: 460) likewise describes nurses and patients experiencing a ‘personality click’ that demonstrates to the patient the nurse’s commitment to them and thus provides for them a feeling of safety. Those nurses Bill clicks with he trusts on an interpersonal level and is able to experience a relationship that he considers to be a ‘friendship’. Morse (1991) suggests that patients utilise strategies to judge if they can trust a nurse. Firstly they evaluate if a nurse is a good person by asking personal questions to help them place the nurse in a social context. Then patients seek assurance that the nurse is a good nurse by watching her or his behaviour, asking questions about the nurse’s commitment to nursing, and by seeking the opinion of others. However, in the AMAU setting the patients had to decide if they would trust the nurses quickly due to the acute nature of their illness and the short time spent on the unit. The patients’ narratives supported this, as they perceived a friendly nurse as a nurse who would look after them well whilst recognising that the nurses were constrained in their time to ‘chat’ due to their work place demands.

The unit was clearly busy and patients interviewed and met during participant observation recognised this. However, as noted the nurses were able to make the

relationship work by a social aptitude together with a talent to appear friendly during these short interactions. Clifford (1995: 40) suggests that nursing, to reflect the reality of practice, would be better viewed as a formal social role rather than 'an ideal which sees caring in practice as altruistic rather than functional'. Such a conceptualisation of nursing offers, Clifford (1995) contends, an understanding of the reality of practice where cost-effectiveness agendas and the economic necessity to earn a salary are nurses' real-world concerns. This contention, whilst holding some resonance, was not supported totally in my findings where altruistic acts were commonplace. For instance during participant observation it was noted that nurses routinely missed their meal breaks and it was common for nurses to stay on duty well past the time that the shift should have finished:

I had gone to the unit for an afternoon shift and there had been a steady stream of admissions. It got to seven o' clock in the evening and I asked the staff nurse 'don't you people ever have a cup of tea!' That afternoon and evening the nurses took no breaks at all just worked steadily for over eight hours: this was not unusual practice. I don't know how they can work so hard whilst not eating or even drinking for hours on end.

*(Reflexive Diary)*

The nurses worked hard and gave of themselves over and above their contracted time. They did not complain but seemed to accept these ways of working as the norm within their community of practice. The communal nature of their practice and their mutual engagement had developed a shared approach and common ways of working which included not having meal breaks when busy (which was most of the time).

The patients interviewed for this study all demonstrated a belief in the professional trustworthiness of the nurses whilst not knowing any nurse individually. Confidence and trust was displayed in the way individual nurses interacted with patients and with the AMAU nurses as a professional group. Findings from this study support Hupcey *et al.* (2001) who distinguish between impersonal trust that is embedded in the systems that the professional works within and interpersonal trust that occurs between individuals. Building a therapeutic relationship in a care environment that seeks to move the patient through it as quickly as possible leaves little time to develop a close nurse-patient

relationship. This is despite influential nursing theorists who imply that such relationships are the expectation of nursing practice (Johns 2001; Watson & Smith 2002). Findings from this study support Aranda & Street (1999) who report nurses describing their relationships with patients as being mutually constructed and suggest:

*Calls for authenticity mean that nurses structure nurse-patient relationships in similar ways to social relationships in the belief that social interactions offer greater capacity for the nurse to be authentic (Aranda & Street 1999:81).*

The reality of the AMAU nurses' practice was that of brief interactions and the patients expressed understanding of this. However, friendliness and 'clicking' were part of the patients' criteria to judge the trustworthiness of the individual nurse. Looking for friendliness from the nurse is not a unique expectation of the AMAU patient. For instance, Kralik *et al.* (1997), utilizing a phenomenological approach, described nine women's experiences of nursing care following total hip surgery and identified two major themes of being 'engaged' or being 'detached'. An 'engaged' nurse presented her/his self as authentic and became engaged with the patient's humanness' (Kralik *et al.* 1997: 401). The detached nurse 'avoided personal contact with the patient, which then lead to feelings of vulnerability and insecurity in the women' (p.403). Several of the women interviewed expressed an understanding that nursing was more than just an occupation and that nurses 'required a special nature, which included personal warmth, friendliness and sincerity' (Kralik *et al.* 1997: 405). Findings from this study echo these attributes as described by Kralik *et al.* (1997) as being fundamental to a positive patient experience. This is not to neglect the potential for increasing impoverishment of nurse-patient relationships that the AMAU setting of short stays and the minimal safety levels of instrumental care delivery could encourage.

A comparable nursing environment to the AMAU is the A&E setting with its fast throughput and high numbers of acutely ill admissions. Byrne & Heyman (1997) describe A&E nurses seeing their predominant role as dealing with the critically ill, despite most of their patients having minor injuries, and so limit engagement with the majority of their patients. Further, as Loveridge (2000) acknowledges in

A&E settings the priority that must be given to patients' physical needs then constrains the time available to attend to their emotional needs. Findings from this study reflect these phenomena as potentially relevant to the practice of AMAU nurses. Moreover, Malone (1996) has warned that A&E staff who have to assess patients quickly, as on the AMAU, are at risk of stereotyping patients and objectifying people's bodies and so reduce the potential for human engagement. McQueen (2000) argues for important interpersonal emotional work, often invisible and undervalued in the present day climate of cost containment, to be made a priority and suitable resources be made available so that patient focused care be no longer a mere rhetoric but a reality.

The personal communication needs of the individual patient are McCabe (2004:41) argues a 'basic component of nursing'. Williams & Irurita (2004), utilising a grounded theory approach, sought the opinions of 40 patients as to the perceived therapeutic effect of interpersonal interactions that they experienced whilst in hospital. The emotional comfort of these patients was identified as being promoted by feelings of security, level of knowing, and level of personal value. Williams & Irurita (2004) note that relationship development to be more likely to develop if hospital staff spoke with patients. Such interaction could be brief and seemingly superficial but patients identified verbal and non-verbal interactions that were interpreted as being personally valuing. Consequently, Williams & Irurita (2004) argue, the length of time spent with the patient is not the only way to convey caring but rather it is the quality of the interaction. The findings from this study of nurse-patient interactions as witnessed in an AMAU setting support Williams & Irurita's (2004) contention that patients recognise a caring interaction by the way in which the nurse presents her-himself, even if the interaction was very brief. Patients interviewed were pragmatic if not philosophical, as they knew that their time on the AMAU would be short and that the unit was busy. They trusted the nurses and knew that they were there if needed and that the nurses would 'have a chat if they had more time'. Findings from this study support Clifford (1995:39) who argues:

*The tendency for patients to perceive the instrumental role of caring as most important is simply a reaction to the realities of health-care provision, whilst nurses identifying the importance of the expressive role are seeking an ideal that is not possible in organised health care today.*



Likewise Ersser's (1997), ethnography of nursing as therapeutic activity, noted that patients were positive about the potential of groups of nurses to help them cope with their situation and did not seek an in-depth relationship with individual nurses. Nystrom *et al.* (2003: 767) however, caution against accepting patients' apparent non-critical perspective of nursing care as it may reflect that merely 'a lack of nursing care was taken for granted, and dissatisfaction was not verbalised'. However, demands on the AMAU nurses' time restricted relationship building in the AMAU setting. Time, as a key element of a nurse-patient relationship (Peplau 1992), could not be provided on the AMAU so brief interactions were the norm. The nurses were engaged in formalised caring in that 'the reality of care giving may be dictated by the resources available' (Clifford 1995:40). In the next category the practice knowledge that nurses utilised to provide care in this time restricted environment of acute illness and rapid patient transition is explored.

### **6.3 'Knowing Your Stuff': Professional Credibility**

Within this category the specific clinical acumen and the distinct professional abilities required by the AMAU nurse are discussed. The sub-category of *collaborative competence* considers the nurses' professional proficiency when dealing with both medical and nursing lead interventions. In the second sub-category of *dealing with critical situations* the nurses' clinical skills and the value given to dealing calmly with such occurrences is considered. Insights drawing on Wenger's (1998) contention that communities of practice are where knowledge is acquired but also where knowledge is created the practice learning of the AMAU nurses is explored in the sub-category of '*you are always learning*': *acquiring knowledge*. Firstly an overview of the knowledge and skills required for the AMAU nurses' role is presented.

The development of the AMAU nurses' systems of working was geared to promote efficient organisation of the unit and the coordination of patients' care needs. (This has been detailed in Chapter five.) The nurses' contribution was key to the maintenance of the AMAU as a space for the acutely ill medical patient to be assessed and cared for:

“I think that organisation is one of the mainstays here and being able to delegate because you can't do every thing yourself. If you want to do everything you can't the way that we are staffed at the moment any way. I think yes, organisation and delegation; they are the top things.”

*(Staff Nurse. Interview 5:3)*

Efficient organisation and suitable delegation were the fundamental skills required for the proficient running of the unit. This necessitated the combining of skilful patient care provision whilst managing the environment of care effectively:

“The skills needed to work here include the ability to look at patient and think this is normal, that is not normal. The ability to prioritise and to delegate work in a suitable manner is something that you get better at as you go along. But, I do think that you need to be able to recognise urgent situations and emergency situations.”

*(Senior Nurse. Interview 1:1)*

Both of these interview extracts stress the organisational abilities needed by an AMAU nurse, skills that included prioritising, delegation, and dealing with critical and emergency situations. Patients also noted the need for the AMAU nurses to be adaptable so as to deal with differing illness presentations, often before a medical diagnosis had been reached:

“Patients come in, they don't know what is wrong with them and they have to sort them out.”

*(Eve. Interview 16:3)*

However, the nurses had not received any formal preparation for their role as an AMAU nurse and the required knowledge, skills, and attitudes were gained whilst working as an AMAU nurse. These skills were developed over time and by exposure to situations from which the nurses learnt. As the senior nurse above noted ‘you get better as you go along’. The distinct aspects of the role of the AMAU nurse were related directly to the AMAU's system of organising care that was without precedent in the hospital:

“The nearest parallel to the AMAU is A&E by the fact that they're geared to anything and of course the high pace as well. It's not something can be appreciated, I don't think, if you don't work in that situation because it is very, very busy on the AMAU. It can be very, very nice and quiet as well but that is about one percent of the time...”

*(Junior doctor. Interview 11:1)*

The doctors interviewed all expressed appreciation of the high level of knowledge and skill that the AMAU nurses held and the interface of such expertise with the ability to manage the unit as the following extract illustrates:

“On the AMAU as a nurse I think you have to be attentive, you have to be appropriately skilled, very organised...and I think to be well organised is good and able to prioritise things that need doing. Familiar with all emergencies, well composed, attentive, and able to organise things.”

*(Senior Registrar. Interview 8:3)*

The variety of medical conditions and the clinical status of the patients admitted required the nurses to be ready for to deal with any medical eventuality:

“I think here that you have to have good basic knowledge about everything. I think probably critical care experience is very useful for the major events but I think you do have to have a basic knowledge about a lot of things, not just one subject. It is no good just being a cardiac nurse and not being able to see anything else. I think that you have to have some knowledge about all the problems that come into us as you get a bit of everything.”

*(Senior Nurse. Interview 2:4)*

“Now patients, for instance on the respiratory ward that come out from ICU, or that come out of HDU. These patients will be sicker than some of the ones coming to AMAU but it is their own area of expertise, the expertise needed isn't as broad as needed for the patients that come in to the AMAU.”

*(Consultant Physician. Interview 9:6)*

The ability to be adaptable when dealing with the variety of clinical presentations was one of the core abilities required by the AMAU nurses. This included high-level decision-making skills, which included a capacity to remain open-minded to competing alternatives, as the nurse above noted ‘it is no good being a cardiac nurse and not being able to see anything else’. Premature closure to other judgement options by not considering differing explanations or diagnoses can result in faulty decision-making if other plausible options are discounted too readily (Thompson & Dowding 2002). Additionally, the AMAU nurses were expected to demonstrate this adaptability without constant guidance by a more senior nurse:

“You know if you work here you have to be able to see things for yourself: not to need someone drawing you pictures”

*(Senior Nurse. Interview 2:6)*

The nurses valued this freedom to make decisions autonomously, discussed in the organisation of nursing in Chapter five, and this contributed to their clinical confidence:

“Here you make your own decisions. You can ask but no one is checking up on you. You are an autonomous practitioner and I like to work like that”

*(Staff Nurse. Interview 6:4)*

The senior nurse did not have ‘time to draw pictures’ she needed to work alongside nurses who were capable of acting as autonomous practitioners and thus able to respond quickly to the changing environment without being told constantly what to do. Sbaih (1997a and 1997b), from an ethnomethodological study which explored the work of A&E nurses, discusses how these nurses acknowledged that being knowledgeable involved at times asking for help and support. However, there had to be a balance for to ask too many questions would, as was also noted on the AMAU, interfere with the work of the unit. All of the patients admitted to the AMAU were medical emergencies and so had the potential to require immediate critical interventions. Therefore the capacity for prompt and skilled reactions was needed:

“...and if some patient deteriorates, goes downhill, you have to be there quickly. It is the same on the other wards but they can deteriorate quicker here because they are more poorly coming in.”

*(Senior Nurse. Interview 1:5).*

An in-depth knowledge of all medical conditions would be an unobtainable goal nonetheless the need to respond quickly to patients who were already ‘poorly coming in’ was required. This required a nurse who could respond to the variety of medical conditions and illness presentations and in particular ‘to be familiar with all emergencies’. Dealing with a variety of medical diagnoses was a particular aspect of the AMAU nurse’s role that differed from the knowledge requirements of nurses working on the general medical wards. There were of course acutely ill patients on the general wards however the nursing staff there dealt predominantly with those medical conditions that they had expertise in. Moreover, the busyness of the AMAU did not allow the nurses the option of thinking about one patient at a time, as in ITU settings, or with one problem at a time as would be possible with a more stable patient population:

**PG.** “What always strikes me is that it is always so busy here. How do you work out what to do first?” *(Both laugh)*

“Ah ha! I mean obviously you have got your priorities haven’t you. So if there is a patient who is more poorly than another then you are going to deal with them first so if you need medications giving them. Just in that way really I think, otherwise you do it as it needs to be done.”

*(Staff Nurse. Interview 5: 5)*

The nurses developed methods of prioritising needs in situations of ambiguity and uncertainty and with flexibility of work organisation that expected autonomous decision-making. The high numbers of admissions and the variety of clinical presentations required the nurses to detect promptly those patients needing immediate medical care and those who could wait to be seen. When patients came to the unit they were first taken to the nurses’ bay and there they were greeted and then shown to their bed. To be welcomed, as an expected admission, was a positive experience for patients. Patients I met during participant observation and those interviewed all commented on the value that they gave to the friendly welcome they received, as this extract illustrates:

**PG.** “Can you remember what happened when you first arrived on the AMAU?”

“Well basically I arrived in the AMAU and it was quite nice actually because I was greeted by people, obviously the staff who knew that I was coming there, and it was very friendly, which was my first impression and that they were aware of who I was and why I was there.

*(Dave. Interview 15:2)*

Patients saw this initial welcoming episode as the nurses just being ‘friendly’ but the nurses were actually conducting a triage assessment.

“When the patient’s is admitted on the ward we tend to see the patient first... we check them out clinically...check with the obs [*observations*] and things because if the blood pressure is below normal for instance we need to call the doctor at once.”

*(Staff Nurse. Interview 4: 5)*

An initial assessment of the patient’s airway, breathing, circulation, disability, and exposure (Harrison & Daly 2001; Ahern & Philpot 2002) would be used to evaluate the severity of the patient’s condition: the patient would be triaged. The term triage, from the French word ‘*trier*’ meaning to pick, sort or select, means

to sort out more acutely ill patients from those who can wait and is used in battlefield situations and in A&E departments (Bruce & Suserud 2005). A triage tool used commonly in A & E departments in the UK is the Manchester Triage Tool (Manchester Triage Group 1997). One AMAU staff nurse throughout most of the time of participant observation had been seeking to set up a modified version of the Manchester Triage system for AMAU use (the assessment form developed is presented in appendix 15). Towards the end of fieldwork this had been implemented and patients were assessed on admission and graded as a red (urgent), green (soon) or yellow (can wait) priority. This assessment was demonstrated on the board by use of the coloured triangles so that the admitting doctors could see at a glance which patients were the priorities. However, not all of the nurses were convinced that such a formal tool was needed:

“Hmm, I suppose it does make a difference but the thing is when patients come onto the unit you don’t have time to triage them. If the patient is so poorly on admission then you can just tell the doctor that this patient needs to be seen straight away before the other patients who may have been admitted. ...even if we are busy once the patient comes onto the unit we always go and have a look and then ask the auxiliary to do the obs [*observations*]. Usually we just don’t have time to score the patient.”

*(Staff Nurse. Interview 6:7)*

“We always did it. So it was never a problem. You can flag up on the board if you like but as experienced nurses I don’t think we need it. If we have four patients coming in together, try and identify which one the doctor should see first and which one can wait. Direct the doctor to that patient. You don’t need another form.”

*(Senior Nurse. Interview 7:6)*

The nurses on the unit, apart from the nurse who instigated the triage system, expressed reservations as to its usefulness and as noted above suggested it was considered to be just another form to fill in. The Manchester triage system has been described as being useful to enable less experienced nurses to carry out triage following its prescribed protocol and systematic assessment (Bruce & Suserud 2005). Nonetheless, Walsh & Kent (2001) have warned that these assessments tend to be less individualised but are useful for the inexperienced nurse and can help ensure that patients are assessed more promptly. The AMAU nurses therefore relied primarily on their practice skills and their experience to identify those patients in need of urgent attention:

“Say we have got a patient who arrives and we put him into bed initially I would then go and speak to the patient and have a look at them and see what they look like, see how they are, do observations see how they are, and then let the doctors know that they are here. If I feel that they need to be seen sort of there and then I will say. And then I would go back and do the assessment documentation and planning of the care.”

*(Staff Nurse. Interview 5:6)*

The nurses interviewed considered that they knew just by looking if a patient was a priority case. Although the nurses complied with the formal triage scoring system it was a form of ceremonial compliance (Allen 2001) as their clinical experience, they considered, enabled instant recognition of critical situations. The AMAU nurses referred frequently to the use and value of a visual dimension to their assessment:

I asked Kitty about these informal triage assessments [*This field note was recorded before the formal triage system was in place*] and how she did it. She explained that she looked at the patient and just knew if a side ward was needed or a ‘fast bleep’ to get the doctor to the unit at once. She added that she looked at the paramedics and if they looked worried then she was too.

*(Field notes)*

“Well, we know that we have booklet to fill in anyway and we have to get as much detail as possible but you have got information that you can get by looking that you don't have to ask questions about, ...you can also phrase questions in different ways to get different answers... it becomes clearer, not so hazy you can actually see a possible outcome.”

*(Staff Nurse. Interview 4:5).*

The staff nurse in the previous extract described the process of assessment and using the metaphors of ‘clearer’ and ‘hazy’ to explain her reasoning process. Latimer (2000) likewise discusses nurses conducting patient assessments using expressions related to vision that convey both a literal and a virtual meaning. That for the nurses ‘looking’ had a deeper significance than the use of these terms in every day speech. Supported by Wilson & Williams (2000) who in a study of community nurses experiences of using telephone consultations, noted that metaphors of vision and seeing were still used by the nurses in their assessments. Nurses are used to seeing patients and involving a visual dimension to their assessment and with experience can see a problem instinctively, often before conscious awareness. Knowing without conscious reasoning is sometimes described as tacit knowledge that is difficult for the nurse to articulate

(Meerabeau 1992). Such ability has been described as intuition (King & Macleod Clark 2002) but seems to reflect the ability of the nurse to rapidly gain an understanding of the picture that the patient presents (Cioffi 2001). Pyles & Stern (1983: 52) describe such knowing as the 'Nursing Gestalt', defined as:

*The synergy of logic and intuition involving both conceptual and sensory acts and is a matrix operation combining basic knowledge, past experiences, identifying physical and sensory cues and what the nurses called 'gut feeling'.*

Easen & Wilcockson (1996) suggest that the use of the term intuition in the context of nursing decision-making reflects tacit appreciation of situations that permits identification of familiar patterns from past experience. This concurs with psychological explanations of the use of memory in that large chunks of related knowledge (schemata) are held in the long-term memory and are accessed by prompts from short-term memory or stimulation: often a falling out of a normal pattern will act as stimulation (Baddeley 1980). This offers a useful model with which to explain the reasoning of the AMAU nurses and is developed later in this chapter. The abilities of the AMAU nurses to respond rapidly to patients' needs were of particular relevance when working collaboratively with medical staff as will be discussed next.

### **6.3.1 Collaborative competence**

The nurses would often start suitable treatment or instigate appropriate investigations before the doctor arrived. In particular, they would have appropriate equipment ready for use and so would be prepared to carry out the prescriptions of medical staff immediately and with minimal instruction:

**PG.** "Can you think of something which would seem to encapsulate really good nursing care taking place, maybe an incident in which you have been involved on the AMAU?"

"There was a young diabetic came in over the week-end, a sixteen year old, with ketoacidosis [*a serious blood acid –base imbalance*] and everything was ready to go. Then the monitoring that he had and the way the nurses organised this especially the insulin and they checked his urine regularly without being asked to do that. It is that sort of thing. It is knowing what is needed for monitoring a diabetic."

*(Consultant Physician. Interview 9:5)*



The implementation and monitoring of medical directions was an essential and a complex aspect of the nurses' work and was crucial for the coordination of patient care. Patients recognised the nurses' involvement in this aspect of their care as this extract from an interview with Adam who had been admitted with a pneumothorax (collapsed lung) illustrates:

“When I first got in, I don't know what is called, but the nurse and doctor tried a kind of syringe first. They did that first to see if that was any good but it wasn't, so about three hours later they came back and said that I needed the chest drain. So in it went, it wasn't as bad I thought it would be. The nurses kept coming back then to see me to make sure that I was comfortable. To make sure that when they put the chest drain in that all the padding was bandaged on tight. They were making sure that I was okay.”

(Adam. Interview 12:7)

Adam describes the nurses' role in his care as working alongside the doctor, checking that the drain was functioning but also checking his comfort and that he was 'okay'. This is an example of collaborative working found where medicine and nursing, whilst each holding unique discipline expertise, share expertise and common problems:

*Collaborative problems are certain physiologic complications that nurses monitor to detect onset or changes in status. Nurses manage collaborative problems using physician-prescribed and nursing-prescribed interventions to minimize the complications of the events (Carpentio 1997: 27).*

The AMAU nurse's role involved the monitoring of patients for medical problems as the doctor providing medical cover was often away from the unit or dealing with other patients. This included the nurses being available to explain to patients and relations what the planned treatment, medical and nursing, that that patient would be receiving. The nurses would judge also if the patient's relations or carers needed to see a doctor and would then coordinate this meeting. Patients interviewed appreciated this crossover of medical and nursing care delivery. Bill, a patient with several admissions in the past the hospital, drew a distinction between the AMAU nurses and the medical ward nurses, in particular related to the AMAU nurses' ability to deal with a variety of different medical conditions:

“The nurses on the AMAU know exactly what they are doing, exactly. They have to deal with so many different things yet they know what to do. The evening I came in there were drunks, strokes, diabetics all sorts yet they always know what to do.”

(Bill. Interview 13:3)

This was supported by Cled who considered that the AMAU nurses were on ‘a higher level’ and needed to be ‘more senior’ than the nurses on the ‘ordinary wards’ (Cled. Interview 14:5). Likewise Francis thought that the AMAU nurses were at the ‘sharp end’ of care delivery more than were the ward nurses where it was ‘quieter’ (Francis. Interview 19:4). Baldursdottir & Jonsdottir (2002) describe the caring behaviours that patients in an A&E setting sought primarily were related to instrumental –technical safety needs, such as the nurses knowing what they are doing. This corresponds with not only what patients interviewed for this study identified as a key nursing competence but was noted as a priority by all participants

Another professional group who interacted with the nurses were the paramedics who brought patients referred by GPs to the AMAU. Once the patient arrived on the AMAU the paramedics would hand over the patient to the nurse who would then be responsible for passing this information on to the admitting doctor. It was very unusual on the AMAU for medical staff to interact with the paramedics so the nurses held key information to inform the patient’s medical diagnosis and subsequent care. The paramedics interviewed noted that they were conscious of the high level of knowledge that the AMAU nurses had. I had asked the paramedics interviewed what were the differences, if any, from the receiving of a patient on the AMAU and receiving onto a medical ward. The paramedics’ described the nurses on the general medical wards only speaking to them when indicating a bed for the patient. The only query directed to the paramedics typically was to ask if the patient’s relatives were coming in or not. The reception on the AMAU, the paramedics interviewed considered, was more receptive and inquisitorial. This interest was valued by both of the paramedics interviewed:

“On the AMAU they are more focussed on the information related to the patient’s condition... the information that they want is very, very focussed based around the presenting complaint of the patient. And that to me is the main difference in that they tend to know what they want from you as a pre-hospital care provider and therefore they make a decision where they go from there. If there is information that they haven’t had they will ask you”

*(Paramedic 1. Interview 17:5)*

Both paramedics interviewed respected the expertise and interest that such questioning demonstrated:

“A good handover is if you gave the patient details plus any other clinical information about how the patient was on the journey and what had actually happened to them. And you usually knew that it was received well when they clarified things, you know asked you questions. That was good because they took on board what you said and then organised the immediate care and management of the patient.”

*(Paramedic 2. Interview 18: 3)*

The paramedics noted that the AMAU setting was similar to the A&E department in many respects, apart from the lack of major trauma patients, and the knowledge and experience of the AMAU nurses, like the A&E nurses, was demonstrated in their questioning. Bruce & Suserud (2005), writing from an A&E perspective, have contended that the handover between the nurse and the paramedic was pivotal in ensuring that the patient received appropriate care and at the correct level. The ability to accept the patient from the paramedics and to probe so as to gain fuller information with which to inform the subsequent clinical judgments, medical and nursing, was an important aspect of the AMAU nurse's role. After the nurses accepted the patient and the paramedics had left the unit then that source of information was gone leaving only the GP's letter for reference. It was very important therefore to attend to the paramedics' handover as the patient could have deteriorated after being assessed at home by the GP. The nurses were acting in a nursing capacity but also as a proxy for medical staff by asking those questions that would inform the medical diagnosis and treatment.

The nurses were therefore very experienced in dealing with accepting and dealing with medical emergencies with their differing presentations and could respond appropriately without guidance because of their previous exposure to these situations. Wenger (1998) argues that mutual engagement in a common enterprise leads to a fine-tuning between experience and competence. Knowledge can be acquired and such a community of practice offers a privileged locus for the development of competence. Learning also develops creatively Wenger (1998: 214) suggests as:

*A history of mutual engagement around a joint enterprise is an ideal context for this kind of leading edge learning, which requires a strong bond of*

*communal competence along with a deep respect for the particularity of experience.*

Learning by participation Wenger (1998) suggests, leads to the development of a specific identity, with a past and a valued future, and a context for developing new understandings. One aspect of identity that the AMAU nurses claimed characterised their practice, and this was supported across cases, was the ability to deal efficiently with a variety of critical situations as will be discussed next.

### **6.3.2 Dealing with critical situations**

Ensuring that patients needing admission to a critical care setting were sent directly to the appropriate areas was more difficult for those patients who deteriorated *en route* to the AMAU following the GP's referral. Patients could leave the GP in a clinically stable condition but could be very ill and medically unstable by the time they reached the AMAU, as was witnessed several times during participant observation. The nurses then required, as well as knowledge of the variety of acute medical conditions, suitable resuscitation skills and to be ready to apply such skills speedily in an adaptable manner:

“With all the admissions we get you never know what is coming through the door next and you never know what is going to happen because the patient may come in looking reasonably well and suddenly go off on you.”

*(Senior Nurse. Interview 3: 5)*

“I do think that you do need [*as an AMAU nurse*] to be able to recognise urgent situations and emergency situations so you need your life support skills honed. I mean, we may not use them everyday but if you know that you have got them you can be confident and get on with other things without worrying.”

*(Senior Nurse. Interview 1:7)*

The AMAU nurses' discourses indicated that they valued and enjoyed participating in critical care episodes. During fieldwork I witnessed patients requiring resuscitation and such incidents featured in the positive critical incidents that the nurses related. This critical incident describes the story of a man admitted with hypovolaemic shock (circulatory collapse) secondary to a gastrointestinal bleed. The patient was moved to the ICU in a well-resuscitated state and was transferred back to the AMAU (which was unusual) from where he was discharged:

“We had a man that we sort of resuscitated basically and he ended up in intensive care, he had bleeding varices [*oesophageal varices*] and I think he had about 12 units of blood plus Gelofusion [*a plasma expander*]. It was just being poured into him you know and I mean that was just a major event with so many people there you didn't know which way to turn but it was a matter of still making sure that the bloods were checked because the doctors just wanted to pour it in you know and you had to say 'No. Wait a minute it has got to be checked first!' I hadn't been here long then and I was a bit daunted I must admit and all the girls on the ward still talk about it because it was such a big bleed.”

(*Senior nurse. Interview 2:3*)

This was a vivid event and was seen to be a satisfactory episode of care for the nurse because the patient, despite being so acutely ill, survived and the nurse was involved in a completed care episode. The AMAU nurses enjoyed the demands that a major clinical incident brought as it allowed them to demonstrate their critical care skills and provided confirming evidence that they had done their job well. Similarly, Byrne & Heyman (1997: 97) referring to A & E nurses' preference for major trauma work noted that 'the major trauma patients therefore provided nurses with an opportunity to feel both technically expert and rewardingly useful'. To contribute in a positive manner to the saving of another's life provided a personally and professionally rewarding experience and such incidents allowed the AMAU nurses to combine their nursing knowledge with doing good. Moreover, how the individual nurse dealt with a critical care incident was another criterion with which the AMAU nurse's effectiveness was judged:

“Cardiac arrests usually sort the wheat from the chaff because on the AMAU right it's almost like 'an arrest' [*said in a calm and slow voice*] because it happens so often and everybody knows what to do. Well you contrast that then with a ward like Seacole [*a specialist cold surgery ward*] ward, you get an arrest there once every two years, and they're like a headless chicken scenario. You know what I mean?”

(*Junior Doctor. Interview 11:5*)

Medical staff judged calmness to be an attribute of an effective AMAU nurse. Clearly, a nurse who was lacking in confidence or was easily ruffled would not aid the busy work of the unit especially when dealing with emergency situations:

“They [*the AMAU nurses*] usually can cope with medical emergencies with an air of calmness that some of the ward nurses don't have.”

(*Consultant Physician. Interview10:4*)

A unique aspect of AMAU nursing was the combination of high proportions of acutely, often critically, ill patient admissions being cared for alongside those patients already admitted: many of who still needed acute care and some who required non-acute care. The multiple challenges that the AMAU nurses faced therefore could only be dealt with in a reasoned and calm manner otherwise the unit could not have functioned effectively. Part of the responsibility to the team and to the work of the unit involved displaying a demeanour that was calm and in control: a way of being that was socially constructed and therefore socially valued. (This is developed further in Chapter seven.) Someone who demonstrated over excited behaviour would not enhance the practice of AMAU nursing for as Wenger (1998: 81) notes ‘that these relations of mutual accountability are sometimes taken to be violated only confirms their influence as a communal regime.’ The ability to demonstrate clinical expertise and to deal with emergency situations or other problematic circumstances was a significant element of the AMAU nurse’s role. How the nurses gained their knowledge and skills to function so expertly without a specialist educational programme will be discussed next.

### 6.3.3 ‘You are always learning’: acquiring knowledge.

Although the nurses undertook in-house courses, such as resuscitation training, and had undertaken, or were undertaking post-registration academic qualifications they had not received any special educational preparation to work in the AMAU. Despite, as has been indicated from the findings of this study, the AMAU nurses demonstrating a distinctive range of knowledge, skills, and attitudes:

**PG.** “Are there differences when working on a general medical wards and when working on the AMAU

“Things are more intense up here [*on the AMAU*] than they are on the ward. And I think you have to be a quick thinker because things happen so quickly up here. We could have a patient in at nine-o clock and they are gone by ten. So it has to be somebody that can be calm but quick to be able to do things but not to take risks and to ask if you don’t know. There is no shame in that.”

*(Staff Nurse. Interview 5:6)*

Learning to be an AMAU nurse required time to reinforce and practice such skills, as they would not be within the range of a newly qualified nurse:

“I think that you do have to be confident to work here. I think it's probably quite difficult for a newly qualified nurse to come here but you have to be confident in your own ability to assess a patient. Certainly patient assessment skills are the most needed, as obviously you have to do that as part of an admission.”

*(Senior Nurse. Interview 2:5)*

This extract describes a particular level of ability needed on the AMAU as newly qualified nurses might lack the assessment skills that were required. I was interested in how the AMAU nurses developed their knowledge and skills and this interview extract articulates a view of their learning that was voiced by all of the nurse participants:

“You learn, you are always learning and that is how. You might get someone coming in that you wouldn't necessarily know everything about so you have to go and learn about it, read about it. It is just through experience.”

*(Staff Nurse. Interview 5:7)*

This nurse was not contradicting herself. She indicated that she learnt all the time and would learn from searching literature or looking up medical conditions and treatments in the textbooks on the unit but the motivation to do this was the actual presentation of a patient with the condition. The many illnesses presentations that the nurses dealt with required an inquisitive mind and the energy to seek out knowledge:

**PG.** “What sort of person gets on well as an AMAU nurse?”

“I think that obviously they have to have an interest in it initially because you have got a lot of acute problems, just somebody who is going to be dynamic and interested. There are a lot of changes going on during a shift and generally so you need somebody who is willing to accept change and uncertainty.”

*(Staff Nurse. Interview 4:12)*

The nurses interviewed all noted that they learnt by experiencing prior situations. The senior nurse in the critical incident excerpt noted previously commented that she ‘was a bit daunted’ as she ‘hadn't been here long’ (Senior Nurse: Interview 2:3). The experience of seeing situations before was a mode of learning that all of the AMAU nurses valued highly:

**PG.** Can you tell me how you have gained the knowledge needed to do this job?

“I think it is experience definitely. I have learnt so much since coming here and I have only been here a relatively short time but all the other places that I have worked as well I have learnt and got experience. I don’t know how to explain it, you just know what to do.”

**PG.** “So learning from experience but are there any other ways that you learn how to deal with things?”

“Well, life experiences. I mean you can learn from books but not every body can learn from books. I know I can't. I have to be able to be there, to have been through it.”

*(Staff Nurse. Interview 4:7)*

This eagerness by the nurses to learn about new medical cases and treatments was noted during participant observation with textbooks and the Internet being searched regularly for information. Internet access was available on all wards and units in the Trust and to gain access the nurses just needed to obtain a personal identification code. If there had been an unusual case the nurses would spend much time seeking out and sharing information and sometimes preparing a teaching board. The medical staff were seen as a source of information too and often the nursing and medical staff were learning together. Learning that arises through direct encounter with persons, places, or things is termed as experiential learning (Higgs & Jones 2000). The nurse’s comments noted above support the concept of experiential learning and reflects learning occurring by the use of ‘book knowledge’ (propositional) and by ‘doing it herself’ (practical knowledge) (Reason & Heron 1986). Adult learners seek to learn about issues that seem relevant to them and value discovery learning (Davies 1981) and this was apparent when the AMAU nurses spoke of having to see something before really learning about it.

By being a nurse in the AMAU the knowledge, skills and attitudes to function as successful AMAU nurse were developed in their situated practice and therefore experience was held in high regard. Rossing & Long (1981: 25) have discussed the effect of ‘surprising information’ on the stimulation of epistemic curiosity, the desire to gain knowledge. However, learning on the AMAU was a not static



and a once and for all occurrence due to the diverse patient presentations and diagnostic uncertainty. The AMAU nurses' learning can therefore be described as 'an evolving, continuously renewed set of relations (Lave & Wenger 1991: 50). However, the lack of dissemination of the practice learning of AMAU nurses, as demonstrated by the paucity of related literature, indicates that AMAU nurses' knowledge and skills that are developed locally are not shared more generally. As Kim (1999) warns the embedded nature of much nursing learning is tailored to specific situations however if it is then inaccessible to validation it remains personal knowledge.

Such practical knowledge, Schon (1987) argues requires recognition and professional craft knowledge should be valued and its importance not diminished by the hegemony of technical knowledge. Such knowing can be aided in its articulation, it has been suggested, by the use of reflection in and on practice and by metacognition (Rolfe *et al.* 2001) and by research conducted in the interpretative paradigm (Benner 1984; Lawler 1991). The AMAU nurses developed their knowledge using propositional and experiential learning, with the latter valued highly. Lave & Wenger (1991) describe learning in communities of practice as the inclusion of the newcomer in tasks and obligations of the community so that centripetal participation in the learning occurs that develops to full membership of the community of practice. In other words effective learning would include the newcomer feeling of value to the aims and goals of the community by their contribution. This contention was supported on the AMAU where the nurses described their learning as gained by their participation in practice and not merely from observing practice. By experiencing and engaging in what is meaningful to the community of practice of AMAU nursing had lead to the construction a new identity for the nurse, that of an AMAU nurse.

Learning that takes place in a social context Wenger (1998) contends occurs through on-going practice that draws on social energy and power generated through interaction in joint enterprises. When first on the AMAU even a qualified nurse would require time to develop the skills and the social identity to practice effectively in the AMAU nurses' community of practice. Wenger (1998: 100) uses the expression 'legitimate peripheral participation' to describe the process

by which newcomers can become members of a community of practice. Two types of modification occur in this process: peripherally and legitimacy. Peripherality gives exposure to practice but without full participation but nonetheless allows newcomers to become engaged and gain a sense of how the community operates. Legitimacy requires that new comers be treated like potential members and this would include forbearance when their abilities do not match those expected by 'old timers' (those who had developed the particular skills to work effectively in the area) (Wenger 1998: 100). However, much of the AMAU nurses' knowledge was tacit and not shared in any formal manner. Kim (1999) suggests that tacit knowledge can become shared knowledge by the use of reflection to develop articulation of such knowledge. Despite reflection being a key component of pre and post registration nursing programmes (Rolfe *et al.* 2001) the AMAU nurses did not refer to the utilisation of reflection nor was there clinical supervision available.

Lave & Wenger (1991) argue that learning is as natural to the human experience as eating or drinking and that learning which occurs in a social context is best understood as situated learning. The person learns from their legitimate peripheral participation in the social world and the meaning of learning is 'configured through the process of being a full participant in a sociocultural practice' (Lave & Wenger 1991:26). The AMAU nurses learnt to become AMAU nurses by participating in a community of practice that provided a setting of situated learning. This learning evolved and was non-static and guided directly by the explicit requirements of the setting and so was responsive to change and to new challenges.

#### **6.4 Summary**

The AMAU nurses had adapted their approaches to patients and patient care to reflect their clinical reality, which included their capacity for interaction and communication with patients in a time short care environment. The AMAU patients appreciated the busyness of the nurses and trusted them as a professional group to care for them despite the lack of time to develop enduring or therapeutic relationships. Findings from this study support Clifford (1995) who suggests that the reality of clinical practice requires a conceptualisation of the nurse's role as

formalised caring. However, as Morse (1991) warns when neither patient nor nurse remembers one another, as was the usual case on the AMAU, then a clinical relationship results with nurses becoming like 'excellent waiters' (p.467). Such a relationship then results in the role and contribution of the nurse remaining invisible and their work only noted when things are not done. The AMAU nurse's role was complex and required knowledge from medical and nursing paradigms including the ability to deal with a wide variety of clinical presentations and resuscitation scenarios calmly and in an in-control manner. However, the nurses had no distinct preparation for their role as an AMAU nurse. Wenger's (1998) conceptualisation of practice as learning and new members experiences of peripherality and their need for legitimacy so to be able to learn by doing (Lave & Wenger 1991) were useful theoretical approaches to aid understanding of the AMAU nurse's role.

As has been demonstrated the nurses worked in a demanding environment where they had developed a negotiated practice that required distinct skills and abilities. In the following chapter the work place demands, the degree of control over working practices experienced, and the positive effect of social support on the AMAU nurses' role performance is examined.

## CHAPTER SEVEN

### 'I LOVE THE BUZZ': THE AMAU NURSES' WORK PLACE STRESSES AND BALANCES

#### 7.1 Introduction

This chapter provides an interpretative discussion of the effects of occupational stressors and balances on the AMAU nurse's role. As has been discussed in Chapters five and six the AMAU provided high workload demands in a distinct care setting. Understanding was sought of the AMAU nurses' apparent capacity to balance high work demands whilst evidencing job satisfaction and convivial interpersonal relationships. The demand-control-social support (DCS) integrated model of occupational stress (Baker *et al.* 1996) was drawn on to organise the abductively derived categories discussed in this chapter and has been reviewed in Chapter four. In the first category of this chapter the *Work place demands* that the AMAU nurses experienced will be considered. The second category explores the *Contested areas of control* that the AMAU nurses experienced over their working practices. In the final category of '*Supporting each other*' the extent to which social support acted as a buffer to work place stress for the AMAU nurses is examined. Firstly, the work place demands that the AMAU nurses experienced and the effect these demands had on their role is discussed.

#### 7.2 Work Place Demands

The role of the AMAU nurse involved responding to exacting physical pressures, especially related to their workload capacity, together with the psychological demands experienced. In this category the workplace demands experienced by the AMAU nurses are discussed. These demands included the psychological stress of providing emotional labour (Hochschild 2003), which is discussed in the sub-category of '*sort of give the impression*': *emotional labour*. The patients admitted to AMAU as medical emergencies were often extremely ill on admission and in consequence the nurses had to deal frequently with sudden and unexpected deaths; this aspect of the nurse's role is considered in the sub-category of *dealing with death*. However, the apparent paradox of nurses enjoying the stimulation of high workload, and indeed frequently work and role over load is then examined in the subcategory of '*thriving on stress*': *considering*

*burnout*. An overview of the physical and psychological workplace demands experienced by the AMAU nurses is discussed first.

The AMAU nurses were subject to high work demands that were immediate and held the potential for negative effects on the health and safety of patients if not addressed swiftly and competently. This senior nurse recounted an incident when she left the unit several hours after the official end of her shift due to the high numbers of admissions and acutely ill patients who required care. She describes feeling scared and tearful because of the limited care that she had been able to give:

PG. “When it is so busy what happens?”

“Only the basics are done then. I mean you give the drugs or set up infusions. Obs [*observations*] that should have been done weren't getting done because you just didn't have the time to get around everybody and it easily, it could have easily deteriorated into something, somebody dying [*pause*] you know and that would have been the long and the short of it.”

(*Senior Nurse. Interview 2:6*)

Such shifts were not rare on the AMAU, as witnessed during participant observation and as described by critical incidents within interviews, and these situations then caused the nurses to worry that care delivery could be compromised. The nurses expressed their concern when work demands exceeded their capacity to provide suitable care for patients, those being admitted and those already on the unit:

“We have been so short staffed lately and that makes it really hard and very unsafe sometimes I must admit that and I have done incident forms because of that. Between being tired and it had been a horrendous shift it really was not safe. We hadn't had any help and I think that there was two of us on, two trained on, and you know that was really unsafe and I did do an incident form for that one to cover my back. But if you do too many they don't take any notice anyway. You don't sleep after that sort of shift.”

(*Staff Nurse. Interview 5:6*)

Nurses described frequently work overload where ‘there is just too much to do in one role’ (Handy 1999: 67) as a precursor to negative incidents of care delivery on the AMAU. There was a managerial requirement within the Trust that the nurses make a written report, an incident form, if they considered that there had been an unsafe or a potentially hazardous situation. This incident form was then

forwarded to the hospital risk management team and the directorate's senior nurse. There was however a degree of scepticism expressed by the nurses regarding any useful effect that such reporting would have. The nurses did complete these incident forms but only to 'cover their backs' rather than in the belief that doing so would lead to any benefits to their situation, then or in the future. The degree to which excessive work demands can jeopardise patient safety was the main negative consequence that the nurses worried about in such situations. The primary concern was the patient's safety with secondary concerns related to the possibility of professional or legal repercussions if there should be a mishap.

A situation that caused the AMAU nurses to experience particular concern was the prospect of a shift with a bank staff nurse. I had gone on to the unit just before the afternoon report. Eileen (an E grade staff nurse) was sitting at the nurses' bay looking angry. She told me:

"They have moved Clare [*E grade AMAU nurse*] to Cavell ward and will be giving me a bank nurse at 5pm. It is not fair because it means that I will have all the responsibility and we have got four stacked already. I am tempted to go home and tell them to stick it."

*(Field Notes)*

Eileen anticipated the problems that she would face if she were the only AMAU nurse on duty and the heavy burden of responsibility that she would carry and therefore experienced anxiety before she had even started her shift. All of the nurses present shared Eileen's frustration and compared episodes where they had been left in the same predicament. Walsh *et al.* (1998: 28) describe a similar problem with staff shortages in A&E departments and note that 'bank or agency staff who have never worked in A&E are of limited use in plugging holes in the duty roster'. To cover this shortage of experienced personnel a senior AMAU nurse volunteered to stay on duty until all the patients had been admitted. However, although this resolved the problem in the short term this could have contributed to the stress of the senior nurse who stayed on duty to provide cover. When individuals draw on their personal resources to fill the gaps in the organisation this can result in the fundamental problems not then being remedied. Nonetheless, this was an example of the AMAU nurses' ethos within their

community of practice and their commitment to their joint enterprise and to one another. Findings indicated that the particular organisation of nursing on the AMAU, and the evolved and distinct skills of the AMAU nurses, had resulted in an expertise gap between the AMAU nurses and the general medical ward nurses. A consequence of the AMAU receiving all acute medical admissions was that the medical ward nurses rarely had to deal with an acute admission:

“...the nurses on the wards do feel that since the AMAU has been opened that they had been deskilled because all the acute things are happening here as we stabilise the patients before sending them out.”

*(Senior Nurse. Interview 4:7)*

This disparity in the assessment and treatment skills of the medical ward nurse and the AMAU nurse had also resulted in the ward nurses not then having the ability to work effectively on the AMAU. Wood (2000a) argues that hospitals with AMAUs should operate an internal rotation so that ward nurses do not become deskilled at dealing with emergency medical admissions. Further, Mayled (1998) adds that rotation systems that move nurses between AMAUs and general medical wards would help to prevent AMAU nurses from experiencing potential burnout related to their high workloads. Thus registered nurses without AMAU experience lacked the skills to work effectively on the AMAU: the AMAU nurses had developed a sense of joint enterprise and identity and thus a shared praxis that outsiders would not have (Wenger 1998).

However, the work demands on the AMAU were challenging even for those nurses who were very experienced in AMAU nursing. The nurses and the junior doctors on-call described the workload of the shift in degrees of busyness from ‘we weren’t busy’ to ‘we were very busy’ whilst sometimes describing the unit as ‘too busy’. In this critical incident a senior nurse describes a situation that resulted in her inability to deal with all of her work place demands:

“It wasn’t one incident but the whole shift. I came on duty and there were ten people stacked. There were no beds out there and yet they weren’t closing because there was no one to take for us. And gradually as the day went on we sort of got these patients up. I don’t know where the beds appeared from but by the end of the shift I was very aware that I wasn’t really in control anymore because you had so many patients that had come in and like you would have one with acid inhalation, one with smoke inhalation and another gentleman, I can’t remember what was wrong with him but he had a similar name and had

learning difficulties, and I went to give handover and I thought they are all just going into one person in my head and I thought that it just wasn't safe.”

*(Senior Nurse. Interview 2:5)*

This account offers an honest report of a situation where, despite knowing what needed to be done, there were too many demands on this nurse's time and capacity. On the occasions when, despite good management and effective clinical skills, the nurses were overwhelmed by work demands a situation was created that could produce fear and anxiety in the nurses. The nurses in such situations experienced work overload (Handy 1999) however, there were also elements of role overload. Role overload occurs when 'the number of roles that a person has to handle become just too much' (Handy 1999: 67). The nurse discusses the roles that were expected of her which were to make beds for the 'stacked' patients, admit acutely ill patients, and to deal with the patients already on the unit. She notes that she was 'no longer in control' over the demands placed on her and her limited power to improve resources (extra staff) that could help. However, the expected role performance of the AMAU nurses was that of capability and being in control. The nurses identified in themselves characteristics of confidence and calmness as being essential attributes of an AMAU nurse:

“To work here you need a calm nature. Not to be the kind of person who gets swamped and flustered. You need a sense of humour and you need to enjoy the acute fast paced environment.”

*(Senior Nurse. Interview 1:5)*

When the AMAU nurses reached a stage of work overload an atmosphere of single-minded determination was clearly observable on the unit. The nurses spoke to one another in brief and to the point conversations and although the usual *mêlée* of doctors and nurses surrounded the nurses' bay, the unit would be quieter than usual. This gave to the outsider a perception of calmness and control:

“They [*the AMAU nurses*] need the skills to remain reasonably calm and obviously you need someone leading a team quite effectively so that the whole place doesn't become totally chaotic. They must be able to prioritise what needs to be done and get the best out of other colleagues.”

*(Consultant Physician. Interview 10:8)*



Being able to prioritise is a comforting notion its underpinning tacit assurance that if the individual practitioner is skilled enough then, by the effective ordering of work demands, everything can be dealt with in a satisfactory manner. Prioritising as a nursing concept often refers to the ability of the nurse to order an individual patient's needs according to precedence (Roper *et al.* 1996). Hendry & Walker (2004: 427) define priority setting as 'the ordering of nursing problems using notions of urgency and/or importance, in order to establish a preferential order for nursing actions'. This however, is less than straightforward even when planning care for an individual patient as 'situations often occur as a hodgepodge of contextual factors rather than a specific problem that can be solved in a linear fashion' (Pless & Clayton 1993: 427). This complexity is even more so when faced with multiple admissions all with multifaceted acute care needs, together with the demands on the AMAU nurses' time to make beds and to coordinate rapid patient transition. The AMAU nurses, therefore, experienced frequently workload stress related to pressures between an imbalance between demand and capacity (Tyson *et al.* 2002). Dunn *et al.* (2005) using a survey circulated to all nurses working on one day in a large Australian teaching hospital (response rate 46% *n*= 278) sought the nurses' perceptions of working in an acute care setting. They reported that the highest ranked factor that decreased job satisfaction was lack of time and followed closely by staffing levels. This reflected the voiced concerns of the AMAU nurses. However, the nurses' physical and psychological well-being was not affected by workload stress due to high physical workplace demands solely. The nurses were also exposed to stress that was related to the emotional cost of caring. One aspect of this emotional cost relates to the need for emotional labour (Hochschild 2003) and is discussed next.

### 7.2.1 *'Sort of give the impression': emotional labour*

The work place demands that the AMAU nurses experienced resulted in restricted time to deal with those demands that were non-urgent and most shifts, as evidenced during participant observation, resulted in the nurses experiencing work overload. Therefore the nurses had evolved strategies, or negotiated responses, when presenting themselves to patients:

"I would pop in and say 'I will be along to see you shortly' and here is an 'information leaflet'. 'My name is Mary and any problems let me know' but it

can be quite rushed but you do it in a calm way and sort of give the impression that you are there if they need you.”

*(Senior Nurse. Interview 3:6)*

This describes the nurse acting a role, that of a calm and interested nurse who is thinking solely about this particular patient. In fact she takes this further in that she is aware that she is acting in a false way from how she is actually feeling, which is ‘quite rushed’. This approach was witnessed during participant observation and was a common practice as utilised by the AMAU nurses. The nurses sought to approach patients so that the patients would think that everything was under control and that the nurses had plenty of time for them. This ability to present a calm and cheerful face in any situation was appreciated by patients as illustrated by this interview extract:

“They are always calm and cool. I don't know how they manage that with everything they have to put up with. They are always pleasant and happy, despite being over-stressed but they don't show it. They manage to be friendly and chatty and they cheer you up. They can't afford to be miserable with the long hours that they work.”

*(Bill. Interview 13:4)*

The nurses worked at presenting themselves as being happy, composed, and in control for the benefit of the patients. This strategy seemed to work, as all the patients interviewed and met during participant observation thought that the nurses were uniformly cheerful and happy. Being cheerful and calm was, for the patients, an indicator of a good nurse. However, the nurses' reality expressed backstage (Goffman 1959) and out of the sight of patients was often different:

“I think that if I am on alone I try to do my best actually but at the end of the day it is you who is stuck then: what if I have done wrong? If I am trying to cope with everything and trying to please every body, please the bed manager, then I have to move the patient; please the patient that you have then settled in a bed on the ward; but what if in the middle of my work, being so busy that you have a mistake on the medication that you give? At the end of the day it is you who is going to be blamed then. There is nobody who can help you because you have signed for those medications. So it is difficult but you learn to cope but at the end of the day what happens is that I just pray and let the Lord help me.”

*(Staff Nurse. Interview 6:5)*

The demands on the nurses came from their patient workload and from their coordinating and connecting role between GPs and the AMAU, between patients and doctors, doctors and patients, the A&E department and the AMAU, and the AMAU and the transfer wards. Role over load (Handy 1999) was experienced in that, as this staff nurse describes she saw all of these responsibilities as hers and she was required to 'please everybody' but there was insufficient time and/or resources to attend to them all. This busyness was the constant expectation on the unit as this extract from an interview conducted in the summer illustrates:

“We have been so fraught here since Christmas. A lot of the patients have been elderly needing a lot of care, quite dependent and we have had a run of very confused patients. Of course when the relatives come in they only think about their relative, and I don't blame them. But in the middle of it all you have to sit down and appear interested in the home situation of the elderly patient when the relations nab you. A patient who will be transferred within a few hours.”

*(Senior Nurse. Interview 4:6)*

The account describes the nurse acting a role that of a nurse who is interested in the details of the patient's home situation knowing that she will not be dealing with this patient's on-going care, nor indeed was she particularly interested. She was responding to what the relations wanted and needed. So 'giving the impression' of having time and interest in the individual patient and appearing interested in such social information were acted roles: this Hochschild (2003) termed emotional labour. Hochschild's (2003) study of flight attendants and debt collectors, describes the managerial requirement for workers in many service industries to provide emotional work as well as their physical and mental labour. Hochschild (2003) drawing on Goffman's (1959) concept of impression management and the maintenance of face offered an understanding of the emotional labour that many employers expect from their staff: noting that such caring and emotion work is most frequently carried out by women. Emotional labour may demand that the employee presents an emotion that they do not feel. This Hochschild (2003) describes as surface acting when the expression on the face feels put on and not part of the real person and leads to a separation of display and feeling. Such emotional labour can lead to stress and subsequent burnout if the individual struggles to offer an emotional presentation that is misaligned with their true feelings. Such a strategy that requires from the person

a suppression of their true feelings and the presentation of a happy and professional face can result in detachment and alienation to the work subjects (Hochschild 2003).

The flight attendants in Hochschild's (2003) study were with their passengers only for the duration of the flight whereas, as Smith (1992) notes, nurses have a more prolonged relationship with their patients generally. However, the relationships on the AMAU were of short duration generally and mimicked more closely the relationship time-spans of flight attendants. Hochschild (2003) describes experienced flight attendants developing the ability to distinguish between work and personal selves to prevent burnout. The AMAU nurses saw the presentation of a happy, calm, and interested face as part of their work therefore a form of emotional labour was being enacted. Presenting this positive cheerful face when the nurse's feelings are different from this outward show can be at expense of the psychological harmony of the nurse. Tension can then appear due to emotive dissonance as 'maintaining a difference between feeling and feigning over the long run leads to strain' (Hochschild 2003: 90). This is an area that would warrant further investigation with its potential for increasing AMAU nurses' emotional stress levels. Another area that was demanding for the nurses emotionally was dealing with deaths on the unit and this aspect of their role will be discussed next.

### **7.2.2 *Dealing with death***

Any patient admitted to the AMAU who then died would frequently have been exposed to treatments and interventions such as cardiac arrest calls and/or invasive and complex medical treatments. When a patient was resuscitated the nurses experienced elation and pride. However, should all efforts fail and the patient died then they experienced worry that they had not done everything that they could, and they also had to deal with being confronted with the raw grief of the suddenly bereaved. This senior nurse provided two critical incidents of 'good' nursing care. The first incident had related to a very dramatic resuscitation episode and this second incident concerned the care of a dying man:

“And the other one was a gentleman that died and the family were all there and it was really distressing. He was very poorly but he hadn't been in with us long and ‘he was slipping away quietly’ [*made quotation marks gestures with her fingers*] and the family were really upset and I had been involved with him since admission. I think the thing that upset me most was the grandson was there who was only small and I am hopeless, I am hopeless I can cry even if I don't know them [*little laugh*] [*pause*] I was really trying hard not to cry because they were breaking their hearts and the little boy was there and it was him that upset me the most. And I think, even though I get upset at the time, I can go home and switch it off you know.”

(*Senior Nurse. Interview 2: 6*)

This nurse describes her involvement with the grief of this family although she did not know them well but as she had been the nurse who had admitted the patient she experienced a connection with the family. She concludes by noting that once home she was able to ‘switch it off’. I am not suggesting that she was acting her emotional reaction to the incident rather that she viewed this as an incident that went well, on an emotional as well as a clinical level. To unpick the elements that caused this to be a positive incident for this nurse would include the fact that the death was expected, the family were present, they were suitably informed, and the nurse had time to be with the family and to develop a relationship with them. These factors are comparable to Kindlen's (1994) description of the needs of the terminally ill patient. The development of such an emotional bond, a cognitive connection, between patient and nurse has been described as being rewarding and energizing professionally (Ramos 1992).

However, the short time that patients spent on the AMAU resulted in there being no, or at best a limited, relationship with the patient or the patient's family. Sometimes the patient would have died soon after admission and often before the family had even reached the unit. If this was the case the nurses made sure that all on duty knew the patient's name so as to respond to the family or friends in an appropriate manner should they come to the ward or telephone. Such sudden and often distressing deaths were upsetting for the nurses:

I came onto the unit at 8.30am. One of the side wards was empty and the bed had not been made up. Sian [*senior nurse*] was standing in the doorway holding a large bunch of flowers. Sian, looking very sad and rather shocked, said “oh dear these have been delivered for Mrs Smith from her daughter. She came in last night but didn't make it”. This patient was only forty-seven and Sian had admitted her with abdominal pain just before finishing her late shift

the evening before but at 5am that morning Mrs Smith had a massive gastrointestinal bleed and despite a lengthy attempt at resuscitation had died.

*(Field Notes)*

Patients who died on the unit were in the main unexpected deaths so the nurses were required to break this news to families to whom they were strangers. These deaths were also classified, from a legal perspective, as sudden deaths and therefore were reported to the coroner (Mason & McCall Smith 1994). The AMAU staff were then required to explain the role of the coroner and the likely process of the coroner's involvement to the relatives. This can be very distressing for relatives at an already difficult time (Dimond 1995). Many of those patients who had died would have also been subjected to resuscitation attempts. In situations requiring patient resuscitation the nurses expressed frustration if their input was not heeded, as they would often have a more in-depth understanding of the patient than an on-call junior doctor would have. This senior nurse recounted an episode where a man was resuscitated, in the nurse's view, inappropriately (he had had a large cerebral vascular accident demonstrated on Computerised Tomography (CT) scan) because the doctor got 'excited' and so 'prevented' the patient from dying peacefully:

“This gentleman was then put on a portable vent (*ventilator*) The anaesthetist wouldn't take him to ITU, just looked at his CT and said 'no'. It took that man four days to die and his wife was just devastated. And the death it was always inevitable. They did two separate brain stem tests but he just responded each time so they were then reluctant to take him off the ventilator.

It was so difficult for everybody including the unit staff and I thought, you pompous person you [*the doctor*]. It's the relatives, the wife, and the family that came down afterwards that we did get involved with and felt for. Thinking all the time 'you should be grieving, not sitting here waiting'.”

*(Senior Nurse. Interview 7:6)*

Such disagreements with medical staff over end of life issues were an often-noted occurrence by the nurses and incidents of inappropriate, in the nurses' opinions, resuscitation noted. Although the nurses contributed to decision making in many aspects of the care of the patients the decisions made regarding patients' status for resuscitation, or not to attempt resuscitation, had to be made in a very short time frame. The views of the nurses were secondary to those of the medical staff who carried the ultimate legal responsibilities for such clinical judgements (Dimond 1995). Muncer *et al.* (2001) report nurses identifying such

feelings of powerlessness as causing stress. The lack of power that the nurse describes is similar to the decision-making described by Porter (1991) as unproblematic subordination. This refers to a situation when doctors make the important decisions about patients and the nurse's role is to assist patients and support the doctors. The AMAU nurses, in a similar fashion to critical care nurses (Chaboyer *et al.* 2001), held special and unique knowledge and the doctors valued their contributions but, as will be discussed later in this chapter and developed in Chapter eight, the professional relationship between doctors and nurses was not always collegial. Nonetheless, all of the AMAU nurses expressed a desire to stay on the AMAU despite the high physical and emotional demands that they experienced: this apparent paradox will be discussed next.

#### 7.2.4 *'Thriving on stress': considering burnout*

A universal finding from the nurses interviewed, and those I had discussions with during participant observation, was that the variety and challenges of their work was a major incentive to work on the unit. The senior nurse in the following extract had worked on the AMAU for two years:

**PG.** "Why do you like working here?"

"Everyday is hectic. I mean it is not often that we get a quieter day and I think that you do get a 'buzz' from that. I do enjoy it. I mean when you get tired sometimes it gets a bit much and you think 'oh why am I doing this?'"

*(Senior Nurse. Interview 2:3)*

In addition, junior staff nurses also noted the job satisfaction that the demanding nature of AMAU work provided:

**PG.** "What would you say attracts you to working here on the AMAU?"

"Well, it is just the acuteness of it, the emergency situation because you don't know what is going to come in through the doors. You know that you are having someone coming in with shortness of breath but you don't know how they are going to present when they come here so that is a challenge in itself really. Hmm, just the other challenges are things like making beds, the bed management and things like that. You have got to talk to the wards, talk to the bed manager, and liaise with everybody to try and overcome these problems. That is what I would say are the attractions for me any way."

*(Staff Nurse. Interview 5:7)*

This nurse expresses her enjoyment of the 'acuteness of it' and of the variety and excitement of AMAU nursing and so, despite multiple role expectations and

work uncertainty, considers these demands to be stimulating challenges. All of the nurses interviewed, including those with whom I had discussions during participant observation, appeared to thrive on the fast and often, as has been discussed, rather frantic atmosphere. One senior nurse noted that she knew it would be time to move on from the AMAU ‘when nothing fazed’ her anymore (Interview 7:5) Another senior nurse echoed this when she noted that when she first worked in the hospital she was placed on a general medical ward, which she ‘had to confess’ she found ‘boring’ (Interview 3:3). Findings indicate that for the AMAU nurses the stimulation of the unit’s multiple and exacting work demands were positive factors in their overall job satisfaction. Thus the nurses, as discussed in Chapter six, despite being attached to the medical directorate recognised in themselves specialist knowledge and skills and viewed the variety and fast pace of their practice as a positive aspect of their work. Additionally, as has been noted earlier in this chapter, although the nurses describe situations when they experienced work and role overload none of the nurses interviewed wanted to move from the AMAU:

“It is nice to see them going home but it is nice to be able to deal with the acute admissions as well and you can't have long-term patients on an acute admissions ward. I mean some people like that and I think after working on the AMAU I would not want to go back to ward work. I really don't because I like the intensity of the unit and the degree of freedom in your work.”

*(Senior Nurse. Interview 2:6)*

This was a universal finding from the interviews with the AMAU nurses who all reported that their freedom to work autonomously and without interference from a more senior member of the AMAU nursing staff enhanced job satisfaction. However the staff nurse in the following extract recognised the potential for an AMAU nurse to experience negative stress related affects due to the unit’s work place demands:

**PG.** Why do you like working here on the AMAU?

“Hmmm, I just like it here and sometimes you think ‘oh, why am I here?’ and other times I feel like I have done a good job. If something came up [a *chance for promotion or an ‘acting up’ position*] I would go for it, just for a change but I think I would come back. I don’t think that you could work here for a long spell of time and not have a break. You need to do something different in between. You need to keep going and coming back because it is stressful and some people thrive on stress but even so you need a break.”

*(Staff Nurse. Interview 4:7)*



This nurse acknowledges the stress inducing nature of AMAU nursing from her personal experience. She suggests that 'taking a break' would be a good strategy even for those who enjoyed the demands of the work. In-depth analysis of the AMAU nurses' workplace stress was not the aim of this study however it would seem that findings from this study indicate there to be a potential risk for AMAU nurses to experience burnout. Burnout has been defined as a consequence of 'long-term involvement in emotionally demanding situations and ineffective coping with enduring stress' (Ekstedt & Fagerberg 2005: 60). One of the senior nurses had experience of working in AMAUs in other hospitals in the UK and considered that AMAUs are high-risk areas for nurses to experience burnout:

"I think that on admission units generally the turn over is quite high because there is a high burn out rate."

**PG.** "How do you mean?"

"You know you can only manage so long. I think I burnt out a long time ago [*laughs*]. Perhaps I have got the temperament for it because I have been doing it for quite a few years and I am still here. There is a fast turn over generally."

**PG.** "Is that the more junior people or the senior people in your experience?"

"Both"

*(Senior Nurse. Interview 3:6)*

This nurse's observation was not verified during the period of data collection during which the nursing team remained stable. This team consisted mostly of nurses who were under thirty years old with one senior nurse who was in her late thirties and one who was in her mid forties. It may be that older nurses are not attracted to AMAU work although further research is needed to substantiate such a claim. Piko (1999) suggests that nurses aged 51-60 years old are most vulnerable to high levels of work-related stress, countering other literature that suggests that older and more experienced workers have created ways of coping over time (Lease 1999). Another reason that the unit employed younger nurses may have been related to the staffing situation in the hospital during the data collection period during which there was a nationwide shortage of nurses. Nurses with experience, especially if they worked full time, had a wide array of choices to further their careers such as bed manager, nurse specialist, discharge co-ordinator, and educator roles that took them away from the bedside. This

shortage was apparent particularly in the medical directorate with problems recruiting nurses to work on the general medical wards during the data collection period. However, recruitment to the AMAU was not problematic during this study:

“There were several of the girls that did leave at the beginning, when we set the AMAU up. They’d had enough. You know, this was always emphasised right from the beginning that potentially you have the potential for burnout: a stress burnout situation. You need the kind of person who can take it. Nurses fight to come here now.”

*(Senior Nurse. Interview 7:6)*

The nursing establishment on the AMAU was drawn from nurses who worked in the medical directorate and the criteria of ‘who can take it’ were self-assigned: the nurses stayed because they enjoyed the work. They experienced rewards in their work and satisfaction together with contingent rewards related to their distinct skills that developed self-belief in their abilities. High decision authority, discretionary responsibility over the order in which work is done, and the valuing of autonomous working have been described as acting as buffers to potential burnout (Demerouti *et al.* 2000; McVicar 2003) and were both evidenced within the narratives of the AMAU nurses. Additionally, the AMAU nurses valued the degree to which they organised their work without constant monitoring or inference by the senior staff nurses or the unit’s sister. This finding supports Stordeur *et al.* (2001) who examined the effects of head nurses’ transactional and transformational leadership on their staff’s level of emotional exhaustion. Those leaders who closely monitored their staff whilst performing their duties so as to prevent mistakes were found to generate higher levels of emotional exhaustion in their staff (Stordeur *et al.* 2001). The nurses however did not work in isolation and another health professional group that the nurses interacted with, and who understood emergency provision demands were the pre-hospital care providers, the paramedics. The paramedics interviewed valued interactions with those AMAU nurses who listened and took over the patient’s care in a thorough manner whilst recognising the pressures that the nurses faced:

“They just get frustrated and probably burn out and then you take patients in and your assessment is that they need something there and then and in the scale of things, from the nurse’s point of view, they have got ten other patients who are far more needy.”

*(Paramedic 2. Interview 18:8)*

The paramedics interviewed noted that, in their opinion, there were similarities in the demand-capacity problems that the AMAU nurses experienced and those of the A&E nurse. Paramedics also work under stressful work demands, both from volume of work and the seriousness of patients' conditions, and this likely gave them insights into the demands that the AMAU nurses faced. However, one paramedic had developed a personal categorisation system of the AMAU nurses that was adjudged by the nurse's response to the paramedic's handover. There were firstly those nurses who were, in the paramedic's opinion, well-educated and asked searching questions. Then there were the new, or novice, nurses who asked lots of questions to make sure that that they did not miss anything. The worrying category, to this paramedic, was that of the 'comfort zone nurses':

"It is the ones between in the 'comfort zone' that are the problem. Whether it is lack of ambition, whether it is boredom, whether it is the amount of time that they have spent there I don't know. I probably shouldn't say that but it is the ones in between. I don't know who they are by name but you can always pinpoint them [*pause*] I probably shouldn't say that but it is the ones in between who do not display any interest who are the problem."

*(Paramedic 1. Interview 17:5)*

Sustaining a commitment to care provision and learning is a necessity for a nurse if he or she wishes to provide good care. This perception of the 'comfort zone' nurse may offer support for Janssen *et al.* (1999) who suggest that the affect of experience in the work role can lead to a sense of complacency developing that inhibits further development towards expertise. However, after this interview the concept of being in a 'comfort zone' by knowing and doing just enough to get by caused me to reflect upon the importance of human caring and developing a relationship with the patient. However, as has been discussed in Chapters five and six the nurses' evolved practice within their community of practice had led to restricted interactions with patients being the norm of practice. As this senior staff nurse noted whilst discussing the assessment process:

"... you are just wishing them to answer you quickly because you have to get onto other things."

*(Senior Nurse. Interview 2:12).*

I tried to explore the nurses' approach to assessing patients and the views expressed tended to note the need to get the admission done quickly as there were so many other work demands that required the nurses' attention. Whilst this

reflected a truthful account of the nurses' experiences this would be at variance with nursing rhetoric that emphasises the time-span that the nurse should spend with the patient to develop a relationship, for instance Peplau (1992). Menzies (1960) noted nurses avoiding patients for whom they had little to offer and suggested such strategies are a defence against anxiety. Further, as Malone (2000:3) suggests emergency room nurses experience:

*'...a rapidly changing pool of patients and the temporal constraints of urgency, which may serve to shield clinicians somewhat from confronting their own vulnerability'*

There is a potential risk that the role of an AMAU nurse with its multiple demands can lead to burnout or other stress reactions including avoidance of personal involvement and depersonalisation of patients. Clinical relationships, as described by Morse (1991) were, as identified in Chapter six, the usual nurse-patient relationship as evidenced on the AMAU:

*Should the nurse be committed to herself rather than to the patient, she may do only what is necessary for the patient, and perhaps be less likely to invest in connected relationships with patients, preferring clinical relationships* (Morse 1991: 467).

If nursing becomes just a series of tasks that just happen to involve a person then humanistic caring is lost (Williams & Irurita 2004). Interest and connecting can be achieved in busy clinical settings however all nurses may not share the attributes that promote this. Such a 'comfort zone' may reflect a form of detachment or depersonalisation, which if it is indicative of the nurse's personal approach to the role, be it with patients or other professions, can be symptomatic of stress, and indeed burnout (Kralik *et al.* 1997). McVicar (2003) describes those who experience severe distress or burnout demonstrating depersonalisation and disengagement towards their work, which would seem to reflect the 'comfort zone' nurses who do enough and no more.

Maslach & Jackson (1986) suggest that burnout in those who do people work may be manifest by evidence of emotional exhaustion, depersonalisation, and a reduction in personal accomplishments. Getting in a panic or a 'headless chicken scenario' was unhelpful but so also was the reaction of being in a 'comfort zone', and acting towards patients and colleagues in a disengaged manner. McVicar

(2003) describes two approaches to coping: emotion-focused coping and problem-focused coping. Negative use of emotion-focused coping includes distancing and escape/avoidance (McVicar 2003), which may echo the phenomenon of the comfort zone nurse. Walsh *et al.* (1998) contend that the high levels of depersonalisation exhibited by A&E nurses is related to short relationships with patients and the dominance of a medical model of care. However, any formal assessment of the stress levels of the AMAU nurses was not part of the Trust's risk assessment strategy. Work overload, coupled with staff shortages and shift working have been shown to contribute to nursing staff experiencing the physical effects of stress such as tiredness and difficulty sleeping (Walsh *et al.* 1998: Piko 1999). Therefore, it seems that on any measure of work place stress there were many aspects of the AMAU nurse's role that had the potential for harmful stress reactions. An individual's stress hardiness will depend upon their personal characteristics, experiences and coping mechanisms but also the particular circumstances of the incident that causes the demand will affect the individual's stress threshold (McVicar 2003).

The clinical background of the AMAU nurses was medical nursing predominantly. In the AMAUs surveyed by Wood (2000a) the nurses' experience was mainly A&E nursing but these nurses worked alongside some nurses from medical ward backgrounds. Wood's hypothesis, supported by Sbaih (1997a and 1997b), was that those nurses with an A&E background would find rapid diagnosis, treatment, and transfer of patients to be the norm of practice. Medical nurses might, Wood (2000a) suggests, experience such rapid patient interactions and transfers to be problematic as not being their usual approach to care delivery. However, the AMAU nurses contradicted that hypothesis in that despite all being 'medical nurses' the speed of transfer, the variety of patients and patient acuity were all positive factors in their work. Findings from this study indicate a comparable care philosophy between the AMAU nurses studied and the A&E nurses described by Byrne & Heyman (1997). Byrne & Heyman (1997), describe nurses working in the A&E department preferring the exciting aspects of the work, such as major life threatening events, and who cited the excitement factor as a reason why they chose to work in the A&E department. As been discussed earlier these findings mimic the rationales offered by the AMAU

nurses as to why they wished to continue working on the AMAU. Additionally, the alternative to working on the AMAU was to be transferred to a general medical ward within the directorate, which for the nurses interviewed was a decidedly less attractive option. The AMAU nurses valued unvaryingly the variety and excitement of their work and all expressed a desire to avoid boredom in their working day. Positive stimulation leading to increased job satisfaction can become stressful and the point when this happens will vary with the individual. Similarly, under stimulation for one person can lead to boredom and frustration yet another person could perceive the area as a perfect working environment (McVicar 2003). Wenger & Synder (2000) suggest that a community of practice would exist for as long as the members wish it to: I would suggest that the nurses' desire to remain on the AMAU helps to illustrate this phenomenon. The nursing culture was that of independence and self-reliance and the enjoyment of fast paced work and being able to 'deal with everything' was pleasing to their self-image. This stimulation, intellectual and physical, provided a working environment that the nurses valued and affected positively staff retention.

To work in other specialist areas in the hospital such as coronary care, accident and emergency, or intensive care, certainly at a senior staff nurse or sister/charge nurse, required a specialist qualification but the AMAU did not. There was no specialist qualification for AMAU nursing despite the nurses requiring, as evidence by this study, a distinctive set of knowledge, skills, and attitudes. Similarly theatre nursing, where nursing staff are not required to have specialist qualifications, nonetheless provides a clear nursing role identity and job satisfaction (McGarvey *et al.* 2000). These theatre nurses, like the AMAU nurses in this study, describe their work as contributing significantly to positive patient outcomes, requiring unique skills, and providing interesting and challenging work (McGarvey *et al.* 2000). The shared practice of the AMAU nursing team had been a collective process of negotiation (Wenger 1998) and had developed a satisfying working environment. However, situations that resulted in a lack of workplace control for the AMAU nurses were evidenced and these are discussed next.

### 7.3 Contested Areas of Control

The degree of control over work place demands that the AMAU nurses exercised is discussed in this category and areas of contested control are considered. Whilst the nurses, as discussed in Chapter five, exercised high decision authority over many aspects of their work the nurses also experienced work and role overload as has been discussed earlier in this chapter. The degree of control that workers experience in and over working practices has the potential for negative and positive effects on their job satisfaction (Tummers *et al.* 2002; Shirey 2004). Two contested areas of control are considered in the two sub-categories of *working with hospital doctors* and *'doing the writing': meeting managerial demands*. Firstly the nurses' ability to work collegially with medical colleagues and to exercise control over their working patterns is discussed.

#### 7.3.1 Working with hospital doctors

As was discussed in Chapter five the nurses exercised certain organisational controls over the process of patients' transition through the AMAU however medical staff, GPs and hospital doctors, controlled the number of requests for admission. Once the patient was admitted the AMAU nurses would then work closely with medical staff, and in particular with the junior doctors on-call who would assess patients when admitted. The AMAU was always full of doctors and the AMAU nurses worked with all of the medical teams, dependent who was on call:

“The nature of the work on AMAU forces you to become, or work more closely with the team...the team thing is a lot more pronounced in the AMAU. It's less so on the general wards.

*(Senior Registrar. Interview 8:6)*

“I think because of the environment here that we do all [*nurses and doctors*] have a laugh. You have to get on together because we work together so closely. It's just the atmosphere; it is more relaxed and enjoyable.”

*(Senior Nurse. Interview 3:13)*

Such friendly relationships were evident on the AMAU with relaxed interactions and shared social events between the junior doctors and the nurses, which contributed to the positive working collaboration evidenced. However, the nurses expressed dissatisfaction if a hospital doctor, junior or senior, would not listen to them or did not give appropriate consideration to the nurse's contribution. This

senior nurse recounted an incident when she was trying to persuade the doctors to amend a fluid regime for a patient who had been 'nil by mouth' for two days:

"I think doctors, like nurses have to be motivated. Some of them are more motivated than others, others will pick up on problems quickly and others will just bypass them you know which leads on to other problems. You can think of a few doctors who you know you can go up to and you know that they will listen to you and believe what you are saying and others who just poof, poof you ..."

*(Senior Nurse. Interview 2:6)*

Having to repeat their concerns regarding patients' needs was a frustrating element of the nurses' work. Nonetheless, the nurses could not control an individual doctor's attention to their input, so to have their voice heard would often require perseverance and draw on the individual nurse's own clinical confidence. A staff nurse, who was new to Wales and to the UK, had worked previously in a country where the role of the nurse was firmly that of an assistant to the doctor, nonetheless was philosophical and confident in her dealings with medical staff:

**PG.** "How would you describe the relationships with the doctors here on the unit?"

"It is okay though but sometimes there are some doctors when you chase them for things and they are not happy. But then just don't listen and forget it because you are doing it for the sake of the patient and so just say 'sorry to bother you but this is for the good of the patient and I need to know this'. It is not nice that you are doing things without telling the doctor, without their 'go' signal. So I don't mind, although I know those doctors it is difficult to approach but I don't care. I am not doing it for myself. I am doing it for the patient."

*(Staff Nurse. Interview 6:3)*

As many of the admitting doctors were in their pre-registration year, and often in their very first position, they needed and relied on the nurses to support them and to help them to avoid making mistakes. Doctors who chose to become over bearing or rude would be denied help or critical remarks made such as "You can't do that. If you don't know what you are doing call someone who does" (Field Notes). Junior doctors who wanted to succeed learnt about this nurse/doctor liaison quickly:

"I don't think I've ever been as scared as the first day and I was on call. I think a lot of the time if a junior doctor is worried or if they're anxious, and sort of



panicky over a patient, I'm sure some people can shut down...you know in their social skills, they just sort of go void and almost insular...I'm not trying to paint a rosy picture of myself, I mean I'm sure I can be a right sod if I'm in a mood and the day is not going well, and I've been a bit, like, short or something, but I've always gone back after and said, look I'm really sorry about that [*pause*] call it stress [*laughter*] forgive me..."

(*Junior Doctor. Interview 11:7*)

The AMAU nurses worked with all of the medical teams dependent on which team was on-call but had most contact with the pre-registration junior doctors who all came from a specific UK teaching hospital and all were British. The higher-grade doctors, from senior house officer to consultant, were from all over the world. The nurses demanded from doctors of all grades a collegial relationship that demonstrated mutual respect and further expected the doctors to work towards the shared goals of AMAU care:

PG. "Can you tell me what makes a good doctor?"

"One who answers his bloody bleep" (*Senior Nurse. Interview 1:2*)

However, on the AMAU there were occasional incidents of poor inter-professional relationships between doctors and nurses. This nurse was relating an incident that occurred when a locum registrar refused to take the nurse's call one night when she wished to refuse a GP's admission. The locum registrar had told her not to bother him during the night (the junior doctor would have been assessing and prescribing treatment for the patients admitted and not this registrar) and just to accept patients until the unit was full:

"I told him 'well I have been doing this job for (*several*) years and I think I know what the procedure is' but no he wasn't having any of it. So he calls the bed manager and tells her that I 'needed to know my place'. So that just shows you doesn't it. That is where he thought I should be [*points to the ground*] there on the ground somewhere. Yeah, he just wanted to get paid for being in bed. Sister spoke to Dr Adams [*consultant*] and I haven't seen him since! [*Laughs*].

(*Staff Nurse. Interview 5:6*)

These negative incidents between doctors and nurses related most commonly to dealings with locum doctors, especially those locum doctors who undertook an occasional shift and were hired through an agency to cover short-term sickness or

holidays. These doctors were then not part of the established team and could exhibit behaviour that was contrary to the normal working practices agreed and developed between the doctors and nurses. Svensson (1996) suggests that negotiation between doctors and nurses takes place over issues that were previously non-negotiable and nurses' influence on defining rules for interaction is stronger. Like the nurses in Svensson's (1996) study the AMAU nurses were not seen to engage in the doctor-nurse game as described by Stein (1967) where the nurse informed and advised the doctor without challenging the doctor's position of authority. Nor was there evidence, as described by Friedson (1970), of doctors holding a strong and unchallenged position by virtue of their social position and monopoly of knowledge.

Stein *et al.* (1990) revisited the doctor-nurse game and described changes in the relationships between doctors and nurses related to nurses seeking a more equal and autonomous role. Stein *et al.* (1990) describe nurses as more ready to challenge and confront doctors and make their own decision than was the case (Stein 1967). The AMAU nurses, unlike the nurses described initially by Stein (1967), did not appear to employ any of the doctor-nurse games of smoothing medical staff egos or by using self deprecation rather they employed a friendly yet direct form of communication with the medical staff no matter what grade. Often the nurses seemed to extend their remit of providing care for the patients to the doctors with what was a spirit of 'we are all in it together' provided that the doctors treated them with suitable respect. Budge *et al.* (2003) investigated the health correlates of autonomy, control, and professional relationships in a survey of 225 registered nurses in a New Zealand general hospital. Findings indicated that nurses perceived their health status, in measures on control and exercise of autonomy, as being relatively poorer than a sample of New Zealand adults. However, the measures for the nurse-physician relationship were perceived as being favourable. Budge *et al.* (2003) suggest that this positive experience of interprofessional relationships may be related to medical and nursing staff sharing common problems related to diminished control over their working practices and workload. This insight can help explain the good relationships between the nurses and the regular teams of medical staff, in particular with the junior doctors, as evidenced on the AMAU.

However, difficulties could arise if doctors did not listen to or did not respect the nurses' contributions, which could be compounded if there was a language barrier. Some of the senior doctors whose first language was not English had a reduced command of the language. This was not only a problem for the nurses but also for the patients many of whom spoke Welsh as their first language, or spoke English with a Welsh accent:

I was helping with admissions when a doctor asked me to come and translate for him as the patient was speaking Welsh. The patient was in fact speaking English but with a Welsh accent.

*(Field notes)*

The cultural differences related to the Welsh language and the Welsh people are beyond the scope of this study. However, misunderstandings and failures of communication between patients and doctors were noted frequently due to language issues and the particular uses of English by Welsh speakers when speaking English. The nurses often translated what the patient or family were saying for the medical staff. Further, as the nurses understood the area and the implications of where the patient lived and the local availability of services they could offer useful insights due to this knowledge. Problematic issues between doctors and nurses arose when medical staff failed to show respect for the nurses and their professional contribution. This was an issue that was noted commonly by the nurses that was particularly apparent when dealing with the senior doctors. Overt racism against doctors was not noted but the nurses did discuss professional and personal respect related issues, which they attributed to cultural differences as the following example demonstrates:

**PG.** "What about the doctors that you work with here, the physician teams, what to you makes a good doctor?"

"Somebody who hasn't got a problem with women to start with, because we have a couple here at the moment, Egyptian in origin, and they don't take orders from women at all, they don't listen to women at all. Well, as we are all women here obviously and well ... You need somebody who is willing to listen to your point of view ..."  
*(Staff Nurse. Interview 4:3)*

This nurse's concerns related to the ability of certain doctors to work with and accept the input of the nurses, she required 'someone who will listen to your point of view' and who conducted her/himself in an appropriate professional manner. Hughes (1988) described female nurses in an A&E setting

demonstrating less deference to doctors from the Asian sub-continent than with other doctors. However, like Porter (1991) who studied a group of nurses working in Northern Ireland, the AMAU nurses were noted as displaying collegial respect to all regardless of creed or colour as long as the person did their job. Being able to work in a climate of trust with medical colleagues was important to the nurses. A senior nurse recalled an incident when she had been attempting to get a junior doctor to attend to a patient:

“We'd bleep him and he would answer but he would be like 'yeah I will be there in a moment' and he didn't appear and he kept doing that and he wasn't doing his work and it wasn't just us that noticed it was actually the team. And the registrar had to speak to him. I remember at one point he said 'oh I didn't know about this patient' like a few hours later I said 'excuse me; I spoke to you on the phone.'”

*(Senior Nurse. Interview 3:4)*

The nurses exercised a degree of control over the doctors, especially the junior doctors and would inform the appropriate registrar or consultant if a doctor were considered not to be performing adequately. The behaviour of some consultants was less easy to modify by the nurses with a particular irritation being consultant rounds that went on for too long:

“Most of the consultants are fine and if we are busy some will poodle off and just let us know what is happening but there are one or two [*pause*] Dr Davis for instance his round goes on and on, he uses it to teach the doctors. Now I would love to stand and listen but I don't have time. If you wander off he is calling 'where is my nurse?'”

*(Staff Nurse. Interview 4: 5)*

The nurses saw this consultant as being rather a subject of fun in his behaviour rather than someone with whom they were in a less powerful relationship. The doctor-nurse relationship on the AMAU was a negotiated order (Svensson 1996) with working roles and norms developed that new doctors would adhere to if they wished for a positive collegial experience. The doctor-nurse relationship on the AMAU was controllable by the nurses to some extent. If a junior doctor did not act in an appropriate manner various sanctions were available to the nurses such as being unfriendly or unhelpful or even complaining formally to the consultant. For the AMAU team to function safely and in a timely manner then all involved were required to fulfil their roles adequately. As Sexton *et al.* (2000)

notes poor working relationships can lead to stress and subsequent negative effects such as clinical errors.

As discussed in Chapter five the nurses at the level of direct patient care had high-level decision authority generally and as discussed in this chapter they influenced the work of the doctors, especially the junior doctors. However, as Goodwin *et al.* (2005) demonstrate professionals who work within communities of practice with doctors are restricted in the demonstration of professional autonomy by the differential in knowledge and unequal power and status held by the medical profession. Nonetheless, the doctor-nurse relationship on the AMAU was collegial predominantly even if occasionally conflict was present. The AMAU nurses and doctors experienced complementary connections (Allen 2001) at the boundary of nursing and medicine. (This is developed in Chapter eight.) Throughout data collection the absence of intra-professional (nurse-nurse) conflict on the AMAU was noteworthy despite the demands of the working environment.

The AMAU nursing ethos encouraged social support and mutual respect between the nurses, bounded as they were by a common purpose, 'to make beds' and care for the acutely ill medical admissions. High degrees of work place control have been noted to lead to improved job satisfaction and higher good health indices (Janssen *et al.* 1999). And conversely low control has been linked to negative psychological work reactions, such as emotional exhaustion (Tummers *et al.* 2002). The AMAU nurses due to their professional confidence exercised high workplace control but for many aspects, such as numbers of admissions and the behaviour and decisions of some medical staff, they lacked control. However the nurses had developed a clear understanding of what was controllable and developed their work patterns to reflect this. Another area of contested control related to the documentation that the nurses were required to complete and will be discussed next.

### 7.3.2 'Doing the writing': meeting managerial demands

The Patient Care Record (or 'the booklet') (appendix 16) had been in use Trust wide for two years and was used in all ward settings in the Trust apart from the critical care areas, including the A&E department. These critical care areas had developed their own documentation and the paramedics used a prepared *pro-forma* that contained brief clinical and social information. The AMAU nurses however, despite the high daily throughput of patients, were required to use the Trust's Patient Care Record in its entirety. The AMAU nurses complained that this documentation took too long to complete and that the type of information required was inappropriate for AMAU use:

**PG.** "Can you tell me about the Patient Care Record?"

"I don't like it at all. It is too [*pause*] there is too much detail there for an initial assessment and the ideal is that you do an initial assessment and then when it goes to the wards they reassess. But I don't think that often happens and our assessment is done within the first half an hour to an hour of somebody appearing on the ward and things often change. And they have just come into hospital so they are quite traumatised by that and you don't get the full picture."

(*Senior Nurse. Interview 2:5*)

This nurse worries that the information that is obtained is unsuitable as the patients were not in a physical or a psychologically suitable condition to be asked these questions. She indicates the need for an on-going assessment with information gained at a more appropriate stage of the patient's stay in hospital. The admission time is a transition point, a time when the patient needs to adjust to a new identity, that of a patient, and often on the AMAU a seriously ill one also. At such transition points what human beings seek is to achieve balance and to retain control (Meleis *et al.* 2000). So to ask questions that would reflect the patient's immediate concerns was the approach to assessment that the nurses would have preferred to adopt:

"You can't do a proper assessment in the short time that we have can you? It is very superficial so I don't think we need to be filling the whole book in we should need to do basic details, you know past medical history, drugs and that sort of thing and next of kin and not all of the book. Some of it should wait a bit. I mean it is planned for you really with the documentation that you have got, there are specific questions that you need to ask but if I don't think it is relevant then I am not going to ask them. For some people it is not, if you

have got somebody young that is coming in with a DVT (*Deep Veined Thrombosis*) then what they had for breakfast isn't really relevant."

*(Staff Nurse. Interview 5:4)*

"When I am admitting I don't like writing in front of them so I might tick a few boxes but while doing that I will be all the time looking, listening and asking questions. I will then fill it in quickly after. I will have ticked or crossed certain boxes to remind me to write on that, and to write on that. You just ask the questions that you think are right."

*(Senior Nurse. Interview 3: 3)*

Therefore, despite the limitations of the Patient Care Record the nurses conducted their assessments in an adaptive manner to suit their individual practice and were able to centre on key aspects. This was a competence that participation in the AMAU's practice of nursing developed. This view was supported by observations of the admitting process where the nurses identified key problems and then offered suitable interventions rapidly. They had to prioritise care needs and the Patient Care Record contained much information that could have been obtained more appropriately, in the nurses' opinion, at a later stage of the patient's stay. The Patient Care Record with its many sections requiring completion was evidenced as being reductionist in its effect rather than as facilitating of holistic and individualised care delivery. As well as the Patient Care Record the nurses were required to complete multiple risk assessment forms. The nurses often expressed frustration that all of the risk assessment forms had to be completed, even if some were clearly inappropriate:

"We have got all of these risk assessment forms, even if the patient clearly isn't at risk. But we have to cover ourselves, if the Trust was sued we would be disciplined."

*(Staff Nurse. Interview 5:4)*

The written assessment was therefore structured by the layout and content of the Patient Care Record (or 'the booklet') and the various risk assessment forms rather than by a conceptually guided nursing assessment:

**PG.** Do you use a nursing model here on the AMAU?

"Hmmm, I think the booklet is based on, [*pause*] I think the assessment form is based on Roper, Logan and Tierney but no I don't think that we do use a nursing model as such."

*(Senior Nurse. Interview 7:5)*

The Patient Care Record required answers to certain questions as in the first stage of the nursing process, that of assessment (Pesut & Herman 1999). However there was a lack of a conceptual nursing approach within it:

The 'booklet' guides the nurses' admission so decisions about what to ask are not based explicitly on a nursing model. It is based on a sort of systems type approach lacking any nursing conceptualisation. This booklet and the various loose sheets are mainly to do with the assorted risk assessments the nurses are required to do.

*(Documentary evidence analytic note: patient care record)*

The nurses' assessments centred on bio-medical problems and this contributed to a poorly addressed problem identification stage (Pesut & Herman 1999) within the nurses' application of the nursing process. AMAU patients generally had one problem noted in the nursing documentation that was identified on admission and related invariably to the medical diagnosis, or presenting medical condition. This finding resonated with earlier research, for instance Griffiths (1996), that describes medical ward nurses identifying one patient problem in their formal documentation, a problem that was identified on admission and was related predominantly to the medical presentation. As Benner & Wrubel (1989: 83) noted:

*When the person/situation are analysed into objective lists, meaningful distinctions are lost and it is hard to determine which aspects of the situation are most important.*

A reductionist approach to patient assessment may reflect a lack of managerial trust in the capacity of nurses to conduct an appropriate nursing assessment of the specific needs of the individual patient (Hardey *et al.* 2000). Allen (1998: 1229) has suggested that the nursing record, if used within a quality assurance system by hospital managers, becomes part of an 'elaborate accounting mechanism'. Whilst documentation of care is an essential component of the nurse's professional responsibility (NMC 2005) the AMAU nurses expressed concerns regarding the Patient Care Record's suitability for their practice needs and time it took to complete. Annandale (1996) contends that the growing culture of litigation within UK society has increased the volume of documentary evidence that nurses have to complete. With the increased use of multiple risk assessment forms used as defensive practices in a risk culture that seeks to



increase individual accountability for practice and views the patient as someone 'who generates risk' (Annandale 1996:448). Annandale (1996) argues that the dual impact of consumerism and the risk culture of the NHS have produced defensive practices that do not serve patients or health care staff. Concerns about litigation influenced the managerial systems within the NHS Trust where the AMAU was located, as evidenced by the formal nursing assessment and the risk assessment forms whose completion did not then inform the nurses' practice. Nonetheless, these formal systems stressed the individual nurse's accountability as the admitting nurse could be sanctioned if these formal requirements were not completed on admission and there was a subsequent untoward incident. Likewise, Hardey *et al.* (2000) have described the potential for formal nursing records to provide a form of organisational and monitoring tool rather than a theoretical guide to support nursing care delivery. Wenger (1998) contends that such bureaucratic rigidities can become counterproductive, this is supported by Burkitt *et al.* (2001) who suggest that external institutional power structures can lead to formalised and bureaucratic nursing care delivery. Such enforced structures do not reflect the needs of nursing practice but rather are 'the iron fist of institutional practice which define the nature and limits of practice' (Burkitt *et al.* 2001: 61). Baker *et al.* (1996) report that lack of control in the work place contributes to work place stress which then leads to negative health effects for the worker, especially if coupled with high workload. However, the AMAU nurses expressed high job satisfaction finding a balance between their workplace demands and contested areas of control with those aspects of their role that provided positive stimulation and an internal locus of control (Landau 1995). A particular finding from this study related to the friendship networks and the social support that the AMAU nurses experienced and how this contributed to a positive working experience will be discussed next.

#### **7.4 'Supporting each other'**

The AMAU nurses, as has been discussed in Chapters five and six, had developed a community of practice and a shared enterprise and a common identity (Wenger 1998). Therefore, despite the AMAU being part of the medical directorate, the nurses were a separate group who exercised distinct skills and

abilities in their practice. The nurses' dependence on one another was a noteworthy aspect of this community of practice:

“I think we do support each other here. We all have our moans and our groans the same as everywhere, but no I think that this is the best place that I have ever worked for people not picking holes in one another and supporting each other. I think every body supports each other well. I really do think they just accept you and you are just taken in as part of the ward team straight away.”

*(Senior Nurse. Interview 2:6)*

The nurse in the above extract comments on the prompt acceptance into the nursing team that she experienced and the value that she gave to the non-critical culture that the AMAU nurses had evolved. The nurses' friendly relationships and the degree to which the nurses relied on and offered support to one another was evident from participant observation and from the nurses' narratives as illustrated in this extract:

“People do work together well; we have a laugh as well. People generally seem to have a good sense of humour. I think that I give them support. I feel as though they appreciate the support I give them but I get that back. And they do help me with things. I feel quite able to be myself here. I don't feel that I have to pretend that I am something that I am not. If I don't know something I can quite happily say 'oh I didn't know that we had to do that' [*Laughs*].”

*(Senior nurse. Interview 1:4)*

The AMAU's nursing culture encouraged non-judgemental, close and supportive working. The community of practice with its mutual engagement had developed a trusting, non-threatening and confidence building work place culture. This was enhanced by the nurses' ability to work in an autonomous manner within a non-hierarchical distribution of work as discussed in Chapter five. The nurses therefore appreciated one another's contributions as they all did the same work within their shared working practice:

“Sometimes there are three of us on a late shift. It is usually the late shift which is very busy but it is okay then if there are three of us but even if we are left with two we just work hard, have a laugh and get through. We help each other in any way that we can.”

*(Staff Nurse. Interview 6:12)*

The close friendships of the AMAU nurse were also apparent in the informal interactions that were witnessed during participant observation. For instance

when one of the HCAs became a father this was written on the board with a drawing of a stork. The nurses supported each other in informal ways and used story telling to tell, re-tell and distil an upsetting or traumatic episode until it made sense to them. When I heard the critical incidents of the nurses it was clear that these were often well-rehearsed stories. Barr (1994) notes that staff need a forum where they can express grief and re-run traumatic incidents to see if lessons can be learnt for the future. Such stories Wenger (1998) suggests help build an accumulated history of shared experiences and help create knowledge. Jokes and stories were told related to the unit's work, in particular those amusing anecdotes that were patient or doctor related. It was evidenced by this study that the team of AMAU nurses and doctors, in particular the junior doctors, were close and shared many common stories and experiences. Additionally, the AMAU was also seen as the preferred meeting place for junior doctors:

**PG.** What sort of relationship do you have with the AMAU nurses?

“Great. It is my favourite place. That is where I do most of my work and I know all of the nurses as we spend time together and have a laugh. I only go to Cavell ward [*the consultant's ward*] to do the chores and for the round. I'd always come to the AMAU for a cup of tea.”

*(Junior Doctor. Interview 11:5)*

Additionally, the effective running of the AMAU required the nurses to have friendly relationships with all of the medical teams:

“I am based on Nightingale ward so I see more of my patients on there than I do anywhere else. The AMAU nurses yes they have to know all of us; they have to have close relationships with every team whereas each individual ward will tend to have close relationship with one team.”

*(Consultant Physician. Interview 10:8)*

The community of practice of the AMAU nursing team esteemed friendliness and helping of one another as the accepted way of working and offers confirmation of the positive effect social support (Tummers *et al.* 2002) has on worker satisfaction. Social support has been defined as ‘the product of interpersonal work relationships that has the feasibility to promote the well-being or coping abilities of the recipient’ (Abu Al Rub 2004: 75). Such support was

practical as well as emotional. I witnessed occasions when the night shift could not be covered and a nurse left the ward at lunchtime to return for the night shift (on two occasions this was the ward sister). Such staff shortages were as a result of sickness or a particular need such as the transfer of a patient to a regional specialist unit that took a qualified nurse off the AMAU. The nurses did this with a sense of duty to the unit and to their colleagues and would volunteer themselves:

I was on an early shift and had booked to undertake an interview at 2pm with Sue who was on the early shift too. There was no one to cover nights so Sue said that she would do the night shift but said that she would stay on to do the interview otherwise 'it wouldn't be fair' on me. I said 'let's make another appointment'.

*(Field Notes)*

Walsh *et al.* (1998) report that A&E nurses experience stress related to such disruptions of shift patterns. Findings from this study support McVicar (2003) who agrees that shift working is a source of stress for nurses but even so this stress can be alleviated if nurses exercise control over shift allocation and a perception of equality in shift allocation. Further, the covering of the night shift was another testament to the uniqueness of the nurses' abilities, as a non-AMAU nurse would not have the necessary expertise to run the unit. This awareness of their distinctive abilities served to enhance the AMAU nurses' self worth, with the directorate nursing manager and bed managers acutely aware of the difficulty in providing replacement cover for the AMAU. This finding supports Bradley & Cartwright (2002) who suggest that an important factor in global job satisfaction is the perception of nurses that they were valued by the organisation. The nursing culture on the AMAU, with its flatten hierarchical structure and the clinical confidence of the nurses, provided an environment that promoted cohesion and a common purpose as illustrated in the following field note extract:

Beth and Claire [*two senior nurses on the AMAU*] were talking about the problems when there are no beds and Claire was recounting her experiences on the last shift she worked.

**Beth:** "Wouldn't they let you close to admissions?"

**Claire:** (with eyes to heaven) "Of course not. The bed manager wanted me to take a haematemesis [*vomiting blood a sign of a gastric bleed*] from cas [*casualty*] and sit her in the day room. I said no-way. Once they are on the unit they become our responsibility.

**Beth :** Oh and the other day they wanted me to take a discharge from the CCU to sit in the day room to free a bed. I said no

**Claire:** They think that we can work miracles.

**PG:** Some hospitals have tried discharge lounges but with limited success I believe.

**Beth:** Oh no that is asking for trouble. What if they 'go-off'? That would be just our luck.

**Claire:** No. If we are full then we are full. I won't have someone waiting in the chair if the patient waiting to go is still here. (Field Note)

The two nurses demonstrated a common understanding and approach to bed demands from bed managers. They supported each other by their mutual agreement as to the correct way to deal with such demands that then strengthened their resolve by articulating the philosophy that their community of practice had evolved. Therefore, the AMAU nurses although confronted with high work demands experienced variety and professional autonomy in their work and demonstrated generally high motivation for their work demonstrating that:

*Intrinsic work motivation proved to be primarily determined by elements of the job that make the work challenging and worth while, such as skills variety, autonomy, social contacts and opportunities to learn (Janssen et al. 1999: 1366).*

Muncer *et al.* (2001) utilising a network drawing approach that investigated causes of nurses' stress, describe managers' behaviours as acting as direct or indirect stressors. An indirect stressor was related to inadequate support and a direct stressor related to the over controlling behaviour of managers. The management of the AMAU by the unit manager (the sister) was seen to be supportive yet trusting and whilst during fieldwork there were changes in personnel nonetheless the AMAU nurses' cultural ethos remained the same. Additionally, Handy (1999) contends that the more an individual can develop deep inter-personal bonds the better able they are to deal with stress. Likewise, Marchand *et al.* (2005) describe social support as a coping resource and notes that non-job-related positive communication and social support among nurses reduces occupational stressors. Poor doctor /nurse relationships are cited (Taylor *et al.* 1999) as contributing to workplace stress but any negative incident between doctors and nurses on the AMAU were isolated and not a continuing pattern of working. Benner (1984: 156) describes gaining of social support from other nurses as team spirit and that 'the sense of being "under fire" together generates a

sense of camaraderie that cannot be duplicated under other circumstances'. One aspect of this is a social climate that perceives and desires human relationships to be valuable and that chatting with colleagues is a good indicator of a good social climate (Muncer *et al.* 2001). The decision authority that the AMAU nurses exercised related to nursing activities was high despite the high workload over which they had little control. Nonetheless, the nurses' work practices reflected autonomous work groups and were self-organising systems, supporting Tummers *et al.* (2002: 200) contention that:

*Decision authority in particular appeared to be predictive for a high level of social support. When nurses perform several different kinds of tasks or have the authority to make decisions about ongoing nursing activities, social support appears to be higher.*

Hatch & Cunliffe (2006) discuss the value of work place organization that satisfies the psychological needs of individuals by promoting team working, multi-skilling, and self-management. However, the work practices of the AMAU nurses that enhanced social support and clinical autonomy had developed organically rather than by the application of organisational theories. Likewise, the development of a community of practice is socially negotiated and constructed by human agency rather than external structural plans (Wenger 1998). Wenger (1998:152) has argued that a community of practice develops 'mutuality of engagement' or a certain way of being part of the whole. That certain expectations about how interactions take place, how people treat one another, and how they work together enable the community of practice to become what it is and an identity develops. On the AMAU the nurses' community of practice valued, and perpetuated, a friendly and negotiated environment where learning and shared support was esteemed. The social support that the nurses provided for one another and other team members was likely a key element in reducing work place stress. However informal support networks were the sole strategy in place to provide work place support. There were no external strategies in place such as formal time allocated for clinical supervision. Nonetheless, these informal support systems provided friendship but also a trusting and valuing environment that the AMAU nurses considered the norm in their community of practice.

## 7.5 Summary

The AMAU nurses experienced many work place demand stressors such as work overload, role overload, and role conflict. However, modifying or buffering factors to work place stress, such as social support and environmental /organisational decision authority were also evidenced in the AMAU nurses' practice. The nursing community of practice on the AMAU valued autonomous practice and self-reliance and any negative stress inducing incidents consistently came from issues that were beyond the control of the nurses. Although the AMAU was a very demanding work area it seemed that the nurses considered the challenges stimulating and motivating and wished to remain on the AMAU. However the AMAU nurses' potential for experiencing burnout, the stress involved when dealing with sudden death, and the need to engage in emotional labour (Hochschild 2003) would be worthy of further investigation. The nurses were a self-contained working unit with good social support and working relationships, intra-professionally and inter-professionally, with evidence of trusting friendships despite the high work place demands. Wenger's (1998) contention that communities of practice develop mutuality of engagement and ways of being constructed by the participants, which then contribute to perceptions of personal or internal locus of control, was supported by this study.

The AMAU nurses were also confronted with external pressures related to powerful organisational and professional boundary structures. However, these demands, over which the nurses had limited control, then served to strengthen the nurses' mutuality of engagement and their shared identity. The negotiated responses of the AMAU nurses' community of practice to these pressures will be discussed in the next chapter which is the final findings and discussion chapter of the study.

## CHAPTER EIGHT

### ORGANISATIONAL CONSTRAINTS AND PRACTICE BOUNDARIES FOR AMAU NURSING

#### 8.1 Introduction

The theme of this chapter is the influence on the role of the AMAU nurse of organisational constraints and professional practice boundaries. The political agendas that drive NHS management value rapid throughput of patients and the achievement of targets (McQueen 2000) and were the rationale behind the development of AMAUs across the UK (Kendrick 1996). The subsequent usage and availability of hospital beds that contributed to the construction of the AMAU nurse's role as the facilitator of rapid patient transition is developed within this chapter. Additionally, the evolved nature of this role and the developed work place strategies and ways of being that lead to patients being considered in terms of their suitability for an AMAU bed is discussed. This is followed by a consideration of the AMAU nurses' role when confronted with professional boundaries and, at times, incompatible priorities. Lastly, the future for AMAU nursing is considered and contrasted to the agenda of medicine. The three categories of this chapter are therefore: *Institutional influences on the role of the AMAU nurse*; *Boundaries of medicine and nursing*; and *Future developments of the AMAU nurses' role*. Firstly institutional influences on the role of the AMAU nurse to sustain the AMAU as a space for the delivery of acute medicine are considered.

#### 8.2 Institutional Influences on the Role of the AMAU Nurse

As has been discussed in previous chapters the AMAU nurses practiced in a clinical setting that required rapid patient transition and the nurses played a key role in this endeavour. The mutual engagement of the AMAU nurses within their community of practice (Wenger 1998) had led to the development of locally negotiated and distinct responses to care delivery to achieve this managerial demand. The identification of external demands and the evolved adaptations to the AMAU nurses' practice are considered in this category. Within the sub-category of *caring or caretaking* the nurses' role as the caretaker of the AMAU's geographical and functional space is contrasted with professional goals of



holistic caring. Firstly, the institutional milieu that the nurses practiced within is considered.

As discussed previously the role of the AMAU nurse was affected directly by the number of patients that medical staff sought to admit, this being a factor that was beyond the control of the AMAU nurses. Nonetheless, bed unavailability caused the nurses to experience personal concern:

“I must admit sometimes you are so obsessed about the beds that people can take second place [*Voice slower and quieter*] and that upsets me. Like yesterday [*pause*] I mean we were really stuck for beds it was really bad and we knew that there had been an arrest [*cardiac arrest*] on another ward and you thought 'Oh, it's another bed' [*small mirthless laugh*] you know and I mean you shouldn't be thinking like that really but it just the way because you are so desperate because you have people waiting down in cas [*casualty*]. You knew you had to get them up and just, you know [*voice tails off*].”

(*Senior Nurse. Interview 2:6*)

As the nurse in charge of the unit the pressure to provide empty beds was filling this nurse's mind. By telling me about this occurrence she demonstrated trust in me as a person, and as a nurse who would understand. Such backstage confessions can act as safety valve for the individual but may shock the public or indeed other nurses away from the particular setting. As Parker & Gardner (1992) have discussed nurses work in a world of extraordinary occurrences but by talk make it less strange and further what is acceptable and ordinary to the nurses may seem disturbing or uncaring to outsiders. Therefore, at times the AMAU nurses' primary concern was to provide empty beds to receive acute admissions:

“I suppose that you do the things, you do the things that are most urgent, to solve the most pressing problems that you have got and I suppose that if beds are the most pressing problem then you sort the beds”

(*Senior Nurse. Interview 1:2*)

The nurses, as discussed Chapter seven, described how they thrived on the busyness of the AMAU and were reluctant to move to an ordinary medical ward, as they would miss the 'buzz' and the stimulating stress of the unit. However, the nurses did indicate that their ways of working resulted in patient care that was to a degree compromised. In the following interview extract a staff nurse and I had been discussing differences between AMAU nursing and medical ward nursing:

“I mean obviously we do get discharges from here but it is not that often, unless for some reason that have had to stay with us then that is the only way that you will see continuity of care.”

**PG.** “Do you miss that?”

“Yes, you do miss it to in some respects but then it is nice to come in and always have somebody different to look after as well rather than coming in and seeing the same patients day in and day out.”

*(Staff Nurse. Interview 5:7)*

Lack of a prolonged nurse-patient engagement on the AMAU was inevitable and as this nurse notes, in a sentiment echoed by all of the nurses interviewed, the variety of patients and the rapidly changing patient population actually contributed to job satisfaction rather than distracted from it. The time to develop relationships, despite being a nursing claim to a distinct professional contribution to health care (May & Fleming 1997), was restricted on the AMAU due to rapid patient throughput. Therefore the potential for professional conceptualisations of care management such as holistic care delivered within a nurse-patient relationship (Hagerty & Patusky 2003) were restricted by organisational demands. However the nurses had evolved their skills and abilities to reflect the clinical reality of AMAU nursing practice. Additionally, the AMAU nurses were uniformly pragmatic about their workload capacity and accepted that decisions on what care would be delivered, and at what level, were required:

“You have you your priorities so if there is a patient who is more poorly than another then you are going to deal with them first and if you need medications giving then that is important. Other than that you do what needs to be done and I prefer working that way. Obviously if a patient wants you for something, and you have the time, you do it but if you get distracted things do get held back a little bit.”

*(Staff Nurse. Interview 4:8)*

This nurse describes her response to patients being restricted by the available time as the priorities for the nurse included ensuring that ‘things’, implicitly instrumental actions or tasks, were not held up by a patient who may ‘want’ something and so ‘distract’ the nurse from these tasks. The giving of purely instrumental care without engagement with the patient has been the subject of criticism for some time (Menziés 1960) with the added risk of limited communication due to professional stereotyping (Stockwell 1972) or negative

social judgements (Johnson & Webb 1995a and 1995b). Additionally, lack of patient engagement has been identified as an issue of concern in A &E nursing with nurses wishing to concentrate on exciting major cases, despite minor cases being their predominant work demand (Byrne & Heyman 1997). Patients whilst acknowledging that there would be no prolonged relationship with an individual AMAU nurse, as discussed in Chapter six, nonetheless had opinions on the best use of the nurses' time:

**PG.** "From your time on the AMAU how would you describe the role of the AMAU nurse?"

"You see what I feel, and I maybe wrong, but I mean when you are in hospital you think, well I do any way, I think to myself well 'come on now, they are nurses they are not here to juggle papers and to juggle beds'. There are more important jobs to do. It is valuable time, and valuable skills. Better to use their skills more, rather than time being wasted on those other things."

*(Eve. Interview 16:4)*

Eve's observation, that reflected the views of all the patients interviewed, indicated that, in her opinion, a more worthwhile use of the nurse's time was the use of hands-on skills, rather than administrative tasks such as paper and bed 'juggling'. To be juggling beds and papers meant that the nurse did not have time to be with patients and took the nurse away from the bedside where clinical skills were visible. Additionally, such lack of contact with the nurses could prove to be disconcerting for patients:

"I could hear that they were busy, with the bells going. During the night I could hear beds being moved. It was a bit unsettling to be honest."

*(Dave. Interview 15:5)*

The above extract would indicate that Dave considered that he was rather isolated from unknown and yet worrying occurrences out of his sight. This concern could have been ameliorated, it is suggested, had there been more interactions with or visual sightings of the nurses. The AMAU's bed layout, as illustrated in appendix 1, with four, two, and single bedded rooms resulted in patients being rather isolated from the nurses' bay as patients could not see the nurses, nor could the nurses see the patients. Such modern layouts, as opposed to the traditional Nightingale ward where the majority of a ward's patients were in an open plan setting, can promote privacy and may reduced disturbance and cross

infection. However the AMAU's design (which was common to all wards within the hospital) resulted in patients being rather remote from and out of sight of the nurses and this was compounded by the work demands of the nurses that required them to prioritise and thus ration their time for new admissions and the very ill.

To juggle to is to keep several different items or activities in motion, or in progress simultaneously (Chambers Dictionary 1998) and is used by Eve metaphorically. Benner (1984: 146) likewise used the term 'juggling' and contended that expert nurses have the ability to 'juggle and integrate multiple patient requests and care needs'. The organisational pressures, that the AMAU nurses had subsequently internalised as their own professional goals, required nursing staff to admit and to treat patients speedily and to restrict their interactions with patients to immediate care needs. However, if a patient were to be seriously ill on admission then the admitting nurse's time would be spent exclusively with that patient:

"Each patient can take two or three hours a time if they have got a lot of problems. Diabetic patients coming in need sliding scale [*a method of delivering controlled amounts of insulin dependent on blood glucose levels*] but it is not just the sliding scale you have got the IVIs [*intravenous infusions*], you have got the urine you have got everything around that one problem. Then if they have got three or four problems then you could be stuck with that patient all shift."

(Staff Nurse. Interview 4:5)

The ability of this staff nurse to respond in a comprehensive and skilful manner to the medical needs of the patient is apparent. However, this staff nurse then notes that such care then causes her to become 'stuck' with the patient and thus unavailable to contribute to the unit's work. The lack of sufficient numbers of appropriately skilled nursing staff to cope with the steady stream of acutely ill patients in transition through the AMAU was a constant issue of concern for the nurses. The staff nurse in the following extract likewise notes her worries about getting 'stuck' with a patient with demanding (and time consuming) needs:

"...you want to do everything for the patient but if there are only two of you and you have discharges, admissions, poorly patients so how can you cope then? And then the bed manager is asking for the bed, A&E asking 'are you ready for this one?' but then if you are stuck with one patient who is poorly

what will you do you do first? Transferring or admitting patients or taking care of this patient who is actually there: you are trying to save the patient aren't you? So I think that it is more or less the staffing. If the staffing is good then everything would be fine."

*(Staff Nurse. Interview 6:3)*

A distinct aspect of the role of the AMAU nurses was dealing with the high numbers of acutely ill patients, together with the need to care for those patients already admitted and the constant pressure need to provide empty beds:

"We get full up with cardiac patients and we can't move but then at least you know what you've got. We're just blocked, blocked at the moment and that happens often."

*(Senior Nurse. Interview 2:5)*

AMAUs, it was envisaged, would avoid mixing acute admissions with admitted longer stay patients (Cooke *et al.* 2003) but on the AMAU patients were at times on the unit for several days due to a lack of transfer beds. As discussed in Chapter five patients on the AMAU were admitted as emergencies by a GP referral, via the A&E department, following a consultant clinic or a domiciliary visit. The latter two options were less common with 43% of patients admitted via the A&E department and 42% via GPs for the year from 1.10.01-30.09.02 (Trust Data 2004). This figure is in contrast to the admission route figures for an earlier three-year period, from 1.10.98-30.09.01. During this earlier time period 64% of admissions were via GP referrals and 29% via A&E. This change in mode of admission rates however requires further analysis. The apparent change in referral origins, with greater numbers of patients admitted to A&E, was related directly to the enduring problem of bed unavailability in the hospital. When there were no beds available, and the other hospitals in the vicinity were also full, GPs had no choice but to send their patients directly to the A&E department where they would wait until a bed became free (Trust Data 2004).

Throughout fieldwork the extreme pressure on beds was a constant concern for health care staff, as has been discussed throughout the findings of this study. In Chapter five the nurses' role as gate keeper to patient admissions and their function in screening out inappropriate admissions by refusing GP referrals if the patient was a 'social' admission rather than a 'medical' admission was discussed. Part of this screening was driven by a concern to prevent patients who were high

risk for being potentially difficult to discharge, and who may end up ‘blocking beds’, from being admitted. Reflecting Heartfield’s (2005: 23) contention, whilst discussing the changing relationship of the practice of nursing and the conceptualisation of the hospital bed as a site for nursing care, that:

*‘...visibility and knowledge of nursing practice was not found in the appearance of hospital beds but in their movement in and out of the wards and the status of their occupation by patients. It is in this sense that indicators of nursing quality and efficacy have shifted from the appearance of beds to the administration of bed occupancy.’*

This echoes the working practice of the AMAU nurses, as the need to make a bed free by coordinating admissions and transfers was a time consuming and skilful element of their role. Handy (1999) suggests that such a coordinator role can become very stressful if there is lack of control over demands and /or resources to deal with these demands. For instance, hospital bed occupancy rates within the medical unit as a whole were in excess of 95% during 2001-2002 (Trust Data 2004). However, as Armitage & Davidson (2001) have noted a 90-95% bed occupancy rate reduces the ability to deal with emergency admissions and causes bed crisis to occur all year round. This blockage in patient throughput had a paradoxical effect on the AMAU nurses. The static patient population meant that there were no admissions and so they approached their work demands with a degree of certainty but at the same time the nurses experienced concern (and indeed anxiety) in their drive to ‘make beds’. However, it was noted during participant observation that the nurses did not engage in conversations with patients even when there seemed to be time. When the unit was quiet the nurses would sit at or stand around the nurses’ bay and talk amongst themselves out of view of the patients:

When it is quiet the nurses have a chat and hang around the bay. When I came onto the unit today a new staff nurse (who looked bored) sat swinging back and forward on a chair. She was waiting to go on escort. One staff nurse was pottering around and tidying up the forms and the senior nurse was reading ‘Hello’ magazine. Two health care assistants were leaning against the notes trolley chatting. ‘The lull before the storm’ remarked the senior nurse and went back to her magazine.

*(Field Notes)*

Menzies (1960) contended that such behaviour by nurses was a defence against the anxiety that engaging with patients and their distress and other needs would

cause. I would suggest that although there may have been elements of such anxiety avoidance it was also due to an internalisation of behavioural norms. The constant demand for empty beds caused the nurses to endeavour to combine the roles of carer and of 'bed maker'. A situation that compares to Burkitt *et al.*'s (2001) suggestion that nursing identities are constructed with imagined roles (core values of nursing such as caring and holism) and practice roles (constructed on a day-to-day basis by participation in their community of practice). Handy (1999) describes such situations as role overload leading potentially to role strain and other harmful stress reactions. However, one coping strategy to reduce role strain in such a situation is to downgrade the importance of some roles and then to provide low performance in these downgraded roles. The role taker must then, Handy (1999) argues, accept that performance fall off is consistent with the approved reduced importance of the downgraded roles. It may be suggested that the AMAU nurses had constructed engaging with patients as a downgraded role. The psychological concept of cognitive dissonance also contributes a potential concept to better understand this phenomenon. Festinger's theory of cognitive dissonance has been defined as:

*The condition in which one has beliefs or knowledge that disagree with each other or with behavioural tendencies; when such cognitive dissonance arises, the subject is motivated to reduce dissonance through changes in behaviour*  
(Hilgard *et al.* 1979: 592).

The reduced patient interaction and the constant drive to empty patients out of beds and so admit new patients rapidly into them had become the nurses' behavioural norm. Therefore, it may be argued, to avoid causing them psychological distress and to achieve cognitive congruence this approach to care then became the behaviour that was valued. As Handy (1999) suggests the role taker of downgraded roles must then develop personal psychological approval of lower performance standards. On the AMAU this acceptance of, and indeed the valuing of, nurse-patient relationships that were characterised by minimal engagement had emerged as the nurses' shared cultural response. This supports Wenger (1998: 81) who notes that the negotiation of a joint enterprise gives rise to understandings of mutual accountability; this then includes 'what matters and what does not'. New nurses were then, it can be suggested, socialised into this

approach to care as being the cultural norm on the AMAU and so internalised these values into their own value systems.

March & Simon (1993) describe workers internalising the rules of the organisation so that these rules then become the valued mode of working, over and above the mere attainment of the explicit work task goal. Nurses on the AMAU exhibited an alliance to speedy working, not only as a response to individual work situations but also as their esteemed mode of working. This resulted in the nurses' approach to patients remaining the same no matter what was the actual degree of busyness of the unit. Rodney & Varcoe (2001) report similar findings related to nursing work from two ethnographic studies. The former, a feminist ethnographic account of nurses' enactment of their moral agency on two acute-care medical units and the latter, a critical ethnography of nurses' practice in relation to violence against women in two emergency units. Rodney & Varcoe (2001) describe nurses lacking time to offer psychosocial support to patients and further that such input was devalued and actively discouraged. Those nurses who took the time to talk to patients were subject to derision as 'bleeding hearts' or being 'slow' (Rodney & Varcoe 2001: 39). Rodney and Varcoe (2001:46) note that:

*Organisational priorities and processes implied a valuing of aspects of nursing work different from the aspects valued by nurses. Faced with excessive workloads, the nurses had to prioritise their work, sacrificing 'invisible' labour for the more valued visible work (for example, administering medications or discharging a patient).*

Depersonalisation is a sign of a person experiencing the role stress reaction of burnout (Maslach & Jackson 1986). Additionally, the competing demands for the AMAU nurses' time had effects beyond merely the prioritising of immediate practical needs and had lead to an internalisation of philosophies of care at variance with the professional rhetoric of core nursing values. As Hagerty & Patusky (2003:145) contend:

*The nurse-patient relationship is considered the foundation of nursing care, the context in which nurses practice. The nurse-patient relationship is an interpersonal process that develops over time between patients and nurses.*



However, as Clifford (1995) suggests modern health care systems are not directed by expressive elements of care but rather are guided by cost-containment and quality measurement outcomes. Modern health care demands would appear to deem as inappropriate the use of time to develop in-depth nurse-patient relationships. In practice such relationships are valued as being of secondary importance to the rapid processing of patients through the system (Latimer 2000). Such practice is however inconsistent with theoretical conceptions of holism and humanistic care to guide nursing (Johns 1994). The need to care for increasing numbers of acutely ill patients in a climate of time and resource limitation conflicts with nursing theorists' ideals of a nurse-patient relationship (McQueen 2000).

Theoretical rhetoric, which is not achievable in practice, can cause the nurse to experience guilt (Draper 1993) and denies the realities of practice (Burkitt *et al.* 2001; Arbon 2004). Governmental policies and targets for reduced waiting times in A&E departments and short in-patient stays perpetuate this constant pressure to process patients' transition rapidly (Mather & O'Connor 2002) and thus are the realities of practice. Findings from this study support Crowe's (2000: 962) contention that the discursive context of the nurse-patient relationship is shaped by managerial and institutional discourses that 'rein in the caring potential of nursing practices'. Further, the organisation of the AMAU patient's admission to one area with the goal of transferring them rapidly owed more to a classical organisational theory of work that breaks down a task into individual jobs performed by different departments or individuals (March & Simon 1993) than it did to aspirations for holistic caring. Exploring a conceptualisation of the AMAU nurse's role incorporating the function of AMAU caretaker is now developed.

### **8.2.1 *Caring or caretaking***

The nurses experienced concern related to bed unavailability and the constant pressure that this presented them with throughout the year:

"We did not have beds all the way through the summer, when we are supposed to be quieter, and then of course all through the winter too."

*(Staff Nurse. Interview 4:6)*

Acknowledging the problem with bed availability was at times tempered with understandings of why it continued to be a particular problem and the issue of patients who were delayed transfers of care was an oft-noted problem:

“The situation with the beds at this moment in time though, it’s not working; the patients are here too long. You’ve always got the problems of moving patients in to side wards to start with and the bed situation on the wards generally. Nothing seems to be moving that quickly anymore.”

*(Senior Nurse. Interview 7:2)*

Good AMAU management, as described by the nurses and discussed in Chapters five and six, was providing empty beds swiftly and delivering triaged care to patients. The nurses were echoing what was also a major concern of the medical staff:

“...one of the bigger problems that we have here is discharge out of the AMAU into medical wards because we have so many bed blockers and such a high bed occupancy rate, a 99% occupancy bed rate. It is very difficult to move patients.”

*(Consultant Physician. Interview 10:6)*

The patients who were delayed transfers of care and could not be discharged home from the medical wards due to unresolved social problems or could not leave the AMAU due to such problems as Menicillin Resistant Staphylococci Aureus (MRSA) infections were within the category of ‘problem patients’: these patients were then described by the derogatory term of ‘bed blocker’. Patients who ‘blocked beds’, and thus impeded throughput by using an AMAU or a medical ward bed, caused the nurses and the medical staff frustration in their unvarying, and problematic goal to free up beds. Nursing and medical staff discourses therefore could construct the patient in terms of being a potential ‘bed blocker’ or a ‘bed liberator’. The following extract is an example of what were commonly heard discussions:

The bed manager and the staff nurse were discussing the hospital bed state. The staff nurse indicated to the unit’s bed-planning board said, “So I can’t move any except bed 3. She is a TIA” [*Transient ischaemic attack*]. The bed manager then asked, “She won’t be a bed blocker will she?” Staff nurse “No, I wouldn’t say so. The family take care of her and they didn’t want the social worker. They were happy with the package [*community care package*]...I don’t think that there will be a problem.”

*(Field Notes)*

Such patients were considered to be interfering with the preservation of the unit's purpose, that of admitting and transferring acutely ill medical patients as the transfer wards would be reluctant to accept patients who would be difficult to discharge or would be demanding in their nursing (not medical) care needs:

“When you are liaising with the ward and they are not willing to accept the type of patient that you are sending them. I mean that really gets me; you really get annoyed you know because we have got to look after the patients. We can't decide what comes through the door so how can they be allowed to decide that sort of thing.”

*(Senior Nurse. Interview 2:12)*

“... some wards just think that you are picking on them. It is only them they think that you are doing it to. They say 'oh you are just sending us your confused patients' and that sort of thing.”

*(Staff Nurse. Interview 5:2)*

To ameliorate the transfer wards problems with bed unavailability the AMAU nurses attempted to distribute patients who were going to be difficult to nurse or to discharge in an equitable manner to the transfer wards:

“Not all the problem patients will be transferred to one particular ward as we try to share it out to give them a good mix. They come in and they go out but it is the other wards that can't get bed blockers out is where the fall down is.”

*(Staff Nurse. Interview 4:3)*

Patients with non-urgent medical conditions who put excessive demands on the nurses' time or were unable to liberate their hospital beds for new admissions were discussed as if their presence was polluting (Hendry 1999) of the medical space. To lessen this polluting effect these 'problem' patients were shared out among the transfer wards and so a 'good mix' of patients was thus received. To receive only confused, elderly, infected, or heavy patients (especially if discharge was going to be problematic) would therefore logically, from the nurses' discourses, have been a 'bad mix'. The pressure on the nurses' time and the constant shortage of beds resulted in frustration being expressed when the caretaking role of the AMAU nurses (making beds by managing the environment of the AMAU) was compromised. Additionally, the nurses' time should be, as evidenced by their narratives, more efficiently and properly used in acute medical situations. As Hughes (1971: 21-22) suggests:

*In professional, as in other lines of work, there grows up both inside and outside some conception of what the essential work of the occupation is or should be. In any occupation people perform a variety of tasks, some of them*

*approaching more closely the ideal or symbolic work of that profession than others. Some tasks are considered nuisances and impositions or even dirty work-physically, socially or morally beneath the dignity of the profession.*

Johnson (1997) building on earlier research on unfavourable attitudes to patients, such as *The Unpopular Patient* (Stockwell 1972), Jeffery's (1979) study of attitudes to patients admitted to casualty, and Kelly & May's (1982) literature review and subsequent discussion of good and bad patients, argues that unequal power relations between the nurse and patient are influenced by social judgement rather than by traits such as certain behaviours or medical conditions. Nurses, Johnson & Webb (1995a) argue, utilise strategies to maintain excellent care despite a context of possible negative social judgements. Further, that responses to patients were not predicable due to certain behaviours, physical needs, or traits but rather were the nurses' individualised evaluations: evaluations that were socially constructed (Johnson 1997). Similarly, Roth (1972) describes medical and nursing staff in emergency room settings controlling the behaviour of patients and visitors influenced by moral evaluations of these clients.

Johnson (1997) suggests the term moral evaluation equates to his term social judgement and argues that despite Roth offering early understandings on unpopularity based on social processes there is still evidence of reliance on traits, such as drunkenness, to explain social judgements. Interestingly, Roth suggests that health care staff apply the cultural evaluations of social worth to their clients and that professional training has not been shown to create an 'universalistic moral neutrality' (Roth 1972:840). The use of the term 'bed blocker' seems to reflect a negative social judgement, or indeed a moral evaluation. More recently Dodier & Camus (1998: 413), who conducted ethnographic fieldwork in a French teaching hospital, argue that patients in the emergency settings studied were judged on their 'mobilising worth'. Findings from this study support Dodier & Camus's (1998) contention that such evaluation was dependant on the patient's status as a real emergency, the social demands that the patient made, and the intellectual interest that the case provided (Dodier & Camus 1998). A patient labelled as a 'bed blocker' has been judged as to their mobilising worth by the AMAU nursing staff, medical staff, and bed managers. When using the term 'bed blocker' in their discourse the nurses had constructed patients by their

bed usage status rather than by any classification as an unpopular patient due to stereotypical labelling (Stockwell 1972) or due to the individual's personal characteristics (Johnson 1997) and thus reflected the nurses' clinical reality with its major challenge of maintaining rapid patient transition.

The findings of this study are comparable to Latimer's (2000) ethnography of older people admitted to an acute medical unit that describes nurses valuing 'first class' patients. A first class patient is initially an acute patient, who can be moved rapidly to be a category of patient who is dischargeable; this patient will have a condition that is 'acute, serious and resolvable' (Latimer 2000: 23). An appropriate patient can become an inappropriate patient by not having the capacity for recovery or being reclassified as geriatric or as a social admission (Latimer 2000). The concept of a 'first class patient' holds resonance to Dodier & Camus's (1998: 413) construct of 'mobilising worth' discussed earlier. Latimer (2000:25) argues that viewing patients through a lens that evaluates their ability to move rapidly out of hospital beds as being the 'reality of nursing'. Nurses in Latimer's study indicated that the pressure that they were under to push patients through beds left them feeling guilty and frustrated and of the opinion that hospital management was only interested in making beds free and not in the needs of individual patients. Latimer (2000: 28) notes that:

*In today's NHS, nurses and doctors are continually faced with delivering a public service to consumers as individuals but at the same time they are charged with getting more medicine to more people.*

The AMAU nurses were also engaged daily in what Latimer (2000: 28) notes as 'getting more medicine to more people'. This then resulted in role incompatibility (Handy 1999) as external expectations were balanced with the nurses' own professional identity. As discussed previously to reach psychological congruence I have suggested that the nurses reduced the salience of their professional role of engaging with individual patients. The nurses, to engage in the joint enterprise of the community of AMAU nursing practice, learnt to value organisational skills, in particular making beds and the ability to be 'ready for anything', as discussed in Chapters five and six, to be their primary foci. As Heartfield (2005: 22) insightfully notes the term 'length of stay' was

only added as a subject heading to the databases of MEDLINE in 1972 and to CINAHL in 1984 and further argues that:

*The addition of length of stay as a new heading is significant, in that it captures a movement in an orientation towards time as distinct from the process of being admitted or being provided care in a hospital, as a component of hospital function.*

As has been discussed in Chapter five the nurses experienced a degree of autonomy in the nursing organisation of care on the AMAU that I named flexible primary nursing. However, the nursing team's practice of nursing was affected by organisational constraints to deliver high-level medical care in a restricted physical space. Findings from this study support Zoloth-Dorfman & Rubin (1995) who argue that hospital beds have been translated from locations of care to a rationalised healthcare commodity. The AMAU was an important cog in the NHS's local care provision with the numbers of acute emergency medical patients admitted increasing yearly (Trust Data 2004). Dealing with this demand was compounded by financially driven hospital wide reductions in beds and increasing numbers of delayed transfers of care (or 'bed blockers') so those beds remaining were taking longer to empty. The most desirable patients, seen as legitimate and worthy of medical attention and also, by association, the rightful concern of the AMAU nurse, were those who confirmed to a medical model. Such patients would have a diagnosable and treatable medical condition and, importantly, the potential for early discharge. Such practice reality confronting nurses can lead to role conflict where:

*Employees have to carry out tasks that are in conflict with their own norms and values. Role conflict implies incompatible goals with the result of problematic goal attainment (Tummers et al. 2002: 186).*

To reduce role conflict the AMAU nurses valued the roles that they could perform well, such as managing beds effectively. The nurse's role can therefore be compared to that of a caretaker of the AMAU space by their work in ensuring that the unit was managed so as to maintain the smooth running of the unit. A caretaker is someone who is in charge of a place or a building (Chambers Dictionary 1998). Nurses, like caretakers, are based on the site, often guarding it, and maintaining the space for use by more powerful others, for example, doctors. Gold (1963) describing the work of the janitor (or caretaker) of an

apartment building discusses the judgements that the janitor makes about his tenants. Bad tenants are those who break the rules of the building and interfere with the smooth running of the building. 'Bed blockers' and other patients who interfered with the efficient organisation of the AMAU maybe likewise considered 'bad tenants' by the nurse caretakers of the AMAU. As Latimer (2000: 91) notes this is the reality of practice where nurses act as conductors of care where 'through their conduct, nurses organise their relationships with patients to sustain the social organisation of the acute medical domain...'

Communities of practice, such as the AMAU nursing team, are not self-contained entities having developed in larger contexts and affected by specific constraints and resource issues. However, institutional and professional demands that impinge on the work of a community of practice can lead to organisational alignment and a creative creation of meaning (Wenger 1998). On the AMAU the joint enterprise of the nurses' practice had produced a day –to – day reality that had been produced over time by the nurses' community of practice. This was a collectively negotiated response (Wenger 1998) that was particular to their practice setting's demands and constraints and had thus emerged as their own enterprise. The AMAU nurses valued their skills in 'making beds' and had constructed the limited time to engage with patients as being an inevitable, indeed maybe positive, aspect of their role. Findings from this study indicate that the AMAU nurses studied were caretakers of the AMAU and their role included maintaining bed availability by moving patients out rapidly and protecting medical beds, on the unit and on the wards, from 'bed blockers'. Having explored the AMAU nurses conflicting professional and managerial demands the relationship of the nursing team with the wider professional community and the effect of professional boundary working, in particular relationships when working with medical staff, is discussed next.

### **8.3 Boundaries of Medicine and Nursing**

In this category the role of the AMAU nurse when interacting with the wider context of the health care system, in particular differing medical communities of practice is discussed. Such working required adjustments to promote effective working at the boundaries of communities of practice and how this boundary

working impacted on AMAU nursing practice is examined. The nurses' relationships with GPs and the role that the nurses played in filtering out 'inappropriate' admissions are considered in the sub-category of *working with general practitioners*. In the sub-category of *caring for patients with mental health needs* the enduring concern of the AMAU nurses to provide suitable care for this patient group is discussed. Finally, the nurses' interaction with medical staff at the admission stage of the patient's care journey and the professional boundaries evidenced are examined in the subcategory of *sharing documentation and team leadership*. Firstly, the role of the AMAU nurse when interacting with GPs is examined.

### 8.3.1 *Working with general practitioners*

The nurses were at times distrustful of GPs when they telephoned to seek admission for their patients, especially if these patients were elderly or had non-acute medical conditions, as illustrated in this extract:

"They [GPs] say anything they like just to get the patient in. And if it turned out to be a social problem [pause] well I'm sorry [pause] you know, they're elderly, they've got multi pathology so you're bound to find something wrong with them when they come in. But then they become this problem to the whole hospital therefore leading to the freezing up of surgical and other beds as well that in a crisis situation we'd be able to use."

(Senior Nurse. Interview 7:5)

The nurses were acting in such a manner as to protect the AMAU from unwarranted and inappropriate usage in their role as coordinator and caretaker of the AMAU and at all times they sought to maximise bed availability on the AMAU. In fact they considered that they were more effective at screening out potentially inappropriate admissions than were the medical staff:

"We tend to be a bit more likely to scrutinise than I would say are the medics, because they will accept anything. The GP comes on the phone, it happened the other day, and he says 'I have a man with constipation'. Now that is not a medical problem it is a surgical problem. The way things are with us being so desperate for beds at the minute [*in the hospital generally*] they are trying to admit anywhere because the surgical side are having the same problems as we are. GPs then try to get their patients admitted anywhere."

(Staff Nurse. Interview 4:8)

It seemed from the narratives of the nurses that rather than perceiving the problem of bed shortages as being the result of a particular political agenda or



administrative policies a degree of blaming of other health professionals, especially GPs was identified:

“There's often a problem as well between hospitals and GPs. There's almost a stand-off I think. The GPs know their patients but the hospital then sort of moans that the GPs either sent in somebody inappropriately that could have been treated in the surgery or that the GP's got it wrong or something. And that's not good, because we're all in the same game. Some doctors and some nurses don't treat it as a partnership.”

*(Junior Doctor. Interview 11:6)*

The nurses were more pragmatic and suspicious in their dealings with GPs than was the junior doctor cited above. They had a screening role to perform before accepting patients, which they considered a primary responsibility of their role. The nurses were the link between the GP and the AMAU and so were engaged in accepting, as promptly as possible, acute medical admissions whilst protecting the AMAU space from inappropriate admissions. Additionally, nurses reported that they had then to deal at times with angry GPs on the phone, especially when given the news that there were no free beds. The nurses however, did not take any anger or frustration as directed at them personally and in fact empathised with the GPs:

“I feel that in a way we are sort of caught in the middle because we do get GPs on the line and if there aren't beds available they may take it out on us. I think that you have to have a bit of a rough skin and just remain pleasant and assertive [*pause*]. And don't let it get to you.”

*(Staff Nurse. Interview 5:7)*

The GP at the end of phone was tolerated even if s/he was rather brusque as the nurses accepted the pressures the GPs faced whilst maintaining wariness as to the GPs' intentions. Hendry (1999) notes it is a Western trait to attribute a human cause for any misfortune and GPs were such a human cause, often criticised and blamed for the bed problems on the AMAU. GPs influenced the AMAU's work by being the main supplier of admissions but they were not part of the group of nurses and doctors who met and had face-to-face interactions. GPs were therefore not part of the social grouping of the AMAU team. The GP interviewed was aware that GPs were often cited as being responsible for the bed shortages in the hospital:

“That is the most frustrating thing is that it can be the best AMAU in the world but if it is closed to you then it is frustrating. I think we do realise that there is a crisis with beds all the time [*pause*] and I mean the consultants keep on saying that the admission rates go up and up and up but they don't. We looked at the figures and they are fairly flat to be honest. Where we are under more pressure as litigation is commoner you would expect the admission rate to be spiralling up but they are not spiralling out of control. We looked at the figures recently but the consultants keep on hitting us over the head 'oh it is you GPs sending everyone in' so I think capacity is the single most important thing causing the problem.”

*(General Practitioner. Interview 9:3)*

GPs were, *de facto*, as also reported by Duffy *et al.* (1998), the primary gatekeepers to the AMAU and as has been discussed in Chapter five any patient referred by a GP was generally accepted. With the GPs' expertise valued and their opinion respected nonetheless, as has been discussed, they were monitored for attempts to admit inappropriate admissions. Once a patient was accepted for admission the nurse then had to obtain information from the GP about the patient's current condition and the provisional medical diagnosis. With this information the nurses would prepare a bed and suitable equipment and the ward clerk would seek out the patient's old medical notes. Sometimes the GPs were impatient and did not understand why the nurses required so much detail:

“So they often want the whole history on the phone. Now most, although I don't know, most GPs I would think would write a reasonable letter so I try and give them the bare bones and then write them a letter, but the impression that I get is that some people don't...and if GPs are sending in a reasonable letter they [*the AMAU nurses*] don't need the whole lot.”

*(General Practitioner. Interview 9:3)*

It is essential in acute medicine to have comprehensive information to hand as soon as the patient comes to the unit (Duffy *et al.* 1998). Acutely ill medical patients can deteriorate rapidly and so be unable to give information themselves, a situation that then involves risk for the patient. The nurses were in the front-line when the patient was admitted and I witnessed situations during fieldwork when patients were admitted in a critical state requiring immediate treatment but lacking a comprehensive GP letter. Thus, despite the AMAU nurses and GPs interacting in the same goal of admitting acutely ill patients they nonetheless experienced clashes at their professional boundaries. This was further complicated and contested by the professional power differences between a

doctor and a nurse, which was then contrasted with the power that the nurses held over accepting the patient on to the AMAU. Wenger (1998) describes such a situation as this interaction between the nurses and the GPs as a boundary relation. However, Wenger (1998) suggests that there is then a potential for impaired communication and disharmony when two communities of practice interact at the periphery of their practices. Communities of practice, Wenger (1998) suggests, develop ways of working together that outsiders cannot easily understand as they construct a defined and negotiated understanding of their enterprise. Narratives and artefacts are created and outsiders cannot understand these shared references. This can cause tensions if non-participation in another community becomes a defining characteristic of being a participant in a community of practice. GPs were outsiders who could be held responsible for the problems that the AMAU team faced, especially when the GPs sought to admit patients who did not fit the ideal patient model that the AMAU nurses and doctors wished to accept. However, Wenger (1998: 110) has suggested that if community members themselves move between communities with the goal of sharing knowledge and brokering knowledge then 'complementary connections' can result. Brokers enable new connections between communities of practice so as to promote coordination and ideally new possibilities for meaning. Successful brokering requires processes of translation, coordination, and alignment of differing practices (Wenger 1998). However, interaction between the GPs and the nurses was restricted to telephone calls to request admissions and evidenced little true understanding of the experiences of the each other's community of practice. Another area that evidenced professional divergence and limited understanding of professional roles was caring for patients with mental health needs and this will be discussed next.

### *8.3.2 Caring for patients with mental health needs*

Although statistics were not kept related to patients with mental health needs admitted to the AMAU I witnessed parasuicide patients being admitted almost daily to the unit. These patients may have taken drug overdoses or self-harming actions such as attempted hanging or wrist cutting. Also admitted frequently were patients with accidental overdoses, in particular related to alcohol or opiate

drugs. Occasionally psychotic patients were admitted having being brought to the A&E department by the police. The nurses' risk of verbal and/or physical assault had been increasing on the AMAU with increasing numbers of violent patients being admitted to the unit. To offer some help and protection for the nurses a small portable emergency call alarm system called '*PinPoint*' was available. When the cover was pulled off this radio controlled handset an alarm sounded in the local police station and the police would then attend the unit rapidly.

Patients with mental health problems were admitted in the main via the A& E department and only occasionally from a mental health hospital or nursing home. Those patients admitted from the A&E department would have had their physical status assessed and stabilised. If the patient was in a life threatening physical state then they were admitted to the ICU or transferred to a specialist tertiary unit. So when the patient was admitted to the AMAU the role of the nurse was to monitor the patient's condition and to provide acute medical and nursing care whilst awaiting a psychiatric opinion or the medical consultant's discharge or transfer order. However, a story told by the AMAU nurses, and thus part of the AMAU's folklore, was the story of '*The Bride*', which illustrates the complexity of this aspect of the nurse's role. In essence this story related to a young woman who was admitted on a Saturday morning with a possible overdose. She had been married two days earlier and was still wearing her wedding dress, which she would not take off. Once she woke up she was very noisy, 'wrecking the side ward', and was exposing herself through the ward window:

"The on-call mental health psychiatrist knew her, but because it was a 'personality disorder' it was a case of 'not our problem'. I said well it's certainly not our problem here. A Saturday morning on an Acute Medical Admissions Unit with this girl performing! In the end I managed to get the charge nurse of one of the mental health wards to come up, he knew her, and he talked to her and she got what she wanted – got taken to Green Hill [*local psychiatric hospital*] that was all that she wanted. I took all morning to get that situation under control. And that is the problem, if you've got somebody that's disruptive, it's horrible, and the walls are very thin."

(Senior Nurse. Interview 7:8)

So patients admitted with acute medical health needs were cared for alongside the patients admitted with acute medical problems. The AMAU nurses were unsure as to what their role was when dealing with mental health patients and

were uncertain as to the scope of their responsibility to them. This resulted in the AMAU nurses (and the AMAU doctors) often feeling frustrated, and indeed bewildered by the decisions of the on-call psychiatrists. The following field note extract is a story told following an incident involving a self-harming patient:

The talk was all about an incident that took place over night.

**The pre-registration house officer.** “What a night! This man came in with a paracetamol overdose and his aspirin levels were high too. He did not want to be treated. We contacted the psychs (*psychiatrists*) who said over the phone that they didn't think they could help.”

**Staff nurse 1.** “Well if they can't help someone like that who can they help! Remember the man we had, the one who hit Ellie, the same thing happened.

**Ward clerk.** And he went home and killed himself.”

**The pre-registration house officer.** “We called them again and they said 'we will be there in a couple of hours' I said like well you need to come now. The patient was trying to leave the ward, and he was getting angry. We asked for the police and the security people to come. But when the psychs came they said we can put him on a 20 [*section 20 of the Mental Health Act*] but that only allowed us to restrain him, not to transfer him.”

**Staff nurse 2.** “So what happened?”

**The pre-registration house officer** “ Well we took their advice and just let him go. There wasn't much else that we could do. He kept saying 'no matter what you do next time I come into hospital it will be in a body bag!'.”

Expressions of solidarity with the doctor and her story were offered by all present.

*(Field Notes)*

As the above extract illustrates when mental health patients were involved the AMAU nurses and the on-call medical team shared a common experience. The nurses offered social support to each other and the on-call doctors in a ‘comradeship under fire’ (Benner 1984:156) solidarity. There was a patient that they wished to help but the approach to the patient by the mental health team could be at variance with what the AMAU nurses and doctors considered to be suitable on-going care and treatment. The AMAU nurses provided care for patients with mental health needs by a slight modification of the type of interventions that they would provide (i.e. mainly responding to physical and safety problems with limited engagement) for any patient admitted:

A young man was admitted with epileptic-type fitting related to drug dependence and a recent overdose. He was very thin and pale and just lay still, unless he was fitting. The doctors and nurses were finding it difficult to control his fits. Everyone looked very worried. The registrar was called and the boy was transferred to the ITU.

*(Field Notes)*

A man had been admitted in a semi-conscious state due to excessive alcohol intake after attending a funeral wake. Once he started to wake up he was very loud and was swearing and calling the nurses abusive names. The whole unit was affected and in the end he discharged himself against medical advice. 'Good riddance' one staff nurse told another. (Field Notes)

If the patients were quiet and did not cause the AMAU staff problems or impede the work of the AMAU then they were treated like any other patient. A particular concern that was often expressed related to the possible negative effect on the other patients. Any negative social judgements (Johnson 1997) related to mental health patients as demonstrated by the AMAU nurses studied were proportional to the degree of disruption the patient caused to the work of the unit or to the risk of violence that the patient presented. Patients were often admitted who were a risk to the safety of the health care staff as well as to themselves:

HCA: "Do you remember Lucy Jones in the side ward? She came in with an overdose and went berserk. She was trying to throw a chair out of the window and she broke the glass in the door and was pulling her wrists across the glass. We couldn't get near her. She had Penny [*a staff nurse*] against the wall with her arm across her throat so we used 'PinPoint'. The police came quickly but got to the top of the stairs and had a 999 call so just turned around and went away. So they weren't a lot of help."

(Field Notes)

As this extract illustrates the nurses considered that they lacked support in such situations and whilst dealing the best they could they lacked any educational preparation to deal with such violent patients. The challenging behaviours of mental health patients that interfered with the smooth running of the ward Hopkins (2002:151) termed as 'malignant behaviours'. Further that the nurses studied demonstrated 'half-articulated resentment' (Hopkins 2002:152) towards these patients who were seen as having brought their troubles on themselves. Such resentment was not observed on the AMAU and patients were treated with compassion and patience. Nonetheless, the nurses were often exposed to dangerous situations for which they had no preparation and, importantly, the nurses did not understand why patients had harmed themselves. Any avoidance of patients noted on the AMAU appeared to be related to the nurses' worries about how to approach such patients effectively:

A husband and wife had been admitted after attempting a suicide pact. The wife was still drowsy and her husband sat in an easy chair next to her in a side room. They had hired a holiday cottage and thought that no one would find them. In report we were told that they had done this because they could no longer cope with their daughter who had a severe personality disorder. All having the report were silenced by this sad story. The staff nurse taking the pair on for the shift commented ‘what on earth can you say to them?’

*(Field Notes)*

The nurses worried that they were giving inappropriate care to patients with mental health problems and were also bewildered as to why the mental health services did not accept more of their patients: patients that they were extremely concerned about. Exhibiting what Hopkins (2002: 153) noted as:

*The tension between the nurses’ strong sense of responsibility for patients in their care and their unspoken sense of helplessness in their ability to care for and retain control of this particular group of patients heightens risks for all concerned.*

Findings from this study also support Kerrison & Chapman (2007) who report Australian emergency nurses reporting their lack of knowledge and skill when dealing with patients with acute mental health problems. It seemed from the narratives of the AMAU nurses that the philosophies and underpinning knowledge of caring of the mental health teams and the AMAU team were from conflicting paradigms of care. The AMAU nurses thus experienced role ambiguity that:

*Refers to lack of clarity regarding what exactly employees are supposed to do during work and subsequent performance evaluation.... This may amount to a completely unmanageable working situation, which can lead to serious strains*  
(Tummer *et al.* 2002: 186).

The Royal College of Physicians of England (2001) suggests that there should be on each AMAU a written protocol for common clinical conditions that includes self-poisonings and alcohol withdrawal. There was no such protocol on the AMAU. Additionally, the nurses had to deal with these patients whilst waiting for a psychiatrist’s assessment that often took several hours, or even days, to obtain. Harrison & Daly (2001: 248), in a nursing guide to acute medical

emergencies, devote a chapter to self-harm and alcohol and substance abuse in which three principles of treatment are suggested:

- *Appropriate emergency treatment to ensure the safety of the patient*
- *Proper psychological assessment*
- *Identification of patients at risk from further harm*

Interestingly, the above guide does not consider patients with acute psychosis, which was what the AMAU nurses at times had to deal with. In the example of the story of 'The Bride' the senior nurse overrode the psychiatrist's opinion and called upon a mental health nurse to come and review the patient. This was an experienced and confident nurse who took this decision as she considered that she was the patient's, and the rest of the patients', advocate. Likewise, Hopkins (2002:147) describes AMAU nurses viewing 'disruptive' self-harming patients as being different and as interfering with the work of the ward by impeding their ability to care for the legitimate patients who were 'really ill, poorly people'. Hopkins (2002) suggests further research into this area is required and a closer collaboration between mental health and medical nurses to enhance understanding.

Complimentary connections (Wenger 1998) between mental health services and the provision of care on the AMAU were not apparent. There was an evident need for easier access to a mental health nurse or team from the patient's initial admission. Care that would be therapeutically more appropriate than the kindness, safety, and containment, which was the only care provision that the AMAU nurses could offer. The ability to give appropriate care to mental health patients was an area that all the nurses interviewed identified as being an educational need. Seeking a specific registration qualification in mental health nursing for general nurses was not a realistic option with the system of nurse education funding in place at the time of the research, nonetheless the nurses had ideas of how to gain such experience. The following is one such suggestion:

"I would like to do a swap with a mental health nurse. They could come here and gain experience with medical conditions and the AMAU nurse could go and learn about mental health. I have suggested it but it would mean liasing with two different Trusts and everyone is so busy ..."

*(Senior Nurse. Interview 1:6)*



Findings from this study support Jervis (2000) who argues that AMAU nurses need skills to deal with aggressive and violent patients and that training days can help to develop these skills. Enabling nurses to obtain dual qualifications (general and mental health nursing) may be seen as an area that should be investigated further as the current approach to nurse education may restrict adaptability of service provision. Further, that the nurses' philosophies of care as general nurses appeared to them to be at variance with the care that such patients received from the mental health care system. Once again the nurses were authoritative regarding issues related to day-to-day issues, but from their narratives displayed powerlessness to affect change to the overarching systems. In the following category the negotiated working patterns of the AMAU nurses and hospital medical staff related to the admitting of patients that evidenced inter-professional interactions that lacked a true collegial spirit are discussed.

### *8.3.3 Sharing documentation and team leadership*

A change that became evident during fieldwork was the effect of the reduction of junior doctors working hours as a result of the 'New Deal' (Roughton & Severs 1996) on the nurse's role. This reduction in the junior doctors' hours would sometimes result in the doctor who had admitted the patient going off duty before the consultant's round the next morning. In these situations the nurse caring for the patient would present the patient on the consultant's round, unless the senior house officer or registrar on the round knew the patient:

"Here you work closer with the consultants because like you seem to be their source of information when the patients are first admitted, especially when there is no junior doctor. Also if the patient can't answer they ask you and are able to give the information."

*(Staff Nurse. Interview 4:2)*

The nurses would have patient related information that the rest of medical team would not have and the nurses by presenting patients on the consultant's round had taken on elements of what was traditionally a junior doctor's role. The nurse's role also included the monitoring of patients for medically related problems alongside their own particular nursing responsibilities:

PG “You work closely with the doctors here. What attributes would you think a doctor would look for in a ‘good nurse’?”

“Somebody who knows what is going on the ward and can tell them what is going on rapidly. Being able to recognise a patient who is going downhill straight way. Someone that they can rely on, I think, to carry out their instructions as far as treatment is concerned and they know that it has been done. I think that is what they want; somebody they know will back them up as well.”

*(Senior Nurse. Interview 2:5).*

This ability to recognise changes in the patient’s condition and communicate this to medical staff was an important aspect of the AMAU nurses’ role:

“You rely on them to let you know of any hour to hour change in the patient, because once I’ve clerked them in I might not see them again for the whole night. ...If the nurses didn’t alert me to any change then I wouldn’t know. They’re brilliant, sort of going and keeping an eye on them and they often know them better because they’re doing everything for them.”

*(Junior Doctor. Interview 11:4)*

All of the AMAU patients were acute admissions and so were likely not to have stabilised medical conditions therefore effective monitoring was essential. The junior doctor who was on call had no option but to assess the patient and then move onto the next admission. It was evident that if the nurses had not monitored patients the admitting doctor would not have had the time or capacity to do so. Other authors have noted the observing and monitoring role that nurses conducted for medical staff (Latimer 2000; Allen 2001). This is part of the responsibility of nurses in all areas but the importance of this function was of particular relevance on the AMAU as the patients were acutely ill and their plans of care were in the early stages of development. The nurse in the previous interview excerpt also noted that the doctors would look to the nurses to ‘back them up’ and similarly the doctor noted ‘you rely on them’. Such statements would seem to indicate a trusting relationship between the doctors and nurses however their inter-disciplinary working was somewhat constrained by professional boundaries as will be discussed next.

The nurse would typically start the patient’s assessment before the doctor had seen the patient and it was noted that the doctors would often read the nurse’s written assessment before seeing the patient themselves:

“What usually happens here is that they come to the AMAU from wherever and the nurses go in first of all and do their immediate observations and things like that. So it starts solving the problem because I already know their ideas, they’ve started me thinking, what I need to do for the person. I build on what they’ve done, so thanks to them.”

(*Junior Doctor. Interview 11:3*)

This example demonstrates a degree of sharing of information but the assessment process was a fragmented enterprise and there was a distinct professional boundary to the assessment process. This was exemplified by the use of different documentation by medical and nursing staff to conduct assessment and recording of care delivery. Despite repetition of information gathering there was no common record, despite both professional assessments recording much common information. Such replication is time consuming in terms of the duplication of effort and is inconvenient for the patient (Dyer *et al.* 1998). This approach was maintained despite the Royal College of Physicians of England (2001), and more recently The Department of Health’s *Guide to emergency medical and surgical admissions* (Alberti *et al.* 2005), recommending that a unified approach to care assessment and management should be used to speed up the admission process and improve continuity of care. So despite evidence of friendly and indeed trusting relationships there was an organisational culture that promoted and maintained a professional boundary between nursing and medical work:

**PG.** “Can you tell me about the admission process?”

“... they [*the nurses*] kind of go in and sort of get the ground work done and then I go in and build on it, so definitely. Definitely they help. And occasionally if you are very rushed you’re both doing it together really, so I’m asking the questions and the nurse is writing down the information from what I’m asking. But if they’re very sick then time’s is of the essence obviously”.

(*Junior Doctor. Interview 11:6*)

The junior doctor notes that the nurses do the ‘ground work’ so that he can go in and ‘build on it’ and reports that at times the contribution of the nurse is rather like a secretary noting down information from his questioning. Senior medical staff likewise, whilst respecting the work of the nurses, saw themselves as the team leader in the enterprise as this interview excerpt demonstrates:

“The AMAU nurses need the ability to work in a team, not necessarily as the leader, but able to work in a team, this is including the doctors. That is a key attribute I would say.”

*(Consultant Physician. Interview 10:10)*

The medical staff interviewed indicated that they had a good relationship with the AMAU nurses and all expressed their confidence in the nurses’ knowledge and skills as was explored in Chapters six and seven. However, there was a common thread in the discourse of medical staff that constructed the nurses’ role as maintaining the AMAU patient to await medical intervention:

**PG.** From your experience are there similarities between the organisations of AMAUs?

“...acute medicine is placing patients in a bed acutely, giving them oxygen acutely, being seen by a nurse for observation, maybe acutely, and arranging investigations acutely, and most important of all, consultant input who is an expert in acute medical emergencies.”

*(Senior Registrar. Interview 8:4)*

The professional boundaries between doctors and nurses on the AMAU were constrained by the differing professional views of the right and proper role of the nurse. The doctors constructed the role of the nurse as their helper by presenting the patient for their medical attention and subsequently minimised the nurses’ role in engaging with the patient’s needs from the moment of admission to transfer. These differing views of the nurse’s role could cause the nurses a degree of concern:

“To work well in the team with a doctor you need somebody who is willing to listen to your point of view because they are not always willing to listen to what you have decided, what you have assessed really. You just need somebody that is willing to listen.”

*(Staff Nurse. 5:10)*

A doctor who did not listen to the nurse’s assessment of the patient’s needs was not displaying trust in the nurse’s professional knowledge and experience. Gilbert (2004) suggests that trust is a dynamic process in that it can be claimed, contested and lost and the nurses dealing with a variety of medical staff and other health professionals demonstrated their trustworthiness by their actions. A culture of demonstrating trust between medical and nursing staff on the AMAU had developed over time but as has been discussed in Chapter seven medical staff did not always demonstrate a reciprocal recognition of the body of

knowledge and the skills of the AMAU nursing team. Henneman (1995: 363) suggests 'collaboration is a process by which members of various disciplines share their expertise' and for successful collaboration between disciplines to work then team members must have respect for and trust one another. However, despite friendly and trusting relationships between medical and nursing staff there were still entrenched ways of professional boundary working evidenced on the AMAU that were apparently immutable. As Allen (1997) notes despite evidence of a blurring of the nurse-medical boundary nurses continue to have an inferior status in the hospital division of labour, as without a medical diagnosis there is 'no patient and no need for nursing intervention' (Allen 1997: 511).

Findings from this study support Stein *et al.* (1990) who, whilst discussing the doctor-nurse game (Stein 1967), noted that doctors felt rather confused, as they did not consider that there was a problem of hierarchical roles in the first place nonetheless doctors did prefer nurses who would cheerfully do what they are told. Stein *et al.* (1990: 549) suggest that benefits for both professional groups is possible if the relationship were to be 'mutually interdependent as subservient and dominant roles are both psychologically restricting'. Whilst a relationship of subservience and dominance was not evidenced on the AMAU nonetheless the development of the nurses' professional development was constrained by the professional and legal authority of the doctors' community of practice. This finding supports Goodwin *et al.*'s (2005) ethnography of anaesthetic practice that describes nurses and operating department practitioners experiencing enduring constraints on their professional development and skill attainment due to the dominance of medical professional knowledge. Anderson *et al.* (2000) describe an ideal model of team working as a trans-disciplinary model of practice, with the team sharing a common philosophical perspective and exercising shared decision-making. However this model was not evidenced in the relationships of the AMAU nurses and doctors at the admission phase of the patient's journey. Nonetheless, the nurses had constructed a positive and happy working environment from their practice realities supporting Wenger (1998: 79) who has noted:

*Yet even when the practice of a community is profoundly shaped by conditions outside the control of its members, as it always is in some respects, participants within the resources and constraints of their situation nevertheless produce its day-to-day reality. It is their response to their condition, and therefore their enterprise.*

Therefore consideration of the future enterprise of the AMAU nurse's role is discussed cautiously in the following and final category.

#### **8.4 Future Developments of the AMAU Nurses' Role**

The contest between the AMAU nurse's control of role development and the desires of others, especially medical staff, to influence the nurse's role is discussed in this category that considers the future role of the AMAU nurse. The nurses on the AMAU faced decisions related to the scope of their role. Extending their range of clinical skills to assist medical staff as suggested by Alberti (2003) or resisting such delegation and seeking rather an expansion of their nursing role.

I asked all of the nurses what they would like to develop in the future:

“I suppose one of the things that I would develop, is the discharge planning because it doesn't happen. We try in some respects to start that because obviously it is important for the patients who need social input or what ever but it is not always something that you can do.”

*(Staff Nurse. Interview 5:9)*

This second extract came from an interview with a senior nurse and related to the concerns she had when providing appropriate care for patients admitted with mental health problems:

“We used to get a lot of people with double qualifications but you don't seem to get them anymore and it is something that I did bring up at a sisters' meeting once. Everyone I think thought it was not so much a bit far fetched but a bit too much in the future. I mean though if you don't start dealing with the future now when it comes you won't have got any further.”

*(Senior Nurse. Interview 1:14)*

This staff nurse saw the provision of more space to provide care to be a most useful development:

“I probably have bigger side rooms to start with. When you are ill I think you just want to be with on your own anyway. I'd also have it bigger rooms. I mean sometimes they have seven or eight people around them at one time. I know that you can't do it because of money and what ever but ideally that's the way it should be. You would have more room to move around.”

*(Staff Nurse. Interview 4:7)*

These examples are typical of the nurses' responses in that all of the nurses recognised areas in which improved nursing interventions could be provided if there was time, resources, or indeed managerial will. However, it can be noted that they sought developments that were centred on perceived shortcomings in their existing practice. None of the nurses mentioned such developments as nurse practitioner roles or advanced clinical practitioner roles. However, as has been argued throughout this study the nurses had tacitly developed a distinct and evolved, and evolving, nursing role, that of the AMAU nurse. None of the nurses sought a development of their role by an extended or expanded role but rather expressed a desire to build and improve on their existing nursing role performances: they wanted to do what they already did better. Medical staff however held converse views on the nurses' role development

The responses of the doctors to the development that they wished for the nurses' role was firmly medically centred with calls for nurses to take on more of the traditional responsibilities of medical staff:

“If you have had a particularly busy night, it helps if someone comes behind along you and puts the cannula in and sees to the bloods”.

*(Junior Doctor. Interview 11:6)*

The doctors interviewed indicated that they saw the role of the nurse as their helper and, whilst commending the effective team-working present on the AMAU, suggested that the nurses should undertake more medically delegated interventions:

“As a medic I always think that it is good for nurses to have some extended roles which I think then makes their job more interesting.”

*(Consultant Physician. Interview 9:5)*

The comments of the consultant indicated that there was limited appreciation of the complexity of the AMAU nurse's role of managing the AMAU space and providing and co-coordinating acute care to often very ill patients. This senior doctor by implication constructs the nurse's role as being boring and paradoxically indicates that undertaking junior doctors' tasks, requiring relatively low-level skills, would be more interesting. Likewise, in Coombs & Ersser's (2004) ethnography of intensive care settings medical staff are described as seeking to bequeath clinically superficial care issues to the nursing teams. On the

AMAU the nursing staff had undertaken some extended role training but only undertook such tasks if they were related directly to their nursing role, such as the giving of intravenous drugs. Additionally the ability to insert venous access lines in emergency situations and for patients on intravenous infusions or having intravenous drugs was seen as an appropriate development by the AMAU nurses:

“I think that the Ventflons [*intravenously inserted line*] is the most important thing for us to do training for because we are the ones giving the antibiotics so we should know how to put the Ventflons in but not taking the bloods. I think it is their job so the doctors should see to it really. It is their responsibility to make sure that they have taken the blood.”

*(Staff Nurse. Interview 6:8)*

“They want all the nurses to be trained to cannulate. ...I must admit I do pick and chose just whom I cannulate because I am not very good at it yet. But I think often it would be very handy if we could all do it. But not taking the bloods as they are more of a medical perspective.”

*(Senior Nurse. Interview 2:6)*

The AMAU nurses' community of practice had negotiated a boundary to its practice. Despite the recommendation of the *Scope of Professional Practice* (UKCC 1992) nurses in the Trust still had to undertake training days on extended roles such as giving intravenous drugs or inserting intravenous lines. Inserting 'Ventflons' and giving intravenous drugs were included within the practice boundary created by the AMAU nurses however they had placed the taking of blood for testing as being an unacceptable development of their role. In the following interview extract a staff nurse explains her position as regards taking on extended roles:

“As a qualified nurse you are expected to know so I think you tend to mould yourself into your own way and perhaps take titbits from your mentors or achievements from them. Like if they have got a specific training to do something and you think that would be handy to know how to do that or this particular way because it is better. So you tend to mould yourself around people that you work with anyway and you have got your own little way of doing things.”

*(Staff Nurse. Interview 4: 19)*

She notes that she whilst developing her own practice in general she follows the lead of her mentor as she wishes 'to mould' herself around those she works with. She learns therefore not only explicit knowledge but also the way of being an



AMAU nurse, which includes the boundaries to role extension. Lave & Wenger (1991) describes such situated learning as the whole person acting in the world, which involves learning to act and to talk as a participant of the community. Allen & Hughes (2002) likewise describe nurses being doubtful that role extensions would provide any benefit, job satisfaction or professional status, for them. Rather that the extra tasks would leave them with less time to provide core nursing care that reflected New Nursing ideologies (Allen & Hughes 2002). The role development that the doctors articulated echoed the predominant vision of the AMAU nurse that the literature reviewed in Chapter two espoused. The expertise that the AMAU nurse needs, it has been suggested, should include clerking patients and requesting investigations (Alberti 2003), assisting junior doctors (Wood 2000a), and attending all cardiac arrest calls (Mayled 1998). These were also the developments that the doctors interviewed for this study suggested. However, encouragingly a recent guide to emergency admissions suggests as a key principle that there should be 'agreed multi-professional team working to empower nurses' and that 'specialist nurses are used throughout the system' (Albert *et al.* 2005: 11).

However, if role development is at variance with what that the nurses value this may then result in role incompatibility. Handy (1999) describes role incompatibility as a clash between other people's expectations and one's own self concept or understanding of role. Thus, despite generally happy and close team working between the doctors and nurses it was evident that the two professions also worked in isolation following their parallel professional agendas. Despite friendly relationships the medical staff's discourse placed the role of the nurse as a competent helper to their professional contribution. So even for the doctors who worked closely with the AMAU nurses the complex management roles that were undertaken and the involvement with very ill patients and continuing care of these patients was not acknowledged. The narratives of the doctors indicated that they considered the role development of the AMAU nurses should involve taking on more medically delegated tasks. Echoing Northrup *et al.*'s (2004: 60) warning that increasingly 'only medically driven nursing practice serves the economic purposes of mainstream healthcare'.

The AMAU, as a ward and also a transitional setting for patients was in a unique position in the hospital system. The most powerful discourse was that of the medical need to use the AMAU as a space to deliver acute medical care, not to develop nursing discourses of holism and relationship building. Nonetheless, increasing pressures on medical time, especially related to reductions in junior doctors' hours, has resulted in calls for nurses to take on tasks that were the sole domain of medical staff (CSAG 1995; Alberti 2003). As Jacques (1993) argues nurses' practice is affected by a medical hegemony where the discourse of nurses' caring and connecting form of work is not important to the functioning of organisational life. The knowledge embedded in the role of an AMAU nurse was passed tacitly between old timer AMAU nurses and new timers who were moving from legitimate peripheral participation to full participation in the AMAU nurses' community of practice (Lave & Wenger 1991). Polanyi's (1966) distinction between explicit knowledge, that can be easily articulated, and tacit knowledge that cannot, provides a useful conceptual tool to aid understanding of the limited appreciation of the unique role of the AMAU nurses evidenced within this study. The tacit knowledge of the AMAU nurses, which included personal, intuitive and context dependent knowledge, enabled them to practice competently in their given social context, which was AMAU nursing. However, as Nonaka (1994) describes tacit knowledge transfer occurs through socialisation and direct contact with cultural members and the goal of knowledge development is to access this knowledge and to make it explicit.

The AMAU nurses' community of practice commenced its development in an ambiguous space (Williams & Sibbald 1999) that was formed when the AMAU was instigated. A clinical setting that was, and is, situated somewhere between a general medical ward and an A&E department. The nurses over the years had evolved a community of practice that was distinct and complex but this complexity and uniqueness was not articulated and thus has remained in many aspects invisible.

## 8.5 Summary

The role of the nurse as a professional carer whilst undertaking the role of caretaker of the AMAU space has been discussed in this chapter. The maintenance of the AMAU as space to provide acute medicine and to facilitate patient transition had resulted in the provision of beds being a key goal of the nurses' role. This had resulted in nurses and doctors categorising some patients as 'bed blockers' and therefore as polluters of the AMAU space. Patients who did not move through the bed space quickly were 'dirty work' (Hughes 1971:22) occupying a space that should be preserved for the conduct of acute medicine. The overlaps between professional communities of practice (Wenger 1998) that came together on the AMAU displayed evidence of negotiation of boundaries but there were still areas that demonstrated poor connections. Although doctors and nurses displayed trust in the other discipline's competence and demonstrated superficially effective boundary working findings indicated that each discipline worked in a parallel segregation with their own professional viewpoints and agendas. The future for the AMAU nurse's role may require that the nurses identify a way forward that enhances nursing practice rather than fulfilling short-term managerial demands that would cast the AMAU nurse in the role of the doctor's assistant. The AMAU's organisation of acute medical admissions would seem to be beneficial to all, patients, healthcare staff, and management. Further, the nurses had evolved creative ways of working to promote this care provision. Nevertheless, there is a risk that this system of working might actually be a slippery slope towards further disengagement of nurses from patients in acute hospital settings. If the future for the AMAU nurse is to be as a medical assistant and the guardian and caretaker of the medical space this may not be the best development of the skills and abilities of the nurse to enhance patient care.

The following chapter is the final chapter of the study and here an evaluation of the study is provided and its main claims detailed. The study's relevance to patients, nurses and other health professionals, nurse educators and managers, and the research community is considered and recommendations for practice and research offered.

## **CHAPTER NINE**

### **EVALUATION AND CONCLUSION**

#### **9:1 Introduction**

This study sought to describe and explain the role of the AMAU nurse and this understanding was developed by the use of ethnographic methodology to provide a qualitative interpretation. By prolonged engagement with the practice of AMAU nursing a social construction of the role of the AMAU nurse and the culture of AMAU nursing practice was achieved. A central aspect of the nurses' role involved their common enterprise within their community of practice (Wenger 1998) in the transition of patients into and through the AMAU. Additionally, insights into the situated learning (Lave & Wenger 1991) that occurred in the practice setting were achieved and a new construct, that of an evolving role to articulate the nurses' role development was provided. In this chapter, drawing on Hammersley's (1992) criteria of plausibility and credibility for evaluating qualitative research, as discussed in Chapter three, the validity of the claims made for this study are discussed. This is followed by a discussion of the relevance of the study, in particular the relevance of its main claims to patients, nurses and other health professionals, nurse educators and managers, and the research community. Firstly, the validity of the study is examined.

#### **9:2 Validity of the Study**

The criterion of validity from a subtle realistic perspective was accepted for this study and thus an understanding of validity that perceived truth as; 'the extent to which an account accurately represents the phenomena to which it refers' (Hammersley 1998: 62). The research focus of this study sought a descriptive and explanatory understanding of the role of the AMAU nurse and in Chapter three the conduct of the research was discussed and the application of Hammersley's (1992) criteria to the conduct of the study detailed. The findings chapters, Chapters five to eight, have offered evidential support for the claims made. In this section the main claims made by this study are discussed drawing on the criteria of plausibility and credibility (Hammersley 1992). Firstly limitations of the study are examined.

### 9.2.1 *Limitations of the study*

This study was conducted in the setting of one Welsh AMAU. However, as the research aim was to describe and explain the nurse's role within an AMAU, the selection of one unit was considered appropriate. I was not seeking empirical generalisability but rather to study in-depth one cultural setting. However, whilst the findings are of particular relevance for the AMAU nurses studied the findings may also be theoretically generalisable (Mason 2002) to other AMAUs organised in a similar way. The findings from this study can therefore provide a starting point for research questions related to the AMAU initiative. However, the use of one setting raised particular concerns regarding individuals' rights to privacy. Therefore, to protect anonymity I endeavoured to present data in such a format so as to prevent recognition of any person or place, which I discussed in Chapter three, whilst providing sufficient contextual information to enable the reader to judge the validity and transferability of the findings.

The opportunity for more sustained and intensive periods of time to undertake participant observation may have yielded more comprehensive data. Conducting data collection on a part-time basis limits against total immersion in data collection and the developing analysis, as there are many other demands on one's time and energies. However, the part-time and prolonged nature of data collection enabled observation of changes occurring over time that impacted on the role and function of the AMAU nurses, which a more condensed full-time period of observation may not have revealed. Although I consider the number of participants who were interviewed to be adequate I would have wished to interview more patients, especially more women. This would have provided better gender representation and thus opportunities to explore potential gender differences in patients' expectations of the role of the AMAU nurse. Despite recruiting six female patients to the study prior to their discharge once they went home these patients then withdrew their agreement. This resulted in only two female patients being interviewed. Those female in-patients who were approached all indicated their willingness to be interviewed there and then on the hospital ward. However, the guidance and instruction that I received from the LREC and from the Trust's R&D committee insisted that patient interviews were conducted after discharge. This was to minimise any potential coercion of

patients when consenting to be interviewed and to allow potential participants to have a 'cooling off' period between initial contact and the conduct of the interview. Those men recruited into the study did not withdraw their agreement and the reasons for this apparent gender difference are unclear. All of the potential female participants who withdrew their agreement explained that once they were at home they were too busy and did not have time to be interviewed. Thus there is an imbalance of representation of female and male patients in my account. However, informal conversations in the field with female patients informed the analysis and the subsequent findings of the study. This study did nonetheless present patients with an opportunity to put forward their opinions and experiences of nursing care on an AMAU whilst adding to a social construction of the role of the AMAU nurse. As discussed previously in Chapter two the voices of AMAU patients were silent in the literature reviewed so this research goes some way to rectifying this shortfall. Additionally, the recruitment of GPs into the study was challenging. Despite ten requests being sent to local GPs, with follow up requests two weeks later, only two responses were returned, both of which were positive. Unfortunately one of the GPs who replied was taken ill subsequently and then went onto long-term sick leave. The GP interviewed explained that GPs are not able to partake in all of the studies for which they are approached, due to the vast numbers of requests that they receive.

Notwithstanding these limitations, I consider that the sample of participants was appropriate and adequate as I sought understanding of a social process i.e. the role of the AMAU nurse. My sampling strategy sought access to participants who were knowledgeable and experienced regarding this issue rather than to a representative sample of a total population (Mason 2002). Further, a strength of this study is the across case selection of participants for interview, the use of participant observation, and consideration of documentary evidence that enabled triangulation of data. This approach enhanced understanding of the role of the AMAU nurse from in-depth and varied data sources. So despite the limitations discussed the aim of the study was achieved and the research questions posed were addressed. An evaluation of the validity of the study is discussed next.

### *9.2.2 Evaluating the study's validity*

In Chapter three the strategies adopted to maximise the validity of the study were detailed. These were the use of a reflexive approach, presentation of the conduct of the research that provided an audit trail, the triangulation of data and data sources including across case comparison, searching for deviant cases, and presentation of evidence to support claims. Firstly, a review of the influence of reflexivity on the conduct of the study is discussed.

This research commenced with a desire to understand the role of the AMAU nurse. Due to my occupational background as an ex-medical ward sister and a higher education teacher of nurses I commenced the research with pre-existing knowledge and attitudes to nursing, and in particular to medical nursing. The research enterprise however, caused a personal revision of theoretical and professional views on the role of the nurse. Such revision, which acted as a challenge to pre-existing presumptions, was aided by reflexivity when recording data and interpreting findings. Throughout the study therefore, I attempted a critical reflection. Whilst reflecting upon process and content related experiences I sought also to reflect upon premise perspectives and to interrogate presupposed world-views (Mezirow 1998). By studying the AMAU nurses' work place culture, a perspective changing understanding of what it is that nurses do developed. I had been a ward sister in the 1980s when the use of nursing models to inform the use of the nursing process had been influential in managerial and educational expectations. Whilst I critiqued nursing models during a nursing degree it was only during the conduct of this study that I queried central premises of the major nursing models. In particular the nurse-patient relationship that models espouse was clearly idealist. The care environments and work systems where nurses actually practice often cannot support such a role and this may serve to present nurses with unattainable practice goals. However, the reality of nurses' practice does require high-level skills in the coordination of the environment of care. The understanding that these skills are core nursing skills was always known, and shared tacitly by practitioners, but had been delegated to an issue of peripheral importance by most nursing models.

A particular consequence of the study was a developed understanding of my own sense of self. I had underestimated the demands on my own identity that participant observation would cause. As a nurse who had worked in higher education for over twelve years I found the reality of sickness and death to be at first quite overwhelming for me. No longer discussing patient care in a classroom but actually confronted with real pain and distress. The ethical concerns that I experienced and my responses to these concerns I have considered already in Chapter three. Valuing a reflexive approach I attempted to view such experiences as part of the research process. I did not seek to bury my feelings but rather saw them as part of my interpretation and construction. Further, I acknowledge that the privileged voice of the ethnography is mine and so therefore is the interpretation offered. I recognise that the reader will bring their own sense-making capacities to their reading of this research and so will derive their own understandings (Altheide & Johnson 1998). As will be developed later in this chapter my ontological position, influenced by Hammersley's (1992) description of subtle realism, influenced my reflexive and interpretative stance as seeking objectivity and naïve understandings of 'truth' were not my goal. I was part of and interacted with, and thus helped create, the field of study. I utilised a reflexive diary to record my experiences and feelings and sought to describe honestly the values and interests that affected my position and conduct as a researcher. Used throughout the conduct of the study, this reflexive diary was however of particular significance when conducting participant observation.

The prolonged engagement in the field during participant observation allowed time to gain familiarity with the setting and the participants. This time permitted the development of interpretative insights and the capacity to view these insights from differing perspectives. I sampled people, events, routines, and artefacts, both ordinary and the out of the ordinary, during fieldwork. This flexible approach permitted an organic sampling strategy (Mason 2002) in that what was sampled was responsive to the emerging topics of interest to the study. An example of this was the recruitment and inclusion of a sample of paramedics, a professional group who had not been considered in my initial selection of interview participants. In Chapter three the research decisions made are detailed and the rationale provided so the reader can follow an audit trail that supports



validity claims for this study. Whilst being conscious of the risk of over-identification with participants and thus the potential danger of 'going native', I nonetheless sought to comprehend the nurses' cultural understandings. Using reflection on my researcher role and the research aim, I endeavoured to maintain a fieldwork role that balanced the needs of the research with ethically and professionally correct behaviour. Additionally, prolonged engagement enabled relationships of acceptance and trust to develop between participants and myself. This strategy enabled appreciation of what was relevant for participants and the gaining of novel insights, which was enhanced by triangulation of methods and data sources. The triangulation of methods and data sources used in the study was to gain interpretative understanding (Hammersley 1992) and not to confirm or refute hypotheses. The varied methods of data collection and the contribution of participants from different groupings (doctors, nurses, paramedics, and patients) provided rich in-depth data and a range of perspectives to develop my interpretation of the AMAU nurse's role. For instance, all participants noted that communication was an important aspect of the nurse's role. Despite this the nurses noted that they had limited time to talk to patients and the patients discussed how they wished that the nurses had more time to 'chat' with them.

The consideration of deviant cases also provided alternative insights and led to further exploration of issues. Using comprehensive data treatment no data was excluded from analysis because it did not fit into a category but rather categories were expanded or reviewed to incorporate deviant cases (Silverman 2001). For instance, one nurse when explaining why she liked to work on the AMAU noted that the general medical wards that she had worked on were 'boring'. None of the other nurses explained their preference for working on the AMAU in such explicit terms. This then led to an exploration of work place demands and the effects of decision-authority and stimulation on job satisfaction. Throughout the presentation of findings and discussion evidential support has been provided and data extracts utilised to support contentions made. Such data extracts can aid the reader in reaching decisions about the plausibility and credibility of the evidence offered and the claims made subsequently. The study's main claims are now discussed.

### 9.3 Claims Made by the Study

Hammersley (1998) suggests that in ethnographic accounts there are two kinds of claims to be reviewed, these are the study's main claims and the evidential claims provided to support these main claims. Main claims relate to the findings of the study that refer to the central focus of the study, in this case the role of the AMAU nurse. Evidential claims that support the main claims should also, Hammersley (1998) argues, be critiqued for plausibility and in particular for credibility. Additionally, Hammersley (1998) suggests that claims can be categorised as being definitions, descriptions, or explanations and in ethnographic studies, whilst definitions can be offered, more usually there will be a combination of description and explanation. Further, conclusions will be presented that whilst being related to the focus of the study, will also offer more general contributions; these are classifiable as being either theoretical inferences or empirical generalisations. This study offers claims that combine description and explanation and conclusions that offer theoretical inferences.

This study described and explained the practice of nursing in an AMAU setting and provided a social construction of the role of the AMAU nurse. Four themes emerged which were: *The AMAU nurse's role in co-ordinating patients' transition*; *Professional skills and attributes of the AMAU nurses*; *'I love the buzz': the AMAU nurses' work place stresses and balances*; and *Organisational constraints and practice boundaries for AMAU nursing*. These themes then contributed to the two main claims of the study. These claims are firstly, a conceptualisation of the role of the AMAU nurse as the coordinator of a care environment to facilitate rapid patient transition and secondly an understanding of the AMAU nurses' role development as an evolved role within their unique community of practice. The first main claim is now discussed.

#### 9.3.1 *Managing rapid patient transition: the AMAU nurse's role*

Despite AMAUs being in use for over twelve years they are under explored from a nursing perspective. This study has provided a unique contribution to the body of knowledge of AMAU nursing by the understanding that it provides of the role of an AMAU nurse, albeit in one distinct setting. Further, this study is the first time Wenger's (1998) concept of community of practice has been drawn on to

help develop understanding of the role of the AMAU nurse. The concept of community of practice provided an insightful and novel mode of understanding the practice of AMAU nursing as a socially constructed enterprise. Prior use in a nursing context has included nurse education (Burkitt *et al.* 2002) and anaesthetic care (Goodwin *et al.* 2005).

A core aspect of the nurses' role within their community of practice (Wenger 1998) was their facilitation of rapid patient transition into and through the AMAU. The joint enterprise of AMAU nursing, and thus the role of the AMAU nurse, included the fundamental responsibility of maintaining the AMAU space for the acceptance and treatment of patients who were emergency medical admissions. To facilitate this role the nurses had developed a shared repertoire of distinctive and innovative working practices that valued continuity of care despite the transitory nature of the patients' stay. However, the AMAU nurses were an *ad hoc* grouping of medical nurses of different experiences brought together by nurse managers to work on the unit without any special preparation for this role. Yet, as this study has illuminated, the AMAU nurses practiced in a complex care environment with distinct responsibilities including the pressures of institutional demands over which they had limited control. Nonetheless by working together within their community of practice the nurses had developed shared responses and aspirations that connected their practice. Wenger (1998: 77) terms such connection as mutual engagement that 'reflects the full complexity of doing things together'. The mutual engagement of the AMAU nurses' community of practice valued the competence to ensure rapid throughput of patients and the skills to engage in autonomous working practices that enhanced continuity of patient care. However, this mutual engagement also accepted superficial and instrumentally guided nurse-patient relationships as the practice norm.

The role of the AMAU nurse required abilities to care for acutely ill patients with multiple illness presentations, whilst coordinating a care environment with a rapidly changing patient population. Similar demands are experienced by nurses in other settings however the AMAU nurses experienced this in a unique manner due to the enduring difficulties in freeing up empty beds to accept a constant

stream of new admissions. Thus the nurses were engaged in a perpetual struggle in their goal of 'making beds' in an organisation that was invariably short of beds and as discussed in Chapter five this demand had led to the development of unique aspects to their role. For instance, the acceptance of patient referrals from GPs was a departure from the usual expectations of the nurse and a unique element of the AMAU nurse's role. However, this role development was in fact a medically delegated task that required the nurse to merely note down patient details whilst informing the GP when the patient could be accepted onto the AMAU. In addition, the 'board' as a negotiated response to manage patient transition illustrated further unique elements of the nurses' role when transferring patients and accepting patients for admission. The acceptance of patients for admission when there were no beds immediately available resulted in the patient being 'stacked' and this strategy provided another distinctive element to the AMAU nurses' role. On the AMAU the nurses had the responsibility to contact patients or their carers when a bed became available. The 'stacked' patients were occupying a non-bed patient care space (Heartfield 2005) and the nurses had accepted a duty of care to these patients. This is an area of legal accountability that is unclear currently and whilst the nurses worried about their 'stacked' patients, this may be an area of legal responsibility that could conceivably be explored in the courts in the future. Nonetheless, the nurses had developed pragmatic responses to the demands they faced and a realist acknowledgement of what was possible in the AMAU setting.

Clifford (1995) has suggested that the role of the nurse would be better understood as formalised caring and this study supports this contention. The swift throughput of patients from home to AMAU to transfer ward to discharge actually resulted in the patient's journey being a fragmented enterprise. The acute medical admission was, for the patient, a journey through at least two hospital care environments. The patient's hospital admission and subsequent care journey can therefore be conceptualised as a task broken down into individual jobs as represented by classical organisational theory (March & Simon 1993) rather than as an admission to a site of holistic caring and prolonged engagement. Hospital beds on the AMAU, and indeed within the whole hospital, had been reshaped from locations of care to a 'rationalised health-care commodity' (Heartfield

2005:22). The pressure to 'make beds' had an important effect on the nurses' approach to care in that the nurses had constructed their role as protecting the AMAU from unwarranted use. To this end they monitored GPs' referrals closely in case the patients were in fact 'social cases' that would 'block' the bed that a *bona fide* medical patient could use. Therefore as evidenced within their narratives the nurses, and other health professionals with whom they interacted, constructed the AMAU patients in terms of their 'mobilising worth' (Dodier & Camus 1998: 413) by categorising patients by their 'bed blocking' or 'bed liberating' potential.

Working within organisational and institutional infrastructures that constrained their 'imagined practice' (Burkitt *et al.* 2001: 28) the AMAU nurses had developed their own sense of identity and had developed a distinct community of practice (Wenger 1998). The shared enterprise of AMAU nursing and the pooled ideas of care provision had led to ways of working that promoted individualised patient care freed from adherence to routinized systems of working, as was discussed in Chapter five and which I named 'flexible primary nursing'. The nurses functioned with high levels of practice autonomy and this led to job satisfaction for the nurses as was discussed in Chapters five, six, and seven. However, in Chapter seven drawing on the demand-control-social support model of occupational stress (Baker *et al.* 1996), the nurses' experience of high workplace demands, requirements for emotional labour, and areas of contested control that could contribute to work and role overload and conceivably to burnout (Handy 1999) were discussed. Additionally, the constraints of hierarchies of organisational structures and the agendas of other professionals on the AMAU nurse's role were also experienced and were discussed in Chapters seven and eight. For instance, medical staff interviewed sought to construct the nurses' role more as a helper or aid for medical work with the hospital doctors all expressing a desire for the AMAU nurses to undertake more medically delegated roles. Moreover, the consultant physician interviewed actually contended that these delegated medical tasks would make the nurses' work 'more interesting' thus demonstrating poor understanding of the complexity of the AMAU nurses' role. Such delegation, for instance the accepting of GP referrals and assuming responsibilities for 'stacked' patients' admissions were time consuming and

contributed to high extra demands on the nurses' time and removed them further from the patient. However, the nurses had constructed their role to maintain rapid patient transition and took on delegated medical tasks only when they could see the logic in doing so that related to their responsibilities. Therefore, as noted in Chapter eight the nurses had created a boundary to task acceptance by not taking bloods for testing as that was perceived as a 'more medical' intervention. The nurses' relationships with medical staff were therefore negotiated processes (Svensson 1996) that were collegial despite some occasional inter-occupational conflicts, particularly with locum medical staff. The main interactions, social and professional, were between junior doctors and the nurses and these relationships were constructed in the context of mutual dependency and a shared goal of processing patients safely, and rapidly, through the AMAU.

For although, as Friedson (1970) has argued, medical staff exercised dominance over clinical care by their monopoly of diagnoses making and ordering of medical treatments, this was not an area of concern for the nurses. The nurses sought to expedite a medical diagnosis being made so that they could then provide suitable treatments and interventions and thus accelerate the patient's transition out of the unit. Whilst, the traditional role of the doctor was evident on the AMAU the nurses exercised a degree of control over the managerial coordination of the AMAU space. The nurses had negotiated their own role within their community of practice and demonstrated intra-professional autonomy within in their role: a practice that was guided by practice realities. For instance, the AMAU nurses were used to working in a time short environment and had accepted limiting their time with patients, unless the patient was seriously ill, to be the accepted model of care delivery. Understanding of the AMAU nurses' practice within a community of practice enhances awareness of these communal and socially constructed approaches that have emphasised a caretaker role for the nurse, as discussed in Chapter eight, and resulted in a formalised level (Clifford 1995) of caring. The AMAU nurses worked hard at 'making beds' and providing care to often acutely, even critically ill patients and had instigated working practices, such as the two-stage approach to the handover as discussed in Chapter five, to enhance continuity of care. However, the cost of this high demand resulted in limited engagement with patients and a superficial

relationship, or a 'clinical relationship' (Morse 1991:458), being the norm. Whilst patients did not complain about limited interactions with the nurses all indicated that they would like to have had time to 'chat' with the nurses. Yet, as discussed in Chapter six, the AMAU nurses, even when time was apparently available, did not use this time to interact on an emotional or engaged level with patients. Handy's (1999) discussion of downgrading role performance as a psychological coping strategy if role expectations could not be achieved and Festinger's theory of cognitive dissonance (Hilgard *et al.* 1979) were drawn on to help explain this phenomenon.

From the nursing literature reviewed the role of the nurse espoused within nursing models and by nursing theorists was constructed predominantly as a vision of a nurse engaging therapeutically with an individual patient's health needs over a prolonged time span (Watson 1985; Peplau 1987; Morrison & Burnard 1997). Such understandings however do not acknowledge the fundamental role that the AMAU nurses played in the communal enterprise of managing the care environment of the AMAU. The definition of nursing offered by the UK nurses' professional body The Royal College of Nursing for instance, lacks an articulation of the essential communal element of praxis:

*Nursing is the use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, or death (RCN 2003: 3).*

Therefore, despite this definition being offered for all UK nurses it does not reflect fully the role of the AMAU nurse as has been identified by this study. It was evident during participant observation, and expressed by participants interviewed, that the role of the AMAU nurse required the ability to manage the AMAU space effectively and creatively. It may be argued that theoretical underpinnings derived from nursing models reflect their genesis in the 1960s and 1970s at a time of longer patient stays and less patient acuity in ward and community settings. The practice of the AMAU nurses was a negotiated praxis that had developed in response to the real-life demands of providing nursing care on an NHS AMAU. The nurses' mutual engagement and the relationships between the nurses that demonstrated community maintenance and social

complexity were a continuing thread throughout the findings of this study. The AMAU nurses had thus developed a community of practice that provided a system of working that was evolving and was locally negotiated. The nurses had adapted external demands into their practice so that these demands became part of their mutual engagement within their common enterprise of managing patients' rapid transition. This study supports Wenger (1998) who notes that a community of practice often has to work within parameters that may measure or value factors other than the real concerns that the members face. The AMAU nurses experienced a shared institutional context and this contributed to their shared identity and developed repertoire of resources. However, the coordination function that the nurses' provided was poorly articulated, for instance patients were unaware that the nurses' working practices ensured that each patient's care was a particular nurse's responsibility on every shift. Much of the nurses' work to maintain the AMAU and provide care for patients was hidden work: it was invisible despite being the glue (Wolf 1989) that maintained the cohesion of the unit's work.

In summary the first claim for this study is that a central aspect of the AMAU nurses' role was managing patients' rapid transition. Over time a community of practice had developed with locally negotiated resources and a common identity of mutual engagement to achieve this joint enterprise (Wenger 1998). The second claim offers an alternative mode of conceptualising role development. The accepted role development for the nurse is usually considered in terms of an extended or expanded role (Hunt & Wainwright 1994). I argue that another role development was recognised in the AMAU nurses' practice, that of an evolved role and will be discussed next.

### **9.3.2 *Development of an evolved role for the AMAU nurse***

The AMAU was set up with no specific preparation for the nurses who worked on the unit and there was (and is) sparse interest evidenced from a policy, managerial, or a research perspective in the AMAU nurse's role, both locally and nationally. There appeared to be a belief, indicated by literature reviewed and findings from this study, that managing nursing care on the AMAU would be just the same as a general medical ward and all that would be needed were some



additional registered nurses to care for the extra admissions. However, the AMAU studied, in common with other AMAUs across the UK, provided care for increasing numbers of admissions in an environment of bed shortages and increasing numbers of delayed transfers of care (Houghton & Hopkins 1996; NZHTA 1998). The AMAU studied was established to satisfy such clinical, managerial, and policy demands and was not perceived as an opportunity to develop nursing care delivery in a unique field of practice. Therefore, as the AMAU nurses had no role models with whom to compare and contrast their roles initially, and coupled with the enduring paucity of literature to offer role guidance, the nurses had constructed their own role. This role evolved responsively to the work place demands that the nurses faced which were influenced by managerial targets and other external demands, such as seeking to reduce waiting times in A& E departments and the reduction in the working hours of junior doctors (Roughton & Severs 1996; NAW 2000). However as the findings from this study illustrate the AMAU nurse's role held unique responsibilities. Role expectations that incorporated elements of the role of a general medical nurse and, interestingly, also the role of an A&E nurse were identified by this study. Of interest therefore was how AMAU nurses learnt to be become AMAU nurses.

The nurse when first working on the AMAU would lack the skills to function effectively as an AMAU nurse. Therefore nurses who were sent to help from the general medical wards were noted to be of limited use to the AMAU nurses and their work. So despite having a professional qualification as a nurse, and practical experience in other settings, a newcomer nurse had to learn how to become an AMAU nurse. This was discussed in Chapter six where it was noted that the nurses valued experiencing clinical events highly in their learning and that they 'had to be there and see it' to learn. This process was made possible by the situated learning that involved initially a legitimated peripheral participation (Lave & Wenger 1991) in the AMAU nursing practice. Newcomer nurses, as well as gaining task knowledge and skills, had to develop the identity of an AMAU nurse.

The approach to providing care on the AMAU was not fixed or immutable, rather as new nurses came to the unit, or new demands appeared, these changes would then influence the common enterprise of the nurses' community of practice. The role of the AMAU nurse had evolved by the practice of those nurses who had worked on the unit over the years. The joint enterprise of managing patient transition and the nurses' mutual engagement in this endeavour had led to locally negotiated ways of providing nursing care and managing the AMAU. This had then led to an evolved, and evolving, role for the AMAU nurse. The knowledge, skills, and attitudes required for the AMAU nurse's role had been passed tacitly on to newcomer nurses, who then continue its development. However, this resulted in lack of any formal or explicit articulation of what AMAU nursing practice is. Chapter six demonstrated the importance of experience in the learning of the AMAU nurses and Lave & Wenger's (1991) understanding of situated learning was drawn on to explore this learning. Failure to make visible the unique attributes of AMAU nursing may result in powerful managerial pressures, and other hegemonic groups, distancing AMAU nurses further from care provision that values holistic approaches to care and from suitable financial rewards.

A major aspect of the role of the AMAU nurse related to their ability to bring all the aspects of the patient's admission, care, and transfer process together. They were the glue (Wolf 1989) that ensured that the whole structure and organisation of the AMAU worked in a care environment that required rapid and complex decisions to be made frequently and in short time frames. The nurses deployed distinct skills in managing the needs of patients and the complex coordination of the AMAU space. The identification of the skills and abilities of the care-enhancing boundaries of AMAU nursing requires clinical research to identify key elements of this work and so make the nurses' work visible and hence valued. The nurses' contribution to the organisation of the AMAU, as discussed in Chapters five, six, and eight, was done in multiple small acts, often unique to their practice, with a critical cumulative effect on safe and coordinated patient care. Caring in contemporary health care structures, requiring an evidence practice base with audit and quality agendas, requires strategies to be in place that can make visible the pivotal role of the AMAU nurse in coordinating the

environment of care. The complexity of the management role carried out by the AMAU nurses was made visible by this research and contributes to the articulation and understanding of AMAU nursing work. Nursing theorists, educators, managers, and above all the nurse in practice face the challenge of understanding the work that the AMAU nurse does so as to render this work visible and valued. The visibility of the nursing contribution to effective patient care on the AMAU still requires strategies to make these 'hidden dimensions' (Wolf 1989: 467) more explicit for clinical developments, reward, education, and research enterprises. The AMAU space was managed, on a direct patient care level, as described in Chapter five, predominantly by the nursing team. The degree of personal and professional autonomy that the nurses demonstrated in the organisation of nursing, which was termed flexible primary nursing, was co-existent with the high degree of social support that the nurses gave one another in their practice. The capacity to be a full participant in this community of practice required more than developing practical skills. It required also the development of the social identity of being an AMAU nurse and engagement in the mutual relationships of a shared practice, which was not an expanded or extended role but rather a role that had evolved. The future for the AMAU nurse's role need not be restricted to discussions in terms of a dichotomy between an extended and an expanded role (Hunt & Wainwright 1994). If understanding of the potential of nurses when given clinical autonomy and a positive and valuing working environment, to evolve their role then maybe exciting and clinically relevant developments can result.

The two main claims of the study related to a new understanding of the role of the AMAU nurse. Both claims offered description and explanation drawn from the thematic findings and the evidence provided. Hammersley (1998) suggests that plausibility of claims can be judged by their common sense standing and may need no support. This is, however, unusual in a research study that will seek new knowledge. If claims are not sufficiently plausible then more evidence must be provided to enable assessment of the claim's credibility. Throughout the study data extracts to support contentions and developing interpretations were provided. In the first claim I have argued that the central role of the AMAU nurse was to coordinate rapid patient transition and the second claim describes

and explains how this role was an evolved one. Understanding the role of the AMAU nurse was aided by understanding the social milieu in which the nurse practices. Therefore, as illustrated by this thesis, to understand the role of the AMAU nurse by understanding nursing praxis within a community of practice was a valuable conceptual addition to aid this pursuit. In the following section the relevance of the findings are discussed.

#### **9.4 Relevance of the Findings**

Hammersley (1998) suggests that even if the findings of a study are considered to be true this does not mean that they will necessarily be of value. Two criteria related to the relevance of the study should also be satisfied. Firstly, has the topic importance and secondly do the findings contribute to existing knowledge, for just repeating what is already known about a topic is not a valued addition to knowledge. Additionally, Hammersley (1992) notes that what is important to researchers may be different to what is important to other interested parties. In this section the relevance and the contribution of the findings are considered for a range of audiences including patients, nurses and other health professionals, nurse educators and managers, and the research community.

##### **9.4.1 *Relevance for patients admitted to AMAUs***

The experiences of patients who have been admitted to AMAUs have not previously been investigated and this study rectifies this omission to a limited degree and thus offers new knowledge. This study is unique as it allows the voice of the AMAU patient to be heard and their experiences incorporated into an interpretative construction of the role of the AMAU nurse. Literature reviewed in Chapter two, for example Kendrick (1996), and findings from this study indicate that AMAUs are an excellent development to streamline acute medical care delivery. However, there is need for research that confirms an overall (cost-utility) benefit from the AMAU model of accepting acute medical admissions that incorporates the views of patients and relatives. Although this study provides some insights into the experiences of AMAU patients, further research that would expand understanding of this important area is required and could lead potentially to improvements in the patients' experience of care on an AMAU.

Although the patients interviewed indicated satisfaction with their experience on the AMAU they did note issues of concern related to the problems of obtaining a bed for them and a desire for the nurses to have more time to talk to them. Patients' satisfaction with their care despite brief and transient nurse-patient relationships provided the nurse demonstrated trustworthiness (professional and social), politeness, friendliness, and a general social ability, indicates that acceptable nurse-patient relationships can be achieved despite time shortages. This is offered with the caveat that this may merely be a sign of patients' pragmatic recognition of the realities and possibilities of current NHS practice. As Clifford (1995) notes acceptance by patients of a superficial and instrumentally driven nurse-patient relationship may reflect their acknowledgment of the realities of current health care provision. The relevance of the findings of this study for patients relates predominantly to the identification and understanding of the practice skills and knowledge that the AMAU nurse requires to provide safe and competent care.

#### **9.4.2 *Relevance and recommendations for nurses and other health professionals***

The AMAU nurses had developed unique negotiated responses within their role, for instance the ability to 'make beds' and the nursing work organisation that was termed flexible primary nursing as discussed in Chapter five. This study, by understanding what it is that AMAU nurses actually do, can aid the development of educational programmes that reflect the actual requirements of AMAU nursing as identified from the nurses' practice. Therefore the anticipated impact on nursing practice following this study includes the potential for clinical developments from the understandings provided of the AMAU nurses' role. Although this study was of one unit comparison of its findings with the limited existing literature on the AMAU nurse's role, and parallel literature from A&E nursing, provided evidence of commonality of clinical practices and shared concerns. This study will thus contribute to the development of a distinct body of nursing knowledge related to AMAU nursing. The dissemination of the findings of this study will enable the sharing of knowledge to enhance expertise development within AMAU nursing. A key finding from this study related to how the AMAU nurses had, in the absence of formal guidance, evolved their role

so that their practice was fit for the purpose of their work and their joint enterprise within their distinct community of practice (Wenger 1998).

The conceptualisation of the role of the nurse as an evolving one can aid developments in the nurses' practice by valuing developments that enhance care responsive to local clinical needs rather than merely responding to policy or professional demands. The nurses' appreciation of their working practices that valued self-direction and professional accountability was a noteworthy finding. These characteristics reflect the guidance given in a recent Department of Health document *Modernising Nursing Careers* (DoH 2006) that suggests that modern practice should move away from hierarchically managed nursing teams towards professional autonomy. Further, that patients' needs should define nursing roles rather than old and outdated titles. Understanding a nursing team as a community of practice gives a conceptual term to explain the common identity and shared goals that can evolve which are sensitive and responsive to patients' needs. The social construction of the role of the nurse permits understanding of the social nature of praxis as self-designing, self-managing, and bound by common interests and developed shared repertoires. Additionally, the degree of personal clinical autonomy and decision authority that the AMAU nurses enjoyed and which contributed to high levels of job satisfaction is a construct that can inform nursing leadership.

This study identified doctors', nurses', patients', and paramedics' perceptions of the role of the AMAU nurse and common themes emerged across cases. It was evident however that within the nurse-doctor relationships, although generally positive and friendly, tensions and conflicts were experienced at the boundaries of practice (Wenger 1998). GPs could be treated with suspicion if they tried to admit potential 'bed blockers' and hospital doctors identified clearly their wish to modify the nurses' role to aid their work. This study has supported Wenger (1998) who contends that poor understanding of the boundary work with communities of practice of other professions can lead to impaired collegial working. Recommendations for nurses and other health professionals are that:

- Forums where AMAU nurses could share expertise and so contribute to the development of good practice should be set up. Such forums could

include conferences that discuss AMAU nursing care and the development of a UK wide professional society for AMAU nurses.

- The application of Wenger's (1998) concept of boundary working may enhance understanding and aid inter-professional working in AMAU settings.

#### **9.4.3 Relevance and recommendations for nurse educators and managers**

The unique insights into nursing leadership in an AMAU setting that are provided by this study offers understanding of the working structures and the value of support networks that enabled the AMAU nurses to function effectively. Findings from this study support Janssen *et al.* (1999) who contend that employees who perceive themselves empowered and supported will demonstrate a sense of accomplishment in their work and display higher degrees of job satisfaction. Additionally, even when dealing with heavy workload demands and contested areas of control, the nurses expressed high of levels job satisfaction and evidenced perceptions of an internal locus of control (Landau 1995). The demand-control-social support model (Baker *et al.* 1996) of occupational stress, as discussed in Chapter four and utilised in Chapter seven, identified that the AMAU nurses experienced increased work satisfaction when decision authority and social support were high. This model would be a useful addition to educational programmes and leadership courses for AMAU nurses. Additionally, this study offers support for the measurement of work place stress to be included in AMAU managers' human resources risk assessment strategies.

AMAU nursing practice has developed in an *ad hoc* manner from AMAU to AMAU across the UK verified by the lack of published research. Whilst the AMAU nurses studied had developed their local regime of competence (Wenger 1998), as this is not shared with other AMAU nurses' communities of practice then shared learning is not possible. An area that was identified as requiring educational development was the AMAU nurse's role when caring for patients with mental health needs. This finding, supported by Hopkins (2002), demonstrated the requirement for AMAU nurses to have better preparation and support when caring for patients with mental health problems. Without a shared understanding of the core knowledge, skills, and attitudes that the nurse should

have to practice in the AMAU setting means that just what is effective care in this specialist area remains unarticulated. This study offers a starting place to communicate what is required for professional credibility in the role of the AMAU nurse and can contribute to an identification of, from a professional and legal perspective, the reasonable standard of care that can be expected from an AMAU nurse. As the findings from this study indicate there were distinct nursing skills required for the effective exercise of the role of an AMAU nurse. This knowledge can help inform educational programme development that is suitable for the clinical and leadership needs of AMAU nurses. Recommendations for nurse educators and managers are that:

- Clinically relevant higher education modules should be developed that will enhance the praxis of AMAU nurses.
- The concept of community of practice, to develop AMAU nurses understanding of their personal praxis and the processes involved in the communal nature of nursing care delivery, should be integrated into educational and leadership courses.
- The demand-control-social support model of work place stress could usefully be incorporated into educational and leadership programmes as a tool to help understand AMAU nurses' workplace stress, buffers to stress, and help identify those at risk of burnout.
- Improved preparation of AMAU nurses to provide care for patients with mental health needs should be provided.
- There should be clinical supervision provided for AMAU nurses to aid articulation of their tacit practice knowledge and offer a safe environment for nurses to reflect upon their practice and practice demands.

#### **9.4.4 *Relevance and recommendations for the research community***

To date research that has explored the views and experiences of nurses and patients in the AMAU setting is very limited. This is a key research issue as AMAU nurses and patients are central to the practice and purpose of AMAUs' care provision. This study offers a significant contribution to knowledge regarding AMAU nursing as, apart from Hopkins's (2002) small ethnography of AMAU nurses' interactions with self-harming patients there were no other



qualitative studies were identified. The reality of the practice of nursing on the AMAU resulted in the nurses' key role being identified as that of managing patients' rapid transition. Whilst, these inductively derived findings reflect the clinical reality of one AMAU further qualitative research conducted in other AMAUs could contribute to a shared body of research-based literature. Such research could help articulate the practice of AMAU nurses and enable tacit knowing to become explicit knowing. This study has provided an image of the AMAU nurses' role and practice as being within a community of practice (Wenger 1998), which can offer a theoretical framework to underpin future research into AMAU nursing practice. Another key claim of the study related to the evolved role of the AMAU nurse and the use of situated learning (Lave & Wenger 1991) in the nurses' clinical learning. This has potential relevance for educational research into the clinical learning of both registered nurses and student nurses. Both concepts still require further research to provide evidence as to their validity and applicability to other clinical settings but this study has offered a small contribution to this endeavour. Recommendations for the research community are that:

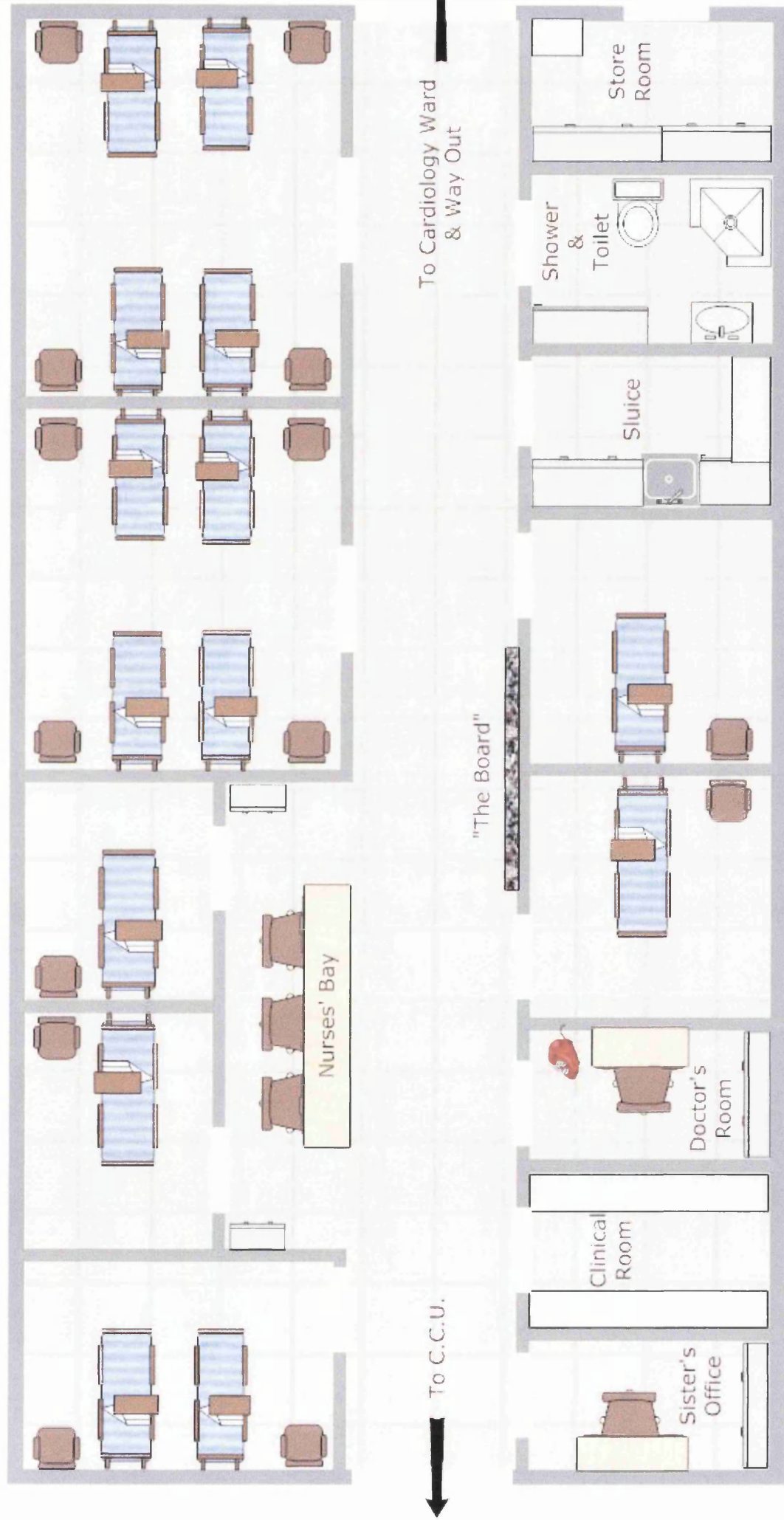
- Further research into the experiences and clinical outcomes of patients admitted to AMAUs is conducted.
- Studies of the AMAU system, in particular related to the patients' experience, that investigate the cost-utility-benefit of this innovation are conducted.
- Further research into the nurse's role in an AMAU setting is conducted. In particular participatory action research (Kemmis & McTaggart 2003) is considered as a strategy to examine the social practice of AMAU nursing. Findings from such studies could help evaluate nurses' contribution to AMAU patient care and understanding of an appropriate role for the nurse can be enhanced.
- Further research into the concept of situated learning as a theoretical framework with which to explore clinical learning is conducted.
- Further research into the concept of community of practice and evaluation of its application and relevance to other AMAU settings is required.

This study has contributed to advancing knowledge related to the role of the AMAU nurse, the practice of AMAU nursing, and a conceptualisation of an evolved role within a distinct community of practice (Wenger 1998) for the AMAU nurses studied. The research strategy utilised and its design has been defended and the conduct of the research has been reported in detail. Throughout the study the collection, analysis, and interpretation of data has been rigorous. Finally, plausible arguments about the significance and validity of the findings and the claims of the study have been offered and their relevance detailed.

In summary the role of the nurse in one AMAU practice setting was described and explained by this study and the AMAU nurse's role in the facilitation of the rapid transition of patients into and through the AMAU was highlighted. This study has therefore contributed to the very limited body of knowledge related to the role of the AMAU nurse and the organisation and management of AMAUs. The insights gained were grounded in the reality of practice by observation and participation in actual practice, together with contributions from participants who could inform the research aim. Ethnography provided a research method that was congruent with the research aim of the study. In particular findings have demonstrated that to understand the role of the AMAU nurse is to appreciate how the nurses worked together to achieve their common goals within their community of practice (Wenger 1998). The role of the AMAU nurse was therefore conceptualised as a socially constructed enterprise. The nurses articulated their learning in terms of a social enterprise, they had to 'be there before to know how do it' thus the nurses' learning reflected the concept of situated learning first described by Lave & Wenger (1991).

Observing care delivery from an insider (and yet outsider) perspective the overwhelming impression gained was of a praxis that faced the enduring challenge of providing care in a health care system that was continually under pressure. In the absence of any guidance on AMAU nursing, formal or informal, the nurses had constructed a praxis that had evolved to satisfy the demands of the AMAU model of care. However, the many negotiated responses to manage the care environment of the AMAU are at risk of remaining invisible to those outside the nurses' community of practice if not made explicit. Additionally, the

boundaries to their practice established by the AMAU nurses were at risk of being affected by economically driven managerial interests. In particular, if the AMAU nurses are required to accept more medically delegated tasks this may then result in patient care that is compromised. This study has described and explained the role of the AMAU nurse in one cultural setting from an ethnographic perspective. Therefore, the study's aim was achieved and the specific research questions answered but as indicated by the recommendations noted this study provides only a starting point to understanding the role of the AMAU nurse.



Appendix 1. Diagram of the AMAU (not to scale)

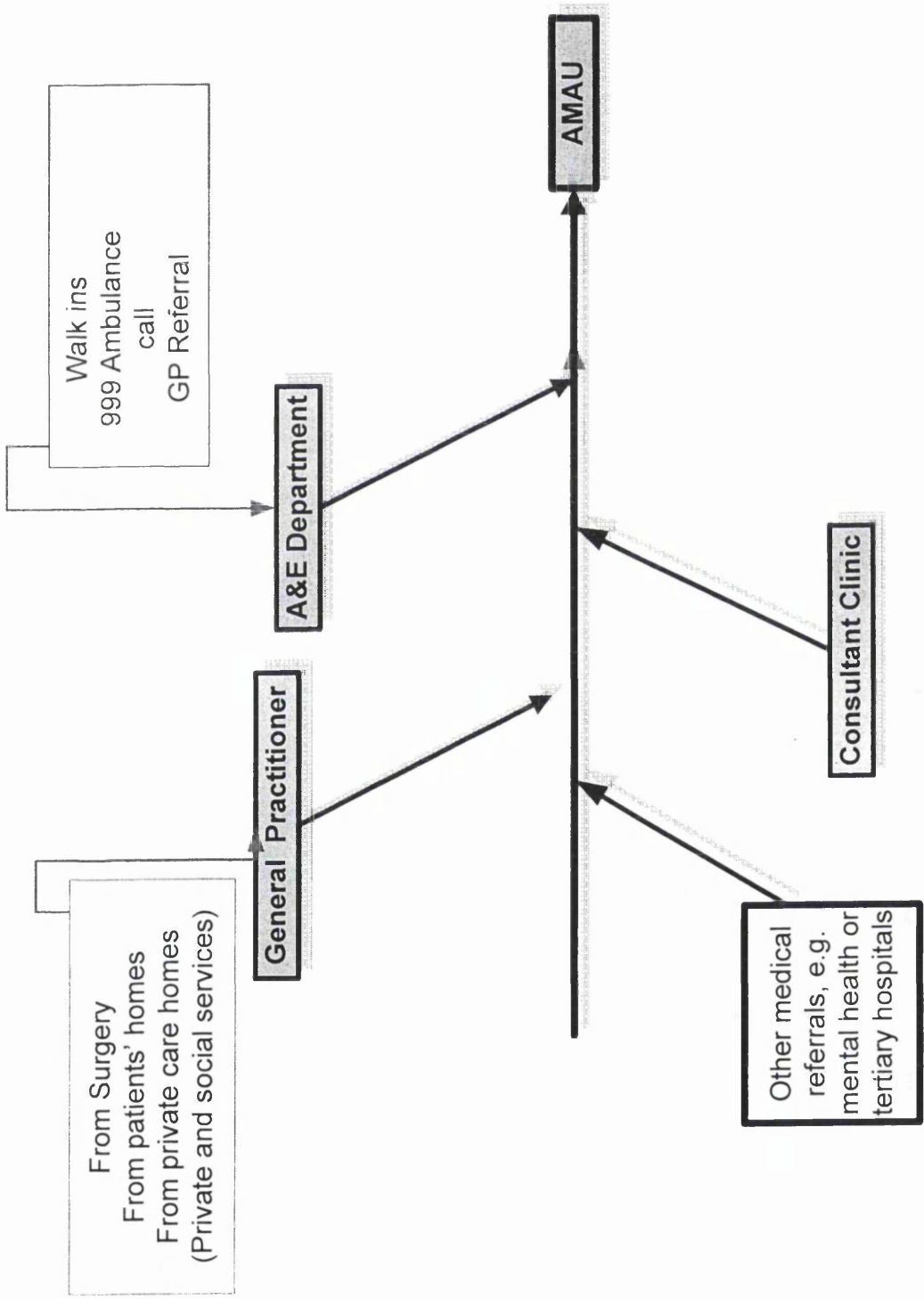
## Appendix 2

### WELSH ASSEMBLY GOVERNMENT INNOVATIONS IN CARE EMERGENCY PRESSURES (February 2002) Assessment Units and Admissions wards –(Medicine) (19 sites; 15 Assessment wards)

TRUSTS WITH ACUTE SITES	Got Y/N	Developing	Nurse led	SpR led	Consultant led	A&E attached
<b>Cardiff and Vale</b>						
UHW Med/Surg/Urology	Y		✓			✓
Llandough	Y			✓		
<b>North Glamorgan</b>	Y		✓			
<b>Royal Glamorgan</b>	Y				✓	
<b>Gwent</b>						
Royal Gwent	Y		✓			
Neville Hall	Y		✓			✓
Caerphilly Miners	Y		✓			
<b>Swansea</b>						
Morrison	Y		✓			
Singleton	N		NA			
<b>Bro Morgannwg</b>						
Princess of Wales	Y		✓			
Neath General	Y		✓			
<b>Pemb and Derwen</b>	Y		✓			
<b>Carmarthen</b>						
Prince Philip	N		NA			
West Wales General	Y		✓			
<b>Ceredigion and Mid Wales</b>	Y		✓			✓
<b>North West Wales</b>						
Ysbyty Gwynedd	Y				✓	
Llandudno	N		NA			
<b>North East Wales</b>	Y		✓			
<b>Conwy and Denbighshire</b>	N	Y	NA			

Note: 1. This excludes Velindre and Powys Trusts as neither admit emergency admissions

2. SpR = Specialist registrar



Appendix 3. Routes of Admission to the AMAU

**Appendix 4 -Information Sheet GP**

**ACUTE MEDICAL ADMISSIONS UNIT**

**Accident and Emergency Referrals**

**Date:** ..... **Time:** .....

**Name of patient:** ..... **Dob:** .....

**Address:** ..... **Unit No:** .....

.....  
.....  
.....  
.....

**Diagnosis/Presenting factors:**

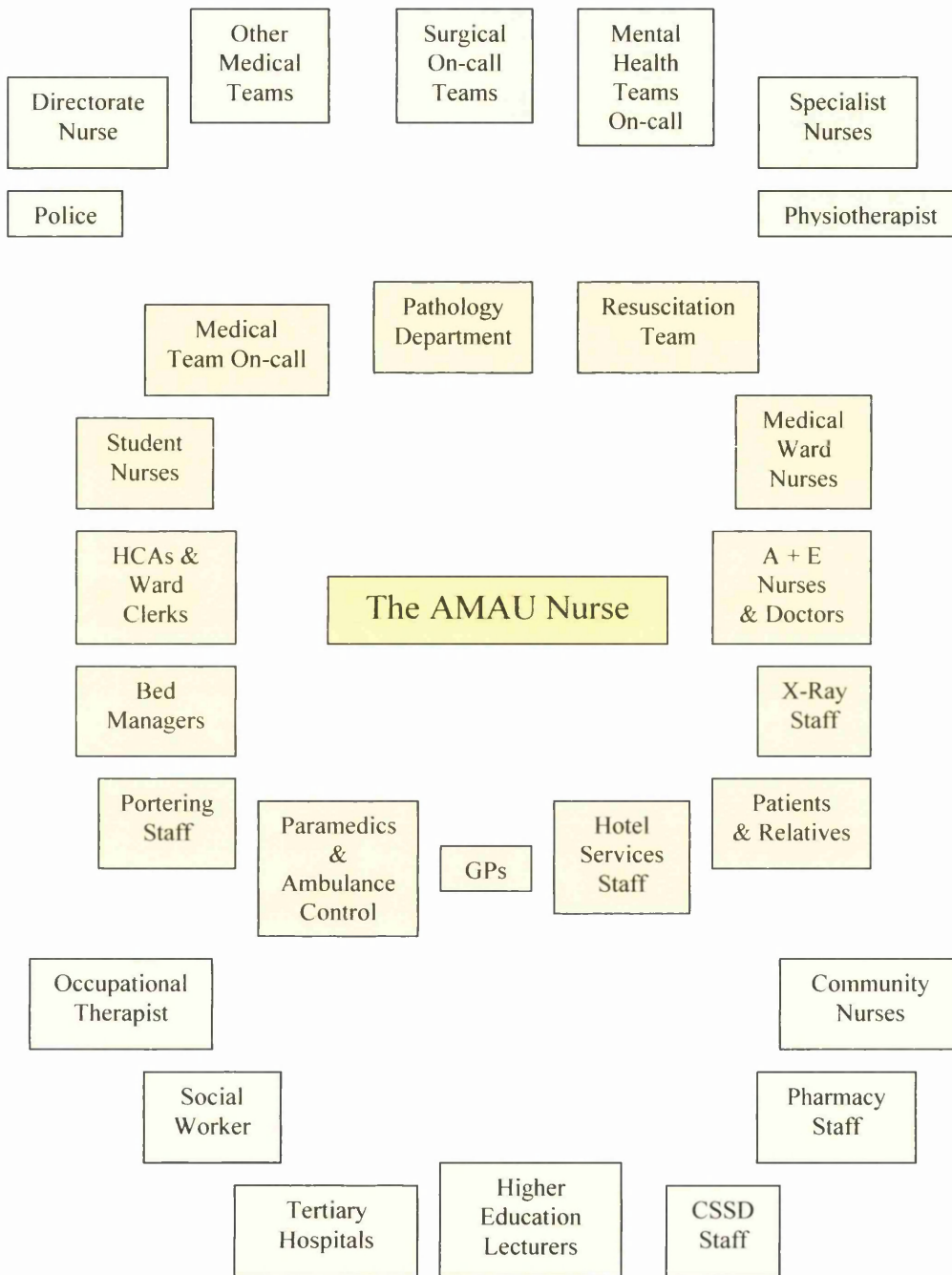
.....  
.....  
.....

**Previous Medical History/Previous Admissions:**

.....  
.....  
.....  
.....  
.....  
.....

**Tick only boxes that apply**

- Direct admission       Casualty officer informing medics on call  
 Delayed in A + E



**Appendix 5 - Role Set for the AMAU nurse.**



## Appendix 6. Initial Approach Letter to Patient Participants (English)

*HEADED PAPER*

*CONTACT PHONE NUMBER*

*DATE*

Dear Sir / Madam

I am a nurse researcher from XXXX XXXXX. The research that I am carrying out is concerned with the organisation of the acute medical admission unit (AMAU) in XXXX XXXXX Hospital.

With your permission I would like to interview you about your experiences as a patient on the unit. I am sorry but I am not able to offer you the choice of being interviewed through the medium of Welsh due to my limited abilities in the use of the language.

The choice of whether to agree or not is entirely yours and your care will not be affected whatever choice you make. I have attached an information sheet with more details and I am very happy to be contacted if you wish for more information. If you do not wish to be contacted then I will not trouble you further. Thank you for seeing me and if you have agreed I will contact you after your discharge to discuss a possible interview. Even if you agree to be interviewed you may withdraw your agreement at any time.

Yours sincerely

Pauline Griffiths  
RGN  
Lecturer in nursing

## Appendix 7. Initial Approach Letter to Patient Participants (Welsh)

*HEADED PAPER*

*CONTACT PHONE NUMBER*

*DATE*

Annwyl Syr / Madam,

Ga'i gyflwyno fy hunan. Ymchwilydd nyrsio ydwyf ym XXXX XXXXX ac r'wyf yn ymchwilio i'r ffordd mae **Uned Derbyn Meddyginiaeth Brys** (Acute Medical Admission Unit) Ysbyty XXXXX yn cael ei rheoli.

Hoffwn dderbyn eich caniatâd i sgwrsio gyda chi am eich profiad fel claf yn yr uned. Yn anffodus ni allaf gynnig cyfweiliad yn yr Iaith Gymraeg, nid wyf yn hollol rugl yn yr iaith. Does dim gorfodaeth arnoch i gymerid rhan yn yr ymchwil yma. Ni fydd eich dewis i gymerid rhan neu beidio yn effeithio'ch triniaeth o gwbl. Rwy'n cynnwys ffurflen sy'n trafod y manylion ond mae croeso i chi gysylltu 'a mi os oes angen esboniad personol. Ni fyddaf yn cysylltu gada chi eto os mae dyna yw eich dymuniad.

Ga'i ddiolch i chi am gytuno i gyfarfod a mi ac os ydych yn hapus am gyfweiliad mi gysyllta'i a chi ar ôl i chi adael yr ysbyty i drafod dyddiad ac amser i gwrdd. Cofiwch fod gennych hawl i wrthod y cyfweiliad unrhyw bryd.

Yn ddiffuant,

Pauline Griffiths. RGN.  
Darlithydd

## **Appendix 8. Information for potential patient participants (English)**

***Research involving the Acute Medical Admission Unit, XXXX XXX Hospital.*** (Title page omitted)

### **Who am I?**

My name is Pauline Griffiths and I am a lecturer in nursing and a PhD student at the XXXX XXXXX who is completing a research-based thesis. I am a state registered nurse who has many years experience of medical nursing care

### **Do you have to agree to be interviewed?**

No.

You do not have to agree to be interviewed and even if you do agree you can withdraw your agreement at any time. Participation or non-participation will not in any way affect your care.

### **Can you be interviewed through the medium of Welsh?**

I am sorry but I cannot offer you the choice of being interviewed in Welsh. My command of Welsh is inadequate and I am the sole researcher in this small-scale research study

### **What is the research about?**

The research is based in the Acute Medical Admission Unit (AMAU) in XXX XXX hospital I am interested in how the unit runs, especially the role of the nurse in the unit. As you have had recent experience as a patient on the unit I would like to interview you about your experiences.

### **What will you have to do?**

Just be interviewed by myself. The interview would last about 40 minutes to an hour and I would arrange to interview you at a place and time convenient for you. The interview could be done in your home if you wish or at another convenient location.

I would like to audiotape the interview but this would only be with your agreement.

### **Are you worried that others will know what you say?**

Your privacy and right to confidentiality are key concerns of mine.

I guarantee that your contribution will be kept confidential and that only I will hear the tape, if used, or see the notes made in the interview. When writing up my research I will do it in such a manner so that you could not be identified from your contribution. Audiotapes, if used, will be destroyed six months after completion of the research.

**What will you be asked?**

I will ask you about your time on the AMAU and in particular about the care that you received from the nursing staff. There are no right or wrong answers. I will be interested in what you tell me about your experiences and what you think is important.

**Have I had permission to carry out this research?**

I have had permission from the managers of the hospital and from your consultant to carry out this research and the research has gained ethical approval from the XXX XXX Ethics committee.

**What will happen to the findings?**

The research will be written up and submitted as my PhD thesis to XXX University. The findings of my research will be offered as articles to nursing and health care journals and as conference papers.

I would be very pleased to send you a summary of the research after its completion if you should wish.

**What is next?**

I would be happy to answer any queries that you may have in person or I can be contacted at the above address. If you have agreed to being interviewed I will contact you to make an appointment in about two weeks time. You can change your mind about being interviewed at any time. If you decline to be interviewed then I will not approach you again.

Thank you for your time

Yours sincerely,

Pauline Griffiths RGN.

Lecturer

## **Appendix 9. Information sheet for patient participants (Welsh)**

### **Prefaced with a title page that noted:**

Gwybodaeth ar gyfer unigolion sy'n ystyried cymerid rhan yn yr ymchwil I Uned Derbyn Meddyginiaeth Brys Ysbyty XXXXXXXXXXXX

Researcher: Pauline Griffiths RN. MSc. Lecturer in Nursing, XXXX University plus a contact telephone number)

### **Gwybo daeth ar gyfer unigolion sy'n ystyried cymerid rhan yn yr ymchwil i Uned Derbyn Meddyginiaeth Brys, Ysbyty XXXX XXX**

#### **Pwy ydw fi?**

Fy enw i yw Pauline Griffiths. Rwyf yn ddarlithydd nyrsio ac yn fyfyrwraig PhD ym Mhrifysgol XXXX XXXX ac yn ysgrifennu traethawd (thesis) sy'n ddibynnol ar ymchwil. Mae gen i brofiad helaeth o nyrsio meddygol fel SRN dros flynyddoedd lawer.

#### **Oes rhaid i chi gytuno i'r cyfweiliad?**

Nac oes.

Does dim rhaid i chi gytuno i'r cyfweiliad. Os ydych yn cytuno mai'r hawl gennych i wrthod cytuno ar unrhyw bryd. Ni fydd derbyn neu wrthod y cyfweiliad yn effeithio'ch triniaeth mewn unrhyw ffordd.

#### **Ydy'n bosib cynnal y cyfweiliad trwy gyfrwng y Gymraeg?**

Mae'n ddrwg gennyf ond fydd yn rhaid cynnal y sgwrs yn yr iaith Saesneg gan nad wyf yn rhugl yn yr iaith Gymraeg.

#### **Beth ydy testun yr ymchwil?**

Rwyf yn ymchwilio i'r modd y rheoli'r Uned Derbyn Meddyginiaeth Brys, Ysbyty XXXX . Mae gen i ddiddordeb yn y ffordd mae'r uned yn gweithredu o ddydd i ddydd yn enwedig rôl y nyrs yn yr uned. Gan fod gennych brofiad diweddar o'r uned hoffem gael sgwrs am eich profiad.

#### **Beth fydd eich cyfraniad?**

Dim ond cael cyfweiliad gyda mi, sgwrs o tua 40 munud i awr. Fe allwn gyfarfod ble bynnag a phryd bynnag sy'n gyfleus i chi. Mi allaf ddod i'ch gweld gartref neu unrhyw le o'ch dewis sy'n gyfleus i chi. Gyda'ch caniatâd, fe hoffwn dapio'r sgwrs.

#### **Pwy fydd yn clywed y tâp?**

Neb ond fi. Mae eich preifatrwydd yn holl bwysig i mi. Mi allaf eich sicrhau na fydd neb ond y fi yn clywed eich cyfraniad ar dâp neu'n gweld unrhyw nodiadau byddaf yn gwneud yn ystod y sgwrs. Byddaf yn defnyddio ffugenw wrth ysgrifennu fy nodiadau terfynol ac yn eu hysgrifennu mewn modd fydd yn sicrhau na fydd posibilrwydd eich adnabod. Fydd unrhyw dapiau yn cael eu dinistrio chwe mis ar ôl gorffen yr ymchwil.

**Pa gwestiynau fyddaf yn gofyn?**

Fyddaf yn gofyn am eich profiad tra yn yr uned yn enwedig am y gofal nyrsio. Does dim atebion cywir nac anghywir. Mae gen i ddi-ddordeb yn eich profiad o'ch amser yn yr ysbyty ac mewn un rhywbeth pwysig yn eich barn chi.

**Oes gennyf ganiatâd i wneud yr ymchwil yma?**

Oes. Rwyf wedi derbyn caniatâd rheolwyr yr ysbyty, caniatâd eich meddyg (consultant) a chaniatâd Pwyllgor Moeseg XXXXX.

**Beth fydd yn digwydd i'r canfyddiadau?**

Fe fyddaf yn paratoi ac yn ysgrifennu canfyddiadau fy ymchwil ac yn eu cyflwyno fel traethawd PhD i Brifysgol Cymru Abertawe. Hefyd fydd canfyddiadau fy ymchwil yn cael eu paratoi a'u cynnig fel erthyglau i gylchgronau nyrsio, siwrnalau gwyddor iechyd a phapurau cynhadledd. Mae croeso i chi gael crynodeb o'r ymchwil ar ôl ei gwblhau.

**Be' nesa?**

Rwy'n hapus i ateb unrhyw gwestiwn sy'n taro yn bersonol ac mae'n bosib cysylltu gyda mi yn y cyfeiriad uchod. Os ydych wedi cytuno cymeryd rhan byddaf yn cysylltu gyda chi mewn tua phythefnos i drefni cwrdd. Fe allwch newid eich meddwl ynglŷn â'r cyfweiliad unrhyw bryd wrth gwrs. Os nad ydych am gymerid rhan ni fyddaf yn eich trafferthu bellach.

Diolch yn fawr iawn am eich amser,  
Yn ddiffuant,

Pauline Griffiths RGN  
Darlithydd

**Appendix 10. Consent form (English)**

**HEADED PAPER**

*Written consent to be interviewed for the research study entitled 'a case study of an acute medical admissions unit: a qualitative study drawing on ethnographic methods.'*

*Researcher: Pauline Griffiths PhD student*

I

agree to be interviewed by Pauline Griffiths for the above study.

I give this consent freely and I understand that I may stop the interview at any time.

I am assured that if I agree to the interview being audio-taped that only Pauline Griffiths will hear the recording and that she will carry out the transcription herself using pseudonyms to protect my identity. I have been guaranteed that it will not be possible to discover my identity from the written thesis or any other publication. Further that the tapes will be stored in a locked and secure place and will be destroyed six months after the research has been completed

Signature:.....

Name in Capitals:.....

Date:.....

NB. A copy for the researcher and a copy for participant

## Appendix 11. Consent Form (Welsh)

*Caniatâd ysgrifenedig i gyfweiliad ar gyfer astudiaeth ymchwil yn dwyn yr enw*

*'The role of the nurse in an acute medical admission unit: a qualitative study drawing on ethnographic methods.'*

*('Astudiaeth uned derbyn meddyginiaeth brys: astudiaeth ansoddol yn defnyddio dulliau ethnograffig')*

*Ymchwilydd : Pauline Griffiths, myfyrwraig PhD.*

Yr wyf fi

yn caniatáu i gyfweiliad rhyngof fi a Pauline Griffiths ar gyfer yr astudiaeth uchod. Yr wyf yn hollol fodlon i gynnal y cyfweiliad yma. Deallaf fod hawl gennyf ddarfod y cyfweiliad ar unrhyw bryd. Deallaf fod y cyfweiliad i'w recordio ar dâp. Fe'm sicrhawyd mai dim ond Pauline Griffiths fydd yn gwrandao ar y recordiad. Wrth drawsgrifio'r tâp fe ddefnyddir ffugenw yn lle fy enw i. Yr wyf wedi derbyn gwarantiaid na fydd hi'n bosib fy adnabod wrth ddarllen y traethawd gorffenedig neu wrth ddarllen unrhyw erthygl gyhoeddedig. Deallaf fod y tapiau i'w diogelu dan glo mewn safle diogel ac y byddant yn cael eu dinistrio chwe mis ar ôl cwblhau y gwaith ymchwil.

Llofnod:

Enw (Llythrenau bras):

Dyddiad:

Copi i'r ymchwilydd a chopi i'r cyfranogwr / aig.



**Appendix 12. Letter to a health professional requesting their participation**

**HEADED PAPER  
CONTACT PHONE NUMBER  
CONTACT EMAIL  
DATE**

Dear

*Re: Research into the organisation of the AMAU in XXXX XX Hospital*

I am a PhD student in the University of Wales Swansea who is undertaking research into the organisation of the XXXXXX in XXXXXX Hospital and in particular the role of the nurse in such a unit.

I write to ask if you might consider being interviewed by me about your experiences of this unit. The interview would take about half an hour to an hour. I am sorry but due to my limited abilities in the Welsh language I am not able to conduct this interview through the medium of Welsh

I wish to gain an understanding of how the unit functions and will interview professionals and patients who have experience of the unit. A comprehensive literature search has demonstrated a scarcity of literature on the running of such a unit, apart from statistical information on patient numbers and medical conditions.

To aid data collection I intend to use a method within the interview known as critical incident technique (CIT). The rationale for using CIT is that by focussing on specific incidents that aids recall respondents can identify and clarify feelings and meanings that they may attach to these incidents. The term critical refers to the fact that the behaviour described in the incident plays an important and meaningful (critical) role in determining an outcome: a critical incident is an episode within which a number of behaviours are present. The aim of my questioning would be to gain better understanding of your perception of the role of the nurse in the AMAU.

I have gained approval for this study from the XXXX Ethics committee and from the YYYY NHS Trust managers.

Many thanks for your time

Yours sincerely,

Pauline Griffiths RN. MSc.  
Lecturer.

**APPENDIX 13. Letter to a Health Professional Requesting their Participation (Welsh)**

**HEADED PAPER  
CONTACT PHONE NUMBER  
CONTACT EMAIL  
DATE**

*Annwyl*

*Ynglŷn â : Ymchwil i reolaeth Uned Derbyn Meddyginiaeth Brys, Ysbyty XXXXXX*

Myfyrwraig PhD ydwyf i ym Mhrifysgol Cymru Abertawe. Rwy'n gwneud ymchwil i'r ffordd mae Uned Derbyn Meddyginiaeth Brys yn cael ei threfnu, a rôl y nyrs yn benodol.

Rwy'n ysgrifennu atoch i weld os ydy'n bosib eich cyfweld ynglŷn â'ch profiad o ddefnyddio'r uned yma. Fe fydd y cyfweiliad yn para rhwng hanner awr ac awr. Ga'i ymddiheuro na alla'i gynnal y sgwrs trwy gyfrwng y Gymraeg am nad ydwyf yn rhugl yn yr iaith honno, fydd yn rhaid i mi gynnal y cyfweiliad yn yr iaith Saesneg. Mae'n ddrwg gennyf.

Rwyf am ennill dealltwriaeth o sut mae'r uned yn gweithio, felly hoffwn gyfweld ag aelodau proffesiynol o'r staff a chleifion sydd â phrofiad o'r uned. Wedi chwilota cynhwysfawr mae'n ymddangos fod diffyg deunydd darllen yn y maes yma, sef rhedeg uned o'r fath, heb law am wybodaeth ystadegol am niferoedd y cleifion a'r math o salwch.

Rwy'n bwriadu defnyddio dull *critical incident* er mwyn deall sut mae'r uned yn gweithio. Y rhesymeg am hyn yw trwy edrych yn fanwl ar ddigwyddiadau penodol, fe fydd yr unigolyn yn cael hi'n haws cofio'n glir beth oedd eu hymateb emosïynol a'u dealltwriaeth o'r digwyddiadau yma. Mae'r term *critical* yn cyfeirio at y ffaith fod yr ymddygiad a ddisgrifiwyd yn y digwyddiad yn chwarae rhan bwysig ac ystyrlon i arwain at ganlyniad. Disgrifir *critical incident* fel digwyddiad sy'n cynnwys sawl gwahanol ymddygiad. Bwriad fy holi yw deall yn well sut y gwelwch chi rôl y nyrs yn yr uned.

Rwyf wedi derbyn caniatâd Pwyllgor Moeseg XXX XXX a'r Ymddiriedolaeth ar gyfer yr astudiaeth hon.

Diolch yn fawr iawn am eich amser.

Yn ddiffuant,

Pauline Griffiths RN.MSc.  
Darlithydd

**Appendix 14. Facsimile of a Nurse –Nurse Handover or ‘list’ (all names are pseudonyms)**

Bed	Name	Age	Con	Details	Discharge to
1	Olga Barton	57	ABC	SOB.SATs 90%. Old CVA.For mitral valve replacement IV frusemide. Nebs and IV antibiotics given. INR 1 10. Dr / 3L Nasal O <sub>2</sub> . abdo U/S + echo (for)	
2	David Ewing	83	DEF	Chest pain. ?Angina ?peptic ulcer	
3	Jane Smith	75	DEF	Headache viral ‘cerebratitis’. CT / NAD. ? for LP. Puffy eyes not A/B reaction but has rash. FBC and MSU needed	Nightingale ward When side ward free
4	Lucy Allen	62	ABC	Overdose ‘Gamanil’ and alcohol. To psychs. Toxic screed. Telemetry (D) Hypertension	
5	Tony Allen	74	ABC	Overdose ‘and alcohol. To psychs. Toxic screed. Telemetry	
6	Peter Jones	33	ABC	Exacerbation of asthma. O <sub>2</sub> Sats. poor S/B anaesthetist. For O <sub>2</sub> .IV hydrocortisone. Telemetry .IV antibiotics. Hourly obs	Cavell ward after 4pm
7	Martha Lewis	84	ABC	General deterioration. ? UTI. Parkinson’s. Hypertension (PMH) Air mattress, physio, OT. For CT. ?NBM Refer to dietician for a food chart.	
8	Penny Mahon	56	ABC	Unwell chest infection. Oral ABs. Nausea vomiting diarrhoea. OK.	
9	Catrin Davies	73	HIJ	From CCU. Acute coronary syndrome. Trots okay. PMH aortic valve and mitral valve stenosis. Now c/o abdo pain.	
10	Janet Williams	54	ABC	Cellulitis ? insect bite. IV A/B. Need MSU. Migraine and arthritis	?home
11	Ian Thomas	70	ABC	SOB SATS 90%. Abdo pain. Not eating. Chronic chest. Alcoholic. Food chart. Sputum cytology	

12	Hefin Evans	36	ABC	(Lt) weakness-resolving. Blackout / head injury. CT NAD. LP ? Ok--physio	
13	Lara Heard	36	ABC	Rt hemi ? CVA. Hypertension for CT. was NBM S/B consultant. Physio/OT	
14	Clive Bower	43		From A&E this pm ?PE	

Plus in A & E Peter Lewis (41)OD antidepressants) and Lori Peel (50) Collapse ? IC bleed/abscess/ tumour. Had CT. ? to Southfield (*neurological centre*).  
Any GP referrals either 'stack' or refer to bed manager.

### Glossary

(D)- diabetic

3L - 3 litres (oxygen)

A/B-antibiotic

C/O-complaining of

CT-Computerised tomography

CVA – cerebral vascular accident

Echo- abdominal echo scan

FBC-Full blood count

Gamanil- proprietary name *Lofepamine* (a tricyclic anti-depressant)

INR- International

IV-Intravenous

MSU-Mid stream urine

NAD- Nothing abnormal discovered

NBM-Nil by mouth

Nbs- Nebuliser (mode of delivering drugs directly to the lungs)

OT-occupational therapy

PMH- Past medical history

Psychs- psychiatrists

Rt hemi- Right hemiplegia

S/B- seen by

SATS- Oxygen saturation (pulse oximeter reading of  $S_a CO_2$ )

SOB –short of breath

Telemetry- system for recording and monitoring heart rate and rhythm using an electronic i.e. non-attached system.

Trots- Troponin T (blood test that detects damage to cardiac muscle)

U/S-ultra sound

UTI- Urinary tract infection

**Appendix 15**  
**Modified Manchester Triage Score**

**XXXX NHS TRUST**  
**ACUTE MEDICAL ADMISSIONS UNIT**

**Medical Assessment Triage Score**

Score	3	2	1	0	1	2	3
Pulse (BPM)	<40	41-50	51-60	61-100	101-110	111-130	>131
Respiratory Rate and SpO <sub>2</sub>		<8		9-14	15-20	21-29	>30
				or SpO <sub>2</sub> 100-97%	or SpO <sub>2</sub> 96-94%	or SpO <sub>2</sub> 93-91%	or SpO <sub>2</sub> <90%
Temperature (°C)		<35.0	35.1-35.4	35.5-37.0	37.1-38.0	>38.1	
<u>CNS Level</u> Patient Responds to OR GCS	Unresp.	Pain	Voice	Alert	<b>New</b> Agitation / Confusion		
				15	14	9-13	<8
Urine output	<10ml/h	<0.5ml/kg/h					
Systolic BP	<70	71-80	81-100	101-170	171-200	>200	
Circulation	Haematemesis	Postural Drop	Coffee Ground Vomit		Melaena Old	Melaena Fresh	
Pain	Chest Pain on Warding	Chest Pain not on Warding			Pain	Mod Pain	Severe Pain
BM	<2.0	<3.0				>19.0	
NC	3		1				

HR = Pulse, RR = Respiration rate, Temp = Temperature, CNS = Central nervous system, BM = Blood sugar, NC = Nurse concern

**SCORING:**

Appendix 16  
Patient Care Record

Pages 323-334

TAL

HOSPITAL

# PATIENT CARE RECORD

NAME OF PATIENT:

## ADMISSION ROUTE

G.P. Referral  Self Referral  Elective Surgery  Transferred from:  
999 call  Domiciliary Visit  Out Patient Dept.

Date of admission

Ward  
Department

Time of admission

Consultant

Nursing Assessment commenced at

Ward Doctor

Time seen by Doctor

Named Nurse

Date of Discharge

Unit Number







Is there a need to conduct a manual handling risk assessment on this patient? Yes  No

If yes Proceed to SECTION A

### SECTION A: Assessment of Patient/Client Ability

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1 Does the weight, size, shape etc of the person create a risk? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 Are there any communication difficulties?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 May behaviour present a problem?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 Are there comprehension difficulties?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 Is there a history of falls?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 Are there any medical considerations?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 Is pain/discomfort a factor?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 Do clothes, equipment, appliances create a risk?              | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 Does frequent handling present a problem?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 Are there any attitudes/feelings to consider?                | <input type="checkbox"/> | <input type="checkbox"/> |

If Yes then specify

### SECTION B: Manual Handling Instructions (This section must be subject to regular review)

Patient Needs	Assessment Dates	Review Dates				
		1. Ist Assessment	2.	3.	4.	5.
Turning in bed	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Lying to/ sitting in bed	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						

**NOW TURN PAGE OVER AND FINISH SECTION B**

## SECTION B: Manual Handling Instructions (Continued)

		1.	2.	3.	4.	5.
Moving up/down bed	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Lying to sitting at side of bed	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Transfers from bed to chair	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Moving client in chair	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Sitting/ Standing	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Walking	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Toilets Bedpan/ Commode Transfers	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Bath/ Shower Transfers	Independent					
	With Supervision					
	With help of 1					
	With help of 1 or 2					
	With help of 2+					
With hoist/equipment						
Initials of Assessor						

Now return to front page and set date for review of assessment



MAINTAINING SAFETY

Information from	Temperature	Pulse	Blood Pressure	Orientation	Answer Questions	Behaviour/ Mood
Patient <input type="checkbox"/>	<input type="text"/> °C	<input type="text"/> Rate per minute	<input type="text"/> Per Hmg Mercury	Yes <input type="checkbox"/> No <input type="checkbox"/>	Spontaneously <input type="checkbox"/>	Alert <input type="checkbox"/>
Next of kin <input type="checkbox"/>				Person <input type="checkbox"/>	Reluctantly <input type="checkbox"/>	Co-operative <input type="checkbox"/>
Carer <input type="checkbox"/>	Unrecordable <input type="checkbox"/>	Unrecordable <input type="checkbox"/>	Unrecordable <input type="checkbox"/>	Day <input type="checkbox"/>	Repetitively <input type="checkbox"/>	Drowsy <input type="checkbox"/>
Other specify:-	Pale <input type="checkbox"/>	Regular <input type="checkbox"/>		Date <input type="checkbox"/>	Inappropriately <input type="checkbox"/>	Unresponsive <input type="checkbox"/>
	Flushed <input type="checkbox"/>	Irregular <input type="checkbox"/>		Time <input type="checkbox"/>	Vague <input type="checkbox"/>	Agitated <input type="checkbox"/>
	Warm <input type="checkbox"/>	Faint <input type="checkbox"/>		Place <input type="checkbox"/>		Withdrawn <input type="checkbox"/>
	Hot <input type="checkbox"/>					
	Cold <input type="checkbox"/>					
	Perspiring <input type="checkbox"/>					
	Cyanosed <input type="checkbox"/>					
<b>IDENTIFIED PROBLEM</b>						Yes <input type="checkbox"/> No <input type="checkbox"/>

BREATHING

Breathing pattern	Breathlessness	Cough	Sputum	Breathing aids	Oxygen at home	Smoking history
Rate per minute <input type="text"/>	None <input type="checkbox"/>	None <input type="checkbox"/>	None <input type="checkbox"/>	None <input type="checkbox"/>	None <input type="checkbox"/>	None <input type="checkbox"/>
Regular <input type="checkbox"/>	At rest <input type="checkbox"/>	Pain <input type="checkbox"/>	White <input type="checkbox"/>	Peak flow <input type="checkbox"/>	Cylinder <input type="checkbox"/>	Cigarettes per day: _____
Irregular <input type="checkbox"/>	On exertion <input type="checkbox"/>	Dry <input type="checkbox"/>	Frothy <input type="checkbox"/>	Nebulizer <input type="checkbox"/>	Concentrator <input type="checkbox"/>	Given up <input type="checkbox"/>
Laboured <input type="checkbox"/>	At night <input type="checkbox"/>	Productive <input type="checkbox"/>	Yellow <input type="checkbox"/>	Inhaler <input type="checkbox"/>	Hours per day: _____	How long ago: _____
Shallow <input type="checkbox"/>		Irritating <input type="checkbox"/>	Green <input type="checkbox"/>		Percentage: _____	
Wheeze <input type="checkbox"/>			Brown <input type="checkbox"/>			
			Blood <input type="checkbox"/>			
<b>IDENTIFIED PROBLEM</b>						Yes <input type="checkbox"/> No <input type="checkbox"/>

COMMUNICATION

**Pain/discomfort on admission** None  Yes

Location of pain/discomfort \_\_\_\_\_

Type of pain/discomfort \_\_\_\_\_

Analgesia prior to admission None  Yes  specify :- \_\_\_\_\_

Pain Scale 0-4	Outward signs of pain	First language	Speech	Hearing	Eye sight	Visual aids
None 0 <input type="checkbox"/>	None <input type="checkbox"/>	Welsh <input type="checkbox"/>	Clear <input type="checkbox"/>	Clear <input type="checkbox"/>	Clear <input type="checkbox"/>	None <input type="checkbox"/>
Mild 1 <input type="checkbox"/>	Anxiety <input type="checkbox"/>	English <input type="checkbox"/>	Slurred <input type="checkbox"/>	Partially deaf <input type="checkbox"/>	Partially sighted <input type="checkbox"/>	Reading glasses <input type="checkbox"/>
Moderate 2 <input type="checkbox"/>	Grimacing <input type="checkbox"/>	Other: _____	Impediment <input type="checkbox"/>	Totally deaf <input type="checkbox"/>	Totally blind <input type="checkbox"/>	At all times <input type="checkbox"/>
Severe 3 <input type="checkbox"/>	Muscular guarding <input type="checkbox"/>		Incoherent <input type="checkbox"/>	Lip reads <input type="checkbox"/>	False Eye <input type="checkbox"/>	Contact lenses <input type="checkbox"/>
Worst ever 4 <input type="checkbox"/>	Agitation <input type="checkbox"/>		Cannot speak <input type="checkbox"/>	Hearing aid <input type="checkbox"/>		<b>With patient</b> <input type="checkbox"/>
				<b>With patient</b> <input type="checkbox"/>		<b>Left at home</b> <input type="checkbox"/>
				<b>Left at home</b> <input type="checkbox"/>		
<b>IDENTIFIED PROBLEM</b>						Yes <input type="checkbox"/> No <input type="checkbox"/>

**ACCIDENT AND EMERGENCY STAFF ONLY**

PSPS Score: \_\_\_\_\_

Glasgow Coma score \_\_\_\_\_

Blood Glucose \_\_\_\_\_

Peak flow \_\_\_\_\_

Saturated O<sub>2</sub> \_\_\_\_\_

Urinalysis \_\_\_\_\_

E.C.G.

X-ray

Blood samples

Venflon

Urinary Catheter

Central venous pressure line

Sutures

Oxygen % \_\_\_\_\_

Mask

Nasal cannula

Airway

Endo tracheal tube

Artificial ventilation

Naso gastric tube

Other: \_\_\_\_\_

**Identity bracelet** Yes  No  **Admit to :** \_\_\_\_\_

Name of qualified nurse responsible for patients transfer to ward area : \_\_\_\_\_ Status : \_\_\_\_\_

Name of qualified nurse accepting the patient into their care : \_\_\_\_\_ Status : \_\_\_\_\_ Time: \_\_\_\_\_

WORK

**EMPLOYMENT :** Full Time  Part time  Self employed  Unemployed   
Retired  School/college  Not applicable

**Occupation/previous if retired:** \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

Problems with employment due to hospitalisation None  Yes  Specify: \_\_\_\_\_

HOME CIRCUMSTANCES

**PATIENT LIVES WITH:** \_\_\_\_\_

Who is your main source of support at home? \_\_\_\_\_

Are they in good health Yes  No  Specify: \_\_\_\_\_

**ACCOMMODATION:**

**Do you have any:-**

Type of accommodation: \_\_\_\_\_ No Yes Specify: \_\_\_\_\_

Location of bathroom: \_\_\_\_\_ Dependents living at home   \_\_\_\_\_

Location of toilet: \_\_\_\_\_ Problems with pets   \_\_\_\_\_

Location of bedroom: \_\_\_\_\_ Home help   \_\_\_\_\_

Meals on wheels   \_\_\_\_\_

Day centre attendance   \_\_\_\_\_

Social worker   \_\_\_\_\_

District nurse   \_\_\_\_\_

Other \_\_\_\_\_

**Who usually does the:**

Cooking \_\_\_\_\_

Shopping \_\_\_\_\_

Cleaning \_\_\_\_\_

Laundry \_\_\_\_\_

Who will be responsible for laundering your clothes whilst you are in hospital? \_\_\_\_\_

**IDENTIFIED PROBLEM** Yes  No

SLEEPING

**USUAL SLEEPING PATTERN**

Retires at: \_\_\_\_\_ p.m. No. of Pillows \_\_\_\_\_

Rises at: \_\_\_\_\_ a.m.

Do you have: No Yes Specify: \_\_\_\_\_

Tiredness   \_\_\_\_\_ Special mattress/aids   \_\_\_\_\_

Night time breathlessness   \_\_\_\_\_ Sleeps in a bed   \_\_\_\_\_

Night sweats   \_\_\_\_\_ Sleeps in a chair   \_\_\_\_\_

Wakeful periods   \_\_\_\_\_ Takes night sedation   \_\_\_\_\_

Daytime naps   \_\_\_\_\_

**IDENTIFIED PROBLEM** Yes  No



**Do you have any problems with:-**

No Yes Specify:

No Yes Specify:

- Climbing steps/stairs   \_\_\_\_\_
- Joint pain   \_\_\_\_\_
- Limb weakness   \_\_\_\_\_
- Limb stiffness   \_\_\_\_\_

- Unsteady balance   \_\_\_\_\_
- Impaired sensation   \_\_\_\_\_
- Artificial limb   \_\_\_\_\_
- Mobility aids   \_\_\_\_\_

Specify other difficulties :

IDENTIFIED PROBLEM Yes  No

**CONDITION OF SKIN**

No Yes Specify:

**PERSONAL HYGIENE**

**Do you normally need help to:-**

No Yes Specify:

- Laceration   \_\_\_\_\_
- Friable (tears easily)   \_\_\_\_\_
- Rash   \_\_\_\_\_
- Ulcer   \_\_\_\_\_
- Sores   \_\_\_\_\_
- Recent surgical wound   \_\_\_\_\_
- Bruising   \_\_\_\_\_
- Oedema   \_\_\_\_\_
- Other: \_\_\_\_\_

- Wash   \_\_\_\_\_
- Dress   \_\_\_\_\_
- Undress   \_\_\_\_\_
- Access bath   \_\_\_\_\_
- Access shower   \_\_\_\_\_
- Washing/dressing aids   \_\_\_\_\_

IDENTIFIED PROBLEM Yes  No

**URINARY HABIT**

**Any history of:** No Yes Specify:

- Frequency   \_\_\_\_\_
- Waking to pass water   \_\_\_\_\_
- Pain on passing water   \_\_\_\_\_
- Bleeding   \_\_\_\_\_
- Discharge   \_\_\_\_\_
- Stress incontinence   \_\_\_\_\_
- Incontinence   \_\_\_\_\_
- Unable to pass water   \_\_\_\_\_
- Catheter   \_\_\_\_\_

**BOWEL HABIT**

**How often do you normally have your bowels opened:-**

Any history of: No Yes Specify:

- Constipation   \_\_\_\_\_
- Pain on opening bowels   \_\_\_\_\_
- Bleeding   \_\_\_\_\_
- Diarrhoea   \_\_\_\_\_
- Bowel incontinence   \_\_\_\_\_
- Incontinence aids   \_\_\_\_\_
- Stoma   \_\_\_\_\_
- Laxatives   \_\_\_\_\_

IDENTIFIED PROBLEM Yes  No

No Yes Specify:

- Appears well groomed   \_\_\_\_\_
- Appears disinterested in self   \_\_\_\_\_
- (Female patients only)**
- Menstrual cycle   \_\_\_\_\_
- Pregnant   \_\_\_\_\_
- Contraception   \_\_\_\_\_
- Hormone Replacement Therapy   \_\_\_\_\_

IDENTIFIED PROBLEM Yes  No

E  
A  
T  
I  
N  
G

Weight	Height	Body Mass Index	Teeth	Dentures	Gums	Tongue
Unable to record weight & height Specify reason:		40+: very obese <input type="checkbox"/>	Own teeth <input type="checkbox"/>	Full upper set <input type="checkbox"/>	Clean <input type="checkbox"/>	Clean <input type="checkbox"/>
		30-39: obese <input type="checkbox"/>	Healthy <input type="checkbox"/>	Partial upper set <input type="checkbox"/>	Moist <input type="checkbox"/>	Moist <input type="checkbox"/>
		25-29: overweight <input type="checkbox"/>	Decayed <input type="checkbox"/>	Full lower set <input type="checkbox"/>	Dry <input type="checkbox"/>	Dry <input type="checkbox"/>
		20-24: healthy <input type="checkbox"/>	No teeth <input type="checkbox"/>	Partially lower set <input type="checkbox"/>	Coated <input type="checkbox"/>	Coated <input type="checkbox"/>
		19+ below: Underweight <input type="checkbox"/>	Caps/Crowns <input type="checkbox"/>	<b>With patient</b> <input type="checkbox"/>	Bleeding <input type="checkbox"/>	Bleeding <input type="checkbox"/>
			<b>Lips</b>	<b>Left at home</b> <input type="checkbox"/>	Odour <input type="checkbox"/>	
	Dry <input type="checkbox"/>					
	Cracked <input type="checkbox"/>					
	Ulcerated <input type="checkbox"/>					
	Bleeding <input type="checkbox"/>					

IDENTIFIED PROBLEM Yes  No

**Any history of**

	No	Yes	Specify:		No	Yes	Specify:
Weight loss in past 6 months	<input type="checkbox"/>	<input type="checkbox"/>	_____	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight gain in past 6 months	<input type="checkbox"/>	<input type="checkbox"/>	_____	Special diets	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight steady in past 6 months	<input type="checkbox"/>	<input type="checkbox"/>	_____	Supplements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dislikes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____	Impaired taste	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain during or after eating	<input type="checkbox"/>	<input type="checkbox"/>	_____	Assistance needed to feed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with swallowing	<input type="checkbox"/>	<input type="checkbox"/>	If Yes refer to Speech Therapist _____	Feeding aids required	<input type="checkbox"/>	<input type="checkbox"/>	_____

IDENTIFIED PROBLEM Yes  No

D  
R  
I  
N  
K  
I  
N  
G

**Do you normally have any of the following feeding difficulties?**

**If Yes refer to Occupational Therapist**

	No	Yes
Poor hand/eye co-ordination	<input type="checkbox"/>	<input type="checkbox"/>
Poor sitting balance	<input type="checkbox"/>	<input type="checkbox"/>
Neglect of one side	<input type="checkbox"/>	<input type="checkbox"/>
Limited upper limb movement or control	<input type="checkbox"/>	<input type="checkbox"/>
Problems gripping cutlery	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>
Problems with food and plate control	<input type="checkbox"/>	<input type="checkbox"/>

**Prior to this illness - what would you normally eat for:-**

Breakfast : \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner/tea \_\_\_\_\_

Supper: \_\_\_\_\_

Snacks: \_\_\_\_\_

How much fluid do you drink in a day: \_\_\_\_\_

How much alcohol do you normally drink per week :  None

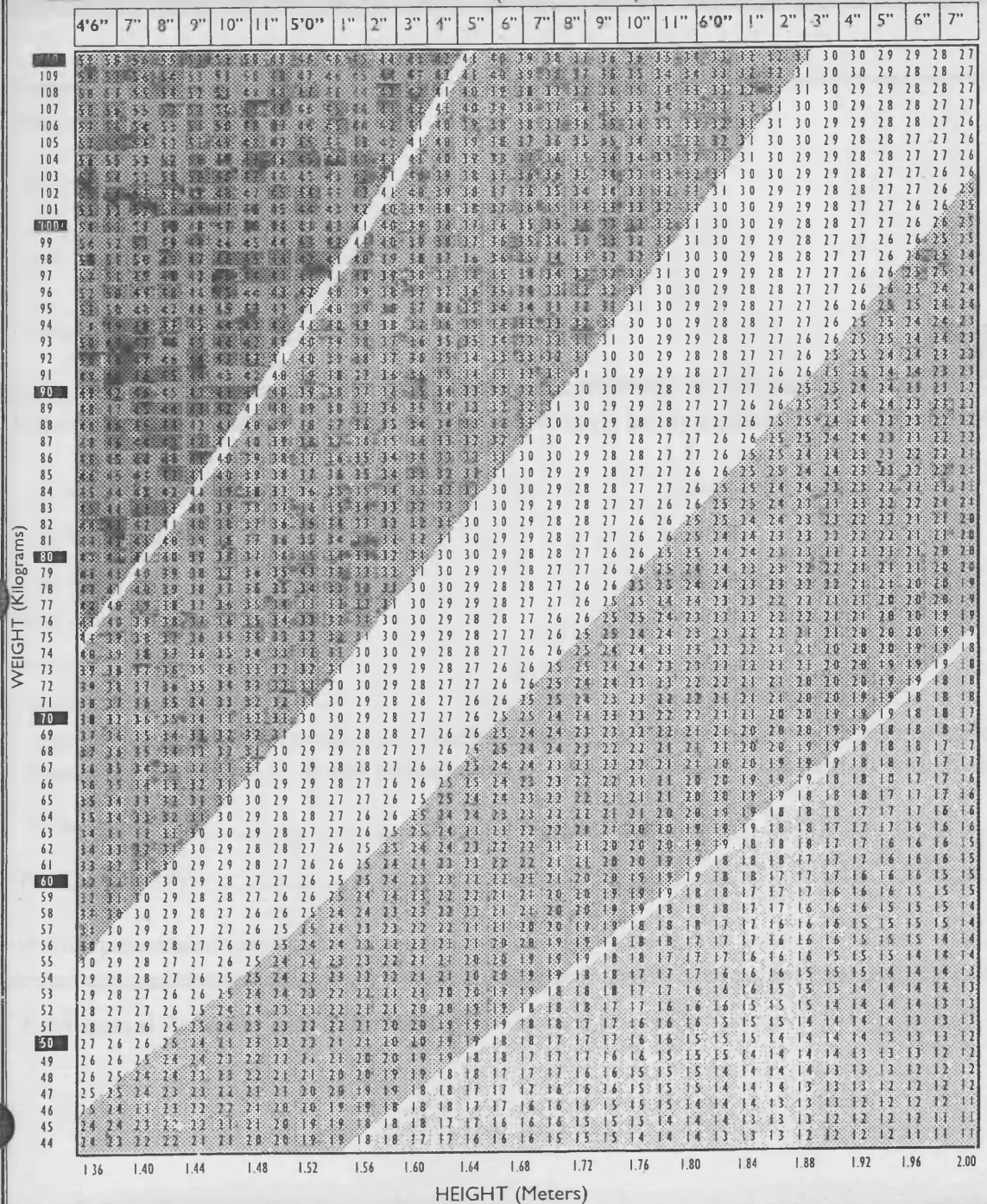
Specify amount: \_\_\_\_\_

**Pressure Sore Prediction Score (PSPS)**

6+ above. Patient at risk

IDENTIFIED PROBLEM Yes  No





**40 +**  
**Very Obese**  
 Health is seriously at risk. Losing weight immediately is essential

**30 - 39**  
**Obese**  
 Health is at risk. Losing weight Now should be seriously considered.

**25 - 29**  
**Overweight**  
 Health could suffer. Some weight loss should now be considered.

**20 - 24**  
**Healthy**  
 A desirable BMI figure indicating a healthy weight.

**19 & below**  
**Underweight**

**WEIGHT (Stones and Pounds)**

-17st  
-7lbs  
-16st  
-7lbs  
-15st  
-7lbs  
-14st  
-7lbs  
-13st  
-7lbs  
-12st  
-7lbs  
-11st  
-7lbs  
-10st  
-7lbs  
-9st  
-7lbs  
-8st  
-7lbs  
-7st

**PRESSURE SORE PREDICTION SCORE (PSPS)**

	No	No, but	Yes, But	Yes
Sitting up? (long time)	0	1	2	3
Unconscious ?	0	1	2	3
Poor general condition ?	0	1	2	3
Incontinent ?	0	1	2	3
	No	Yes & No	Yes	
Lifts up ?	2	1	0	
Gets up and walks ?	2	1	0	

NB: If pressure sore present minimum PSPS 10 6+ above Patient at Risk



**Patients own words.**

Do you have any worries or concerns at present?

Have you ever suffered with your nerves?

Do you ever feel lonely or miserable?

IDENTIFIED PROBLEM Yes  No

**Please ensure that all details listed below have been explained to the patient or relative:**

- |                                 |                          |                                 |                          |
|---------------------------------|--------------------------|---------------------------------|--------------------------|
| Importance of identity bracelet | <input type="checkbox"/> | Information booklet given to Pt | <input type="checkbox"/> |
| Use of call bell system         | <input type="checkbox"/> | Meal times                      | <input type="checkbox"/> |
| Use of radio facilities         | <input type="checkbox"/> | Visiting times                  | <input type="checkbox"/> |
| Toilet + urinal facilities      | <input type="checkbox"/> | Newspaper trolley               | <input type="checkbox"/> |
| Bathroom/wash bowl facilities   | <input type="checkbox"/> | Hospital chaplain               | <input type="checkbox"/> |
| Named Nurse concept             | <input type="checkbox"/> | <b>NO SMOKING POLICY</b>        | <input type="checkbox"/> |

**Does the patients next of kin understand why this admission to hospital was necessary ?**

Yes  Specify: \_\_\_\_\_

No  Specify: \_\_\_\_\_

Has the patient been introduced to other patients Yes  No  Specify: \_\_\_\_\_

**Additional Assessment Information** None  Yes  Specify: \_\_\_\_\_

**Please list and priorities all actual/potential problems identified in the assessment.**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_
- 6 \_\_\_\_\_

Signature of the admitting nurse: \_\_\_\_\_ Status: \_\_\_\_\_

*If a student nurse completes this patient assessment, the details must be checked and counter signed by the qualified nurse who is supervising the student.*

**CHECK YOUR ASSESSMENT CAREFULLY  
ANY PROBLEMS YOU HAVE IDENTIFIED NEED A PLAN OF CARE.**









**Appendix 17. Letter to AMAU staff at the commencement of data collection**

*Headed Paper*

*Telephone Contact Number*

*Email Contact*

*Date*

Dear Colleague,

I am a lecturer in nursing in XXXX University and I am undertaking research into the role of the nurse working in the acute medical admission unit. I have been granted permission to access the unit by the trust and have gained approval from the XX XXX Research Committee for this research.

Over the next two years I will be coming to the ward to gather the data for this research. This will be through participant observation by working along side the team. As the research progresses I will be carrying out interviews with the members of the team. I hope that you will feel happy talking to me but if you do not wish to you are under no obligation to do so.

All information collected would be subject to strict conditions of anonymity, with only me having access to participants' names.

I will be available to discuss the research if you should wish to when I am on the unit or I can be contacted as detailed above.

Yours sincerely,

Pauline Griffiths RGN. MSc  
Lecturer

Appendix 18  
Interviews Schedules  
Pages 336-343

1. Appendix 18a AMAU nurse.....	336
2. Appendix 18b Doctors (hospital and GP with modification).....	338
3. Appendix 18c Patients.....	340
4. Appendix 18d Paramedics.....	342

## Appendix 18a. Interview schedule (nurse)

### INTERVIEW SCHEDULE: AMAU NURSE

Thank you for agreeing to be interviewed by myself. The interview should take about 30-40 minutes and I am very grateful to you for sparing the time to be interviewed by me

My study's main areas of interest are the running of the AMAU and the role of the nurse in such a unit so my questions will be related to these areas.

- ✓ Written consent?
- ✓ Use of tape?
- ✓ Use that information will be used for
- ✓ Self-verification
- ✓ Phones off

#### *General information*

1. How long have you worked here?
2. Why did you choose to work in an AMAU?
3. If someone was thinking of applying for a job as a nurse on the AMAU how would describe the job? Is it different from other areas?

The aim of my questioning is to gain better understand of your perspective of the role of the nurse in the AMAU.

#### **1. Role**

- ✓ How would you define /describe the function of the AMAU?
- ✓ Have you worked in an AMAU elsewhere? Can you tell me about it
- ✓ How would you explain the main role of an AMAU nurse?
- ✓ What attributes would a good AMAU nurse have?
- ✓ Are there different expectations from a nurse on an ordinary ward?
- ✓ Are there particular challenges?
- ✓ What gives job satisfaction?
- ✓ How do you know when you have done a good job?

#### **2. Incident**

*Think back to an episode of that is memorable to you as an example of excellent AMAU nursing*

- ✓ Try and recapitulate the event and tell me about it as accurately as possible
- ✓ What did you or the nurse(s) involved do?
- ✓ What was actually happening/ can you describe this?
- ✓ How did you respond before, during and after the event occurred?

- ✓ Please describe your feelings during and after the situation occurred, positive or negative feelings. What was the most demanding when the event occurred?

**Lead On questions:**

2. If incident positive ask about a *negative case* (or if negative ask for a positive)

**3. *Clinical decision-making***

- ✓ Can you tell me about your thinking –your approach when admitting a patient? What do you do?
- ✓ What preparation have you had to undertake a nursing assessment?

**3. *Caring***

- ✓ What knowledge is important for you to do your job?
- ✓ Tell me about relationship building with patients? Examples?
- ✓ Tell me about relationship building with relations? Examples?

**4. *Collaboration***

- ✓ How would you describe your relationships with other wards?
- ✓ How would you explain the role of the medical staff on the unit? How do you think they see your role?
- ✓ On the unit the nurses and doctors work closely together. What other professionals are important to care provision on the unit?

**5. *Any questions for me?***

Thank you very much



## **Appendix 18b. Interview schedule (doctor)**

### **Interview with Doctor-hospital (modified for use with GPs)**

Introduce myself and the purpose of interview---PhD

Why interested---new, not investigated from participants (nurses, Doctors, Patients perspective), what is the role of the nurse? Is it different from the ordinary wards?

Explain confidentiality—only me to hear, locked, pseudonyms, aggregated

Ethical approval----hospital and ethics committee

Signed consent form?

Agreed to use of audiotape?

#### ***1. AMAUS.***

- Have you experience of AMAUs or EMUs in other hospitals?
- If so how do they differ in organisation compared to the AMAU in XXXX

*Prompts: consultant lead, on-call rota, admitting policy*

- Have you experience of working in a hospital without an AMAU or similar? What happened in these hospitals?
- As a doctor what are the benefits of the AMAU?
- What are the disadvantages of the AMAU?

#### ***2. NURSES***

- In your opinion what are the qualities of a 'good' nurse?
- Do nurses working on AMAUs require different skills compared to nurses who work on ordinary medical wards?

*Prompts: Knowledge, skills, attitudes, personality?*

- Can you think of a recent episode that you could describe to me in detail when you witnessed a nurse on the AMAU displaying, in your opinion, excellent nursing ability?



*Prompts: What was going on? What did she/he do? What was the nurse actually doing? Can you pick out specifics of what made this an excellent example of nursing ability? Why was this incident significant to you? What were your thoughts when the incident was happening?*

- Can you now think of another recent incident that you could tell me about that you would consider gives an example of nursing that you would consider, in your opinion, to be less than excellent?

*Prompts: What was going on? What was the nurse doing? What were the specific details of this incident—what was it that the nurse was doing that demonstrated this? Why was this incident significant to you? What were your thoughts when the incident was happening?*

- Can you detect a difference in the different grades of nurses?
- If so what are these differences?
- Are the relationships between you and your team and the AMAU nursing team in anyway different from those with the ward nurses? Maybe in particular the nurses who work on your consultant's wards?

### **CARE**

- Can you tell me what normally happens when a patient is admitted to the AMAU?

### **CONCLUDE**

If there were one thing that you could change about the AMAU system in [REDACTED] what would it be?

Any questions or anything that you would like to add?

Thank You

## **Appendix 18c Interview schedule patients**

### **Interview Schedule Patients**

#### ***Prior to interview***

1. Overview of research aims: check understanding of information already given in the booklet.
2. Discussion of the format and purpose of the interview
3. Information on confidentiality and right to stop interview at anytime
4. Agreement to use of tape recorder and completion of consent form
5. Demographic and general information: Name, age, date and time of admission, length of time on the unit. At initial approach meeting will have sought permission to view their records so may be actually confirming information

#### ***Pre-Admission***

- ✓ Can you tell me about the time just before you were admitted to the hospital?
1. Did you go straight to the acute medical admission unit ward or did you go through casualty?
  2. If to casualty can you tell me about your time there?

#### ***AMAU-Admission***

- ✓ Can you tell me about your experience during the first hour or so on the unit?
1. When you went into the admissions ward how did you feel?
  2. What were your main worries?
  3. Can you tell me your first impressions on arriving at the ward?
  4. Who was the first person that spoke to you?
  5. Can you tell me about how you were greeted?
  6. How soon after arriving did the nurse come to admit you?
  7. Did the nurse see you before the doctor?
- ✓ Can you think back to the nurse who admitted you? Will you tell me what you remember about this time?

***AMAU-On-going care***

- ✓ Have you been in hospital before?
- 1. If patient has been an in-patient before ask –‘How does this experience compare to other time(s) when you have been in hospital?’
- 2. If patient hasn’t been an in-patient before ask—‘ How did this experience compare with what your expectations of being a patient on a hospital ward.’
- ✓ In your opinion what makes a good nurse?
- ✓ Can you think of an example of a situation when you were on the unit when you received very good care from one of the registered (qualified) nurses?
- 1. Can you tell me in detail about this incident? What was the nurse doing?
- 2. Why does this incident stand out to you as being an example of very good care?
- ✓ Can you think of an example of a situation when a registered (qualified) nurse was giving care to you that could have been improved on?
- 1. What was the nurse doing?
- 2. Can you tell me in detail about this incident?
- 3. What could have improved the care?

***AMAU-Moving on***

- ✓ Where did you go to after your time on the AMAU?
- ✓ Can you tell me about your transfer/discharge?

***Finish***

- ✓ How would you sum up your experience on the AMAU?
- ✓ Does anything stick out as being noteworthy?
- ✓ If you could tell the hospital manager how to improve the experience of a patient on the AMAU what would it be?
- ✓ Anything that you would like to ask or add?

Thank You.

May I contact you again if there is any issue that I wish to clarify?

## Appendix 18d. Interview Schedule (paramedic)

### Paramedic Interview #1

#### *Prior to formal interview*

1. Discussion of the format and purpose of the interview
2. Agreement to use of tape recorder and completion of consent form.
3. Can review transcribed interview if wishes
4. Demographic and general information: Name, age, date.

#### *Interview*

- How long a paramedic?
- Do you go to other AMAUs? What are the main similarities/differences?
- What is your opinion of the concept of AMAUs?
- *'Can you think of one specific episode when you brought a patient into the AMAU in XXXXX that you considered went very well?'* The episode could be offered as a model of a good admission of a patient.

**Prompts:** What was wrong with the patient? How was her/his condition?

How were you greeted? What was said? What was done? What were you thinking at the time? What were your concerns at the time? What did you think afterwards?

Why do you think this incident 'stood out' for you?

- *'Can you think of one specific episode when you brought a patient into the AMAU in XXXXX Hospital that you considered did not go well?'* The episode could be offered as a model of now AMAU staff, especially the nurses should not receive a patient from a paramedic.

**Prompts:** What was wrong with the patient? How was her/his condition?

How were you greeted? What was said? What was done? What were you thinking at the time? What were your concerns at the time? What did you think afterwards?

Why do you think this incident 'stood out' for you?

- What are the key qualities that an AMAU nurse needs?
- Are there differences in the knowledge, skills attitudes of an AMAU compared to a nurse on an ordinary medical ward?
- Thinking about the AMAU in XXX XXXX generally: is there anything that you would like to suggest that would improve the system from your perspective?
  - Any thing that you would like to ask?

Thank you

## **Social Admissions**

If the patient that the GP seeks to admit who would clearly be better referred to social services then the following advice should be given:

1. The contact information for the on-call social worker for the particular area (see below)
2. If the GP is not happy with this advice then suggest that you transfer the call to the on-call medical registrar to seek her/his advice.

### **Contact Social Workers:**

*(list provided of phone numbers for specific areas)*

**Appendix 20. Example of a letter that confirmed an interview appointment with a health professional**

**HEADED PAPER**

**CONTACT PHONE NUMBER**

**CONTACT EMAIL**

*Name & address of participant*

*Date*

Dear

*Re: Research project: The role of the nurse in an acute medical admission unit: a qualitative study drawing on ethnographic methods.*

Thank you for agreeing to be interviewed by myself for the above study at 11am on Thursday 17<sup>th</sup> December 200X in XXXX XXXXX . The interview will take about half an hour to an hour. I am sorry but due to my limited abilities in the Welsh language I am not able to conduct this interview through the medium of Welsh. I will ask if you will consent the audio taping of the interview but this will be your choice.

I have permission from the XXX XXX Ethics committee and XXXXX NHS Trust to conduct the research. I have also gained permission from ambulance trust's research committee to approach paramedics. Normal conventions of confidentiality of participation and contribution will be observed. Only I will see the interview transcript and any contribution from yourself will be written up in such a manner so as to protect your anonymity. Participation is totally voluntary and participants have the right to withdraw from the study at any time.

**The study**

I am a PhD student from the University of Wales Swansea. My research is about the organisation of the AMAU in XXXXX Hospital and in particular the role of the nurse in such a unit. I wish to gain an understanding of how the unit functions and the nurse's role within it. I therefore wish to interview professionals and patients who have

experience of the unit. A comprehensive literature search has demonstrated a scarcity of literature on the running of such a unit, apart from statistical information on patient numbers and medical conditions.

To aid data collection I intend to use a method within the interview known as critical incident technique (CIT). Researchers who have used this method in the past have found it useful to give the respondent some background information prior to the interview so I note below the kind of questions that I will ask when using the CIT.

CIT was developed by Flanagan (1954) and has been used in health care research in a variety of studies. The rationale for using CIT is that by focussing on specific incidents that aids recall respondents can identify and clarify feelings and meanings that they may attach to these incidents. The term critical refers to the fact that the behaviour described in the incident plays an important and meaningful (critical) role in determining an outcome: a critical incident is a complete and clearly demarcated occurrence within which a number of behaviours are present. The term critical incident as used within the NHS can refer to an untoward/adverse incident I do not seek such incidents but rather I will ask for an occurrence or a story that illustrates your understanding or experience.

In the interview I will ask *'can you think of one specific episode when you brought a patient into the AMAU in XXXXX Hospital that you considered went very well?'* The episode could be offered as a model of a good admission of a patient. Then on the contrary *'can you think of one specific episode when you brought a patient into the AMAU in XXXXX Hospital that you considered did not go well?'* The episode could be offered as a model of now AMAU the nurses should not receive a patient from a paramedic.

Many thanks for your time

Yours sincerely,

Pauline Griffiths RN.  
Lecturer.



**APPENDIX 21. Example of Free Node Coding Summary from a Patient Interview Using N6 that Aided the Literal Reading Stage of Data Analysis.**

Licensee: YYYYYYYY YYYYYYYY

PROJECT: AMAU 25 JUNE 04, User PAULINE, 12:42 pm, 5 Jan, 2007.

++++  
++++

+++ ON-LINE DOCUMENT: Patient interview Eve

+++ Document Description:

\*patient interview #5

\*Eve \*Wednesday 9th xxxxx xxxx \*in patient's home

(F 4) //Free Nodes/Doctors

++ Units:154-164

(F 7) //Free Nodes/getting the beds

++ Units:430-431

(F 15) //Free Nodes/health care before arriving on the unit

++ Units:9-16 25-31 45-133

(F 18) //Free Nodes/'Just general questions'

++ Units:154-164

(F 20) //Free Nodes/They are constantly busy

++ Units:302-306 412-415

(F 21) //Free Nodes/Didn't matter where I was

++ Units:134-144 146-150 154-164 166-203 310-328

(F 24) //Free Nodes/Differences between unit and ward nurses

++ Units:378-391

(F 25) //Free Nodes/Having a chat

++ Units:274-277 304-310

(F 26) //Free Nodes/Some you click with

++ Units:278-286 288-291

(F 27) //Free Nodes/Getting to know the nurses

++ Units:362-370 372-373 416-420

(F 29) //Free Nodes/communicate patients are people ++ Units:274-277

(F 31) //Free Nodes/general impression ++ Units:258-260 412-415 460-463

+++ Retrieval for this document: 548 units out of 548, = 100%

++ Text units 1-548:

**APPENDIX 22. Example of a Thematic Development**

**Very small segment from patient interview with ‘Dave’ that helped develop the key theme of ‘effective communication’**

**PG.** So now from your experience of being in the unit, what are the attributes that the nurses need?

*Intrepre-  
tative  
reading*

**Commu-  
nication**

Inform-  
ation

Knowle-  
dge  
needed

**Skill**

At ease

Friendlin-  
ess

Kind

**\*Dave.** The attributes of a good AMAU nurse, hmm, communication I would think would be one of the most important ones certainly from my point of view and I guess there is a lot of people that would go in to hospital that are either not aware or are not interested in what they are doing and why. Whereas I was interested in everything they were doing, every time anything happened I was asking why, what it does and all that sort of thing. That is just my curious mind I can’t help it. So from my point of view it would be someone that communicates well and I think friendliness as well which I don’t know whether if it is the right word but you do need to be able to put the patient at ease certainly. One thing that I found when I came out was all the nurses that I dealt with both in the AMAU and in XX ward seem to me to very kind and that made me feel very good. It made me feel looked after which I think I probably wanted. So those I think would be, I can’t speak from a medical point of view, but from the interaction of the patient and the nurse that I would say would be important is communication and enough information if you want it, which I certainly got.

**\*PG.** It is interesting what you are saying about the communication that was the one thing on your mind ‘what is going on, what is going to happen?’

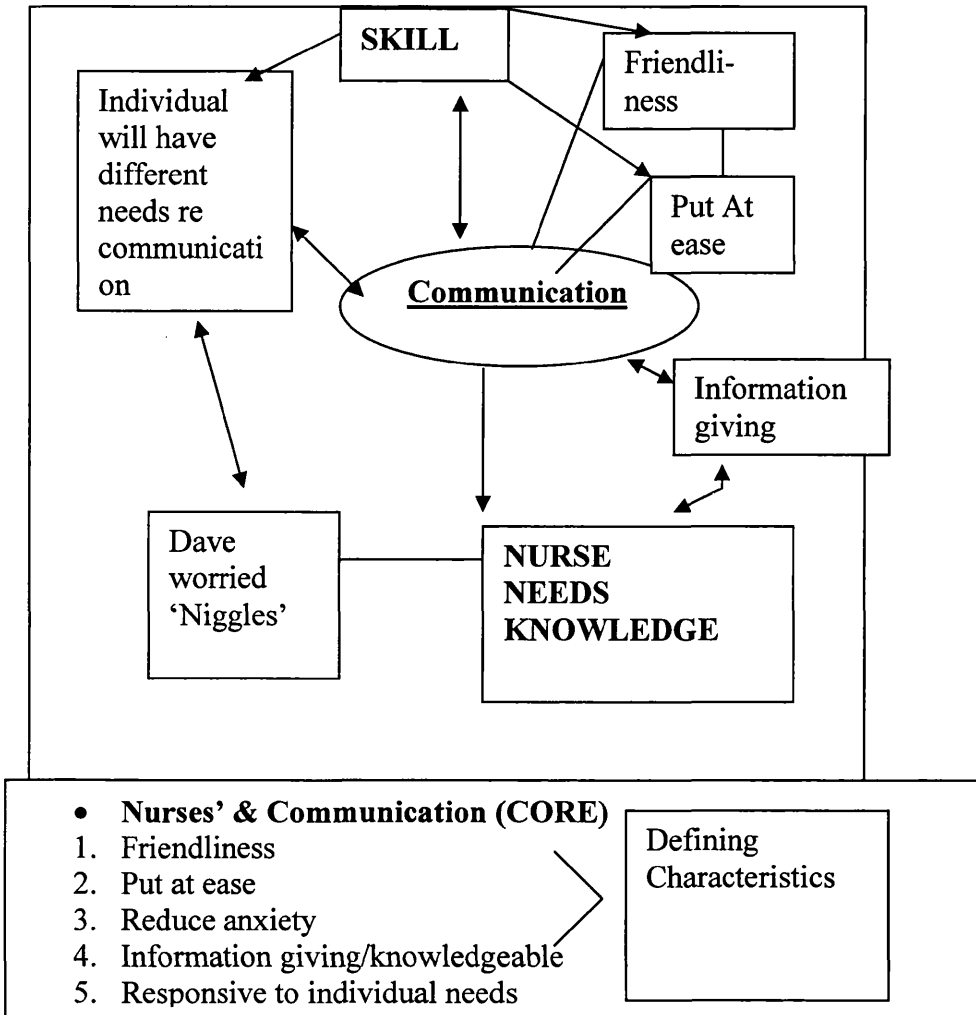
**\*Dave.** I think that is what you do. I was worried about the blood tests, I didn’t know what they were going to show up I mean cholesterol I have always thought that my cholesterol was bound to be high so when they started taking blood for cholesterol I was thinking oh no it will make me (unclear) but actually it came out quite low so I was quite lucky, but yeah things like that the little niggles that you think ‘oh, I want to ask’ and you get the information. I thought that was quite important to calming me down any rate. I mean I wasn’t running around terrified but I was just concerned about what was happening.

*Literal  
Reading  
Attributes  
Communication*

*Patient interest  
may vary  
Dave wanted to  
understand  
Communication  
ability  
Plus  
Friendliness  
‘Put people at  
ease’  
Being kind  
‘Made to feel  
good’ & looked  
after  
Interaction  
between patient  
and nurse need  
communicati-on  
and information*

*Happy results were  
OK  
‘Niggles’  
Being able to ask  
Worried about the  
blood tests and the  
results of the tests  
him.  
Was concerned.*

*Diagrammatic representation*



## References

- Aamodt, A. M. (1982) Examining ethnography for nurse researchers. *Western Journal of Nursing Research*, 4(2), 209-221.
- Abu Al Rub, R. F. (2004) Job stress, job performance, and social support among hospital nurses. *Journal of Nursing Scholarship*, 36(1), 73-78.
- Adams, A., Bond, S. and Hale, C. A. (1998) Nursing organisational practice and its relationship with other features of ward organisation and job satisfaction. *Journal of Advanced Nursing*, 27, 1212-1222.
- Adhern, J. and Philpot, P. (2002) Accessing acutely ill patients on general wards. *Nursing Standard*, 16(47), 47-54.
- Alaszewski, A. (1995) Parsons, professions and the sociology of health care. *Nursing Times*, 91(33), 40-41.
- Alberti, G. (2003) *Emergency assessment units -a checklist*. Department of Health, London.
- Alberti, G., Colin-Thome, D., and Asbridge, J., (2005) *A guide to emergency medical and surgical admissions*. Department of Health, London.
- Aldridge, J. (1991). Research accounts, method in sociology and 'social reality': some reflections on the production of a thesis. In J. Aldridge & V. Griffiths & A. Williams (1991) *Rethinking: feminist research processes reconsidered*. Manchester: Feminist Praxis: Studies in Sexual Politics No.34.
- Alfaro, R. (1990) *Applying nursing diagnosis and nursing process*, J.B. Lippincott Company, Philadelphia.
- Allen, D. (1997) The nursing-medical boundary: a negotiated order? *Sociology of Health & Illness*, 19(4), 498-520.
- Allen, D. (1998) Record-keeping and routine nursing practice: a view from the wards. *Journal of Advanced Nursing*, 27, 1223-1230.
- Allen, D. (2001) *The changing shape of nursing practice*, Routledge, London.
- Allen, D. and Hughes, D. (2002). Expanded nursing roles: different occupational perspectives. In *Nursing and the division of labour in healthcare* (Eds, D.Allen and D.Hughes) Palgrave Macmillan, Basingstoke.
- Allmark, P. (1995) A classical view of the theory-practice gap in nursing. *Journal of Advanced Nursing*, 22, 18-23.

- Altheide, D. L. and Johnson, J. M. (1998) Criteria for assessing interpretative validity in qualitative research. In *Collecting and interpreting qualitative materials* (Eds, Denzin, N. K. and Lincoln, Y. S.) Sage Publications, London.
- Amin, A. and Cohendt, P. (2000) Organisational learning and governance through embedded practices. *Journal of Management and Governance*, **4**, 93-116.
- Anderson, G., Monsen, R. and Rorty, M. (2000) Nursing and genetics: a feminist critique moves us towards transdisciplinary teams. *Nursing Ethics*, **7**(3), 191-204.
- Andersson, A.-K., Omberg, M., & Svedlund, M. (2006). Triage in the emergency department-a qualitative study of factors which nurses consider when making decisions. *Nursing in Critical Care*, **11**(3), 136-145.
- Annandale, E. (1996) Working on the front-line: risk culture and nursing in the new NHS. *Sociological Review*, **44**(3), 416-451.
- Aranda, S. K. and Street, A. F. (1999) Being authentic and being a chameleon: nurse-patient interaction revisited. *Nursing Inquiry*, **6**, 75-82.
- Arbon, P. (2004) Understanding experience in nursing. *Journal of Clinical Nursing*, **13**, 150-157.
- Armitage, M. and Davidson, C. (2001) General medicine in the UK-back stage or centre stage? *European Journal of Internal Medicine*, **12**, 535-538.
- Armitage, M. and Flanagan, D. (2001) Improving quality measures in the emergency services. *Journal of the Royal Society of Medicine*, **94**(Suppl. 39), 9-12.
- Armstrong, D. (1998) Decline of the hospital: reconstructing institutional dangers. *Sociology of Health & Illness*, **20**(4), 445-457.
- Armstrong, D. (2002). Clinical autonomy, individual and collective: the problem of changing doctors' behavior. *Social Science & Medicine*, **55**, 1771-1777.
- Armstrong, D., Gosling, A., Weinman, J. and Marteau, T. (1997) The place of inter-rater reliability in qualitative research: an empirical study. *Sociology*, **31**(3), 597-606.
- Astedt-Kurki, P., Paavilainen, E. and Lehti, K. (2001) Methodological issues in interviewing families. *Journal of Advanced Nursing*, **35**(2), 288-293.
- Audit Commission (1992) *Lying in wait: the use of medical beds in acute hospitals*, HMSO, London.
- Audit Commission (1995) *For your information: A study of information management systems in the acute hospital*. HMSO, London.

- Aull Davies, C. (1999) *Reflexive ethnography: a guide to researching selves and others*, Routledge, London.
- Baddeley, A. D. (1980) Human memory. In *New horizons in psychology* (Ed, Dodwell, P. C.) Penguin, London.
- Baillie, L. (1995) Ethnography and nursing research: a critical appraisal. *Nurse Researcher*, 3(2), 5-21.
- Baillie, L. (2005) An exploration of nurse-patient relationships in accident and emergency. *Accident & Emergency Nursing*, 13, 9-14.
- Baker, E., Israel, B. and Schurman, S. (1996) Role of control and support in occupational stress: an integrated model. *Social Science & Medicine*, 43(7), 1145-1159.
- Baldursdottir, G. and Jonsdottir, H. (2002) The importance of nurse caring behaviours as perceived by patients receiving care at an emergency department. *Heart & Lung*, 31(1), 67-75.
- Baly, M. (1980) *Nursing and social change*, William Heinemann Medical Books Ltd, London.
- Barr, T. (1994) The patient who experiences trauma. In *Nursing practice. Hospital and home: the adult* (Eds, Alexander, M. F., Fawcett, J. N. and Runciman, P. J.) Churchill Livingstone, Edinburgh.
- Barriball, K. L. and While, A. (1994) Collecting data using a semi-structured interview: a discussion paper. *Journal of Advanced Nursing*, 19, 328-335.
- Barry, C. A. (1998) Choosing qualitative data analysis software: Atlas/ti and Nudist compared. Vol. <http://www.socresonline.org.uk> Sociological Research Online. [Accessed 10/10/05]
- Barton, T. D. (2006) Nurse practitioners-or advanced clinical nurses? *British Journal of Nursing*, 15(7), 370-376.
- Beauchamp, T. L. and Childress, J. F. (2001) *Principles of biomedical ethics*, Oxford University Press, Oxford.
- Becker, H. S., Geer, B., Hughes, E. C. and Strauss, A. L. (1961) *Boys in white: student culture in medical school*, University of Chicago Press, Chicago.
- Benner, P. (1984) *From novice to expert: excellence and power in clinical nursing*, Addison-Wesley Publishing Company, California.
- Benner, P. and Wrubel, J. (1989) *The primacy of caring*, Addison-Wesley, Menlo Park, CA.

- Benton, T. and Craib, I. (2001) *Philosophy of social science: the philosophical foundations of social thought*, Palgrave, Basingstoke.
- Biddle, B. J. and Thomas, E. J. (1966) The nature and history of role theory. In *Role theory: concepts and research* (Eds, Biddle, B. J. and Thomas, E. J.) John Wiley & Sons, Inc., New York.
- Blaikie, N. (2000) *Designing social research: the logic of anticipation*, Polity Press, Cambridge.
- Bloor, M. (1997) Techniques of validation in qualitative research: a critical commentary. In *Context and method in qualitative research* (Eds, Miller, G. and Dingwall, R.) Sage, London.
- Blue, C. L., Brubaker, K., Fine, J. M., Kirsh, M. J., Papazian, K. R., Riester, C. M. and Sobiech, M. (1994) Sister Callista Roy. In *Nursing theorists and their work* (Ed, Marriner-Tomey, A.) Moxby, St Louis.
- Bond, J. and Bond, S. (1994) *Sociology and health care*, Churchill Livingstone, Edinburgh.
- Bowling, A. (2002) *Research methods in health*, Open University Press, Buckingham.
- Bradley, J. R. and Cartwright, S. (2002) Social support, job stress, health, and job satisfaction among nurses in the United Kingdom. *International Journal of Stress Management*, **9**(3), 163-182.
- Brewer, J. D. (2000) *Ethnography*, Open University Press, Buckingham.
- Brink, P. J. and Edgecombe, N. (2003) What is becoming of ethnography? *Qualitative Health Research*, **13**(7), 1028-1030.
- Bruce, K. and Suserud, B.-O. (2005) The handover process and triage of ambulance-borne patients: the experiences of emergency nurses. *Nursing in Critical Care*, **10**(4), 201-209.
- Brykczynska, G. (1998) Can nursing research be a caring process? In *Nursing research: setting new agendas* (Ed, Smith, P.) Arnold, London.
- Buckley, W. (1967) *Sociology and modern systems theory*, Prentice-Hall Inc., New Jersey.
- Budge, C., Carryer, J. and Wood, S. (2003) Health correlates of autonomy, control and professional relationships in the nursing work environment. *Journal of Advanced Nursing*, **42**(3), 260-268.
- Buller, S. and Butterworth, T. (2001) Skilled nursing practice: a qualitative study of the elements of nursing. *International Journal of Nursing Studies*, **38**, 405-417.

- Burkitt, I., Husband, C., Mackenzie, J., Torn, A. and Crow, R. (2001) *Nurse education and communities of practice*, The English National Board for Nursing, Midwifery and Health Visiting, London.
- Burnard, P. and Naiyapatana, W. (2004) Culture and communication in Thai nursing: a report of an ethnographic study. *International Journal of Nursing Studies*, **41**, 755-765.
- Byrne, G. and Heyman, R. (1997) Understanding nurses' communication with patients in accident & emergency departments using a symbolic interactionist perspective. *Journal of Advanced Nursing*, **26**, 93-100.
- Cahill, J. (1998) Patients' perceptions of the bedside handover. *Journal of Clinical Nursing*, **7**, 351-359.
- Cameron, S., McKenzie, F., Warnock, L. and Farquhar, D. (2000) Impact of a nurse led multidisciplinary team on an acute medical admissions unit. *Health Bulletin*, **60**(6), 512-514.
- Capewell, S. (1996) The continuing rise in emergency admissions. *British Medical Journal*, **312**, 991-992.
- Carnwell, R. and Daly, W. (2001) Strategies for the construction of a critical review of the literature. *Nurse Education in Practice*, **1**, 57-53.
- Carpenito, L. J. (1997) *Nursing diagnosis: application to clinical practice*, J.B. Lippincott, Philadelphia.
- Carper, B. (1978) Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, **1**(1), 13-23.
- Castledine, G. (2005) Preserving nursing 's identity in interdisciplinary working. *British Journal of Nursing*, **14**(12), 681.
- Chaboyer, W., Najman, J. and Dunn, S. (2001) Factors influencing job valuation: a comparative study of critical care and non-critical care nurses. *International Journal of Nursing Studies*, **38**, 153-161.
- Chambers Dictionary (1998) (Eds, Anderson, S., Carey, L., Cullen, K., Flackett, S. and Grandison, A.) Chambers Harrap Publishers Ltd, Edinburgh.
- Charters, S., Knight, S., Currie, J., Davies-Gray, M., Ainsworth-Smith, M., Smith, S. and Crouch, R. (2005) Learning from the past to inform the future-A survey of consultant nurses in emergency care. *Accident & Emergency Nursing*, **13**, 186-193.
- Cheek, J. (2000) *Postmodern and poststructural approaches to nursing research*, Sage Publications, Inc., London.



- Chinn, P. L., Maeve, B. and Bostick, C. (1997) Aesthetic inquiry and the art of nursing. *Scholarly Inquiry for Nursing Practice: An International Journal*, **11**(2), 83-96.
- Christians, C. G. (2003) Ethics and politics in qualitative research. In *The Landscape of Qualitative Research: Theories and Issues* (Eds, Denzin, N. K. and Lincoln, Y. S.) Sage Publications, London.
- Cioffi, J. (2001) A study of the use of past experiences in clinical decision making in emergency situations. *International Journal of Nursing Studies*, **38**, 591-599.
- Clark, J. and Lang, N. (1992) Nursing's next advance: an international classification for nursing practice. *International Nursing Review*, **38**(4), 109-112.
- Clifford, C. (1995) Caring: fitting the concept to nursing practice. *Journal of Clinical Nursing*, **4**, 37-41.
- Clifford, C. (1996) Role: a concept explored in nursing education. *Journal of Advanced Nursing*, **23**, 1135-1141.
- Clifford, C. (2000) International politics and nursing education: power and control. *Nurse Education Today*, **20**, 4-9.
- Clinical Standards Advisory Group(CSAG) (1995) *Urgent and emergency admissions to hospital: the report of a CSAG committee and the government response*. HMSO, London.
- Cooke, H. (1993) Boundary work in the nursing curriculum: the case of sociology. *Journal of Advanced Nursing*, **18**, 1990-1998.
- Cooke, M. W., Higgins, J. and Kidd, P. (2003) Use of emergency observation and assessment wards: a systematic review. *Emergency Medicine*, **20**, 138-142.
- Coombs, M. and Ersser, S. J. (2004) Medical hegemony in decision-making- a barrier to interdisciplinary working in intensive care? *Journal of Advanced Nursing*, **46**(3), 245-252.
- Cope, P., Cuthbertson, P. and Stoddart, B. (2000) Situated learning in the practice setting. *Journal of Advanced Nursing*, **31**(4), 850-856.
- Coyne, I. T. (1997) Sampling in qualitative research: purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing*, **26**, 623-630.
- Cronin, S. N. and Harrison, B. (1988) Importance of nurse caring behaviours as perceived by patients after myocardial infarction. *Heart & Lung*, **17**, 374-380.
- Crowe, M. (2000) The nurse-patient relationship: a consideration of its discursive context. *Journal of Advanced Nursing*, **31**(4), 962-967.

- Cutcliffe, J. R. and McKenna, H. P. (2002) What do we know that we know? Considering the truth of research findings and the craft of qualitative research. *International Journal of Nursing Studies*, **39**, 611-618.
- Davies, C. (1995) *Gender and the professional predicament in nursing.*, Open University Press, Buckingham.
- Davies, I. K. (1981) *Instructional technique*, Mc-Graw-Hill Book Company, New York.
- de Laine, M. (2000) *Fieldwork, participation and practice*, Sage Publications, London.
- deJonge, J., Mulder, M. J. G. P. and Nijhuis, F. J. N. (1999) The incorporation of different demand concepts in the job demand-control model: effects on health care professionals. *Social Science & Medicine*, **48**, 1149-1160.
- deLaat, M., deJong, F. and terHuurne, J. (2000) Supporting a community of practice: the role of workers as learners. In *Ed-Media* Montreal, Canada. June 26-July 1, 2000.
- DeMeester, D., Lauer, T., Marriner-Tomey, A., Neal, S. and Williams, S. (1994) Virginia Henderson. In *Nursing theorists and their work*(Ed, Marriner-Tomey, A.) Mosby, St. Louis.
- Demerouti, E., Bakker, A. B., Nachreiner, F. and Schaufeli, W. B. (2000) A model of burnout and life satisfaction amongst nurses. *Journal of Advanced Nursing*, **32**(2), 454-464.
- Denscombe, M. (1998) *The good research guide: for small-scale social research projects*, Open University Press, Buckingham.
- Denscombe, M. (2002) *Ground rules for good research: a 10 point guide for social researchers*, Open University Press, Buckingham.
- Denzin, N. K. and Lincoln, Y. S. (1998) Introduction. In *Collecting and interpreting qualitative materials*(Eds, Denzin, N. K. and Lincoln, Y. S.) Sage Publications, London.
- Denzin, N. K. and Lincoln, Y. S. (2003) The discipline and practice of qualitative research. In *The landscape of qualitative research* (Eds, Denzin, N. K. and Lincoln, Y. S.) Sage Publications, London.
- Department of Health (1999) *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare*, Department of Health, London.
- Department of Health (2000a) *The NHS Plan*, Department of Health, London.

- Department of Health (2000b) *A health service of all the talents: Developing the NHS workforce*, Department of Health, London.
- Department of Health (2001) *Research governance framework of health and social care*. Department of Health, London.
- Department of Health (2003) *Improving the flow of emergency admissions*. The NHS Modernisation Agency. DoH, London.
- Department of Health (2004a) *Agenda for change*, Department of Health, London.
- Department of Health (2004b) *Knowledge and skills framework for practice*, Department of Health, London.
- Department of Health (2006) *Modernising nursing care- setting directions*. DoH, London.
- Dimond, B. (1995) *Legal aspects of nursing*, Prentice Hall, London.
- Dodier, N. and Camus, A. (1998) Openness and specialisation: dealing with patients in a hospital emergency service. *Sociology of Health & Illness*, **20**(4), 413-444.
- Donaghy, E., Cunningham-Burley, S., Parker, S. and Waker, D. (1997) *Emergency admissions in Scotland- a national investigation into factors associated with admission and attitudes towards alternatives*, Scottish Office. Department of Health, Edinburgh.
- Dorward, A. J. (1997) Patterns of acute medical receiving in Scotland. *Health Bulletin*, **55**(3), 162-166.
- Dowling, M. (2004) Hermeneutics: an exploration. *Nurse Researcher*, **11**(4), 30-39.
- Draper, P. (1993) A critique of Fawcett's 'Conceptual models and nursing practice: the reciprocal relationship'. *Journal of Advanced Nursing*, **18**, 558-564.
- Duffy, R., Bain, J., Neville, R. and Staines, H. (1998) Relationship between route of referral for acute medical admissions, patient characteristics and appropriateness of admission. *Health Bulletin*, **56**(6), 863-870.
- Duguid, P. (2005) 'The art of knowing': social and tacit dimensions of knowledge and the limits of the community of practice. *The Information Society*, **21**, 109-118.
- Dunlop, M. J. (1986) Is a science of caring possible? *Journal of Advanced Nursing*, **11**(661-670).
- Dunn, S., Wilson, B. and Esterman, A. (2005) Perceptions of working as a nurse in an acute care setting. *Journal of Nursing Management*, **13**, 22-31.
- Dyer, M., Harte, J. and Brereton, J. (1998) Reducing paperwork in a medical assessment unit. *Nursing Times*, **94**(12), 50-51.

- Easen, P. and Wilcockson, J. (1996) Intuition and rational decision -making in professional thinking: a false dichotomy. *Journal of Advanced Nursing*, **24**, 667-673.
- Eisenhardt, K. M. (1989) Building theories from case study research. *Academy of Management Review*, **14**(4), 532-550.
- Ekstedt, M., & Fagerberg, I. (2005). Lived experience of the time preceding burnout. *Journal of Advanced Nursing*, **49**(1), 59-67.
- Ersser, S. J. (1997) *Nursing as a therapeutic activity*, Avebury, Aldershot.
- Fatovich, D. M. (2002) Emergency medicine. *British Medical Journal*, **324**, 958-962.
- Fawcett, J. (1992) Conceptual models and nursing practice: the reciprocal relationship. *Journal of Advanced Nursing*, **17**, 224-228.
- Fawcett, J. (1995) *Analysis and evaluation of conceptual models of nursing*, F.A. Davis Company, Philadelphia.
- Fawcett, J. (2003) Guest editorial: on bed baths and conceptual models of nursing. *Journal of Advanced Nursing*, **44**(3), 229-230.
- Flanagan, J. C. (1954) The critical incident technique. *Psychological Bulletin*, **51**(4), 327-358.
- Foster, M., Davies, P. and Williams, E. (1996) True admissions. *Health Service Journal*, **4th January 1996**, 24-25.
- French, K. (1981) Methodological considerations in hospital patient opinion surveys. *International Journal of Nursing Studies*, **18**(7-32).
- Friedson, E. (1970) *Professional dominance*, Atherton Press Inc., New York.
- Friedson, E. (1976) The division of labour as social interaction. *Social Problems*, **23**(304-313).
- Gabby, J., le May, A., Jefferson, H., Webb, D., Lovelock, R., Powell, J. and Lathlean, J. (2003) A case study of knowledge management in multi-agency consumer -informed 'communities of practice': implications for evidence-based policy development in health and social services. *health: An interdisciplinary journal for the social study of health, illness and medicine*, **7**(3), 283-310.
- Gadamer, H. G. (1976) *Philosophical hermeneutics*, University of California Press, California.
- Gamarnikow, E. (1978) Sexual division of labour: the case of nursing. In *Feminism and materialism. Women and modes of production*(Eds, Kuhn, A. and Wolpe, A. M.) Routledge & Kegan Paul, London.

- Garbett, R. (1994) Applying the BNFU Model in an acute medical unit. In *The Burford NDU Model*(Ed, Johns, C.) Blackwell Science, Oxford.
- Geertz, C. (1993) *The interpretation of cultures*, Fontana Press, London.
- Gerrish, K. (1997) Being a 'marginal native': dilemmas of the participant observer. *Nurse Researcher*, 5(1), 25-34.
- Gilbert, T. P. (2004) Impersonal trust and professional authority: exploring the dynamics. *Journal of Advanced Nursing*, 49(6), 568-577.
- Gilligan, C. (1993) *In a different voice. Psychological theory and women's development*, Harvard University Press, London.
- Glaser, B. G. and Strauss, A. L. (1967) *The discovery of grounded theory: strategies for qualitative research*, Aldine, Chicago.
- Goffman, E. (1959) *The presentation of self in everyday life*, Penguin Books, London.
- Goffman, E. (2002) On fieldwork. In D. Weinberg (Ed.), *Qualitative research methods*. Oxford: Blackwell Publishers Ltd.
- Gold, R. L. (1958) Roles in sociological field observation. *Social Forces*, 36, 217-223.
- Gold, R. L. (1963) In the basement-the apartment-building janitor. In *The Human Shape of Work. Studies in the Sociology of Occupations*(Ed, Berger, P. L.) The Macmillan Company, New York.
- Goodwin, D., Pope, C., Mort, M. and Smith, A. (2005) Access, boundaries and their effects: legitimate participation in anaesthesia. *Sociology of Health & Illness*, 27(6), 855-871.
- Grant, N. K. and Bannatyne, J. (1996) Indicators of quality in long-term care facilities. *International Journal of Nursing Studies*, 33(5), 469-478.
- Green, J. and Armstrong, D. (1993) Controlling the 'bed state': negotiating hospital organisation. *Sociology of Health & Illness*, 15(3), 337-352.
- Griffiths, L. (2003) Making connections: studies of the social organisation of healthcare. *Sociology of Health & Illness*, 25(Si).
- Griffiths, P. (1996) An investigation into the description of patients problems by nurses using two different needs-based nursing models. Unpublished MSc Thesis. University of Wales, College of Swansea, Swansea.
- Griffiths, P. (1998) An investigation into the description of patients' problems by nurses using two different needs-based nursing models. *Journal of Advanced Nursing*, 28(5), 969-977.

- Guba, E. G. and Lincoln, Y. S. (1989) *Fourth generation evaluation*, Sage, Newbury Park, CA.
- Hagerty, B. M. and Patusky, K. L. (2003) Reconceptualizing the nurse-patient relationship. *Journal of Nursing Scholarship*, **35**(2), 145-150.
- Halloran, E. J. (1996) Virginia Henderson and her timeless writings. *Journal of Advanced Nursing*, **23**(17-24).
- Hallstrom, I. and Elander, G. (2001) A comparison of patient needs as ranked by patients and nurses. *Nordic Journal of Caring Sciences*, **15**, 228-234.
- Hammersley, M. (1992) *What's wrong with ethnography?* Routledge, London.
- Hammersley, M. (1998) *Reading ethnographic research*, Longman, London.
- Hammersley, M. (2005) What can the literature on communities of practice tell us about educational research? Reflections on some recent proposals. *International Journal of Research & Methods in Education*, **28**(1), 5-21.
- Hammersley, M. and Atkinson, P. (1995) *Ethnography: principles in practice*, Routledge, London.
- Hampton, J. R. and Gray, A. (1998) The future of general medicine: lessons from an admissions ward. *Journal of the Royal College of Physicians of London*, **32**(11), 39-43.
- Handy, C. (1999) *Understanding organizations*, Penguin Books, London.
- Hanks, W. F. (1991) Foreword by William F Hanks. In *Situated learning. Legitimate peripheral participation*(Eds, Lave, J. and Wenger, E.) Cambridge University Press, Cambridge.
- Hardey, M., Payne, S. and Coleman, P. (2000) 'Scraps': hidden nursing information and its influence on the delivery of care. *Journal of Advanced Nursing*, **32**(1), 208-214.
- Harmer, B. and Henderson, V. (1955) *Textbook of the principles and practice of nursing*, Macmillan, New York.
- Harrison, R. and Daly, L. (2001) *Acute medical emergencies*, Churchill Livingstone, London.
- Hasrati, M. (2005) Legitimate peripheral participation and supervising Ph.D. students. *Studies in Higher Education*, **30**(5), 557-570.
- Hatch, M. J. and Cuncliffe, A. L. (2006) *Organization theory*, Oxford University Press, Oxford.

- Hayes, B. and Adams, A. (2000) Parallels between clinical reasoning and categorization. In *Clinical reasoning in the Health Professions* (Eds, Higgs, J. and Jones, M.) Butterworth Heinemann, Oxford.
- Heartfield, M. (2005) Regulating hospital use: length of stay, beds and whiteboards. *Nursing Inquiry*, **12**, 21-26.
- Henderson, V. (1966) *The nature of nursing: A definition and its implications for practice, research and education.*, Macmillan, New York.
- Henderson, V. (1978) The concept of nursing. *Journal of Advanced Nursing*, **3**, 113-130.
- Hendry, C. and Walker, A. (2004) Priority setting in clinical nursing practice: a literature review. *Journal of Advanced Nursing*, **47**(4), 427-436.
- Hendry, J. (1999) *An introduction to social anthropology. Other people's worlds*, Macmillan Press Ltd, London.
- Henneman, E. A. (1995) Nurse-physician collaboration: a post-structuralist view. *Journal of Advanced Nursing*, **22**(359-363).
- Herzberg, F., Mauser, B. and Synderman, B. B. (1959) *The motivation to work*, Wiley, New York.
- Herzlich, C. (1973) *Health and illness*, European Association of Experimental Social Psychology with Academic Press, London.
- Hewison, A. (1995) Nurses' power in interactions with patients. *Journal of Advanced Nursing*, **21**, 75-82.
- Higgs, J. and Jones, M. (2000) Clinical reasoning in the health professions. In *Clinical reasoning in the health professions*(Eds, Higgs, J. and Jones, M.) Butterworth Heinemann, Oxford.
- Hilgard, E. R., Atkinson, R. and Atkinson, R. (1979) *Introduction to psychology*, Harcourt Brace Jovanovich, Inc., New York.
- Hochschild, A. R. (2003) *The managed heart. Commercialization of human feeling*, University of California Press, Berkeley.
- Hoeyer, K., Dahlager, L. and Lynoe, N. 2005. Conflicting notions of research ethics. The mutually challenging traditions of social scientists and medical researchers. *Social Science & Medicine* **61**, 1741-1749.
- Holland, C. K. (1993) An ethnographic study of nursing culture as an exploration for determining the existence of a system of ritual. *Journal of Advanced Nursing*, **18**, 1461-1470.

- Holloway, I. and Fulbrook, P. (2001) Revisiting qualitative inquiry: interviewing in nursing and midwifery research. *NT Research*, 6(1), 539-550.
- Holloway, I. and Wheeler, S. (1995) Ethical issues in qualitative research. *Nursing Ethics*, 2(3), 223-231.
- Holloway, J. (1992) The media representation of the nurse: the implications for nursing. In *Themes and perspectives in nursing* (Eds, Soothill, K., Henry, C. and Kendrick, K.) Chapman and Hall, London.
- Hopkins, C. (2002) 'But what about the really ill, poorly people?' (An ethnographic study into what it means to nurses on medical admissions units to have people who have harmed themselves as their patients). *Journal of Psychiatric and Mental Health Nursing*, 9, 147-154.
- Houghton, A. and Hopkins, A. (1996) Acute medical admissions: results of a national study. *Journal of the Royal College of Physicians of London*, 30(6), 551-559.
- Huberman, A. M. and B, M. M. (1998) Data management and analysis methods. In *Collecting and interpreting qualitative materials*(Eds, Denzin, N. K. and Lincoln Y.S.) SAGE Publications, London.
- Hughes, C. C. (1992) "Ethnography": what's in a word-process? product? promise? *Qualitative Health Research*, 2(4), 439-450.
- Hughes, D. (1988) When a nurse knows best: some aspects of doctor/nurse interaction in a casualty department. *Sociology of Health & Illness*, 10, 1-22.
- Hughes, E. (1971) *The sociological eye: selected papers*, Aldine, Chicago.
- Humphreys, L. (1970) *Tearoom trade, impersonal sex in public places*, Aldine, Chicago.
- Hunt, G. and Wainwright, P. (1994) *Expanding the role of the nurse*, Blackwell Scientific, Oxford.
- Hupcey, J. E., Penrod, J., Morse, J. M. and Mitcham, C. (2001) An exploration and advancement of the concept of trust. *Journal of Advanced Nursing*, 36(2), 282-293.
- International Council of Nurses (2004) The ICN definition of nursing. Found at <http://www.icn.ch/definition.htm> [Accessed 01/06/2004]
- Jacques, R. (1993) Untheorized dimensions of caring work: caring as a structured practice and caring as a way of seeing. *Nursing Administration Quarterly*, 17(2), 1-10.
- James, N. (1989) Emotional labour: skill and work in the social regulation of feelings. *Sociological Review*, 37(1), 15-42.



- Janssen, P. P. M., deJonge, J. and Bakker, A. B. (1999) Specific determinants of intrinsic work motivation, burnout and turnover intentions: a study among nurses. *Journal of Advanced Nursing*, **29**(6), 1360-1369.
- Jeffery, R. (1979) Normal rubbish: deviant patients in casualty departments. *Sociology of Health & Illness*, **1**(1), 90-107.
- Jervis, J. (2000) Brief but to the point. *Nursing Times*, **96**(3), 42-44.
- Johns, C. (1990) Autonomy of primary nurses: the need to both facilitate and limit autonomy in practice. *Journal of Advanced Nursing*, **15**, 886-894.
- Johns, C. (1994) A philosophical basis for nursing practice. In *The Burford NDU Model. Caring in practice*(Ed, Johns, C.) Blackwell Science, Oxford.
- Johns, C. (2001) Reflective practice: revealing the [he]art of caring. *International Journal of Nursing Practice*, **7**, 237-245.
- Johnson, M. (1997) *Nursing power and social judgement*, Ashgate, Aldershot.
- Johnson, M. and Long, T. (2003) Rigorous governance, yes-but let's get the controls right. *Nursing Research*, **11**(1), 4-6.
- Johnson, M. and Webb, C. (1995a) Rediscovering unpopular patients: the concept of social judgement. *Journal of Advanced Nursing*, **21**, 466-475.
- Johnson, M. and Webb, C. (1995b) The power of social judgement: struggle and negotiation in the nursing process. *Nurse Education Today*, **15**, 83-89.
- Kahn, S. and Fawcett, J. (1995) Continuing the dialogue: a response to Draper's critique of Fawcett's ' Conceptual models and nursing practice: the reciprocal relationship. *Journal of Advanced Nursing*, **22**, 188-192.
- Kellett, J. (1999) Acute hospital medicine in Ireland-past, present and future. *European Journal of Internal Medicine*, **10**, 177-180.
- Kelly, M., & May, D. (1982). Good and bad patients: a review of the literature and a theoretical critique. *Journal of Advanced Nursing*, **21**, 466-475.
- Kemmis, S., & McTaggart, R. (2003). Participatory action research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of qualitative inquiry*. London: Sage Publications.
- Kemppainen, J. K. (2000) The critical incident technique and nursing care quality research. *Journal of Advanced Nursing*, **32**(5), 1264-1271.
- Kendrick, S. (1996) The pattern of increase in emergency hospital admissions in Scotland. *Health Bulletin*, **54**(2), 169-183.

- Kenny, G. (2002) The importance of nursing values in interprofessional collaboration. *British Journal of Nursing*, **11**(1), 65-68.
- Kerr, M. P. (2002) A qualitative study of shift handover practice and function from a socio-technical perspective. *Journal of Advanced Nursing*, **37**(2), 125-134.
- Kerrison, S. A., & Chapman, R. (2007). What general emergency nurses want to know about mental health patients presenting to their emergency department. *Accident & Emergency Nursing*, **15**, 48-55.
- Kim, H. S. (1999) Critical reflective inquiry for knowledge development in nursing practice. *Journal of Advanced Nursing*, **29**(5), 1205-1212.
- Kindlen, M. (1994) The terminally ill patient. In *Nursing practice. Hospital and home: the adult*(Eds, Alexander, M. F., Fawcett, J. N. and Runicman, P. J.) Churchill Livingstone, Edinburgh.
- King, L. and Macleod Clark, J. (2002) Intuition and the development of expertise in surgical ward and intensive care nurses. *Journal of Advanced Nursing*, **37**(4), 322-329.
- Kleinman, S. and Copp, M. A. (1993) *Emotions and fieldwork*, Sage Publications, Inc, Newbury Park.
- Kralik, D., Koch, T. and Wotton, K. (1997) Engagement and detachment: understanding patients' experiences with nursing. *Journal of Advanced Nursing*, **26**, 399-407.
- Lally, S. (1999) An investigation into the functions of nurses' communication at the inter-shift report. *Journal of Nursing Management*, **7**, 29-36.
- Landau, R. (1995) Locus of control and socio-economic status: does internal locus of control reflect real resources and opportunities or personal coping abilities? *Social Science & Medicine*, **41**(11), 1499-1505.
- Langford, C. P. H., Bowsher, J., Maloney, J. and Lillis, P. P. (1997) Social support: a conceptual analysis. *Journal of Advanced Nursing*, **25**(1), 95-100.
- Lathlean, J. and LeMay, A. (2002) Communities of practice: an opportunity for interagency working. *Journal of Clinical Nursing*, **11**, 394-398.
- Latimer, J. (2000) *The conduct of care: understanding nursing practice*, Blackwell Science, London.
- Lave, J. (1996) The practice of learning. In *Understanding practice. Perspectives in activity and context*(Eds, Chaiklin, S. and Lave, J.) Cambridge University Press, Cambridge.

- Lave, J. and Wenger, E. (1991) *Situated learning: legitimate peripheral participation*, Cambridge University Press, Cambridge.
- Lawler, J. (1991) *Behind the screens*, Churchill Livingstone, London.
- Lease, S. H. (1999) Occupational role stressors, coping, support and hardiness as predictors of strain in academic faculty: an emphasis on new and female faculty. *Research in Higher Education* **40**(3), 285-307.
- LeCompte, M. D. and Schensul, J. J. (1999) *Ethnographer's toolkit: Vol 1. Designing and conducting ethnographic research*, Academic Press, Walnut Creek, CA.
- Leddy, S. and Pepper, J. M. (1989) *Conceptual bases of professional nursing*, J.B. Lippincott Company, Philadelphia.
- Lelean, S. R. (1975) *Ready for report nurse. RCN research project. Series 2, no 2.*, RCN, London.
- Liaschenko, J. and Fisher, A. (1999) Theorizing the knowledge that nurses use in the conduct of their work. *Scholarly Inquiry for Nursing Practice: An International Journal*, **13**(1), 29-41.
- Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic Inquiry*, Sage, Beverly Hills CA.
- Lincoln, Y. S. and Guba, E. G. (2003) The discipline and practice of qualitative research. In *The landscape of qualitative research: Theories and issues*(Eds, Lincoln, Y. S. and Guba, E. G.) Sage Publications, London.
- Loveridge, J. (2000) The therapy of touch. (how touch can assist in developing a therapeutic relationship during resuscitation. *Emergency Nurse*, **7**(10), 9-?
- Lowenberg, J. S. (1994) The nurse-patient relationship reconsidered: an expanded research agenda. *Scholarly Inquiry for Nursing Practice: An International Journal*, **8**(2), 167-190.
- Lupton, D. (1995) Perspectives on power, communication and the medical encounter: implications for nursing theory and practice. *Nursing Inquiry*, **2**, 157-163.
- Mackay, N. and Barrowclough, C. (2005) Accident and emergency staff's perceptions of deliberate self-harm: attributes, emotions and willingness to help. *British Journal of Clinical Psychology*, **44**, 255-267.
- Malinowski, B. (1992) *Argonauts of the western pacific: an account of native enterprise and adventure in the archipelagos of Melanesian New Guinea*, Routledge, London.
- Malone, R. E. (1996) Almost 'like family': emergency nurses and 'frequent flyers'. *Journal of Emergency Nursing*, **22**(3), 176-183.

- Malone, R. E. (2000) Dimensions of vulnerability in emergency nurses' narratives. *Advances in Nursing Science*, **23**(1), 1-11.
- Manchester Triage Group (1997) *Emergency triage*, BMJ Publishing Group, London.
- March, J. G. and Simon, H. A. (1993) *Organizations*, Blackwell Business, Oxford.
- Marchand, A., Demers, A. and Durand, P. (2005) Does work really cause distress? The contribution of occupational structure and work organization to the experience of psychological distress. *Social Science & Medicine*, **61**, 1-14.
- Mark, A. (1991) Clinical directorates. Will the glass ceiling be double-glazed? *Health Manpower Management*, **17**(4), 14-17.
- Marriner-Tomey, A. (1994) Introduction to analysis of nursing theories. In *Nursing theorists and their work*(Ed, Marriner-Tomey, A.) Mosby, St Louis.
- Maslach, C. and Jackson, S. (1986) *Maslach burnout inventory manual*, Consulting Psychologists Press, Pal Alto, USA.
- Maslow, A. (1968) *Toward a psychology of being*, Van Nostrand Reinhold, New York.
- Mason, J. (2002) *Qualitative researching*, Sage Publications, London.
- Mason, J. K. and McCall Smith, R. A. (1994) *Law and medical ethics*, Butterworths, London.
- Mather, H. M. (1998) Coping with pressures in acute medicine. *Journal of the Royal College of Physicians of London*, **32**(3), 211-218.
- Mather, H. M. and Conner, H. (2002) Coping with pressures in acute medicine: the third RCP consultant questionnaire survey. Royal College of Physicians. Found at <http://www.rclondon.ac.uk> [Accessed 26/04/2002].
- May, C. (1992) Nursing work, nurses' knowledge, and the subjectification of the patient. *Sociology of Health & Illness*, **14**(4), 472-487.
- May, C. and Fleming, C. (1997) The professional imagination: narrative and the symbolic boundaries between medicine and nursing. *Journal of Advanced Nursing*, **25**, 1094-1100.
- Mayled, A. (1998) Medical admissions units: the role of the nurse practitioner. *Nursing Standard*, **12**(27), 44-47.
- McBryde-Foster, M. and Allen, T. (2005) The continuum of care: a concept development study. *Journal of Advanced Nursing*, **50**(6), 624-632.
- McCabe, C. (2004) Nurse-patient communication: an exploration of patients' experiences. *Journal of Clinical Nursing*, **13**, 41-49.

- McFarland, G. and McFarlane, E. A. (1993) *Nursing diagnosis & intervention. Planning for patient care*, Mosby, St. Louis.
- McFarlane, J. K. (1970) *The proper study of the nurse*, Royal College of Nursing and National Council of Nurses of the United Kingdom, London.
- McFarlane, J. K. and Castledine, G. (1982) *A guide to the practice of nursing using the nursing process*, The C.V. Mosby Company, London.
- McGarvey, H. E., Chambers, M. G. A. and Boore, J. R. P. (2000) Development and definition of the role of the operating department nurse: a review. *Journal of Advanced Nursing*, **32**(5), 1092-1100.
- McKane, M. and Tolson, D. (2000) Research, ethics and the data protection legislation. *Nursing Standard*, **4**(22), 36-41.
- McKenna, H. (1997) *Nursing theories and models*, Routledge, London.
- McLureWasko, M. and Faraj, S. (2000) "It is what one does": why people participate and help others in electronic communities of practice. *Journal of Strategic Management*, **9**, 155-173.
- McQueen, A. (2000) Nurse-patient relationships and partnership in hospital care. *Journal of Clinical Nursing*, **9**, 723-731.
- McVicar, A. (2003) Workplace stress in nursing: a literature review. *Journal of Advanced Nursing*, **44**(6), 633-642.
- Meerabeau, L. (1992) Tacit nursing knowledge: an untapped resource or a methodological headache. *Journal of Advanced Nursing*, **17**, 108-112.
- Meerabeau, L. (2004) Be good, sweet maid, and let who can be clever: a counter reformation in English nursing education? *International Journal of Nursing Studies*, **41**, 285-292.
- Meleis, A. I. (1991) *Theoretical nursing: development and progress (2nd Ed.)*, J.B. Lippincott, Philadelphia.
- Meleis, A. I., Sawyer, L. M., Im, E., Hilger Messias, D. K. and Schumacher, K. (2000) Experiencing transitions: an emerging middle-range theory. *Advances in Nursing Science*, **23**(1), 12-28.
- Melia, K. (2000) Conducting an interview. *Nurse Researcher*, **7**(4), 75-89.
- Menzies, I. E. P. (1960) A case study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital. *Human Relations*, **13**(2), 95-121.

- Merrell, J. and Williams, A. (1994) Participant observation and informed consent: relationships and tactical decision-making in nursing research. *Nursing Ethics*, **1**(3), 163-172.
- Merriam, S. B., Courtenay, B. and Baumgartner, L. (2003) On becoming a witch: learning in a marginalized community of practice. *American Association for Adult and Continuing Education*, **53**(3), 170-188.
- Mezirow, J. (1998) On critical reflection. *Adult Education Quarterly*, **48**(3), 185-191.
- Mitchell, J. C. (1983) Case and situation analysis. *Sociological Review*, **3**, 187-211.
- Morrison, P. and Burnard, P. (1997) *Caring and communicating: the interpersonal relationships in nursing*, Palgrave, Houndsmill, Basingstoke.
- Morse, J. M. (1991) Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing*, **16**, 455-468.
- Morse, J. M., Bottorff, J., Nealand, W. and Solberg, S. (1991) Comparative analysis of conceptualizations and theories of caring. *Image: Journal of Nursing Scholarship*, **23**(2), 119-126.
- Morse, J. M. and Field, P. A. (1996) *Nursing research: the application of qualitative approaches*, Chapman & Hall, London.
- Muncer, S., Taylor, S., Green, D. and McManus, I. (2001) Nurses' representations of the perceived causes of work-related stress: a network drawing approach. *Work & Stress*, **15**(1), 40-52.
- Murray, R. B. and Zentner, J. P. (1989) *Nursing concepts for health promotion*. Prentice Hall, New York.
- National Assembly for Wales (NAW) (1999) *Realising the Potential. A Strategic Framework for Nursing, Midwifery and Health Visiting in Wales into the 21st Century*, The National Assembly for Wales, Cardiff.
- National Assembly for Wales (NAW) (2000) *Emergency pressure planning guidance winter 2000/01*. NHS Cymru Wales, Cardiff.
- National Assembly for Wales (NAW) (2001a) *A plan for the NHS with its partners. Improving health in Wales*, National Assembly for Wales, Cardiff.
- National Assembly for Wales (NAW) (2001b) *Improving access for patients. Business plan 2001-2002. Innovations in care team*. National Assembly for Wales, Cardiff.
- National Assembly for Wales (NAW) (2001c) *Emergency Pressures Planning Guidance*, National Assembly for Wales, Cardiff.

- National Assembly for Wales (NAW) (2001d) *Research Governance Framework for Health and Social Care in Wales*. The National Assembly for Wales, Cardiff.
- New Zealand Health Technology Assessment (NZHTA) (1998) *Acute medical admissions: a critical appraisal of the literature*. NZHTA Report 6. New Zealand Health Technology Assessment, Christchurch, New Zealand.
- NHS Trust Federation (1995) *Analysing changes in emergency admissions*, NHS Trust Federation, London.
- NHS Executive (1999) *Protecting and using Patient Information: A Manual for Caldicott Guardians*. Found at <http://www.doh.gov.uk/confiden/cgminto> [Accessed 01/08/2002]
- NHS Modernisation Agency (2001) *Improving the flow of emergency admissions*. DoH, London.
- NHS Modernisation Agency (2002) *Improvement in emergency care: case studies*. DoH, London.
- Nonaka, I. (1994) A dynamic theory of organizational knowledge creation. *Organization Science*, **5**(1), 14-37.
- Northrup, D. T., Tschanz, C. L., Olynyk, V. G., Makaroff, K. L. S., Szabo, J. and Biasio, H. A. (2004) Nursing: whose discipline is it anyway? *Nursing Science Quarterly*, **17**(1), 55-62.
- Nursing & Midwifery Council (NMC) (2004) *The NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics*, Nursing & Midwifery Council, London.
- Nursing & Midwifery Council (NMC) (2005) *Guidelines for records and record keeping*, Nursing and Midwifery Council, London.
- Nystrom, M., Dahlberg, K. and Carlsson, G. (2003) Non-caring encounters at an emergency care unit- a life-world hermeneutic analysis of an efficiency-driven organization. *International Journal of Nursing Studies*, **40**, 761-769.
- Pang, S. M. C., Wong, T. K. S., Zhang, Z. J., Chan, H. Y. L., Lam, C. W. Y. and Chan, K. L. (2004) Towards a Chinese definition of nursing. *Journal of Advanced Nursing*, **46**(6), 657-670.
- Parker, J. and Gardner, G. (1992) The silence and the silencing of the nurse's voice: a reading of patient progress notes. *The Australian Journal of Advanced Nursing*, **9**(2), 3-9.
- Pearce, L. (2003) Handing over. *Nursing Standard*, **17**(22), 14-17.

- Pearson, A. (1988) Primary nursing. In *Primary nursing. Nursing in the Burford and Oxford nursing development units*(Ed, Pearson, A.) Chapman and Hall, London.
- Peltonen, T. and Lamsa, T. (2004) 'Communities of practice' and the social process of knowledge creation: towards a new vocabulary for making sense of organizational learning. *Problems and Perspectives in Management*, **4**, 249-262.
- Pennington, R. C., Gillen, K. and Hill, P. (1999) *Social psychology*, Arnold, London.
- Peplau, H. E. (1987) Nursing science: a historical perspective. In *Nursing science: major paradigms, theories and critiques* (Ed, Parse, R. R.) W.B. Saunders, Philadelphia.
- Peplau, H. E. (1992) Interpersonal relations: a theoretical framework for application in nursing practice. *Nursing Science Quarterly*, **5**(1), 13-18.
- Pesut, D. J. and Herman, J. (1999) *Clinical reasoning: the art and science of critical and creative thinking*, Delmar Publishers, New York.
- Piko, B. (1999) Work-related stress among nurses: a challenge for health care institutions. *The Journal of the Royal Society for the Promotion of Health*, **119**(3), 156-162.
- Pless, B. S. and Clayton, G. M. (1993) Clarifying the concept of critical thinking in nursing. *Journal of Nursing Education*, **32**(9), 425-428.
- Polanyi, M. (1966) *The tacit dimension*, Doubleday, New York.
- Porter, S. (1991) A participant observation study of power relations between nurses and doctors in a general hospital. *Journal of Advanced Nursing*, **16**, 728-735.
- Porter, S. (1998) *Social theory and nursing practice*, Macmillan Press Ltd, London.
- Porter, S. and Ryan, S. (1996) Breaking the boundaries between nursing and sociology: a critical realist ethnography of the theory-practice gap. *Journal of Advanced Nursing*, **24**, 413-420.
- Prior, L. (2003) *Using documents in social research*, SAGE Publications, London.
- Punch, M. (1986) *The politics and ethics of fieldwork*, Sage Publications, London.
- Pyles, S. H. and Stern, P. N. (1983) Discovery of nursing gestalt in critical care nursing: the importance of the gray gorilla syndrome. *Image: Journal of Nursing Scholarship*, **XV**(2), 51-57.
- QSR (1997) NUD\*IST version 4. QSR. Melbourne.
- Ramos, M. C. (1992) The nurse-patient relationship: theme and variations. *Journal of Advanced Nursing*, **17**, 496-506.



- Reason, P. and Heron, J. (1986) Research with people: the paradigm of cooperative experiential enquiry. *Person-Centred Review*, **1**, 457-476.
- Redsell, S. A. and Cheater, F. M. (2001) The Data Protection Act (1998): implications for health researchers. *Journal of Advanced Nursing*, **35**(4), 508-513.
- Reed, J. and Bond, S. (1991) Nurses' assessment of elderly patients in hospital. *International Journal of Nursing Studies*, **28**(1), 55-64.
- Reed, P. G. (1995) A treatise on nursing knowledge development for the 21st century: beyond postmodernism. *Advances in Nursing Science*, **17**(3), 70-84.
- Resuscitation Council (The) (2003) First responders. Found at <http://www.resus.org.uk/pages/FirstRsp> [Accessed 09/01/2006]
- Riehl, J. P. and Roy, C. (1980) *Conceptual models for nursing practice*, Appleton-Century Crofts, Norwalk.
- Robson, C. (1993) *Real world research: a resource for social scientists and practitioner-researchers*, Blackwell Publishers Ltd, Oxford.
- Rodgers, B. L. (1989). Concept analysis and the development of nursing knowledge: the evolutionary cycle. *Journal of Advanced Nursing*, **14**, 330-335.
- Rodney, P. and Varcoe, C. (2001) Towards ethical inquiry in the economic evaluation of nursing practice. *Canadian Journal of Nursing Research*, **33**(1), 35-57.
- Rolfe, G., Freshwater, D. and Jasper, M. (2001) *Critical reflection for nursing and the helping professions. A user's guide*. Palgrave, Basingstoke.
- Roper, N., Logan, W. W. and Tierney, A. J. (1996) *The elements of nursing. A model for nursing based on a model of living*, Churchill Livingstone, New York.
- Rossing, B. E. and Long, H. B. (1981) Contributions of curiosity and relevance to adult learning motivation. *Adult Education*, **32**(1), 25-36.
- Roth, J. A. (1972) Some contingencies of the moral evaluation and control of clientele: the case of the hospital emergency services. *The American Journal of Sociology*, **77**(5), 839-856.
- Roughton, V. J. and Severs, M. P. (1996) The junior doctor handover: current practices and future expectations. *Journal of the Royal College of Physicians of London*, **30**(3), 213-216.
- Roy, C. (1984) *Introduction to nursing*, Prentice-Hall, Englewood Cliffs, NJ.
- Royal College of Nursing (2003) *Defining nursing*. Royal College of Nursing. Found at [www.rcn.org.uk](http://www.rcn.org.uk) [Accessed 12/09/2004]

- Royal College of Nursing (2004a) *The future nurse: evidence of the impact of registered nurses*. Royal College of Nursing, London.
- Royal College of Nursing (2004b) *Research ethics: RCN guidance for nurses*. Royal College of Nursing, London.
- Royal College of Physicians of Edinburgh (1998) *Acute medical admissions and the future of general medicine*, Royal College of the Physicians of Edinburgh, Edinburgh.
- Royal College of Physicians of England. (2001). *Consultant physicians working for patients. The duties, responsibilities and practice of physicians*. London: Royal College of Physicians.
- Sadler, J. J. (1997) Defining professional nurse caring: a triangulated study. *International Journal of Human Caring*, **1**(3), 12-21.
- Sakr, M., Kendall, R., Angus, J., Suanders, A., Nicholl, J. and Wardrope, J. (2003) Emergency nurse practitioners: a three part study in clinical and cost effectiveness. *Emergency Medicine Journal*, **20**, 158-163.
- Salvage, J. (1992) The new nursing: empowering patients or empowering nurses? In *Policy issues in nursing*(Eds, Robinson, J., Gray, A. and Elkan, R.) Open University Press, Milton Keynes.
- Salvage, J. (1995) Political implications of the named nurse concept. *Nursing Times*, **91**(41), 36-37.
- Sandelowski, M. (1986) The problem of rigour in qualitative research. *Advances in Nursing Science*, **8**, 27-37.
- Sandelowski, M. (1995) Triangles and crystals: on the geometry of qualitative research. *Research in Nursing & Health*, **18**, 569-574.
- Sandelowski, M. (1996) One is the liveliest number: the case orientation of qualitative research. *Research in Nursing & Health*, **19**, 525-529.
- Sandelowski, M. (1997) (Ir) Reconcilable differences? The debate concerning nursing and technology. *Image: Journal of Nursing Scholarship*, **29**(2), 169-174.
- Savage, J. (1995) *Nursing intimacy: an ethnographic approach to nurse-patient interaction*, Scutari Press, London.
- Savage, J. (2000) Ethnography and health care. *British Medical Journal*, **321**, 1400-2.
- Sbaih, L. (1997a) The work of accident and emergency nurses: Part 1. An introduction to the rules. *Accident & Emergency Nursing*, **5**, 28-33.

- Sbah, L. (1997b) The work of accident and emergency nurses: part 2. A&E maxims: making A&E work unique and special. *Accident & Emergency Nursing*, **5**, 81-87.
- Schatzman, L., & Strauss, A. (1973). *Field research: strategies for a natural science*. Englewood Cliff, New Jersey, USA: Prentice-Hall.
- Schmitz, N., Nuemann, W. and Opermann, R. (2000) Stress, burnout and locus of control in German nurses. *International Journal of Nursing Practice*, **37**, 95-99.
- Schofield, J. W. (1993) Increasing the generalizability of qualitative research. In *Social Research: Philosophy, Politics and Practice*.(Ed, Hammersley, M.) Sage, London.
- Schon, D. A. (1987) *Educating the reflective practitioner*, Jossey-Bass Publishers, San Francisco.
- Schwartz-Barcott, D. and Kim, H. S. (1986) An expansion and elaboration of the hybrid model of concept development. In *Concept development in nursing: Foundations, techniques and applications*(Eds, Rodgers, B. L. and Knafl, K. A.) W.B. Saunders, Philadelphia.
- Sexton, J. B., Thomas, E. J. and Helmreich, R. L. (2000) Error, stress, and teamwork in medicine and variation: cross sectional surveys. *British Medical Journal*, **320**, 745-749.
- Sherwin, S. (1992) Feminist and medical ethics: two different approaches to contextual ethics. In *Feminist perspectives in medical ethics*(Eds, Holmes, H. B. and Purdy, L. M.) Indiana University Press, Bloomington.
- Shirey, M. R. (2004) Social support in the workplace: nurse leader implications. *Nursing Economic\$,* **22**(6), 313-319.
- Silverman, D. (2001) *Interpreting qualitative data*, Sage Publications, London.
- Smith, P. (1992) *The emotional labour of nursing. How nurses care*, Palgrave Macmillan, Basingstoke.
- Snelgrove, S. and Hughes, D. (2000) Interprofessional relations between doctors and nurses: perspectives from South Wales. *Journal of Advanced Nursing*, **31**(3), 661-667.
- Snelgrove, S. and Hughes, D. (2002) Perceptions of teamwork in acute medical wards. In *Nursing and the division of labour in healthcare*(Eds, D.Allen and Hughes, D.) Palgrave Macmillian, Houndsmills, Basingstoke.
- Spradley, J. P. (1979) *The ethnographic interview*, Holt, Rinehart & Winston, New York.
- Spradley, J. P. (1980) *Participant observation*, Holt, Rinehart & Winston, New York.

- Squires, A. (2004) A dimensional analysis of role enactment of acute care nurses. *Journal of Nursing Scholarship*, **36**(3), 272-278.
- Stake, R., E (1994) Case studies. In *Handbook of qualitative research*(Eds, Denzin, N. K. and Lincoln, Y. S.) Sage Publications, Thousand Oaks.
- Stapleton, S. R. (1998) Team-building: making collaborative practice work. *Journal of Nurse-Midwifery*, **43**(1), 12-18.
- Stein, L. (1967) The doctor-nurse game. *Archives of General Psychiatry*, **16**, 699-703.
- Stein, L., Watts, D. T. and Howell, T. (1990) The doctor-nurse game revisited. *Nursing Outlook*, **36**, 264-268.
- Stockwell, F. (1972) *The unpopular patient*, RCN, London.
- Stoecker, R. (1991) Evaluating and rethinking the case study. *The Sociological Review*, **39**, 88-112.
- Stordeur, S., D'hoore, W. and Vandenberghe, C. (2001) Leadership, organisational stress, and emotional exhaustion among hospital nursing staff. *Journal of Advanced Nursing*, **35**(4), 533-542.
- Strauss, A., Schatzman, L., Butcher, R., Ehrlich, D. and Sabshin, M. (1963) The hospital and its negotiated order. In *The hospital in modern society*(Ed, Friedson, E.) Free Press, New York.
- Svensson, R. (1996) The interplay between doctors and nurses - a negotiated order perspective. *Sociology of health and illness*, **18**(3), 379-398.
- Sweet, S. J. and Norman, I. J. (1995) The nurse-doctor relationship: a selective review. *Journal of Advanced Nursing*, **22**, 165-170.
- Takase, M., Maude, P. and Manias, E. (2006) Role discrepancy: is it a common problem among nurses? *Journal of Advanced Nursing*, **54**(6), 751-759.
- Taxis, K. and Barber, N. (2003) Ethnographic study of incidence and severity of intravenous drug errors. *British Medical Journal*, **326**, 684.
- Taylor, C. and Benger, J. R. (2004) Patient satisfaction in emergency medicine. *Emergency Medicine*, **21**(528-532).
- Taylor, S., White, B. & Muncer, S. (1999) Nurses' cognitive structural models of work based stress. *Journal of Advanced Nursing* **29**(4).
- Tedlock, B. (2003) Ethnography and ethnographic representation. In *Strategies of qualitative inquiry*(Eds, Denzin, N. K. and Lincoln, Y. S.) SAGE publications, London.
- Thomas, J. (1993) *Doing critical ethnography*, Sage Publications, Newbury Park.

- Thompson, C. and Dowding, D. (2002) Clinical decision-making and judgement in nursing-an introduction. In *Clinical decision making and judgement in nursing* (Eds Thompson, C. and Dowding, D.), Churchill Livingstone, London.
- Tierney, A. J. (1998) Nursing models: extant or extinct? *Journal of Advanced Nursing*, **28**(1), 77-85.
- Trust Data (2001) AMAU statistics (Financial year 2000/2001)
- Trust Data (2003) Review of the operation and effectiveness of the acute medical admissions unit (AMAU) @ XXXX General Hospital.
- Trust Data (2004) Activity analysis 2003/2004. Medical directorate. XXXX NHS Trust.
- Trust Data (2005) Nursing establishment (medical directorate). XXXX NHS Trust (personal correspondence).
- Tummers, G. E. R., Landeweerd, J. A. and G.G.vanMerode (2002) Work organisation, work characteristics, and their psychological effects on nurses in the Netherlands. *International Journal of Stress Management*, **9**(3), 183-206.
- Tyson, P. D., Pongruengphant, R., & Aggarwal, B. (2002). Coping with organisational stress among hospital nurses in Southern Ontario. *International Journal of Nursing Studies*, **39**, 453-459.
- United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (UKCC) (1987) *Project 2000: the final proposals*. UKCC, London.
- United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (UKCC) (1992) *The Scope of Professional Practice*. UKCC, London
- United Kingdom Central Council for Nursing, Midwifery, and Health Visiting(UKCC) (1999) *Fitness for practice: the UKCC commission for nursing and midwifery education*. UKCC, London (Chair: L. Peach).
- United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (2002) *Report of the higher level of practice pilot and project*. UKCC, London.
- van Manen, M. (1990) *Researching lived experience: Human science for an action sensitive pedagogy*, ON: Althouse, London.
- Verplanken, B. (2004) Value congruence and job satisfaction among nurses: a human relations perspective. *International Journal of Nursing Studies*, **41**, 599-605.
- Vidich, A. J. and Lyman, S. M. (2003) Qualitative methods. Their history in sociology and anthropology. In *The landscape of qualitative research. Theories and issues*(Eds, Denzin, N. K. and Lincoln, Y. S.) Sage Publications, London.

- Walsh, M., Dolan, B. and Lewis, A. (1998) Burnout and stress among A&E nurses. *Emergency Nurse*, **6**(2), 23-30.
- Walsh, M. and Ford, P. (1989) *Nursing rituals*, Butterworth-Heinemann, Oxford.
- Walsh, M. and Kent, A. (2001) *Accident and emergency nursing*, MPG Books, Cornwall.
- Walton, M. (1997) *Management and managing: leadership in the NHS*. Stanley Thornes (Publishers) Ltd., London.
- Wanklyn, P., Hosker, H., Pearson, S. and Belfield, P. (1997) Slowing the rate of acute medical admissions. *Journal of the Royal College of Physicians of London*, **31**(2), 173-176.
- Watson, J. (1985) *Nursing: human science and human care-a theory of nursing*, Appleton-Century Crofts, Norwalk.
- Watson, J. and Smith, M. C. (2002) Caring science and the science of unitary human beings: a trans-theoretical discourse for nursing knowledge development. *Journal of Advanced Nursing*, **37**(5), 452-461.
- Watson, R. and Lea, A. (1997) The caring dimensions inventory (CDI) content validity, reliability and scaling. *Journal of Advanced Nursing*, **25**, 87-94.
- Webb, C. (1996) Caring, curing, coping: towards an integrated model. *Journal of Advanced Nursing*, **23**, 960-968.
- Webb, C. (1999) Analysing qualitative data: computerized and other approaches. *Journal of Advanced Nursing*, **29**(2), 323-330.
- Webb, P. (1994) Communication. In *Nursing practice hospital and home: The adult*(Eds, Alexander, M. F., Fawcett, J. N. and Runciman, P. J.) Churchill Livingstone, Edinburgh.
- Weinberg, D. (2002) Qualitative research methods: an overview. In *Qualitative research methods*(Ed, Weinberg, D.) Blackwell Publishers Ltd, Oxford.
- Wells, J. and Bowers, L. (2002) How prevalent is violence towards nurses working in general hospitals in the UK? *Journal of Advanced Nursing*, **39**(3), 230-240.
- Welsh Assembly Government (WAG) (2004) *A statement of healthcare standards-standards for NHS care and treatment in Wales*. Welsh Assembly Government, Cardiff.
- Wenger, E. (1998) *Communities of practice. Learning, meaning, and identity*, Cambridge University Press, Cambridge.

- Wenger, E. C. and Synder, W. M. (2000) Communities of practice: the organizational frontier. *Harvard Business Review*, **Jan-Feb**, 139-145.
- Whyte, W. F. (1981) *Street corner society. The social structure of an Italian slum*, University of Chicago, Chicago.
- Wicks, D. (1998) *Nurses and doctors at work*, Open University Press, Buckingham.
- Wilde, V. (1992) Controversial hypotheses on the relationship between researcher and informant in qualitative research. *Journal of Advanced Nursing*, **17**, 234-242.
- Williams, A. (1991) Practical ethics: interpretative processes in an ethnography of nursing. In *Rethinking: feminist research processes reconsidered*. In Aldridge, J., Griffiths, V. and Williams, A. (1991) *Feminist Praxis: Studies in Sexual Politics No.34*, Manchester.
- Williams, A. (1995) The relationship between ethnography and feminist research. *Nurse Researcher*, **3**(2), 34-54.
- Williams, A. and Sibbald, B. (1999) Changing roles and identities in primary health care: exploring a culture of uncertainty. *Journal of Advanced Nursing*, **29**(3), 737-745.
- Williams, A. M. and Irurita, V. F. (2004) Therapeutic and non-therapeutic interpersonal interactions: the patient's perspective. *Journal of Clinical Nursing*, **13**, 806-815.
- Willis, E. (1989) *Medical dominance: the division of labour in Australian health care*, Allen & Unwin, Sydney.
- Willis, E. and Parish, K. (1997) Managing the doctor-nurse game: a nursing and social science analysis. *Contemporary Nurse*, **6**(3/4), 136-144.
- Wilson, K. and Williams, A. (2000) Visualism in community nursing: implications for telephone work with service users. *Qualitative Health Research*, **10**, 507-520.
- Wiman, E. and Wikblad, K. (2004) Caring and uncaring encounters in nursing in an emergency department. *Journal of Clinical Nursing*, **13**(4), 422-432.
- Wimpenny, P. (2002) The meaning of models of nursing to practising nurses. *Journal of Advanced Nursing*, **40**(3), 346-354.
- Wolf, Z. R. (1989) Uncovering the hidden work of nursing. *Nursing & Health Care*, **10**(8), 463-467.
- Wood, I. (2000a) Medical assessment units in the West Midlands region: a nursing perspective. *Accident & Emergency Nursing*, **8**, 196-200.
- Wood, I. (2000b) Deskillling or extending? *Nursing Times*, **96**(4), 44.

Woodward, V. M. (1997) Professional caring: a contradiction in terms? *Journal of Advanced Nursing*, **26**, 999-1004.

Woolsey, L. K. (1986) The critical incident technique: an innovative qualitative method of research. *Canadian Journal of Counselling*, **20**(4), 242-254.

World Medical Association (2004) World medical association declaration of Helsinki. Ethical principles for medical research involving human subjects. World Medical Association. Found at <http://www.wma.net/e/ethicsunit/index> [Accessed 12/01/2007]

Zoloth-Dorfman, L., & Rubin, S. (1995). The patient as commodity: managed care and the question of ethics. *The Journal of Clinical Ethics*, **6**(4), 339-357.