

**Uncovering complexity in everyday practice:
A post-modern study of community nursing
assessment**

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Abstract

Much skilled nursing practice is described by words which at face value appear low-tech and self-explanatory. Despite being acknowledged as intrinsic to practice “nursing assessment” has few operational definitions.

This thesis critiques and reviews the methodological assumptions that underpin research and the frameworks commonly used to facilitate Concept Analysis (CA). Despite the apparent plethora of approaches to CA, the majority of them used (or adapted without justification or critique) the work of one author, and this was found to be simplistic and ontologically flawed.

A review of the contemporary nursing literature was undertaken to identify uses of the term *assessment*. The subsequent Glasarian Grounded Theory Analysis revealed the *Judicial* as the core of seven overlapping categories.

Evidence of the everyday use of the term *assessment* was obtained through observation and audio recording of nursing assessment practice. Following Foucault, Critical Discourse Analysis of the data recorded in the study’s field work phase was undertaken. This revealed social power and dominance facilitated through subject/object connotations and the discourses of discrimination, surveillance, repression, natural science, resistance and institutional power, and in contrast, examples of empowering practice.

This thesis will argue that the process of nursing assessment is skilled and complex, and that in order to measure and demonstrate the quality of nursing practice within an arena dominated by the hegemonic power of medicine, it requires articulation and understanding.

Nurses use a matrix of approaches to build rapport and assess patients during all interactions. Their work involves integrating intuitive, predictive and logical reasoning within an empathetic and authentic communication with patients and their carers. Hierarchies of nursing practice, government policies, inter-professional agendas and dissonances between the policy rhetoric of placing patients at the heart of assessment and actual everyday practice, produce barriers to meaningful assessments.

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Chapter one

Introduction

“The pattern of the thing precedes the thing”

Vladimir Nabokov (1999).

This thesis adopts the position that the interaction between patients, carers and nurses, typified as “nursing assessment”, constitutes a discourse. Further that analysis using a Foucauldian approach to Critical Discourse Analysis will provide socio-political insights into the participant’s experience of the assessment process. This opening chapter introduces the topic area, aims and purpose of my enquiry. The research questions which gave focus to the study are introduced and the underpinning theoretical positions and structure of the study and this dissertation are outlined.

1.1. Topic area and aim of the study

Nursing assessment, the assessment of patients carried out by nurses, being either a compound verb and/or a noun; a process and/or an outcome, is far from the intuitively simple concept it at first appears. Cheek (1997) and Barry (2002) have respectively drawn attention to the different “*viewing positions*” and “*multiple realities*” of patient care. These differing positions require that we consider the process of assessment from the multiple perspectives of patient, carer and nurse.

The aim of the research reported within this thesis is to enable us better to articulate the complexity of assessment that I contend comprises the core work of nursing practice.

This research provides evidence to support the assertion that assessment is a little understood and complex interaction between professional nurses and their patients.

1.2. Purpose of the study

The purpose of this qualitative, post-modern research study is to provide evidence of the interpretations of nursing assessment: firstly taken from the current literature, and

secondly from analysis of the data obtained in the second phase of this study. From the identification of shared characteristics a picture can be built up about the nature of the practice that constitutes nursing assessment.

This study is divided into two phases: firstly a Concept Analysis (CA), using a Glasarian (1978) Grounded Theory Approach of the term assessment as it is used within the nursing literature between 1990 and 2005.

The second phase comprises the field-work, transcription and analysis stages which commenced with the submission of documentation and the granting of Ethical and Research Approval. This was followed by recruitment of participants for the non-participant observation of real-time assessment interactions between nurses, patients and their informal carers.

Primary source data was obtained from transcription of the audio recordings of eleven assessments and subsequent semi-structured interviews with nurses, patients and, where present, their carers. Additional data was obtained from secondary sources such as patients' nursing notes, protocols and policies. The data obtained was then analysed using a Foucauldian inspired Critical Discourse Analysis (CDA) technique (Howarth 2000).

1.3. Research questions

Five generative research questions provided the focus for this work. Strauss (1987) describes generative research questions as those which:

" ..stimulate the line of investigation in profitable directions:" page 22

These questions are designed to permit new discoveries by focussing on descriptions of the process under investigation. They are all predicated upon the ontological position that assessment is something that nurses do and that it can be understood and interpreted by close observation and analysis. Qualitative research methods aim to discover and understand everyday occurrences that are sensitive to time and culture.

The first research question; *"How is nursing assessment defined in the literature?"*, underpins phase one of this study and comprises a rigorous, transparent and

systematic search of the databases listed in appendix 1. The literature review was carried out in order to analyse the concept of assessment as used within the papers selected. This categorisation of prior understanding of the term enabled the study to build on and develop the work of others.

Glaser's grounded theory model was used to analyse the selected works because it is predicated on the theoretical perspective that it promotes iterative theory development from unbiased observation. Further it avoids the imposition of confirmation or verification of a preconceived hypothesis.

The remaining four research questions were framed to elucidate the processes that influence the practice of assessment and to seek the views of the nurses who assess, the patients who are assessed, and their carers, who are often included in the process. The remaining questions were:

2. *What professional, philosophical and organisational influences affect the nursing role regarding patient assessment?*
3. *What impact does nursing assessment have on patients?*
4. *Does patient inclusion, involvement and empowerment happen as a result of a nursing assessment?*
5. *Does the location of a nursing assessment have an impact on the assessment?*

1.4. The theoretical positions that underpin the study

The theoretical positions on which these research questions are formulated are that understanding of social interactions may be achieved through the deconstruction of the everyday language that comprises the discourse of assessment. This is based upon the theoretical assumptions that all actions are meaningful and construct and contest experiences of social reality, and that this construction is both shaped by and shapes social practices, relationships and institutions (Foucault 1991). Undertaking this study has allowed me to reflect in depth on method and methodology from a variety of philosophical perspectives. This has facilitated a new approach to the presentation of these topics.

Data has been collected in a naturalistic context and investigations are carried out with an approach free from rigid experimental designs. Data analysis is undertaken

bearing in mind the context of the occurrence and that discourses often reflect unequal access to linguistic and social resources. For this purpose Foucauldian inspired Critical Discourse Analysis (CDA) was chosen as the method for analysis of the data obtained during the field work phase. This decision is justified on the congruence of the ontological stance of the researcher and the method. CDA embraces Habermas (1986), Foucault (1973, 1980) and Bourdieu's (2007) accounts of the symbolism and actuality of power of institutions within discourses from micro to macro levels. This provides an approach that is suitable for exploring research questions two to five as it can reveal the language-based iconographic means by which institutions and individuals reveal their power.

Following Derrida's (1967) critique of binary distinctions within post-medieval western thinking the theory of the alchemist is followed embracing that things may be *either/or*, in addition to *either* and *or*. For example Derrida (1978) uses the binary of forgetfulness and memory arguing that rather than their being in opposition there is no need for memory if there is not forgetfulness. For memory to have meaning our conception of it depends on our having a conception of forgetfulness.

1.5. Structure of the dissertation

Following this introduction the dissertation proceeds with an outline of the politico/social background to this study. The dissertation then moves to an exploration of qualitative research methodology and an explanation of the reflexive approach taken for justifying this study's design. Chapter 4 describes and justifies the specific designs adopted for both phases of this study. The description of Phase 1 outlines the methodical process undertaken to identify included studies and explore uses of the term assessment through a modified CA. The approach utilised to identify the literature was an adaptation of a Systematic Review process (Egger et al 2005). This approach was chosen as predefined and transparent inclusion and exclusion criteria and an assessment of the quality of the papers and extracts identified were intrinsic. A Glasarian Grounded Theory (Glaser 1998) technique was used to identify the categories of usage of the term.

The justification for this departure from a conventional literature review rests firstly on a necessity as the literature revealed very few definitions of the term nursing assessment. In addition, to address the first research question (see above), and

explore the ways in which the term nursing assessment was used in the literature analysis at a conceptual level was thought to provide evidence of the wide range of depictions and constructs of this portmanteaux term. This justification is further predicated on both the paucity of intellectually supportable CA frameworks commonly used within nursing literature and the author's need to explore the topic without building on *a priori* hypotheses.

Chapter 4 also contains description and justification of the CDA technique employed for the analysis of the field work data in Phase 2 of the study. This details the recruitment, observation, interview, data collection and transcription methods employed for this study. Foucauldian CDA is used to facilitate deconstruction and interpretation of the field work data. Justification for this approach is based on grounds that CDA can reveal examples of power imbalances within nurse patient interactions and institutional hegemonies implied within research questions 2-5 .

Findings for Phase 1 of the study are presented in chapter 5 and those for Phase 2 in chapter 6. The findings are presented in this way as analysis was achieved through different methods although it is argued that there is both epistemological and ontological congruence to the approaches.

Discussion and synthesis of the Phase 1 and 2 findings are detailed in chapter 7. Chapter 8 provides a conclusion to the dissertation and includes implications and recommendations for future practice.

1.6. Summary

Having introduced the aims, purpose and questions which underpin this study it is important that before detailing the methodology and justification of methods employed we consider the context in which the notion of nursing assessment is considered. The next chapter describes the events that led to this investigation and the back-drop of social and political climates that have influenced the world-wide delivery of health care over the preceding decades.

Chapter 2

Background

2.1. Political and demographic background

Since 1977 the World Health Organisation (WHO) has emphasised links between good primary care and good health, presaging the shift of investment, and practice, from secondary to primary health care delivery. In 2008 WHO again focussed on the importance of the role of primary care with their report Primary Health Care –Now more than ever. Disney et al's (2004) European study indicates the fractured nature of health care delivery across Europe with each member state using a different system but sharing some innovations. For example Foundation Hospital initiatives had their inception in Spain and have subsequently been introduced in the National Health Service (NHS) in England. The Council of Europe (2000) identified both demographic changes and raised patient expectations as fuelling "challenges" to health care provision. In common with nurses in Switzerland, Germany, Thailand, Malaysia and Puerto Rico, (International Council of Nurses [ICN] 2004), nurses in the UK have seen their role extended to meet these challenges.

In the UK new medical contracts and alterations in the composition of the health professional workforce (DoH 1996, 2000, 2003, Wanless 2002) have resulted in challenges to traditional professional boundaries (Nancarrow & Borthwick 2005). The National Health Service and Community Care Act (DoH 1990), Patients Charter (DoH 1991), Fund-holding Practices (DoH 1990) and their abolition, the thrust towards partnership working outlined within the National Service Framework (NSF) for Older People (2001d) and for example introduced as the Single Assessment Process (DoH 2002b) have all engendered fundamental changes in health care provision. Corbin (2008) and Griffiths (2008) have drawn our attention to the need to consider the wider debate regarding the elements that constitute nursing and the bedrock of the art of caring. Both acknowledge the impediments to fulfilling the artistry of nursing which modern practice conditions have engendered. Alterations in demography, disease and illness and political and workforce agendas have resulted in fundamental changes in both the nursing role and nursing practice (Daly and Carnwell 2003; United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) 2002; Wanless 2002; Casteldine 1997).

However Roach (1985) reminded us that caring is a component part of nursing that needs to be delivered in a practice which comprises compassion, competence, confidence, conscience and commitment.

Changes in both philosophical and management approaches to health care have resulted in fundamental shifts in attitude, for example the focus on data collection that purports to demonstrate quality of service. Despite criticism (Freemantle 1994) that the business model Total Quality Management (TQM) would prove incompatible with health care delivery it was introduced during the 1990s. Baggott (2004) notes TQM's four principles as:

- Meeting customer needs through organisational success
- Customer-defined quality is achieved through the production process
- Most employees will work hard and execute their tasks well
- Faults in the process can be revealed through statistical analysis.

To enable the movement towards continuous improvement that is at the heart of TQM the NHS was urged towards developing the culture of a learning institution and the Clinical Governance agenda has been a part of this process.

The quality agenda was further emphasised by the introduction and abolition of the purchaser-provider split in the NHS establishment. The duty of quality care delivery was made explicit through the production of the NHS frameworks in the 1990s and continues through the initiatives such as World Class Commissioning (DoH 2008a) the Darzi review (DoH 2008) and Changing Community Services (DoH 2009).

2. The challenges

Nursing faces challenges both from within and without as much of the skilled practice we undertake seems commonplace and therefore of little worth. Because nursing assessment is described by words in everyday use it would appear, at face value, to be a simple and well-understood process. However nurses have been slow to articulate the complexity of our skilled practice that, like assessment, is often described by words seemingly self-explanatory and appearing low-tech. Kane's (1995) discussion of "Home Care" in America articulates the complex consequences for patients caused by variations in interpretation of the seemingly well understood phrase "homecare". There is a similar lack of consensus about the meaning of

assessment, resulting in a blurring of the term and hampering attempts to measure and monitor the process.

Adaptation and the resultant changes mean UK nurses now undertake formal and informal assessments alone, jointly or as part of a team. The single assessment process (SAP) (DoH 2002b) was introduced to curtail needless information duplication collection and storage by different agencies. The SAP requires health professionals to assess for needs previously outside their role and to share the information they collected. In addition the SAP was intended to ensure a patient centred approach to care, addressing dissonances in care delivery agenda resulting from differences of emphasis between the narratives of health professionals and patients (McKinley and Middleton 1999, Skelton et al 2002, Gillespie et al 2002). However the combination of poorly delineated boundaries between acute and primary health care and social care in the UK (Nancarrow and Borthwick 2005) and conflicting philosophical and implementational positions of care delivery have led to the exposure of unresolved tensions (Dickinson 2006). Threats to professional power and status have been engendered by a pragmatic approach to managing services within diminishing resources. For example, perceived threats to the doctor's role delayed the extension of prescribing rights to nurses by eight years, from inception in the Cumberledge Report (DHSS 1986) until ratification in law in 1994 (HMSO 1994).

Nursing has responded to this maelstrom of change by adapting and widening the scope of practice. However Lord Darzi's (DoH 2008) report articulated the need to understand what constitutes the fundamental elements of health care practice. He stated that in order to measure quality we need to:

“measure and understand exactly what we do.” DoH (2008) p48

Thus nursing, as a discipline, is striving towards;

“Professional, High quality evidence-based practice” (Maben and Griffiths 2008 p10)

founded on clarity of concepts and theories, coupled with appropriate quality measurement techniques. Before it is possible to undertake these evaluative exercises it is essential to better understand the process of assessment and it is to this end that this study has been undertaken.

Chapter 3

Methodology and Reflexivity

“The world does not contain any information; it is as it is. Information about it is created in the organism (the human being) through its interaction with the world. “
Illich (1973) p101.

Following the last chapter’s discussion of the background for this study and before considering the design for this project, it is timely to introduce some of the theoretical assumptions that underpin qualitative research methodology. Silverman (2000) argues that the choice of research method is dependent on “what the researcher is trying to find out”. I would add to this requirement an understanding of the epistemological, ontological and theoretical assumptions that underpin the different research paradigms. In this chapter the term methodology will be discussed and a critical analysis of some philosophical and theoretical positions that inform different research genres will be made. This chapter comprises two interlinked sections: in section one I outline the epistemological basis of the qualitative research paradigm. In order to explain the primacy of the scientific methods there is description of the background to the positivist hypothesis and a brief history of the randomised controlled trial (RCT). An exploration of these paradigms will culminate in the disclosure of considerations and critical understanding that led to the choices made regarding the methodological approach for this research project. The second section of this chapter comprises a description of the process of Reflexivity, which it is argued, offers justification of the methods employed in this study.

Initially I note that complications may arise since the term *methodology* is a contested descriptor being used to identify different subjects within academic writing. Lehaney (1994) describes his quest to define the term *methodology* as “interesting but unsuccessful”. His list of four observed meanings for *methodology*, published in 1989, had expanded to six by 1994 and identified the following uses of the term:

1. ways in which hypotheses become theories – scientific methodology;
2. ways in which techniques are chosen to address a particular problem

3. ways in which problems are chosen that address the question of sponsorship
4. methods or techniques
5. a modelling process that includes hard and soft systems approaches, and the ways in which the relevant variables are chosen for a model, and how reality is concomitantly simplified
6. chronological planning of events – the research programme.

Lehaney (1994)

In addition the word *methodology* is often used interchangeably with research design. To avoid confusion and conflation of these and other meanings and for the purpose of this chapter I will use Kendall's (2007) description of *methodology*, as referring to the study of the science of research methods and their philosophical positions.

I would contend that it is artificial to present paradigms as contained, complete, discrete and mutually exclusive entities, since one school of thought will always influence others. Influences may be by reaction or incorporation, as noted by Murphy et al (1998) in the case of Kant, who stated that:

“many of his arguments were elaborated in response to Hume, though he also reacted against the work of the Prussian philosopher Gottfreid von Leibniz (1646-1716)” Murphy et al (1998) p26

Moving from the methodology of the qualitative approaches to research I will outline relevant qualitative methods.

Section 1

3.1. Epistemology of research paradigms - how do we know what we know?

Buchanan (1977) describes Aristotle, Plato and Socrates as founders of Western philosophical thought. Their enquiries exemplify the need to question what has traditionally been taken for granted and this is the approach followed within this chapter. The term paradigm or paradigm shift is often associated with Thomas Kuhn. He countered the argument that scientific enquiry progressed in a measured linear way by noting that “breakthroughs” were often achieved at times of “crisis” when new ideas overtook their predecessors. However the term originates from the Latin,

paradigma a pattern or example and from the Greek, *paradeiknŷnai*, show or compare side by side (Chambers 2001). This chapter will be using the term to indicate an example attributed to a specific genre.

Research methodology may be categorised as belonging to one of two distinct paradigms. Those of quantitative research which are predicated on positivist assumptions that we can know the world and through this knowledge discover ultimate causes of naturally occurring phenomena. Positivism implies a belief in an objective reality that is perceived by our sensory systems and can be verified by the independent observations of others. Whereas the qualitative research paradigm accepts post-positivist accounts which include notions of multiple realities that are the subjective and the mental constructs of individuals (Hughes 1994).

While acknowledging that the preceding centuries of scientific and technological progress have been based upon the rationality of the quantitative approach to research. It has proved disappointing as a tool for understanding problems of social justice, organisation and social interactions (Bryman 1988). As Garfinkel (1967) has argued the results of any particular research study are contingent on the context from which they were derived. There has been a shift from the quantitative search for generalisable truths towards the discovery of understanding that is sensitive to time and culture, which may be explored through the qualitative approach to research. The word '*qualitative*' implies an emphasis on

"qualities of entities, on processes and meanings that are not measured"
Denzin & Lincoln, 2005 p10

3.1.1. Background

Epistemologically the qualitative approach holds that there is a social reality which is manifest within social interaction and may be understood through the construction (constructivism) of shared meanings and contexts framed in everyday interactions (Flick et al 2004).

Constructivism is inductive and relativistic in approach and does not start with the identification of a theory or problem but generates theory as an outcome. For the purpose of clarity the differences between the three kinds of innovative inferencing inductive, abductive and deductive reasoning, are outlined. Deductive reasoning applies general principles that are *a priori* (already known) to reach specific conclusions. Their truth is dependent on the veracity of the premises within the

argument. It is therefore impossible to deny the conclusion of a logical deductive argument when the premises are true. This syllogistic format relies on the combination of logic and truth at each stage in order to guarantee the truth of the conclusion; the classical example is:

All men are mortal. (truthful premise 1)

Socrates is a man. (truthful premise 2)

Therefore Socrates is a mortal. (therefore logical and truthful conclusion).

Inductive reasoning is based on observation and experience. The premise of an inductive argument supports the argument's conclusion; however it does not ensure the veracity of a premise in the same way as syllogistic argument does. Here the premise directly relates to the truthfulness of the conclusion. It provides a way of generalising from a specific example to other analogous examples. Inductive reasoning is therefore a causal formation of a general conclusion from particular instances which comprise the selection and assemblage of specific cues. For example A is similar to B and A is red therefore B is red. The truth of this depends on whether or not the similarity of A and B include the colour red.

The third approach to the method of logical inferencing, abduction, was first introduced by Pacius in 1597 but it fell into obscurity. Pierce (1839--1914) rekindled interest in abduction at the turn of the nineteenth century. Reichertz (2004) describes abduction as the creation of a logical inference, one that is derived both through reason and science (empirical observation). He outlines the process as a progression from a result or known quantity to the discovery of two unknowns, the rule and the case. Reichertz claims abduction as a "mental leap" which brings together ideas not previously associated with each other.

There has been a resurgence of interest in the late twentieth century, partly spurred by the needs of artificial intelligence as it was hoped that abduction would produce

"a rule-governed and replicable production of new and valid knowledge"

Reichertz (2004) p159.

Further Morse and Niehause (2007), suggest that abduction could reconcile the logic of discovery (theory development) and the logic of justification (theory testing). These two approaches were separated by Popper (1959) in an attempt to nullify the deduction--induction tensions within post-positivism.

Constructivist assumptions, regarding understanding, further rest on the acceptance of “mimesis” which is a term used by Plato in book ten of the *Republic*. Mimesis has no direct translation, but originally referred to “imitation” or “representation” with regards to poetry. Plato saw this as detrimental on two grounds, firstly that as an artifice it could be harmful to those not in the cognoscenti. Secondly that it is a distraction from reality, as it is an imitation, and therefore is artificial and unreal. Adorno (1973) uses mimesis as a challenge to the rationality of scientific conceptualisation. Flick et al (2004) used it to mean a representational or symbolic world, drawing their illustration from understanding productions in the theatre or dramatic texts; they extended the meaning to include all texts including scientific ones. Bruner (1990) using Ricoeur (1981) claims mimesis as the ;

“ capturing of life in action, an elaboration and amelioration of what happened” Bruner p 46 .

The implications that arise from a constructivist viewpoint facilitate the research design methods of observation, discourse analysis, reflexivity and recursion.

Qualitative studies may be described as holistic in approach as they aim to capture experiences of human beings in all of their complexity and in every context. This approach includes exploration of all possible reasons for confounding and outlying data in order to give a rich, deep understanding of the phenomena under review. Qualitative research is suited to explore meaning in the real world. It is neither statistically driven nor seeking to support or defend hypotheses.

3.1.2. Qualitative methodology

Qualitative research has a number of perspectives and theoretical positions that are described by Flick et al (2004) as;

- accessing subjective viewpoints (e.g. symbolic interactionism, phenomenology)
- describing the creation processes of social situations (e.g. ethnomethodology, constructivism)
- using hermeneutic analysis to deconstruct society’s underlying structures (e.g. psychoanalysis).

There are several threads which characterise qualitative methods. Firstly they are tools with a strong focus on the study of everyday occurrences where data is collected in naturalistic context and investigations are carried out with an approach

free from rigid experimental designs. Data analysis is undertaken bearing in mind the context of the naturalistic occurrence.

Consideration is made of the multiple perspectives of all the research participants including the research community. The goal of some research is to reach an understanding rather than offer an explanation of the phenomena being studied. Developmentally qualitative methods have often evolved because of the inappropriateness of quantitative methods for specific projects. For example the narrative interview which questions how agents experienced their reality of a situation and is recreated through communication.

3.1.3. Methods of making meaning for qualitative findings

Turning now to how we make meaning of data gathered through the qualitative approach. Reichertz (2004) suggests a three fold approach, firstly deduction, where the case in question is subordinated to an already known rule. As argued above deduction can only confer truth when the premises of the syllogistic argument are true, thereby extending what is already known to a new and analogous setting. Secondly, “qualitative induction“, where an inference is derived from

“a totality from the qualitative properties of a sample” Reichertz p161

This does not produce new knowledge but generalises from a small sample to a larger one. A third approach, abduction, creates new categories and demonstrates the importance of including outliers and confounders in the data (Reichertz 2004). It occurs when features are discovered which cannot be explained using prior knowledge and a new invention or development is created. However Pierce (1931 in Reichertz 2004) suggests this process is;

“very little hampered by logical rules” p118

3.1 4. Challenges to the qualitative approach

I would suggest many of the difficulties cited with qualitative research arise from trying to justify positions that it does not claim. Qualitative studies face major criticisms that, unlike quantitative research findings, their results are not generalisable. This however is an inevitable implication of the anti-realist stance within an interpretivist paradigm. As, if we accept that reality may be interpreted differently by the researcher and the subject we cannot hope to promote the findings from one individual’s version of reality over another’s, and even less to another setting.

Various attempts have been made to accommodate the positivist hunger for generalisability engendered by the political and economic need to satisfy funding bodies and institutions and to show the relevance of findings to other areas. For example, Mayers (2000) suggests partial generalisation and Stake (1980) refers to naturalistic generalisations, where findings may be related to similar situations. Murphy et al (1998) discuss transferability across areas in which some similarities exist suggesting that it is possible to develop a working hypothesis based on “thick description”. It can be argued that it is not the intention of a qualitative research study to produce directly generalisable findings but to add to the knowledge and understanding held regarding a subject area. To make this clear does not diminish the scholarship, enterprise, insight and understanding generated through qualitative research. However it does avoid the semantic gymnastics employed in trying to square this particular circle.

Aligned to this criticism the low participant numbers in a qualitative study can attract censure. Again this question of study size is in direct comparison to the privileged quantitative approach where the study size is large, especially with a RCT, in order to facilitate statistical evaluation and generalisability. Evidence of this view regarding the status awarded to science may be found in the prominence given to the experimental design of the Randomised Controlled Trial (RCT), which is described by Gomm et al (2000) as:

“the gold standard in health care research “ Gomm et al (2000) p48

Despite their recent origins RCTs are placed in pole position in the typology of supporting evidence used by the National Service Frameworks. (DoH 2001e). Doll (1998) records the move from medical Consultant led recommendations of treatment based on the experience which predominated in the early 1900's to the more systematic approach of “factorial design” (Wilson et al 1946). Through the trials carried out under the auspices of the Medical Research Council between 1930 and 1944 where Doll noted there was a possibility for bias because the researcher would know who had received each of the alternately given treatments. Although the randomisation, an approach used in UK agricultural trials since 1926, was not adopted in the UK medical research until 1946 (Doll 1998) p1218

The claim that the scientific approach to research is superior (Gomm 2000), non-evaluative (Wanless et al 2002), value free and objective (Edwards 2001) relies on

several strategies to maintain a position of dominance. Kitzinger (1986) has coined the phrase “*mythologies of expertise*” which she uses to explain the dualistic division between lay and expert knowledge. This construct places science as the source of “*legitimate knowledge*” reliant on numerical quantitative data often described as “*hard*” data. Putting aside the gendered pejorative connotations of the use of the descriptors “hard” and “soft” data (Halfpenny 1979, Morse 1989) this implies that quantitative data is more robust and generalisable than qualitative. However acceptance that generalisability is not the goal of a qualitative study liberates the approach from defending criticisms of study size.

Qualitative studies are pejoratively referred to as unscientific, antirealist and interpretative (Poses and Levitt 2000). They may occupy all or any of these positions as they espouse an interpretivist paradigm that fundamentally differs from a positivist one. However neither is inherently inferior or superior to the other but each presents alternative ways of seeing the world.

The quantitative approach claims standardisation and replicability to demonstrate reliability but this may not be possible for a qualitative study. It is therefore essential that the methods and processes used for qualitative studies are transparent and auditable. Mayers (2000) suggests that two levels of justification are required. The first involving consideration of the truth of the findings and the second requiring researcher accountability. Using Lincoln and Guba’s explanation of credibility Sandelowski (1986) situates truth in a subject-orientated context. I will return to the problems surrounding appropriate and useful criteria for the evaluation of qualitative research later in this chapter.

Further concerns have been raised regarding the probity of evidence offered in qualitative studies. Bryman (1988) has noted a tendency towards an “anecdotal approach” to the provision of evidence and explanation. Where “snippets of interviews” and “brief conversation” are cited as verification of assertions. These accusations may be ameliorated through exploration of contrary cases, completeness, clarity, systematic data collection, record keeping, analysis and openness of approach.

Accusations of researcher subjectivity and bias have also been levelled at qualitative researchers but as Kaptchuk (2003) has demonstrated bias may be found in quantitative research (Box 3.1). Subjectivity is impossible to deny or overcome if an

interpretivist paradigm is accepted as the world is interpreted through the researcher's experience.

Box 3.1.Types of bias identified from quantitative studies from Kaptchuk (2003)

p1453

“Confirmation bias—evaluating evidence that supports one's preconceptions differently from evidence that challenges these convictions.

Rescue bias—discounting data by finding selective faults in the experiment.

Auxiliary hypothesis bias—introducing ad hoc modifications to imply that an unanticipated finding would have been otherwise had the experimental conditions been different.

Mechanism bias—being less sceptical when underlying science furnishes credibility for the data.

Time will tell bias—the phenomenon that different scientists need different amounts of confirmatory evidence.

Orientation bias—the possibility that the hypothesis itself introduces prejudices and errors and becomes a determinate of experimental outcomes.”

In contrast to the quantitative approach where the researcher is kept at arm's length from the study qualitative research accepts the Hawthorne effect (Franke and Kaul 1978). This suggests that the act of observing behaviour results in behavioural changes. The qualitative researcher is encouraged to own and use this involvement and subjectivity instead of trying to deny or eliminate them. Sartre (1983) has indicated the importance of understanding the ways in which each individual processes reality as the key to understanding them. Dithley's (1996) humanistic view of how individuals make meaning of life proposes that sense is produced through coherence of experience and this approach may be utilised when interpreting qualitative data.

3.2. Qualitative Methods

There are fundamental differences in the theoretical assumptions which broadly inform the qualitative and quantitative approaches to research and their claims to validity. In short quantitative research is based on a realist, positivist empirical philosophical position predominately employing a deductive approach to hypothesis

testing. In contrast the qualitative approach can be described as being relativistic, interpretivist and constructionist and as using an inductive or abductive approach to research hypothesis development.

Many studies employ a mixed method approach in which both qualitative and quantitative methods are used. Either drawing from both of these methods sequentially, that is using each as a complementary tool for a particular goal; or as a way of cross checking one method's findings against another in an attempt to demonstrate truth or verification of these results. Whilst I have argued above that there are similarities across the research process and criticisms of one approach may well be levelled at both, for example bias, when choosing a research paradigm it is important to select the most appropriate tool to answer the research questions underpinning this study.

It may be argued that choices of methodological approach rest on two determinants, the mind set of the researcher and the purpose of the research project. Hammersley (1992) suggests that those choosing a qualitative method focus on attempting to;

“document the world from the point of view of the people studied” p 165

Further bearing in mind the advice of Silverman (2000) to suit the method to the research and after consideration of Firestone's (1987) four domains which differentiate qualitative from quantitative research:

1. Assumptions- choice of theoretical drivers
2. Research purpose-is the research seeking a cause or an explanation
3. Approach-which paradigm best suits the study
4. Researcher role –detached or immersed in the study

It is expedient to reflect on exactly what this research is considering. In essence the aim of this study is to better understand through exploration the process, of assessment, through study of the social interaction between nurses and patients that comprise that process. In the absence of a hypothesis and as the aim of the study is to gain understanding, it would seem appropriate to choose a qualitative research design for this study.

Silverman's (2004) discussion of qualitative methods, categorises approaches as regarding: observation, texts, interviews, talk, and concerning visual data. A brief description of these qualitative methods and their characteristics follows.

3.2.1. Observation

Having roots in anthropological and ethnographical research (Baszanger and Dodier 2004) observation has made claim to providing a tool for sociological descriptions of reality. Observation as a research tool is predicated on the notion that the act of observation is elevated from encounters of everyday life through what Baszanger and Dodier (2004) cite as the three “simultaneous requirements” of ethnographic research (Box 3.2).

Box 3.2. Characterisation of Ethnographic research following Baszanger and Dodier (in Silverman 2004)

- a) The need for an empirical approach
- b) The need to remain open to elements that cannot be codified at the time of study
- c) Concern for grounding the phenomena observed in the field.

Baszanger and Dodier make the point that the objects of the study require *empirical* observation. The use of the term empirical implies a reliance on sensory identification rather than the deductive logic of philosophical approaches to hermeneutics or phenomenology. Their second requirement is that in order to produce findings that are grounded in the particular observation the researcher does not approach the field with a *priori* understanding, expectations or an agenda of what will or has happened in other situations. The third characteristic, that the research be grounded in the field, refers to the need for the researcher to focus on the nature of the culture and ethos in which their observational research is situated and the forms of knowledge embedded within it (integrated ethnography).

Silverman (2000) cites differences between the ethnographic foundations of observation as a research tool based in long term anthropological studies of cultures alien to the researcher and those within modern qualitative research. In the latter he states it is more common for qualitative researches to study.

“subcultures of their own society” Silverman (2000) p 37

Such subcultures are more immediately accessible to the researcher as they do not normally necessitate learning a new language or living in a radically different and unfamiliar milieu. This is referred to by Jackson (1987) and Peirano (1998) as “*anthropology at home*”. Peirano describes this as working within:

“*our own society where “others” are both ourselves and those relatively different from us*” Peirano (1998) p 123

The qualitative approach to observational research is antithetical to the arms length neutral approach of quantitative researchers. Qualitative observational research is carried out in an ethos where the researcher maintains a balance between proximity and detachment with the participants and the field. The proximity is required to achieve and negotiate a relationship of trust between the participants and the researcher to enable the research to take place. Contrastingly the detachment enables the researcher to collect the data required to generate knowledge no matter what!

Practical examples of observation may be participant, where the researcher shares in the experiences in their field of research. Gerrish and Lacey (2006) describe this as the researcher taking the “*emic*” or insiders position in one of three approaches to participant observation:

- Complete participation (often carried out by nurse researchers in their normal workplace).
- Participant as observer (where the nurse observes practice in addition to carrying out their normal role)
- Observer as participant (where the nurse takes a part in the practice he or she observes)

In direct contrast a non-participant observer will not take a part in the action or interaction being studied and will minimise their influence on the practice which forms the focus of their study. Turnock and Gibson (2001) describe this as the “*complete observer*” who has “*literal and phenomenological distance*” p 473. Further Gerrish and Lacey (2006) note when the researcher’s role is clearly delineated to the participants prior to the observation this constitutes “*overt observation*”. This is diametrically opposed to covert observation, observation that is carried out without the participants’ knowledge or consent.

Whyte et al (2006) outline two types of observation which may be carried out by a non-participant researcher. Firstly structured observation method that is aimed at recording specific activities or interactions and uses a framework such as an activity checklist or pre-determined observational schedule for data collection. Secondly the method of unstructured observation, such as the audio recording of nurse patient interactions employed for this study. Using Hammersley's phrase the methodology of unstructured observation aims to reflect the "*view point of those being studied.*"

Observations can also be recorded as field notes which constitute confidential and secure observations of the event being studied. In the case of non-participant observation these may be made contemporaneously. Participant observation can make this difficult and Whyte et al (2006) recommend in these cases field notes be compiled as soon as possible after the event under observation to safeguard accuracy.

As the focus of the fieldwork stage of this study is to explore the remaining five research question;

2. *What professional, philosophical and organisational influences affect the nursing role regarding patient assessment?*
3. *What impact does nursing assessment have on patients?*
4. *Does patient inclusion, involvement and empowerment happen as a result of a nursing assessment?*
5. *Does the location of a nursing assessment have an impact on the assessment?*

The observation of the nurse and patient interaction provides a suitable method to explore these examples of the influence and impact of this practice. Observational schedules may be employed which Lüders (2004) describes as providing focussed or selective observations and Gerrish and Lacey (2006) note may be used to confirm or support previously obtained data. Silverman (2004) refers to the epistemological tensions between using the approach described, which he calls "*a priori codified studies*" p11. Here the researcher is confined to noting activities which have been previously defined in the schedule an approach which sits within the epistemology of the scientific experiment yielding reproducibility and "*in situ studies*". The less structured observational study allows the researcher to be "*open to new data.*" p11. and responsive to the,

"uncertainties of the field" p12.

Peirano (1998) and Silverman (2000) note that *anthropology at home* provides a theoretical approach for this open observational method. Spindler and Spindler (1983) describe the work of anthropologists in the field as;

“*watched, listened and learned*” p 51

The goal of this study is to explore the interaction that comprises assessment. This study neither seeks to prove or disprove a hypothesis as to the nature of assessment by observing the presence or absence of predetermined instances of events in practice. It would therefore be antithetical to use an observational schedule which would limit the range of observations to those specifically included in the schedule.

This study seeks to be open to new data which will be contextualised within the observation and the backdrop of nursing assessments. The approach provided by *anthropology at home* provides a methodological approach suitable for the observation of the nursing interaction and will provide sets of “*situated knowledge*”, Moore (1996), from each example of the discourse of local practice.

3.2.2. Texts

Following Silverman (2000) I am using the nomenclature text to denote

“*A heuristic device to identify data consisting of words and images which have been recorded without the intervention of the researcher.*” P 40

That is to say text seen is a cipher which enables the researcher to discover meanings from language or images which are not created as a response to an interview or questionnaire but are spontaneously occurring. Although structured interviews once transcribed take a written format they do not fall within this category as they are prompted through the questions stimulated by the agenda of the researcher. For this reason a semi-structured approach was taken to the interviews undertaken for this study.

Wolff (2004) has described texts as “*standardised artefacts ... as they typically occur in standardised formats*” p 285. Atkinson and Coffey draw our attention to the implications of working within a literate, self documenting society and culture which contrasts directly with the historic roots of ethnographic fieldwork which was designed for a specifically oral milieu. Consideration of this aspect of textual study influenced both the CA of the literature and review of patients’ nursing notes.

Atkinson and Coffey (2004) also note the importance of recognising influences on documentation such as whether they were produced:

- contemporaneously, retrospectively, or prospectively.
- who produced them
- why they were produced, for what purpose
- to whom they are circulated
- by whom they are read.

In addition to these considerations “intertextuality”, the relationship one text has with another, may also exert an influence on how we make sense of textual communication (Atkinson and Coffey 2004). For example was the text produced as a critique of another text? Scott (1990) identifies the use of documents as a source of information that indicates other underlying phenomena or agendas. These considerations were reflected in the CA, the CDA, and the review of the nursing notes and NHS policy documents undertaken.

Indicating the importance of understanding that texts emanate from different “*genres*” Atkinson and Coffey (2004) p59 identify that text is reliant on the culture and context of the organisation for whom they are generated. For instance the well understood clinical use of the descriptor “comfortable”. This does not refer to the physical comfort of the patient but is used as shorthand to identify the patient’s place on a continuum from a state of wellbeing to being critically ill and in danger of death. These were important considerations when deconstructing texts such as the nursing case notes, CA of policy documents, journal articles and conference presentations. The CDA of the transcribed recordings rendered the spoken word as text. It will be argued, in chapter 4, that nursing assessment does constitute a discourse that can be explored using CDA. The Foucauldian method undertaken for the CDA requires that the discourse be deconstructed in order to explore the power balance between nurse and patient and nurse and the institution of the NHS within the culture of nursing. Whereas the first phase of this study seeks to explore how the term assessment is used within the current nursing literature. To facilitate analysis of how the concept assessment is deployed within the current nursing literature a CA framework was used. The epistemological justifications for these choices are presented in the second section of this chapter and in chapter 4.

3.2.3 Talk

Potter (2004) notes the complexities which lie behind the seemingly straightforward tool referred to as discourse analysis. He differentiates continental discourse analysis (DA), associated with Foucault's theory that objects are constituted through discourse statements, from the more linguistically based or:

..."*straight-laced Anglo-Saxon counterparts.*" Potter 2004 p 201

Observations of talk may be exemplified by video and audio recordings in a naturally occurring interaction. In addition to recording the talk other acts of communications such as body language and non-verbal cues can be obtained from a video recording or the field notes which accompany an audio recording. Silverman (2004) following Saussure (1974) and Sacks (1992) cites the importance of the sequential occurrence of data readily presented in audio and video recordings. This facilitates the analysis of conversation and depending on the agents perspective offers more than one instance of an event. The importance of talk in this study was that it enabled the researcher to explore the covert messages displayed by participants. For example the tone of voice may denote sarcasm, annoyance or panic or body language can betray when the feelings of a person are at odds with what they are saying.

3.2.4 Interviewing

Gubrium and Holstein (2002) and Todd (2006) describe the research interview as one of the most commonly utilised data collection methods in both quantitative and qualitative and mixed method research. It is important to differentiate between the extremes of the interview continuum which range from structured interviews, where questions are formulated prior to the interview. Through the semi-structured or narrative interview, this provides researchers with freedom in question formulation and sequencing. To the unstructured or open interviews which are participant led. Decisions regarding which interviewing technique is most applicable depend on the purpose of the interview. If the primary agenda is to gather specific political affiliations or demographic details, a structured or focussed interview technique is dictated. However the aim of this study is to allow the participant to tell their story of an assessment and to gather some demographic details for these reasons a semi-structured interview was seen to facilitate this approach.

Interpreting the data provided from an interview requires an understanding that the interviewee and interviewer are both constructing meaning from each others use of

language (Silverman 2004). The notion of the interview as a constructed drama may be found in the works of Hermanns (2004), Holstein and Gubrium (2004). Further Cicourel (1974) and Silverman (2000) maintain that interviews impose a particular construct of reality on respondents through the collaborative act of the interview interaction. Holstein and Gubrium (2004) suggest that acknowledgement of these constructs reframes notions of bias as:

“meaning construction not contamination.” P 157

They focus away from questions of bias contamination of data towards understanding how the interview explores the topic under review.

Reflecting back over the reading for and writing of this chapter, a hermeneutic approach to gaining understanding through reflection of patterns combined within an interpretivist position would seem to offer the scope and fit to enable my exploration to take place. Chapter 4 of this dissertation will justify and describe the design chosen for this study which employs the qualitative research methods of CA, observation, the deconstruction of texts and naturally occurring talk through the use of Foucauldian inspired CDA.

Section 2 Reflexivity

3.3.1. Reflexivity: trustworthiness criteria and ethical considerations

This second section of the chapter focuses on the criteria for decision making regarding choices as to which paradigm and approach to follow. Qualitative research has been described as using verbal and non-numerical data and as employing Interpretivist or Constructivist methodological assumptions. These assumptions may be based on theories such as feminism or critical theory (Porter 2007). Prerequisites for any research approach to be valued and accepted are that the author clearly demonstrates rigour and efficacy of execution of the chosen processes. Research outcomes acquire authority through their articulation and peer assessment. In a normative quantitative paradigm where empirical proof is sought and quality may be clearly established through equivalency of statistical representations. In contrast the qualitative approach poses the challenge of how to create justifications and defences to accusations such as those noted by Hammersley and Atkinson (1983), that qualitative processes are:

“merely refinements or developments of those used in every day life” p15

Further Hodgkin (1996) suggests the qualitative paradigm is one where *“anything goes”* and Seale and Silverman (1997) state findings from some studies can be criticised as *“anecdotalism”*. In order to defend the qualitative process against such accusations the researcher must clearly demonstrate a meticulous approach to the choice and execution of the research methods and the analysis of data.

Hope and Waterman (2003) and Rolfe (2004) identify three contrasting broad positions regarding the use of criteria to demonstrate quality in qualitative studies:

1. The criteria used for quantitative studies should also be used for qualitative studies.
2. That qualitative research is so different from quantitative that totally new criteria need to be developed.
3. That it is questionable whether any criteria are appropriate for judging qualitative research since:
 - the ontological scope is so broad that there is no one unified method or theory within the approach.
 - if an interpretivist ontological position is taken the findings will always be verifiable by the person who interprets them and unique to the particular instance, and cannot be judged by other means.

Whilst each of these positions have their champions and dissenters (Lather 1993, Koch and Harrington 1998) I question position 3 and maintain that to demonstrate trustworthiness it remains essential to demonstrate that good qualitative research can be differentiated from bad. Semantically, confusion is added to this debate by the use of the comparator quality as a catch-all descriptor that both assesses and defines the scholarship.

Sandelowski and Barroso (2003) pose a further challenge, suggesting that the only legitimate evaluation of qualitative research takes place at the report stage. This relegates the quality evaluation to that of an appraisal of the aesthetic and rhetoric accomplishment of the author. Arguments regarding reconciliation or critique of Hope and Waterman (2003) and Rolfe's (2004) positions will be put forward within this section of the chapter. The case will be made that the quality of qualitative research may be demonstrated through a reflexive approach that can be described as making research process:

- plausible
- clearly auditable
- moral
- adequately describing “*what is going on*” in the broadest sense (Koch and Harrington 1998).

3.3.2. Reflexivity not objectivity

Reflexivity is a comprehensive and multidimensional approach to forming judgments regarding the suitability and trustworthiness of research approaches and findings. Knoblauch (2004) refers to praxeology, the science of human action, or reflexive methods, in which account is taken of:

“meaning orientations, knowledge, and communicative procedures and ... the relevance of what is being scientifically investigated from the point of view of the informants.” p357

He suggests this is true of all research whether “*subjective or structural/objective*” and in this way the process of the research itself and the research practice of the researcher are subjects of analysis. Of paramount importance to this study is that reflexivity takes account of the researcher’s methods of making meaning. Nightingale and Cromby (1999) note it should:

“ explore ways in which a researcher’s involvement with a particular study influences, acts upon and informs such research” p228

Koch and Harrington (1998) identify four approaches to reflexivity. Firstly “*a personal critique*” that could be seen as reflection but which they emphasise should include more than one voice in order to avoid the practice becoming an exercise in exploring the self-indulgent lone opinion of the researcher. Because of the solitary existence of the PhD student as researcher care must be taken when employing this approach.

Secondly they describe “*sustained objectivity*” leading the researcher to question all aspects of their study. I would suggest this approach is flawed as there is an epistemological confusion. It is paradoxical to acknowledge the influence of the researcher on the study and the inevitable subjectivity of any approach, whilst framing the disclosure in positivist terms of “objectivity”.

Thirdly they note the researcher should consider the representations and “*politics of location*” and the power imbalances that are inherent within these positions as an institution will have influence on the discourses taking place as part of its rituals. For example whether or not it is automatically presumed that it is acceptable to refer to older patient’s by their first names. As research question five prompts this study to identify the power imbalances within assessments that are carried out both in the patient’s home and within healthcare clinics, this approach to reflexivity would seem of particular value.

Koch and Harrington’s (1998) fourth approach asserts that reflexivity is influenced by “*positioning*”. This explores the notion that all work is necessarily incomplete, as it is the sole product of those carrying out the process. In order to gain additional perspectives requires engagement and discourse with others. Echoing this Murphy et al (1998) stress the importance of peer debate including presentation of personal and theoretical bases for interpretations and the perspectives that inform them. To incorporate this approach to reflexivity for this study the researcher has discussed and disseminated plans and outcomes of this research. This has been achieved through:

- publications
- supervision
- obtaining ethical approval and permission from Trusts
- giving presentations at appropriate conferences and seminars.

Reflexivity can be seen as having several endogenous dimensions that are dictated by the ontological stance of the researcher and that direct the research process. These are dependent on the ways in which communities, including the research community, construct their realities and include the areas:

- Values
- Experiences
- Interests
- Political affiliations
- Aims
- Social identities. (Murphy et al 1998)

Sometimes referred to as personal reflexivity this approach has the additional purpose of revealing the ways in which the research may have changed or affected the researcher him/herself. Hand (2003) has seen “*reflection on self*” as a positive, allowing and enabling the:

“*values, assumptions , prejudice and influence of the researcher...to be acknowledged and taken into account*” p18

Bourdieu (1996) refers to these influences as the “*illusions of the intellectual*” noting that the greatest illusion of all may be that there are no illusions.

Additionally reflexivity can be described as having a referential aspect, where the researcher’s relationships with the participants in a research project are explored (May 1998). Murphy et al (1998) note that the researcher may influence both the research process considerations and the outcome and May (1998) reminds us that a researcher joins an area of research for a short period of time and can only glimpse a fraction of the complexity of the interactions they observe.

Worsley (1997) has raised awareness of the risk whereby a researcher may impose an ontology, either personal or from the research community, that is fundamentally different to that developed within the area of research. For example a feminist and a Marxist researcher when undertaking a study of a trade union demonstrating against unfair employment practices may demonstrate different interpretations of the same findings. These constructs, conscious or subconscious, may be influenced by their own experience and agenda and may additionally reflect a different schema to that which motivated those demonstrating.

This work is positioned within the interpretivist ideology and conceptualises the research process as encompassing the notion suggested by the hermeneutic spiral or circle of perception (fig.3.1). Hermeneutics, named after the Greek god Hermes the interpreter of the words of the gods for mortals, is based upon the Heideggerian tradition where knowledge is never free of interpretation. Heidegger (1962) wrote:

“*Meaning is an existentials of Dasein not a property attaching to entities.*”

p151

That is, meaning-making is a function of the interpreter, is a part of being (*Dasein*), not a part of the discourse being interpreted

socialist and a feminist. Each of these personas cloud and obscure the lens through which the research is viewed and interpreted. Additionally I would argue that the reader has a similarly complicated influence on the meaning of the text. As Scholes (in Broderick 1994) suggests:

"In reading we produce text within text; in interpretation we produce text upon text; and in criticizing we produce text against text"
(Scholes in Broderick, 1994: 17).

Further constraints on authorial intent are found in Derrida's (1967) deconstruction theories:

"how can I say what I know with words whose signification is multiple?" p89

The works of Koch and Harrington (1998), Lather (1993) and Murphy et al (1998) influence this study's approach to reflexivity which is seen as a tool to demonstrate quality in the process of qualitative research in practice. Rationales for ensuring transparency and accountability and enabling internal and external questioning of the influences that shape the research process, analysis, and outcomes will be discussed in the next section. It will be argued that by utilising these methods authorial integrity and transparency will yield credibility for the research findings.

3.3.3. The complexity of demonstrating research quality in qualitative studies

As evidenced above there is a debate about how criteria for quality may be designed. Hope and Waterman (2003), Rolfe (2004) and Murphy et al (1998) all discuss the multiplicity of approaches to setting quality criteria. Their exploration and meta-analysis included two additional criteria that can be summarised as:

1. Validity depends on revealing ideological distortions and this can be done across either qualitative or quantitative paradigms (Mies 1983)
2. Quality is judged on the ability of the research to bring about valued change (Owens 1982, Mies 1983).

Before embarking on a discussion of these points it is important to bear in mind the question *what is the purpose of such criteria in research?*

Murphy et al, Hope and Waterman, and Rolfe all take the same position, that the criteria being used to demonstrate quality in quantitative studies be used for qualitative studies. If we examine the purpose of validity criteria used in positivist approaches, these are designed to enable judgements to be made regarding the suitability of methods for testing a specific hypothesis. These hypotheses are created in response to the research question or questions and the purpose of such judgements is to award or deny authority to the research findings. As suggested by Denzin and Lincoln (1994):

“internal validity: the degree to which findings correctly map the phenomena in question” p100

and by Egger et al (2005) where internal validity is described as:

“the extent to which the results of a study are correct for the circumstances being studied” p88

The use of **correct** implies a notion that a “truth” may be discovered and verified through the replicability and equivalence of the research process and findings. Howarth (2000) refers to resultant problems because, once we allow the acceptance of one universal truth that can be verified by correctly carried out research, an ontologically paradoxical position is arrived at. Thus making it impossible to transfer validation criteria from a positivist to a qualitative, Interpretivist, approach. Within the qualitative paradigm, reality is formulated in the mind of each individual and therefore universal truths cannot be found or verified by recourse to replication from other corresponding examples. Lather (1993) discusses the problems arising from this relativistic approach to validity and truth in her four “*framings of validity*” Here she argues that within the quantitative paradigm, validity rests on an intellectual correspondence with “*one regime of truth*”. Further noting that within the acceptance of a multiplicity of interpretations of reality, truth is dependent on the methodological approach being taken, which she refers to as the “*mask of methodology*” p676. In other words there are as many truths as there are routes to interpretation.

Consequently quantitative expressions of internal and external validity are ontologically and epistemologically unsupportable within a post-modern qualitative paradigm wherein multiple perspectives of an event are acknowledged (Cheek 1997). Furthermore once it is acknowledged that understanding and meaning-making

is sought rather than the capture of correspondence with one external truth a reinterpretation from positivist notions of validity is required.

Further, as is argued above, if we accept the quantitative approach to be predicated on testing hypotheses and the disclosure of supporting evidence for one hypothesis over another. Then quality criteria from the quantitative paradigm will not be transferable to a qualitative approach where there are no preconceived hypotheses to verify.

Other qualitative researchers have relied on semantics by suggesting synonyms for validity and truth as a way around this dilemma. Nixon and Power (2007) substitute the generation of interpretative claims for the positivist provision of truth listing fifteen synonyms for the “*replication perspectives of truth*” and twenty-four for the “*parallel perspective meaning*” in their table in the “*Language of Rigour*” p74. However it may be argued that a rose is still a rose even if we call it a bucket.

Regarding the position of Mies (1983), Murphy et al (1998) and Cheek (2004) that it is essential to demonstrate congruence between underpinning theoretical constructs and the analysis being carried out. Mies (1983) and Lincoln and Guba (1985) argue that different paradigms require different criteria for judging quality. Although justifiable this last statement begs the question of sufficiency to ensure trustworthiness of the research findings. Research could be carried out that demonstrates congruency but exhibits bias.

Meaning and understanding are the quarries in qualitative, post-modern, post-structuralist research. Following the work of Potter (2004) and Nixon and Power (2007) there is an emphasis on comprehensiveness in qualitative analysis that is demonstrated by the:

“ consideration of deviant case analysis, participants’ understanding, coherence and readers’ evaluations” p75

These approaches form part of the data gathering and analytical methods and their omission may allow inferences to be drawn about the quality of a study but their inclusion does not ensure the validity of interpretations of the data.

Crowe (2002) suggests that findings could be validated by looking at what has been already published to see if the work of others corresponds with the findings of a

particular study. This is based on an unsupported assumption that only trustworthy, rigorous and reliable studies are published.

The third position noted in Murphy et al's (1998) meta-analysis, is that of Smith (1984), who argues from a post-modern view that the interpretative element of qualitative research renders it incompatible with any form of assessment. From the socio-constructivist paradigm, Shotter (1990) indicates the implausibility of constructing standards for the evaluation of epistemological claims if one accepts that the world is a construct. Thus rendering it impossible to judge anything as incompatible or unacceptable. This results in the validation of accusations such as the ones referred to by Hodgkin (1996) who attacks postmodernism as the creator of disciplines lacking structure and where;

“ everything is relative; fashion and ironic detachment flourish, and yesterday’s dogma becomes tomorrow’s quaint curiosity.” p1568

As Murphy et al suggest if we allow that qualitative research lacks any possible criteria for the assessment of quality there are huge implications for commissioners of research and the qualitative research community. This third stance begs the questions posed in the introduction to this chapter: how will we be able to use qualitative research findings with confidence if we cannot articulate how we differentiate poor qualitative research from good?

The fourth position identified by Murphy et al (1998) is that taken by Mies (1983). This relies on the judgement that a good outcome, which follows the implementation of research findings, verifies the research method. This stance seems to be predicated on an assumption that good ends only come from good processes, the proof of the pudding being in the eating. Whether or not it can be demonstrated that this is an indicator, it does not help in the quest for criteria upon which to defend method and justify research findings.

3.3.4. Ethics and morality

Consideration of both the consequentialist ethics of utilitarianism and the virtue ethics of morality and character might prove useful for the discussion of the minimum set of criteria needed to assess qualitative research. It would seem apparent that researchers want to understand more about processes, interactions, experiences and outcomes within their field of study. To extend this from a personal quest I would suggest that they also wish to share these findings, and in order for the findings to

have currency with others they must be credible. Further as the participants involved in this study have given freely of their time and are revealing their thoughts at often very difficult and challenging episodes of their lives. It would be both unethical and immoral not to conduct the research and present any interpretations of the findings in a way that merits trust and belief from other practitioners.

It is also important to demonstrate awareness and understanding of the legal constraints that pertain to the undertaking of research projects and the collection and dissemination of data. However, when we move away from the area of law and ethics, we are still left with the paradox of trying to create criteria within an approach based on a relativistic paradigm and holding the possibility of multiple realities that necessarily follow from the acceptance that reality is mind-dependent.

On rejecting the notion of correspondence of a truth as the basis of validity for qualitative research Lather (1993) suggests *“validity as simulacra/ironic validity”* p677 as a possible approach. Baudrillard (1981) *Simulacra and Simulation* starts with this quotation from Ecclesiastes,

“The simulacrum is never what hides the truth - it is truth that hides the fact that there is none. The simulation is true.” p1 (2000 edition)

Baudrillard maps the subtle progress from discourses that *“dissimulate something”* to those that *“dissimulate that there is nothing”* p6. He uses the example of Byzantine religious icons where the image may be described thus:

*“it is the reflection of a profound reality;
it masks and denatures a profound reality;
it masks the absence of a profound reality;
it has no relation to any reality whatsoever: it is its own pure simulacrum”* p6

The icon is venerated by those who believe through all the stages of its incarnations regardless of the listed changes. A contemporary instance of a simulacrum is the *“alternative-life”* individuals enjoy in a virtual reality world where they exist via avatars, simulacra, which are both in the virtual world and are not.

A current example of simulacra within the hegemony of health care is the notion of *“political spin”*, where policies are represented, attended to and gain credence but exist only in the multiple interpretations of the listeners. For instance a Government report about assessments for people with cancer in England attempted to

differentiate between treatments that “*saved lives and those that merely “prolonged lives”*” (News bulletin Radio 4, 4.30pm 30th June 2008). I maintain that it is impossible to conceive of a life that is both shortened and is saved. The simulacrum here is the notion that there is a difference and as a result we privilege saving lives above prolonging them. Once this is accepted there is the possibility of resultant funding implications for the Government with the provision of drugs that prolong life being stopped on the grounds that they do not save life.

Further instances from current English healthcare policy are congruent with Bourdieu’s (2007) description of the simulacrum of choice, DoH (2004a), where there are no real alternatives. Bourdieu describes those in power as being the holders of “*linguistic capital*” (p 51), referring to pre-revolutionary French history and the differing types of speech and language used by those in power as compared to those who were oppressed. This exposed the paradox that such use of language is both a means of communication and a bar to understanding, concealing as much as it discloses.

For the legal, moral, ethical and practical reasons outlined it is necessary to produce criteria that will demonstrate quality in this study in order for it to inspire confidence and demonstrate trustworthiness. The next section will outline the areas to be considered in this enterprise.

3.4. Trustworthiness criteria for this study

I have argued that in order for research to be more than an “academic exercise”, qualitative, quantitative and mixed method approaches to research need to demonstrate that they are trustworthy. Unless it is possible to express the rigour, credibility and reliability of research procedures the entire project is meaningless and unsupportable both financially and morally. It is upon these criteria that the research findings will be judged and from their demonstration that defences against “anecdotalism” and subjectivity can be mounted.

As indicated above all four positions identified by Murphy et al (1998) are open to criticism. However the underlying motives for this study are to increase understanding of the process of patient and nurse interactions. A constant focus needs to remain on the moral obligation of the researcher to respect the generosity of

those who participated in the research process, rendering it necessary to demonstrate that the research findings are credible and add to our understanding.

It is possible to make an assumption that many researchers are bound both by personal moral codes and professional ethical codes that preclude lying and deception and which would ensure the interests of the participants be protected from exploitation and harm. This is certainly true within the nursing profession where obligations to beneficence, non-maleficence, confidentiality and the obtaining of consent form part of the nursing ethical code (Nursing and Midwifery Council 2008). It is required that nursing research with NHS patients and staff as participants is assessed by the National Patient Safety Agency through the National Research Ethics Service. These committees are charged with ensuring that the participants in research studies are protected from harm and their “*safety, dignity and wellbeing*” is preserved www.nres.npsa.nhs.uk. It is therefore possible to demonstrate that this study, as an example of nursing research, has been designed with specific criteria of good ethical research practice in place.

It is certain that all researchers in the UK have general and specific legal constraints imposed by for instance anti-discrimination legislation and the Data Protection Act (1998). Any research design has to bear in mind procedures that ensure compliance with these laws and this can also be seen as a criterion of good research practice.

Once it is established that the research methods employed are suitable to explore the research questions it is imperative any further core criteria developed are specific to the research undertaken for this study. Lather (1993) posed the question:

“What might open-ended and context-sensitive validity criteria look like?”

Authenticity and the comprehensive nature of any interpretations would seem to be a fruitful area to explore. Authenticity in the sense used by Sartre (1954) is the absolute 100% act of being and doing. In Sartre’s *Being and Nothingness* a waiter is not acting the role of a waiter exaggerating the attributes that enable us to identify a waiter. He is “being” in the same sense that a glass of water is being glass of water. Guba and Lincoln (1989) identify the domains whereby authenticity may be demonstrated as those that ensure care has been taken regarding the execution of the component parts of the research and the acknowledgements of any underlying value–structures and agendas.

I would argue that the aim of qualitative research is not the discovery of universal truths but the development of understanding and that what we are holding up for scrutiny is a simulacrum, an interpretation by one individual of an event. In this research study the event is the analysis of an interaction between other individuals. The research is not seeking to replicate a representation of practice, since each of the participants - nurse, patient and researcher - will have differing interpretations of the practice interaction that has been observed and audio recorded. The event would have been different if the researcher was not there, and that difference cannot be captured. Therefore the research findings do not represent practice *per se* but are an attempt to interpret an authentic, specific reading of the interaction of several instances of practice from close observation and analysis of the resulting data. It is identification both of commonalities and differences that will broaden our understanding

The comprehensive nature of the research, as Lather put it, is attending to

“the politics of what is and is not done at a practical level ” p 674

“What is done” may be discussed in terms of what Flick et al (2004) refers to as “*comprehensibility*” suggesting that the ability to audit the research may be achieved in three ways. Firstly with meticulous documentation that begins with an examination of the researcher’s prior understanding and expectations of the research process. Secondly a procedure that is transparent and assessable. Thirdly that all documentation is sufficiently detailed in order to give evidence of the;

“unique dynamic that obtains in every qualitative study” Flick et al (2004) p 187

The criteria listed by Flick at al, above, are pertinent to this study and will underpin this research.

3.5. The researcher’s understanding and empathetic response to knowing and being

As presented above this study embraces a hermeneutic approach to gaining understanding through reflection of patterns, combined within a feminist and interpretivist position. It is acknowledged that there are two main tensions when taking a hermeneutic approach to Critical Discourse Analysis (CDA). Firstly the

hermeneutic circle facilitates understanding through appreciation of part in relation to the context of the whole. This raises problems of interpretative veracity as CDA constructs understanding through consideration of free-standing elements or parts of the whole (Wodak and Meyer,2002). They further note that CDA may be considered as a “*text-reducing*” process as close attention is paid to small parts of the text during analysis that it is suggested run counter to the “*text- extending*” practice of hermeneutic interpretation. I would argue that as the CDA is influenced by a Foucauldian approach, both close attention to individual statements, and an extension beyond the text by interrogation and rendering the commonplace strange are achieved. In this way the text is extended as alternatives are considered in order to illuminate possible meanings.

CDA goes beyond engagement in the production of novel interpretations of interactions but analyses the way the participants (social actors) construct meanings within the context of social structures. This is illustrated by Foucault’s (1981) example of changes in society’s attitudes towards sex that he noted moved from a “*lively frankness*” in classical times to a contemporary period of “*growing sexual repression*”.

My research aims to improve understanding of everyday practice. Laclau and Mouffe (1985) identify that every “*social configuration*” (p84) is resonant with meaning. Nothing happens without connotations and it is the identification and exploration of these that give depth of insight and understanding.

I am uncomfortable with the privileging of the “scientific” approach for health care research, for example the RCT as supported in the primacy of evidence tables in the National Service Frameworks. Here the Randomised Controlled Trial (RCT) is given primacy, however, there is a growing understanding that RCTs cannot answer questions that rest on quality issues. For example the study by Rycroft-Malone et al (2004) notes that although a RCT has provided evidence of the efficacy of heavy bandaging for leg ulcer healing this is of little import if patients refuse the treatment.

Further challenges to the empiricism on which RCTs are based are evident as the gulf between objectivity and subjectivity is bridged. Lyas (1992) notes that

“In our everyday discourse we accept that our perceptual judgements sometimes report on how the world is, rather than how we feel or react to the world” Lyas (1992) p370

He continues by citing courts of law where the notion that motorists are capable of stating a fact, for instance a traffic light was red or green, is accepted. Despite taking a post-modern approach we must allow that our perceptions are sometimes verifiable by others. This brings into question the clear-cut dichotomy between the claim of objectivity, the corner-stone of science, and subjectivity. It is however our interpretations of actions and events that cause us to individually make judgements based on our own experiences and agendas. Garrison Keillor (1985) differentiates cultural approaches to life in "Lake Wobegon" describing two types of people, those who saw the amber traffic light before the green as "get ready to go" and those who saw it as "go". As with all symbols, including language and behaviour, we interpret them according to who we are.

Whilst formulating the research questions in 2005 I recorded in my log that my expectations of the research processes were that:

1. Walker and Avants' framework for CA was ontologically sound because it was widely used and the resultant studies were published in peer-assessed journals.
2. The definition resulting from the CA would be identified within the analysis of the transcribed data of the observed assessments.
3. I had always doubted the anecdotal assumptions that patients were more empowered in their own home and therefore expected little difference between assessments based there and those based on healthcare premises.
4. That regional difference and differences of class, gender and education would result in differences of approach.

3.6. Conclusion.

This chapter has commenced by explaining and critiquing the main epistemological and ontological positions that underpin the theoretical assumptions formulating the science of qualitative research methods. Despite qualitative and quantitative approaches adopting different ontological assumptions, rather than viewing them as antithetical, they may be seen as occupying positions at each end of a research continuum that includes all of the mixed method approaches (Ho et al 2007). There

are many criticisms which can be levelled at research methods and understanding and acknowledgement of these shortcomings can deepen the appreciation of the phenomena being studied. In order to make decisions about which approaches to take it has been argued that both an understanding of and empathy with the theoretical positions and a consideration of the type of research project are necessary.

Several criticisms of the qualitative approach have been identified and addressed. Questions of research evaluation criteria in general and explanation of the role of reflexivity within this evaluative process have been made. Notions of fair play and participant involvement have necessitated discussion of the ethical and moral considerations that underpin this project.

This chapter has explored the idea of establishing the trustworthiness of a particular research process through the process of reflexivity. From Murphy et al's (1998) meta-analysis four main positions regarding universal criteria identified for the assessment of quality in qualitative research have been identified. These positions have been explored and critiqued.

The first position proposes the use of the structural indicators of quantitative research for qualitative research. As has been shown this is an unsustainable suggestion as quantitative research criteria rely on the demonstration of the suitability of a specific research method to prove or test a particular hypothesis, whereas qualitative research does not seek to verify *a priori* hypotheses but is exploratory in nature. Feyerabend (1986) refers to this distinction as one between;

“the context of discovery and the context of justification” p15

Further it has been argued that quantitative methods are designed to provide both the correspondence and replicability of “truths” as methods of verification of research findings. A post-modern view of the world ontologically precludes the notion of one definitive truth and embraces multiple realities and therefore multiple “truths”.

The second position refers to the exposure of ideological distortions (Mies 1983) and this has been addressed at the introduction to this chapter as it is a prerequisite that the methods chosen for this research study require congruency with the paradigm that informs the approach and the researcher's ways of making meaning. Fieldwork

methods such as “anthropology at home” and open observations have been described and identified as congruent in approach (Peirano 1998 and Silverman 2000). However, the case has been made that ontological congruence is not sufficient to ensure the quality of a research process, and interpretation of research findings as a case could be constructed where there is an absence of “ideological distortions” but where inherent bias in the reporting and/or interpretation is found.

The third position states that it is impossible to construct criteria that are appropriate within a relativistic paradigm, as each interpretation is unique in time, place and understanding. This leaves qualitative research process open to the criticism that it is merely journalism and any findings lack rigour and trustworthiness. Further it has been argued that it is morally essential to be able to differentiate good research from poor, to enable research findings to be trusted and have credence and currency within the wider world of health care practice.

The fourth position identified by Murphy et al’s (1998) relies on a flawed notion that process can be judged by outcomes. In other words the ends justify the means. This says much about the validity of a practice change being assessed, but does not ensure the validity of the evidence on which it is predicated.

In addition to the legal, moral and ethical criteria that have been identified as forming essential components of good research practice, it is also necessary to produce criteria specific to this research study that will further demonstrate quality, and to achieve this end the following criteria will be established:

1. Authenticity of approach, analysis and ethical considerations of moral obligations.
2. Comprehensiveness demonstrated through transparency of approach and analytical thinking including:
 - the consideration of more than one interpretation of the research findings
 - the inclusion of discussion on the understanding and empathetic response of the researcher to considerations of assumption regarding knowing and being.
3. Documentation of the research process (Flick et al 2004)

It is intended that this study will deepen understanding of the constitutive elements that comprise the interaction between nurses and their patients referred to as *assessment*. The following chapter will specify the design of this particular study. It is anticipated that this level of information will allow assessment to be made by external assessors in the light of their own criteria and thus they can make judgements regarding the quality of this research process and findings.

Chapter 4

Study design - methods and justification

"There's glory for you!" "I don't know what you mean by `glory'," Alice said. Humpty Dumpty smiled contemptuously. "Of course you don't -- till I tell you. I meant there's a nice knock-down argument for you!" "But `glory' doesn't mean `a nice knock-down argument'," Alice objected. "When I use a word," Humpty Dumpty said in rather a scornful tone, "it means just what I choose it to mean -- neither more nor less."

Lewis Carroll (1871) p188

4.1. Introduction

In the previous chapter both the ontology of the qualitative paradigm and the complex question of how quality and trustworthiness may be demonstrated when using qualitative research methods were explored. It was argued that quality and trustworthiness could be accomplished through the use of epistemological reflexivity regarding the suitability and reliability of research approaches. To this end the following study-specific quality criteria were identified:

- Professional ethical guidance,
- Personal moral implications
- Legal constraints
- Authenticity of approach
- Comprehensiveness through transparency of method and interpretation
- The inclusion of discussion on the understanding and empathetic response of the researcher to knowing and being.
- Congruence between the paradigm that informs the approach and the research methods used.
- Suitability of methods for pursuing the research questions posed.

For the purpose of clarity for this chapter the study will be divided into 2 phases:

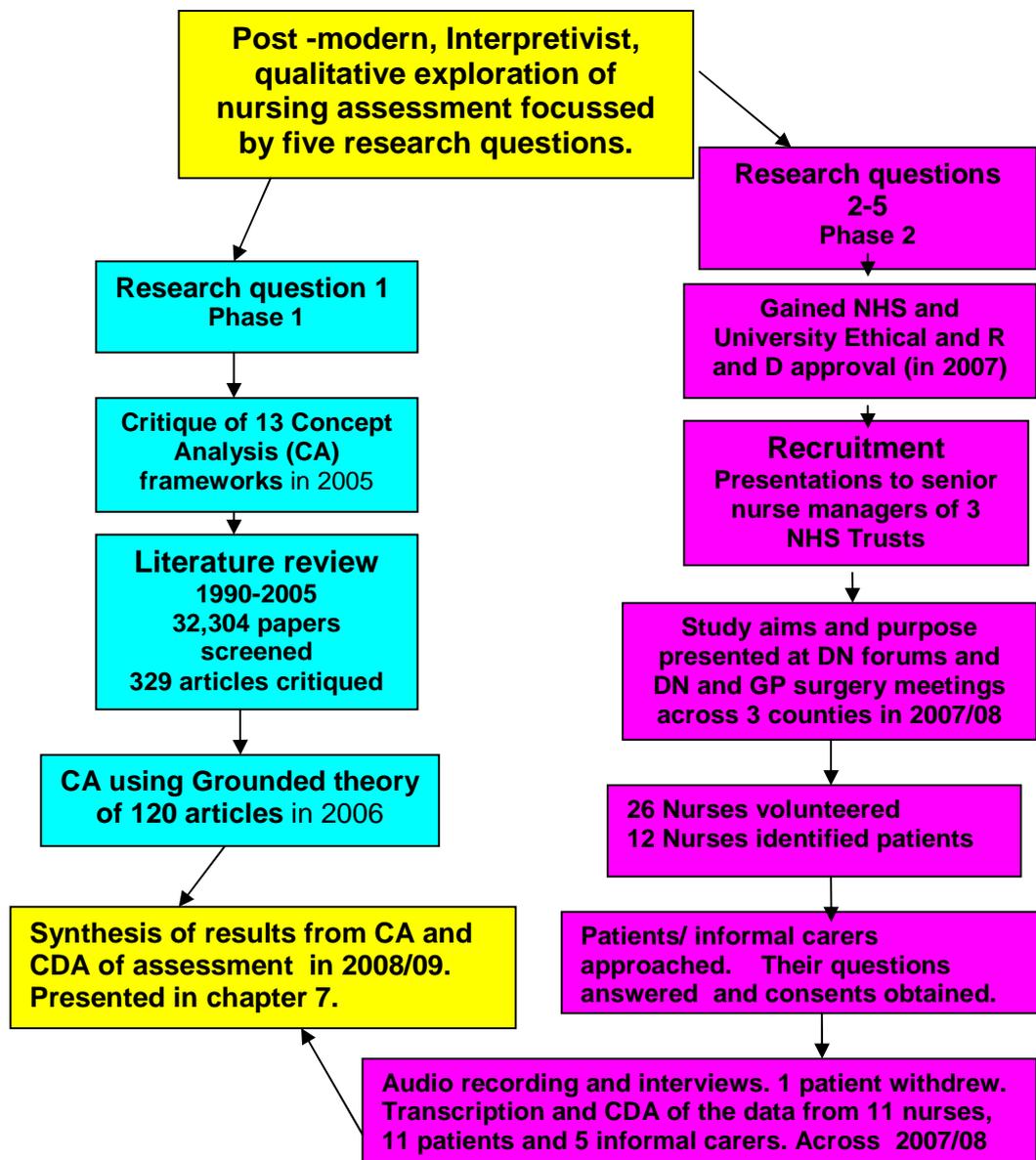
Phase 1. The literature review and concept analysis

Phase 2. Obtaining ethical approval, field work and analysis, and synthesis of data.

Figure 4.1 illustrates the procedures undertaken to explore the research questions:

1. *How is nursing assessment defined in the literature?*
2. *What professional, philosophical and organisational influences affect the nursing role regarding patient assessment?*
3. *What impact does nursing assessment have on patients?*
4. *Does patient inclusion, involvement and empowerment happen as a result of a nursing assessment?*
5. *Does the location of a nursing assessment have an impact on the assessment?*

Figure 4.1 Map of the research procedure



4.2. Phase 1 – Literature review and Concept Analysis

4.2.1 The Literature Review

In order to identify the range of literature regarding nursing assessment a directed search was carried out. Gerrish and Lacey (2006) note the importance of a tightly focussed research question in order to ensure that the literature identified is germane to the area of study. There are several models available for the planning of a research questions and search strategy. For example PICO which is an acronym for Patient problem, Intervention, Comparison, Outcome or SPICE, Setting, Perspective, Intervention, Comparison, Evaluation. However as can be seen both PICO and SPICE are orientated towards the identification of literature which involves the presentation and evaluation of an intervention. This research study seeks to explore the everyday practice of assessment rather than the outcome of the practice and for that reason a framework was not used. The strategy taken to identify the literature utilised seven literature selection steps adapted from the systematic review process (Egger et al 2005) is outlined below. The research question which drove the literature search for this study was;

1. *How is nursing assessment defined in the literature?*

Having identified examples from the literature the next phase was to review each example against the pre-determined eligibility criteria and identify those which provided answers to the research question. The accepted literature was then analysed and interpreted (Greenhalgh 2001, Gerrish and Lacey 2006). It was at this stage that this study departed from a conventional Literature review. As it is the practice of assessment which is the study's focus, every incidence of assessment practice identified was analysed as they all answered the research question at a conceptual level. I will argue that the research method of Concept Analysis (CA) facilitated through Glasarian Grounded theory (GT) was suitable for this analysis. These methods are now justified using the quality criteria of congruence between the epistemological approach and the research methods

4.2.2. Concept Analysis (CA) and Grounded Theory (GT)

A CA approach was chosen in order to explore the first research question and to capture what was understood by the term “assessment” when referring to the interaction

between nurses and their patients. The literature (1990-2005) was reviewed employing the principles of transparency of inclusion and exclusion criteria and the evaluation of each study's research methods. The included literature was then analysed using a Glasarian GT approach to interpret the studies.

As recorded above, the researcher had assumed Walker and Avant's CA framework would be used, as it is commonly employed within nursing research articles. However as a novice researcher and in order to gain more experience of research methods a review of the nursing literature (1993-2005) was undertaken to identify and critique frequently used frameworks. An exploration of the theory of concepts and a critique of the thirteen CA frameworks identified from the literature was therefore undertaken. It became apparent that far from being an accepted term the notion of concept itself was disputed. In order to better understand what I was analysing there follows a critique of the various positions identified.

4.2.2.1. *What are concepts?*

Building on the work of Paley (1996) the following descriptors of the term *concept* were identified from the nursing literature (Table 4.1). The lack of consensus revealed by the range and variety of these theories demonstrated that concept was a contested term.

Table 4.1. Meanings ascribed to the notion of a concept as listed by Paley (1996)

Meaning and properties ascribed to "concept"	Author
Abstractions	Norris (1982)
Mental formulations	Chinn and Kramer (1995)
Mental images	Meleis (1985)
Words describing mental images	Fawcett (1989 in Paley 1996)
Having meanings	Allen (1993 in Paley 1996)
Having usages	Rush and Oulett (1993)
Having definitions	Browne (1993)
The building blocks from which theories are developed	Watson (1991)
Clarified concepts allow theory construction	Chinn and Kramer (1995)

Rodgers and Knafl (2000) note three approaches to the discussion of concept. Firstly, that some authors focus on concepts as empirical reality. For example Walker and Avant (2005) indicated that concepts symbolise objects in the world. Secondly they noted the connection between "*concepts*" and "*cognition*" as in Fawcett's and Meleis' descriptors in

Table 4.1. The third approach concerned the link between concepts and language. Rodgers and Knafl (2000) gave Diers' (1979) description of a concept as "*simply a word to which a meaning has been attached*" - that is echoed by Browne's definition in Table 4.1 and Humpty Dumpty in the opening quotation (Carroll 1871). A consideration of the philosophical approaches to understanding concepts follows.

Frege (1952) proposed that a concept could be distinguished from an object and that there were first and second level concepts that enabled the discussion of such abstract notions as types, which display type differences. Frege's proposition was based on the Augustinian language theory, where a word stood for an object, which was both its meaning and the result of a naming process. In a further simplification of the Augustinian theory Frege replaced ideas (mental entities) with the Platonic notion of the senses. Plato suggested our senses, independently of any empirical relations such as resemblance, determined what references we make for concepts and objects. Based on this idea Frege modelled three realms of communication:

- language
- thought
- the world. (Table 4.2).

These realms explained his theory of speech acts outlined below as the composition of each sentence corresponded with the thought composition, creation and recognition of the proper name, and finally the notion of the concept.

Table 4.2. Frege's three realms of communication (logocentricity) (adapted from a diagram in Baker [1986] *my italics*)

Speech act structures		
A sentence	A proper name (<i>naming word e.g. hat</i>)	A concept (<i>name of an idea e.g . truth</i>)
Sentence contains subject, verb and object	Proper name stands for object	Concept word stands for the idea
Sense of a sentence (combination of words to depict the thought/ idea)	Sense of a proper name (the <i>hatness</i> of a hat)	Sense of a concept word
Reference of a sentence (truth value)	Reference of a proper name (the object)	Reference of a concept/ word (the concept)

Frege seemed to be suggesting that a word had meaning by virtue of the entity it stood for. This elegant theory may have much to do with the fact that Frege was both a mathematician, used to exact symbolic representations, and a native German speaker. In the German language words often comprise the entities they symbolise. For example Father Christmas in English, is compounded to one German word “vaterweihnachten” which represents both “vater” meaning father and “weihnachten” meaning Christmas.

Saussure (1960), a Swiss linguist and philosopher, proposed that language is a self-contained system with its own set of rules. In his theory of semiotics he described the sign (the union of the mental concept and the spoken or written word), the signifier (the sound/ image that makes up a word) and the signified (the mental concept). The sign is arbitrary and the signifier could also be arbitrary with the exception of onomatopoeic words that mimic the signified. (An onomatopoeic word is where the sound is the word, for example “woof” is the word for a dog’s bark. However even these are not universal as French dogs say “*oug ough*”.) Further, there is no preordained connection between sign, signifier and signified.

This theory limits the appreciation of concepts within the mind to only those with which we have already made associative connections - raising the question “would we be able to conceive of anything for which we haven’t a name?” I propose, as evidence of our ability to do this, a story from Alan Bennet (1989) where he described a car journey made with his mother, then suffering from early Alzheimer’s. She delightedly noticed sheep grazing on the hill but was unable to remember their name although she could recall the names of their attributes, such as wool, lamb and mutton. I contend she remembered the “concept of sheep” the *signified* without having the *signifier*, the name sheep.

Barthes (1977a) considered different levels of meaning, proposing that language comprised functional units each with a “correlate”. He described parts of the narrative that are concerned with characterisation, psychological factors, data regarding identity and notation of ambiance as “indices”. Some classifications of narrative, for example folk tales, were more reliant on the functional aspects of language whereas others were dependent on indicial writing e.g. psychological novels. Barthes argued that these components of narrative enable structural analysis of language and thereby the

unravelling of concepts. Thus our understanding of a concept will partly depend on our appreciation of the possible correlates as well as the indices present.

Derrida (1978) invokes punning and double entendre as examples that counter the notion of fixed meanings expounded by Saussure and Barthes. An example of this would be the rather old joke:

Dog owner "My dog has no nose"

Respondent "How does he smell?"

Dog owner "Dreadful!"

This relies on the ambiguity of our connotations regarding the word smell, meaning both to sense an odour and to be an odour. Derrida suggested the "concept" or idea had its pure expression within the mind and that the spoken words captured a concept's essence imperfectly. Written words were even more ambiguous since they were reinterpreted through the text, possibly part of different lexicons and hierarchies in the minds of the reader and the author.

Wittgenstein's (1953) probability notion of concepts uses the analogy of family resemblance where family members share some characteristic properties, attributes, or features with each other. Category membership does not require the display of all features as for example a penguin and a robin can belong to the category "birds", if flight is not chosen as a defining category feature. Rosch (1978) continued the exploration of probabilistic theory of categories and prototypes (best examples of a category) by suggesting use and understanding of concepts as related to an individual's cognitive economy. She asserts the task of category systems is to

"provide maximum information with the least cognitive effort" Rosch (1978) p28

She also claimed that our;

"perceived world structure"

comprised

"structured information rather than arbitrary and unpredictable attributes". Rosch (1978) p28

The consequence of this second statement means that some attributes tend to be combined with other features. For example the attributes of wings are that they are mostly feathered, however this is not true of bats, manta rays, or aeroplanes. To accommodate this Roche placed concepts within a hierarchical framework where concepts with more category properties were more typical of the category.

There are some problematic assumptions with prototypical representations, firstly that differences and similarities in the number of characteristic properties between category members can neither be deduced nor inferred from the prototype. Secondly the prototype gives no information regarding the size of the category and prototypes are not context specific. For example a dog is typically a pet in the European home and not a part of the menu, unless we are in Korea. Rosch however offered the unsupported assertion;

“both basic levels and prototypes are in a sense, theories about context itself,”

Rosch (1978) p43

Sacks (1984) moved the notion of category membership forward with his example; “ *The baby cried. The mommy picked it up*”. Here we are invited to make an inferential assumption that the *baby* is the child of the *mommy* despite not having specific information on which to make this assumption. The use of the name *mommy* leads us to put it and the *baby* in a “relational” set or category. Our default position, as it were, is that this would be the set of “a family”. Sacks refers to this as a “membership category device”. He further observed that there are certain activities that are associated with categories and also that categories may be predicated on certain activities, for example babies and crying. If we firstly compare the phrase:

Mary is telling Jamie to lose weight.

Our impression of Mary and Jamie may be very different if we then say

Mary, the doctor, is telling Jamie to lose weight.

There is an assumption based on the category “doctor” that suggests Jamie is Mary’s patient and that it is socially acceptable and an expected “action” that doctors will “tell” patients to do things presumed to be in their best interest. The category patient precludes offence being taken! However if we identify Jamie as Mary’s lover a number of further interpretations may be inferred. This demonstrates the importance of considering category and context in order to make conceptual meaning.

Critique of concept definitions taken from the nursing literature

In addition to the examples of concept definition from the nursing literature listed in Table 4.1 Morse et al (1996) claim that concepts are the basis of theories acting both as the link between “*abstractions and data*” and being the means by which data is abstracted to form a theory. This circular argument puts a concept in the role of a link between “*abstractions*”, the information that is uncovered when analysing a theory, and “*data*”. I would suggest data in this context can be regarded as an abstraction. Therefore abstractions and data seem to be synonymous and so there is no space in which a concept can provide a link. Morse et al (1996) further refer to concepts as “*abstract representations of phenomena*”; that is at odds with the definition offered by Chinn and Kramer (1995) and proposed by Morse et al (1996) as the “*best description for a concept*” (1996 p386). Chinn and Kramer (1995) define a concept as “*a complex mental formulation*” that I suggest might be synonymous with an “*idea*”. There is a substantive difference between a phenomenon and an idea. In this conception an idea is intangible and can be a construct of an individual mind, subject to change and refinement and may be unique. I would suggest ideas are internal constructs that do not offer tangible and empirical comparisons one with another. I would further argue that a phenomenon is manifest, tangible and recognisable in the real world and has the possibility of being identified independently by many. Logically therefore, one cannot stand for the other as it is meaningless to say I have had a sudden “*phenomenon*” but there is meaning if “*idea*” is substituted for phenomenon within the sentence.

Penrod and Hupcey (2005) postulate the manifestation of two types of concept, the “*everyday*” that they claim is inadequate for scientific enquiry (a positivist stance) and the concept that forms the

“theoretical representation of empirical reality” Penrod and Hupcey (2005) p404.

They neither offer a reason for the need to create this division nor evidence to support their assertions. It seems to be an appeal to place nursing research within the privileged positivist scientific paradigm. Paley (1996) has identified that there are no firm agreements within nursing as to what a concept is and he listed meanings taken from the nursing literature (Table 4.1), further suggesting that the only factor common to these definitions is that it is a word.

Silverman (2000) described the relationship between theories and concepts as one in which sets of concepts are arranged within theories in order to define phenomena. He used the example of the phenomenon “death” that is dependent on the model of “death” determined by the context. If for example death is an execution or euthanasia the concept has different resonances. Thus the model of “death” being discussed is associated with the concepts that make up the definitions of the social situations. Again this postulates an essential link between the idea of a “concept” and the context in which it is manifest.

Taking further this notion of contextual determinism Berard (2005) has examined the importance of categories, using as an example the concept of “institutional racism” that was developed during the 1970s to account for a phenomenon previously described as racial discrimination. Although still discriminatory it avoided the necessary identifiable and accountable perpetrator.

Coulter (1989) has pointed to the need to know how to use the categories with which concepts are associated in order for sense to be made of conversation. Coulter (1989) referred to Garfinkel’s (1967) observation that cultural and societal influences on language are dependent on the concepts that are shared by these groupings. Thus we see the development of a notion that a concept cannot be a universal and if we accept that “*meaning is a function of use*”, as suggested by Wittgenstein, it could be that concepts are determined by their uses that are context and category dependent.

Murphy et al (1998) have alluded to the selective nature of our explanation of concepts, referring to the way in which they are diminished as we try to extrapolate their essence. They further pointed out that we can not arrive at the totality of reality by recombining their core attributes.

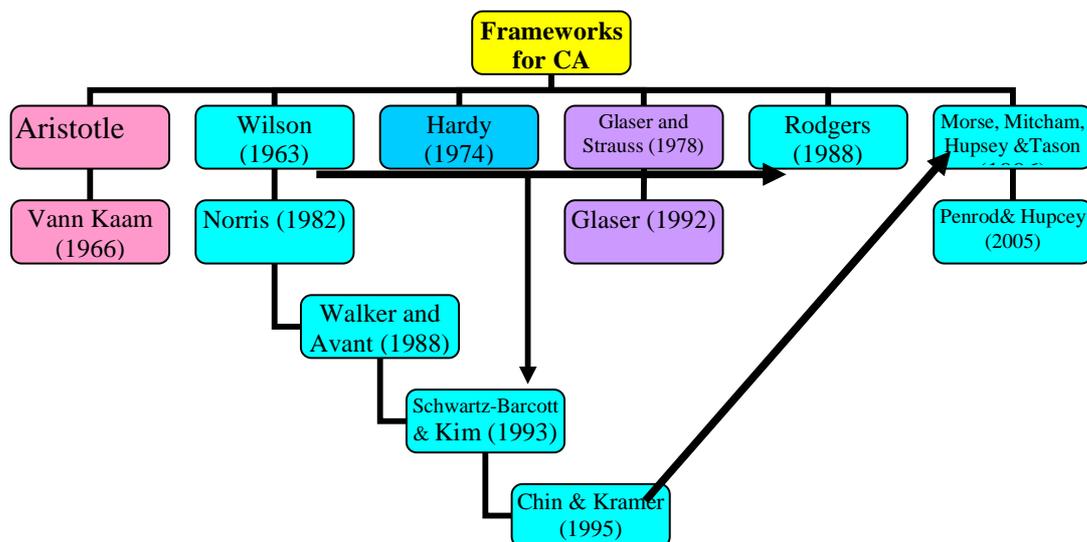
Based on my understanding of the theories above and for the purpose of this analysis the word *concepts* will be taken to mean phenomena that are influenced by the context in which they are placed, thus requiring a CA method in which the concepts remain contextually bound.

4.2.3. Concept Analysis frameworks

Thirteen frameworks were identified from the nursing literature (1993-2005) and

critiqued, in order to select the one most suitable for use in this study. It was found that the identified frameworks (Figure 4.2) were mainly based on hermeneutic propositions regarding understandings and were interpretive procedures founded on self-reflective modes of discovery. However four of the frameworks were developments of the work of Wilson (1963) -- Norris 1982, Rodgers 1989, Chinn and Kramer 1995 and Walker & Avant 2005 – and three were developments of those developments (Fig. 4.2) and all include case reconstruction, in which identified rules are made explicit. Reliance on case reconstruction raises concerns as it proposes that truths are revealed as a result of a causal explanation of the effects of a social action within the “pure case” and the distance and difference between it and other cases. This proposition is based on two philosophical theories, those of casuistry and causality.

Figure 4.2. Concept analysis (CA) frameworks showing antecedents



Casuistry

The philosophical tenet of casuistry originated to explain religious rule-setting in the sixteenth century teaching of Jesuit monks. It is still employed within our legal and medical systems and within the field of ethnography (e.g. Lévi-Strauss’ 1970 work on the universality of human myths). Case law decisions are adjudged against the outcome of similar previously agreed cases (precedents). In other words, outcomes of one case set a precedent for judgements involving other like cases. Arras (1991) describes casuistry as a process whereby principles are derived through moral knowledge which is:

“developed incrementally through the analysis of concrete cases” (p 31)

Beauchamp and Childress (1989) also refer to the process of casuistry as being one where the movement is from cases to principles

Casuistry is supportable in the English legal tradition where there is consensus about rule making and outcomes. It is however less useful within other spheres and has practical limitations in healthcare, since firstly, if the lowest set of nursing standards are accepted and practised, then precedents based on case studies from this area could be used to make judgments in other analogous cases. This would result in a lowering of standards overall. Secondly, any guidance from the example of one case is sensitive to problems arising if the example case is inappropriate for the setting of the case it will inform. These limitations require acknowledgement and consideration when constructing or describing cases as part of a CA framework.

Causality

Dating back to the works of Aristotle causality describes the logical relationship between the cause A, which must be prior or simultaneous to, its effect B. The laws of causality underpin science and mathematics and are implicated in the study of human behaviour. In studies of health and human behaviour causality cannot be universally accepted as, for example, if we say “smoking causes lung cancer” this statement is open to two refutations. Firstly not all people who smoke develop lung cancer and secondly not all people who die of lung cancer have smoked. This then has to be a possible or probable cause, an effect of the theory of probabilistic causation. Care needs to be taken when invoking causality as although syllogisms can define a logical argument they may be untrue (see Methodology chapter). Caveats recording the possibility of accidental cause/effects relationships also need to be considered.

CA frameworks

Wilson, a public-school master, designed his original framework, surprisingly described by Duncan et al (2007) as a seminal work, to enable boys in his class pass their Oxbridge entrance examinations (Wilson 1963). Although fit for that purpose it does not deliver the depth of understanding required for CA on which nursing practice decisions are based. Other frameworks identified included Morse et al’s (1996) that employs a contestable theory of concept maturity. The full discussion of the ontological incongruence and refutable theories that underpin many of the frameworks can be found

in the appended copy of the published article for which I was lead author (Appendix 5).

Based on this exploration of the use of CA frameworks in the nursing literature, concerns were raised regarding the unjustified adaptation and uncritical use of the frameworks. Little evidence was available to show they provided the necessary depth or rigour to enable the development of nursing theories. Further this review demonstrated that the term concept itself was contested and that many of the CA frameworks were based on flawed assumptions

Acknowledging the main limitations imposed by analysis is reductionist, since the framework structure binds the researcher to a consideration of Cartesian binary oppositions. Either evidence fits within the framework or it doesn't. However a framework had utility for a novice in the field of concept analysis as it provided structure and transparency for evaluation. Because of the ontological incompatibilities discovered following the exploration of the CA frameworks a change in approach was dictated.

Firstly In order to identify the literature a seven-step process was synthesised from the works of Clancy (2002), Egger et al (2005) and Greenhalgh et al (2005). Although this method is usually employed as part of a quantitative approach it was intended that the quality criteria for this study:

- authenticity
- transparency regarding paper selection or rejection
- time frame
- areas searched
- bias limitation
- comprehensibility

would be met through its use.

4.2.3.1. Factors for consideration when reviewing research papers

In addition to the selection of a suitable framework it is essential to note that texts are not isolated repositories of truth. It is therefore important to consider who has written them and for whom. Atkinson and Coffey (2004) suggest that the implied readership also need to be considered. Additionally they note status may be claimed for the text if it can be described as,

“factual, authoritative, objective or scientific” Atkins and Coffey (2004)

P 73

They further state that texts not only refer to the real world of existence but also to other texts, *“intertextuality”*, requiring the reviewer to be aware of the influences that one text may exert on another. An extreme example comes from the USA where creationists believe the Biblical narrative of creation is fact. In areas where creationists are in a majority, school science may be taught without reference to either *“the big bang theory”* or to Darwinian evolution.

The nature of the literature review also needs to be considered. Dixon-Woods et al (2005) have adapted Noblit and Hare’s (1988) original distinction between integrative and interpretive reviews. An integrative review involves techniques that pool or summarise the data such as a meta-analysis. This enables comparisons to be made and aggregated for analysis. Dixon-Woods et al assume the categories here are well specified and the key outcome of the work is a synthesis of findings. In contrast an interpretive review will develop concepts and identify the theories with which they are linked. An interpretive review seems a suitable method for this study as the CA seeks understanding of the term *“nursing assessment”* through examination of the literature, drawing inferences regarding the concept, through interpretation of texts.

Hughes and Sharrock (1997) described this as understanding the levels of meaning rather than the causes for events or interpretations of phenomena. Synthesis will also be an interpretive process:

“ an interpretive synthesis of primary studies must be grounded in the data reported in those studies” Dixon-Woods et al (2005) p46

4.2.4. Mixed methods

The nomenclature, mixed method, refers both to the integration of qualitative and quantitative studies within the same review (Thomas et al 2004, Harden and Thomas 2005, Dixon-Woods et al 2005), and to studies where qualitative methods used for hypothesis generation are then verified by quantitative procedures, the *“phase method,”* (Barton and Lazarsfeld 1952). Until recently there has been little discussion regarding the combination of research methods from different paradigms although Cresswell

(1998) described a relatively recent shift in emphasis from the qualitative versus quantitative debate. Hammersley (1992) argues that the

“process of inquiry is the same whatever method is used” p182

The seven-step literature identification process outlined below provided rigour and replicability for the identification, searching, screening, assessment, analysis and interpretation of the studies identified (Egger et al 2005). However, systematic review findings are reliant on the quality of studies included, and are predicated on the assumption that the studies are outcome orientated. Therefore compromises of Egger et al’s process were made for this study, firstly at the quality assessment stage as not all published studies explicitly state the quality components listed. However it would be unsupportable to infer absence of rigour in a study because an article lacked that detail.

This study aimed to keep to the spirit of the key systematic review principles:

- avoiding and acknowledging bias
- maximising transparency
- clarity in decision making
- assessing for reliability and quality in appropriate ways.

I have chosen to use grounded theory as an interpretative tool for analysis and I will argue that the mixing of methods does not add a detrimental tension to this study.

4.2.5. Grounded Theory

Glaser’s (1978) general methodology of grounded theory (GT) was chosen since this is an exploratory study. Using GT avoids the imposition of verification of a preconceived hypothesis that, as was argued within the reflexivity chapter, is incompatible with an interpretative qualitative research paradigm. Once a hypothesis has been created the act of verification or disproval limits the scope of the exploration of the literature as only text which support or undermine the hypothesis are focussed on.

GT was developed in the 1960s as a contrast to the positivist paradigm of the logico--deductive model of inquiry into behavioural science. Glaser and Strauss’ grounded theory approach favoured the principle of theory development rather than that of theory testing. Further, those working within a humanist paradigm saw grounded theory as a tool to re-establish the connection between theory and practice that many felt was becoming lost as the positivist approach become removed from the social phenomena it was studying

(Layder 1982). It is important for this literature to be grounded in examples of current practice to enable the concept of assessment interactions to be fully explored.

The main conceptual criticisms of grounded theory are that it is conceptually akin to “Baconian inductivism”. Francis Bacon’s 1620, work *Novum Organum* promoted an approach for developing theories iteratively from unbiased observation and GT utilises a similar process. Iterative processes are also open to the criticisms that it is difficult to know when they are complete (Wittgenstein 1951). GT has additional practical disadvantages such as researcher time and therefore cost.

However four main advantages were seen in the use of GT for the analysis of portmanteaux-word assessment. GT facilitates the identification of instances at the conceptual or Basic Social Process (BSP) level that allows for:

- transferability between incompatible studies
- context determined concepts to remain contextually bound
- researcher bias limitation as concepts rather than theories are identified and challenged within the process
- avoidance of the imposition or verification of a preconceived hypothesis.

(Glaser 1978)

These qualitative, interpretative processes reflect the ontological stance of the researcher and offer congruency between the approach and the methods used. Comprehensiveness is achieved as confounding data are included and explored and context-dependent or determined concepts remain contextually bound.

4.2.6. Research methods must be suitable for pursuing the research question

4.2.6.1. Literature review method employed for this study

Foucault (1977) and Levine et al (1995) suggest that alterations in use of a term in times of upheaval are particularly revealing. Therefore the time frame of 1990--2005 was chosen as it includes radical changes and challenges in nursing practice outlined in chapter 2.

As stated the literature review was synthesised from those of Clancy (2002), Egger et al (2005) and Greenhalgh et al (2005) and was formulated into a seven step approach to provide comprehensibility and an auditable process for the identification, acceptance, or rejection of the literature.

Step 1. The research question

The following broad research question was formulated in order to focus the study:

How is the term nursing assessment used in the current health care literature?

Step 2. Eligibility criteria

Eligibility, quality criteria and data retrieval forms were based on information from <http://www.policyhub.gov.uk> and the criteria adopted were that the literature included:

1. Qualitative or quantitative studies of assessments made throughout the UK, Scandinavia, Australasia, Canada and western Europe.
2. Assessments made in health care premises
3. Assessments made in care/nursing homes
4. Assessment made in the patients' own homes

Exclusion criteria

Decisions regarding the exclusion criteria reflected the importance of contextual considerations of the:

- Cultural context of the nursing practice
- Whether publication was in an English language journal
- The method of healthcare delivery

Cultural context

The importance of a study's cultural context is exemplified in work from China. Pang (2003) has shown cultural differences of nurses' perceptions of their ethical role and responsibilities. For example their study showed Japanese nurses' responses were found to be "care based", American nurses were "*principle based*" and Chinese nurses were "*virtue based*" (Pang 2003). Pang et al (2004) suggested current nursing practice in China, where there is an experience-based theory of nursing, "*can reflect indigenous practice*" that they suggest may be at variance with Western and

Antipodean models.

Eggar et al (2005) indicate that selecting only from English language journals will bias the results. However as the aim of the review is to discover the use of the term within the United Kingdom (UK) health care arena, only English language journals were searched. Avoidance of multi-contextual backgrounds in the literature enabled usage to be initially discovered within the European, Antipodean and Scandinavian nursing hegemonies. Only literature that reflected the practice of nurses, health visiting and midwifery regarding assessment of patients or clients within the primary, secondary or private sectors were included.

Literature from the USA was excluded because of the cultural differences in health care provision that influence nursing *per se* and the range of conditions assessed by nurses. An example of the difference is found when examining the USA private insurance-based approach to the provision of health care for chronic conditions such as diabetes. USA health care which corresponds to that delivered in the UK is only available to those who are able to pay resulting in large numbers of people with incurable but treatable conditions being denied affordable health insurance and thereby treatment. Thus the diversity of assessment experience and practice encountered by many US nurses is demonstrably different to that of UK nurses.

Step 3. Locate studies

Appendix 1 shows the search terms and data bases used to identify British, Scandinavian and European journal publications between 1990 and 2005.

Glaser (1978) stressed the importance of looking outside the professional literature and use of Lexis Nexis (the European news, business and legal information data base), provided over 5000 references to assessment. A fingertip search was conducted of recent and relevant documents published by the Royal College of Nursing (RCN), conference presentations and nursing textbooks published since 1990 with the term nursing assessment in the index. Hand searching from the Cochrane Collaboration Reviewers handbooks, articles, chapters and reference lists was also employed.

As a base line the key words “nursing” and “assessment” were used combined with the

Boolean logic use of “ and” and the plural “assessments” as this facilitated combination of two different concepts within the one search. Wildcard symbol *, that can represent zero to many letters, was used on stem or root truncation to cover plurals and alternative endings of the search terms e.g. “nurs*” of the word “nursing”. To expand the search “patient and nurs* and assess*”, and “nurs* and assess*” in all fields were used. Following consideration of the current usage of the term and using the Thesaurus the following synonyms for assessment were employed:

- Appraisal*
- Evaluation*
- Judgement*
- Review*
- Measure*

These terms were combined with “nurs*” using the Boolean “and”. It was anticipated that additional keywords would be identified during the search process and that those would be added to the list of search terms used. However this did not prove to be the case and the term “Assess*” proved to be too broad to be of use.

A similar search of the Department of Health (DoH) policy domains was undertaken and a search of the “grey literature” from 1990-2005 was carried out using SIGLE and DISSABS data bases; policy and conference documents were also retrieved and reviewed.

Search terms identified using the thesaurus proved problematic, for example *nurs* “and” appraisal** identified literature that referred exclusively to the appraisal of nurses by employers or educational establishments. Similarly *nurs* “and” measure** yielded only articles pertaining to various physical, psychological or environmental measurements and not the process of assessment per se.

With collaboration between the health and social care professions high on the policy agenda (DoH 2002a and DoH 2002b) it was important to consider the use of the terminology “assessment” from a wider perspective than that of nursing alone (Penrod and Hupcey 2005) and to this end the databases listed go beyond the confines of nursing to embrace the use of the term by other health care professionals and patient groups.

Currell et al (2002), in their systematic review of nursing recording systems, found few nursing assessment tools had been subjected to rigorous evaluation in terms of their influence on nursing practice and by implication patient care. Therefore articles that referred to the description and implementation of assessment tools were excluded.

The task of the reviewer is to locate all the studies available on the topic concerned. Therefore a comprehensive exploration of health care, social care and nursing databases for material in English was undertaken. However this is more problematic than it seems, bearing in mind the imprecise terminology used in the titles of qualitative research publications. Evans (2002) has evaluated MEDLINE searches and found that only 30-80% of Randomised Controlled Trials (RCTs) are identified during a search. Searching for qualitative research papers where the titles often use phrases to rouse the interest of the reader, rather than a straightforward description of the content, makes selection of key words very difficult. For example Pang et al (2004) *“Towards a Chinese definition of nursing”* is a concept analysis of nursing within China but would be missed in a search for “concept analysis” as the words do not appear in the title, abstract or keywords.

The populations chosen were those of patients in acute or secondary care, their own homes or the private sector and comparisons were sought between the uses of the term “assessment/s”. An evaluation of attitudes, views and opinions, of patients, nurses and health and social care colleges regarding the process of “nursing assessment” were noted. Characterisations of the term “nursing assessment” found within the literature were explored to gain understanding of use and to determine what nursing assessment is and what it is not. Articles were excluded if reference was to a reductionist clinical assessment, or assessments made by members of the medical profession, as these were not pertinent to this study.

Step 4. Select studies

The identified papers were initially screened for duplicates. The remainder including papers and examples from nursing textbooks, the grey literature and policy documents were then reviewed. All articles using “assessment” with regard to examinations during education or training of nurses, or referring to nurses’ or patients’ assessment of the

work place, colleagues or environment, or clinical assessment were excluded during screening.

Titles, abstracts and key words were searched as noted above. There is insufficient evidence to show that qualitative research has been indexed accurately and this may lead to relevant studies being missed (Evans 2002). MEDLINE indexes under descriptive terms and CINAHL index using methodological, theory descriptors and content terms. For example Evans (2002) found the indexing for an article “Infant feeding choices for first time mothers” yielded 21 CINAHL indexing terms that included the terms describing the method employed, such as grounded theory, field notes, and convenience sampling to those of infant feeding, whereas the same article was indexed in ten terms in MEDLINE and these ranged from infant nutrition to mothers’ psychology. Therefore Index terms were not used within this search.

Initially a search of the databases listed for articles written since 1997 with “nursing” and “assessment” as the identified key words in the title produced few references relevant to this study. Similarly in 2002 Kennedy conducted a search using the key words “district nursing” with “assessment” but over a longer period, 1982-2002, and found a limited number of relevant studies. However including either “assessment” and/or “nursing” proved to be too wide a search.

Step 5. Assess study quality

All cited titles and abstracts that met the inclusion criteria were retrieved and reviewed using the standard of appropriateness, and the reference lists of these articles were checked for potential additional articles. The value of research articles is dependent on the transparency, rigour and validity of the methodologies used and discussion of findings made. The previous chapter noted problems when evaluating these processes in qualitative research papers (Mays and Pope 1995, Mays and Pope 2000, Evans and Pearson 2001).

As argued, there are no standard sets of criteria with which to assess the quality of qualitative research studies. To address this deficit there has been a proliferation of checklists that were initially considered for use with this review of the literature:

Burns (1989),

Critical Appraisal Skills Programme (CASP) (2002) (adapted Oxman et al 1994), Greenhalgh and Taylor (1997) Egger et al (2005).

All of these approaches differ in emphasis and include different stages, however one commonality is the requirement to clearly describe the study's setting and participants. Greenhalgh and Taylor (1997) and CASP stress the importance of also describing the context in which the study is set in order to improve the generalisability of findings to other settings within similar contexts. In addition to this Greenhalgh and Taylor utilise theoretical sample selection to ensure generalisability and Egger et al suggest that the sample needs to be representative and justified.

CASP claim criteria for judging the validity of a study can be adapted from quantitative or qualitative research although the latter is not outcome focused. Although the checklists raised pertinent questions regarding the setting and population chosen, clarity of design, and rigour of evaluation, it seems that some are predicated on the assumption that evidence will be found to support a preconceived hypothesis. For example, is it possible to judge whether or not you are asking the right questions of the correct population (CASP 2002) unless you have an idea what the answers to those questions will be at the onset? The purpose of a qualitative research study may be independent of any desire to refute or corroborate the findings of other research, or accepted perceived wisdom, or to prove or disprove a hypothesis. It can be to satisfy a curiosity and find out "what and why?" regarding a phenomenon.

Decisions regarding the validity of a study are dependent upon the time the study was conducted, the background or discipline of the appraiser and their methodological training and preferences (Pearson 1997). Jones (2004) acknowledged that some studies with flawed methodologies may merit inclusion; however she suggested the exclusion of studies where "*the researchers' political agenda is evident throughout*" or the data sources were too narrow to trust the findings. However if possible bias of the researcher is acknowledged within the work, this can be taken into account and noted as a caveat when the findings are analysed.

Several checklists do not articulate the possibility of the presence or avoidance of bias in the original research, the publishing journal or the influence a researcher. Barbour

(2001) and Marshall and Rossman (1995) have argued that since qualitative research is an iterative process, reliance on checklists can be limiting as stepwise templates cannot hope to encapsulate this non-linear process.

The basic set of core criteria, (Table 4. 3) was used to assess the quality of the literature under review. The reasons for the exclusion of any papers were noted. However it became apparent that many papers lacked details on which methodological quality could be judged. As noted, absence does not provide necessary or sufficient evidence to infer that the methodological quality of the research was poor, and papers were included if the conclusions made were justified by the evidence presented.

Table 4.3. Methodological quality appraisal for included literature

Quality appraisal	
Methodological quality	<p>Noting for discussion whether:</p> <ul style="list-style-type: none"> ○ The aims and objectives of study are clearly stated ○ A clear and answerable question was asked? ○ Clarity in exposition of a theoretical framework ○ Clear description and justification of the methods, settings and participants chosen ○ Sufficient information to assess the data collection process is provided ○ There is rigour in documentation of the process ○ There is a clear ethical basis ○ Possible sources of bias are acknowledged ○ The researcher's perspective is acknowledged ○ Demonstration of analytical precision ○ Any deviant cases are included and discussed ○ The conclusions are justified by the findings ○ Applicability is discussed

Step 6. Extract data

The initial data base search yielded 32,602 records, including duplicates, which were screened by title, abstract and finally full text. Papers were excluded at each stage initially leaving 329 articles, policy documents and book extracts which were closely read and a critical analysis of their research quality made and recorded on the data collection forms. Additional articles identified from reference lists, that met the inclusion criteria, were added to the study. Following further screening and a full text review 120 articles and policy documents and 12 extracts from books (0.4% of the total number of hits and 40.1% of those read in full), were analysed. A data extraction form was generated for

each study, recording the:

- Study citation
- Philosophical stance
- Research method
- Quality appraisal
- Inclusion and exclusion criteria
- Study setting

And where applicable:

- Intervention and process
- Intervention outcome
- Procedure and process
- Procedure outcome
- Main and subsidiary findings

Step 7. Analyse and present results

Glaser and Strauss's (1967) method employs observation followed by stages of constant comparison until categories and theory properties emerge and the theory is delineated. A split between Glaser and Strauss in the early 1990s has resulted in different interpretations of grounded theory being promulgated at the same time. This has resulted in confusion regarding the exact process to follow. I have taken the work of Glaser (1992) as the basis of my understanding of grounded theory for this analysis. This is predicated on the major difference between the Strauss and Corbin (1990) approach to coding and theoretical sampling. Following the split with Glaser, Strauss and Corbin (1990) introduced a new coding process with a strong emphasis on:

- conditions,
- context,
- action/interaction strategies
- consequences.

They also introduced axial coding that specified the dimensions of a category and linked categories with sub-categories. Glaser (1992) suggested that this model:

“teaches the analyst to force a full conceptual description on data with no questions about whether the links are relevant to any emerging theory that really

explains how the participants process their main concerns” (p63).

Glaser (1992) placed the emphasis on the use of theoretical sensitivity that equates to a researcher’s knowledge, understanding and skill, to generate concepts from the data. It is of note that Glaser does not recommend a literature search before observing in the field as this may compromise the objectivity of the observer.

“There is a need not to review any of the literature in the substantive area under study” Glaser (1992) p31

It was understood that the reason for Glaser’s instruction was to enable the researcher to enter the field with a free and open mind, not building on the constructions of others. The data would then be analysed from the transcriptions produced in that environment. It was these very attributes, the freedom from hypothetical constructs that made GT eminently suitable for this CA. In this review data analysis is approached in order to generate concepts that emerge free from hypothesis justification or rebuttal.

Researchers using GT are frequently criticised for not being grounded, for example Charmaz (2003) questioned the extent to which many researchers actually follow a true grounded theory. She argued that most researchers construct conceptual analyses instead of a substantive theory that is grounded. Glaser however claims the generation of concepts from his GT analysis and in order to generate a concept the component parts of that concept must be identified. This is the precisely the procedure of the CA undertaken for this study. The action of nursing assessment identified from the literature is contradictory, confused and imprecise. GT allows the categories of nursing assessment to be generated from analysis of this data. The concept represents a melding of these categories.

4.2.6.2. Moral and ethical considerations

Quality criteria regarding legal and professional ethics are not applicable for this phase of the study. However there are personal moral considerations for the researcher primarily that they authentically and truthfully represent the process and outcome that they undertook. Secondly that the work is their own, and that when included, the work of

others is clearly referenced.

4.3. Phase 2

4.3.1. Ethical considerations

A prerequisite for carrying out research within the English National Health Service is that ethical approval be applied for and obtained. This requirement is to ensure the protection of research participants. Written application, accompanied by copies of participant information sheets and consent forms was made in December 2006 to the Central Committee for Research (COREC) now known as the NHS Research Ethics Service (iRAS). Documents for this study were submitted to a Multi-centre Research Ethics Committee meeting on January 11th 2007 which the researcher attended. Unfortunately permission to carry out the study was declined and I was asked to consider whether or not it was fair;

“ to tape record the observations or to “publish patients’ verbatim quotes from them as this could affect patients’ interaction with nurse”

(italics are verbatim extracts from the rejection letter).

The notions that to record patients’ interactions with their nurse and to allow them to relate their narrative of the event following the assessment could be unfair suggest a paternalist approach. One of the eligibility criteria for patient participants was that they were capable of giving consent themselves. It is entirely fair that they be offered the opportunity to take part and that to exclude their voices from being heard would be unjust. Observing practice would inevitably change practice, therefore the researcher tried to ensure that disruption would be kept to a minimum.

The ethics committee also raised the issue of regarding publication of *“verbatim quotes”* from participants which it was suggested could affect their interactions with the nurse. This could be seen as framing the nurse in a position where she/he might use the power inherent in nurse/patient interaction in a detrimental way. To decline approval for the study could imply that harm might be done as a result of this abuse of power.

A second submission was made in April 2007 and following minor changes requested by

the committee at the meeting of May 15th 2007 ethics approval was granted for the study in July 2007. Copies of the accepted information sheets and consent forms used in the study are included as part of appendix 6.

The documentation was also submitted to the University Ethics committee and approval for the study was granted on July 4th 2007.

In order to carry out the field work stage of the research Research Governance approval, which included honorary contracts for the researcher were required from each PCT responsible for patient care in the areas chosen for participant recruitment and data collection. Research Management and Governance approval was obtained from the Research and Development Committees of three NHS Community Trusts. In order to demonstrate that the researcher did not pose any known threat to the study's participants a Criminal Records Bureau (CRB) disclosure and references were obtained and copies sent to one of the PCT Trusts. In one area, even after PCT permission had been granted, there were further gate-keepers who each required sight of all the documentation submitted to the ethics committee before allowing contact with the nursing staff. The process ensured that the Primary Care Trust committees were aware of research taking place in their area and that the researcher was contractually obliged and responsible to the Trust to guarantee that the research was conducted in accordance with sound research principles.

Approval was granted in areas, coded B and C in July 2007 and an honorary contract was issued by the Human Resources Department in January 2008. Applications were also made to code area A where the PCT speedily authorised honorary contract.

Completing these stages and obtaining ethics approval ensured that the professional ethical codes already discussed were acknowledged and outlined. It also widens the public assessment and scrutiny of the proposed research method. However the ethical considerations of the committees were of a very different type to the ethical dilemmas which were encountered in the field. These included the decisions made by the researcher not to undertake one audio recorded observation of an assessment despite having gained consent from all the parties. In this case it was apparent to the researcher that the condition of the patient participant had deteriorated since his recruitment the

preceding week. Although both the patient and his wife were still keen to take part I recognised that the patient was dying. Ethically I felt the time he had left should be spent with his family without the intrusion of my audio recorded and interview. Unable to state my reasons I apologised to the patient's wife who expressed disappointment and not being able to take part. Her husband had been critically ill for many months and she had not recognised the deterioration in his condition. He died that evening and she rang me a few days later to thank me for not intruding on his last few hours. Other ethical decisions for example regarding the fine line between sub-optimal practice and negligence in the field have to be made quickly. The research observation covers an isolated instance of practice and when working with terminally ill patients and their families there is little time for the nurse to rectify any situations she or he may have overlooked. Although not the role of the researcher as a fellow nurse and human being I have tactfully addressed some of the issues with the staff responsible. In the cases I am referring to the care was compromised by a lack of knowledge or opportunities for mentorship in hard working teams.

4.3.2. The fieldwork, recruitment and data collection stages

This strand of the research process comprised the fieldwork and data collection phases including:

- participant recruitment
- non-participant observation
- audio recording of assessments
- field notes
- semi-structured interviews
- access to secondary sources
- transcription of audio data

A brief description of the methods used to facilitate this research process will be followed by a consideration of their congruence to the qualitative paradigm, their justification as suitable for pursuing the research questions posed and their conformity with the quality indicators outlined above.

4.3.2.1. Participant recruitment methods

Following the granting of ethics approval and once honorary contracts were obtained meetings were organised with the Community Nurse Managers in areas code B and C

(January 2008) and with the Community Nurse Manager for area A. Invitations were issued to speak to local nursing groups throughout areas B and C in February and March and at the next District Nursing Forum in area A in April 2008.

The meetings comprised either a formal or an informal presentation that introduced the researcher and outlined the aims, objectives and process of the research. A detailed explanation of what participation would entail for the nurses, patients and carers was also given. Information sheets (Appendix 6) and contact details were left and nurses asked to contact me for further information or if they wished to discuss taking part. Once a nurse had volunteered, often after several weeks' consideration, a copy of the consent form was sent to them (Appendix 6) and they were contacted again two or three days later to arrange a meeting. Nursing teams work in different ways and it was therefore important to agree contact methods i.e. email, text, letter or phone call. The project aimed at recruiting 10 nurses in each of the geographical areas. Initial recruitment looked very promising with 16 nurses from areas B and C having volunteered to take part by the end of February 2008.

The procedure to recruit patients and carers to the study was then worked through individually with each nursing participant to reflect their normal working practice. The constraints that patients must have over 24 hours, before the assessment, to consider their participation, meant many assessment visits were unsuitable as they required same day attention by the nurses. It would be unethical to delay the nursing attention in order to comply with the ethics committee ruling.

Once a nurse had identified a prospective patient participant they contacted me and we discussed the proposed assessment visit. If we both felt the patient was a suitable candidate and fitted within the inclusion criteria approved by the ethics committee, the patient was then approached by the nurse regarding taking part in the research study. If the answer was in the affirmative the nurse passed contact details on to me. Following initial contact, depending on the time scale and the patient's needs and wishes, the project was discussed with the patient. In this way the patient was enrolled into the study without involving any increase or delay in the nurses' work. If after the contact with the researcher and comprehensive information about the project the patient still wanted to take part, an information sheet, researcher contact details and a consent form was

delivered. This process was completed a minimum of 24 hours before the assessment took place.

After making contact with the patient it was identified if a relative or carer was going to be present and they were invited to participate in the project. Their consent was sought in the same way as the patient's. Specific consent forms and information sheets were delivered to them a minimum of 24 hours prior to the assessment.

All participants were reassured that they had the right to withdraw at any time during or after the assessment process without their reasons being sought or any other participants being told of their decision. Following their withdrawal all tapes, notes and transcripts would be destroyed. Of the 28 nurses recruited 15 withdrew, 14 of those prior to identifying patient participants and one after the assessment had been recorded. One nurse withdrew because she had changed jobs and was no longer in a position to take part. Several nurses who had expressed an interest in taking part eventually declined to do so because of the pressure of work. Despite approaching several patients one nurse was unable to find a patient willing to take part.

Of the eighteen patient participants recruited, one died on the morning of the assessment, one was admitted to hospital on the evening before the assessment. One patient's condition deteriorated so much during the hours prior to the assessment that the nurse and I decided it was inappropriate to involve them in the research.

By the end of the study 11 nurse participants, 11 patient participants and 9 carer participants had taken part. This yielded 31 individual sets of data from the interviews and 11 assessment transcripts, a total of 42 data streams for analysis.

4.3.2.2. *The chaos of the field*

Although a professional and well organised approach was taken to the recruitment, and field work phases of the study the theory was very different from the reality. Lewis (1968) referring to the ethnographer Malinoski's field diaries notes:

The diaries convey with almost agonising truth a picture of the chaos of fieldwork.

Lewis 1968 p349

The chaos is also noted by Jackson and Ives (1996) and is a situation with which I

empathise. The audio-recorded non-participant observation is an artificial construct and the participants do not initially react as they normally would. For example many early comments refer to being taped and the need to be “*careful what I say*”. The situations in which the observations were made also lend themselves to chaotic interruptions and unexpected interactions. For example following the recruitment of Carol (A2) I visited her two days before the planned assessment and she agreed to participate signing the consent form on the morning before the assessment took place. Her parents were both present at the bungalow on both of my visits but Carol’s father said he was never involved with the nurse’ visits. However whilst the assessment took place he constantly interjected comments. Firstly from the adjacent room, and then by putting his head around the door until he was virtually in the doorway. He was primarily teasing his daughter about her weight and comparing his recovery from a stroke with hers. These interactions and the nurse’s attempts to deal with them, although interesting, could not form a part of this study as I had not obtained his consent. Hermanns (2004) refers to the research process as a drama and a second example was the chaotic home life of Steve in assessment B4. His very recent diagnosis and the families apparent denial of the situation was compounded by the presence during the assessment of their two teenage children. Both were anxious and disruptive and the nurses assessment started with her startled discovery of a plastic rat placed amongst the dressing packs.

4.3.2.3. Non-participant observation, audio recording of assessments, field notes and semi-structured interviews

The participants were informed of all aspects of the study and shown the audio recorder at the first meeting prior to their signing the consent form. Although the digital recorder is small and unobtrusive the action of recording and observing an interaction will alter it in some way.

Field notes included the non-participant observations and were done discreetly with a coded identifier to preserve the anonymity of the participants. Information such as direction of the participant’s gaze, their positioning in the room, adroitness at carrying out tasks, adaptability to carrying out procedures, tone of voice and body language were recorded. As described in chapter 3 an observational schedule was not used for this study as *an anthropology* at home approach was taken (Peirano 1998). The study sought to discover the events as they happened rather than to seek verification of a

priori assumptions or theories.

The semi-structured interviews were carried out separately and immediately after the assessment, usually firstly with the nurse and then with the patient and carer. This policy was adopted as it proved extremely difficult to catch up with the nurses after they had left the patient and were making other visits or had finished their shift. One nurse was paged and had to leave part way through the interview. It proved impossible to recommence the interview with her as she then went on holiday for two weeks.

The interviews with the patients took place within half an hour of the assessment finishing, ensuring the process was still fresh in their minds. Two of the interviews had to be curtailed as these were extremely sick people and one felt exhausted and the other fell asleep. An interview check list was not utilised and participants were encouraged to express themselves freely. This decision is justified below.

4.3.2.4. Secondary sources: nursing notes

Demographic and diagnostic information was obtained by reading the patients' nursing notes where appropriate and available. For patients seen in their own homes these were usually kept there but in one instance they were retained by the nurses in their office and in a second there were two sets of notes. One set that the nurses had in their office and one which was left with the patient. In the two observed Practice Nurse assessments, which took place in the GP surgery, the notes were computerised. There were no facilities to enable the nurse to offer the researcher a printed copy of the patient's notes and the researcher positioned herself to enable her to see the input on the screen. However, the nurse seated the patient behind the monitor. The only other secondary source accessed was from assessment C2 where the patient participant had a diary in which she recorded her blood glucose levels. Several other sources were referred to; such as diet sheets, referral letters, and advice on giving up smoking, but the nurses did not routinely carry them with them and they were not used as part of the assessment process but sometimes delivered to the patient at a subsequent visit.

4.3.2.5. Audio data transcription

Each audio recording was given the same code as the appropriate field notes and the code list is kept separately from the transcripts, in a locked filing cabinet. The researcher

transcribed all of the 13 hours of recordings to gain familiarity with the data. Although annotations can be made in the transcripts to denote such things as voice inflections, butting in or laughter, which can be then listened to again by the researcher. I felt that more information was gathered by transcribing myself for instance the intensity of laughter can be identified in the transcript but when listening to a recording laughter can be identified as false, polite, embarrassed, defiant, macabre, wicked, insecure, a belly laugh, a giggle or a chortle. All of these differences can be appreciated with the ear and confirmed within the field notes.

Corden and Sainsbury (2006) have noted that punctuation acts as a construct made by the person who transcribed the tape. Further Reeve (2008) has noted the use of punctuation marks in transcribed data act as a form of editing as in the following example;

“ A woman, without her man, is nothing.”

“ A woman: without her man is nothing”

To avoid constructions and editing during transcription and in order to try to capture the essence of what has been said, the data is presented in the main without punctuation. The exceptions being where a voice inflection was noted as an indication of a question then a question mark was used. Further if a pause was noted, this was indicated as either a row of dots and when the pause was in excess of three seconds the timing of that pause was included in parenthesis. The transcription conventions followed are reported in appendix 7.

4.3.3. Congruence between the approach and the research methods of non-participant observation and audio recording

4.3.3.1. *Observing events in the real world*

It was of paramount importance that the observed assessments were as close as possible to those that occur in every day life since the aim was to discover commonalities and differences that constitute the practice of nursing assessments. Certain influences such as the digital recorder and the presence of the researcher as observer added an unavoidable degree of artificiality. It was hoped that these were minimised as the researcher had met and talked to the participants, often several times,

before the observation took place. It was hoped that this increased the participant's ability to relax and be comfortable with an extra person present. Additionally great efforts were made to convince the participants that the observation was not to do with assessing the nurses' practice but just to note down what was actually happening. That there were no right or wrong approaches, answers, or practices. The only caveat, included in the consent form, was that the ethical codes of nursing must be upheld and the researcher was bound by these to report any dangerous or illegal practice. To paraphrase Denzin (1997) this researcher hoped to be a window into the world of everyday nursing practice.

Non-participant observation was selected practically on two counts. Firstly because the researcher felt that it would be professionally inappropriate to intervene in care giving in the context of primary care on a one off basis. Secondly it could increase the propensity of bias if the researcher were to become involved with the process under observation as involvement could create a vested interest in the outcome of the process.

Theoretically, Bourdieu (1990) draws our attention to the implications of having an observer who is outside the practice they observe but is also a participant in that practice. This he suggests is inherently contradictory as it is another method of avoiding the discussion regarding the connection between the observer and the observed. He states that if the argument given for participant observation is that it is less artificial than having a person whose function is solely to observe someone else carry out their practice. Then as the participant observer is both carrying out aspects of practice and observing their own practice both will be artificial. As to observe and then account for practice is not normally a function of practice. To exemplify this point Bourdieu quotes Hocart who stated:

"Long ago {man} ceased merely to live and started to think how he lived; he ceased merely to feel life he conceived it." Hocart (1970) p32

Further anthropology claims ethnography, in this case patient observation, as the only research method that provides authentic data whilst recognising researcher as *"grounded in the field"* (Baszanger and Dodier 2004 p12).

Observation recorded what happened without prompts or verification of expectations.

The use of semi-structured interviews allowed patients, nurses and carers to tell their own story of the interaction rather than using set questions to verify pre-existing hypotheses - a method redolent of the positivistic quantitative paradigm. Although it may be argued that without the use of an interview checklist the interviews undertaken for this study would be better described as open interviewing. However I refute this as the structure was firstly guided by the research questions which required the consideration of philosophical, organisational and professional influences on the assessment practice. Prompts drawn from the specific observations were utilised to start the interviews. Taking as an example the opening question to the nurse in the interview B2 (see appendix 7)

“ was there anything you didn't expect or was difficult?”

The nurse then described her approach, agenda and impression of the assessment with the researcher adding reinforcing and non-directing noises such as *mmm* or statements for example *“that was very much coming through...”*. The patient was encouraged to describe his experience of the assessment with the researcher's opening prompt,

“have you found that useful?”.

This was followed by 19 lines of transcription in which the patient revealed that he felt the nurse;

“has much more time to discuss things and going through things in greater depth she could also organise antibiotics for me and it meant I wasn't going down and sitting in the surgery amongst other people who were coughing and sneezing...”

The patient then paused for a reply and the researcher added *“good point...”*. before the patient continued to describe other benefits he had identified.

In this way individual observations provided cues to be explored and had an open interviewing technique been used the data may have strayed into themes and topics that were outside of the overall scope of the study. Therefore the research methods of non-participant observation and semi-structured interviews were deemed ontologically congruent within a post modern, interpretivist, qualitative paradigm. Using the undirected

descriptions made by the participants offers authenticity to the account of practice described.

4.3.3.2. Legal, ethical and moral considerations

Legal (Data Protection Act, CRB check), ethical (COREC approval, NMC Code of Conduct) and moral considerations (fairness, lack of coercion, respect) informed stages (1) to (4) of the research process. Recruitment was sensitively carried out without exerting any pressure on prospective participants. Several of the nurses who agreed to take part had second thoughts but were reluctant to verbalise this. However once a final contact was made their views were respected and reasons were not sought for their withdrawal.

Prior to the assessment the patient and the nurse participants were visited separately to see if they had any misgivings and to obtain signed and witnessed participant consent forms. To preserve confidentiality and anonymity these, the 11 CDs on to which the audio data was transferred and the copies of the transcripts are also labelled with only the code and the date and kept locked in a separate drawers of a filing cabinet.

All references to people by name or geographical identification were anonymised and pseudonyms were used throughout the quotations within this dissertation. Out of respect for the patient, when transcribing the tape, if a portion of the recording was deemed as irrelevant or intrusive it was not transcribed but square brackets were used to indicate the omission.

4.3.4. Justification that the research methods chosen are suitable for exploring the remaining research questions

4.3.4.1. Research questions

2. What professional, philosophical and organisational influences affect the nursing role regarding patient assessment?
3. What impact does nursing assessment have on patients?
4. Does patient inclusion, involvement and empowerment happen as a result of a nursing assessment?
5. Does the location of a nursing assessment have an impact on the assessment?

In response to research question 5 it had been planned that half of the assessments

would take place within the patient's home and half on NHS premises. However it proved impossible to recruit sufficient participants in the second category in the time frame allowed for this study. Only two of the 11 observed assessments took place in GP surgeries with Practice Nurses. However, the skill mix of the recruited nurses still retained a breadth of experience and expertise and included Practice Nurses (n=2) District Nurses (n=7), and Specialist Nurses (n=2). As the aim of this qualitative study is to improve understanding by identifying commonalities in the practice of assessment and not to produce generalisable truths, this deviation from the original plan was not seen as detrimental.

4.3.4.2. Audio recording

Silverman (2000) saw the use of audio recordings of naturally occurring interactions as a useful method of gathering research data. Referring to the use of "multiple methods" of data gathering; audio data, field notes, semi-structured interviews and the analysis of secondary data in this study, Silverman warned that this may be problematic as this complexity suggests the topic of the research has not been sufficiently narrowed. However these methods were chosen in order to give contextual depth. For example a first visit palliative care assessment necessitates a different approach to a routine assessment as part of a structured delivery of care for a chronic condition. The data collected from the nursing notes added to the contextual understanding of where each interaction sat within the care delivery process. Field notes provided an adjunct to the transcribed data as they indicated information such as observation of times when body language and the words spoken were at odds. For example when irony was used to emphasise a point the body language, such as raising an eyebrow or shrugging, made it clear that the opposite meaning to what was said was implied.

The semi-structured interview process was chosen to:

- preclude the imposition of the researchers ontological understanding of what had transpired
- eliminate any pre-decided hypotheses that would inform the selection of set questions (Murphy et al 1998)
- give the participants their own voice

Knoblauch (2004) stressed the importance of taking into account

"the point of view of the informants." p357

The decision to use digital audio recording rather than video recording was based on the practicalities and efficacy of their use, although Pringle and Evans' (1990) study of doctors, to ascertain whether video recording affected their consultations, found there was no significant difference when video was used or when not. However this reductionist study of four doctors used an objective coding system acronym TIMER that divided the consultation process into 27 components. The differences sought were in the presence or absence of these components -- which begs the question as to how well they reflected the overall process of a consultation. The patient's opinions were not sought in this study. Coleman's (2000) meta-analysis of the use of video recorders for research in Primary care stated that although there is little evidence of any influence on the participants' behaviour; caution needs to be employed as bias may be incurred regarding the types of participants who will consent to video recording. Weingarten et al (2001) study of 856 consultations found video and audio recording to be equivalent when assessing patient centeredness of consultations. In other words there was no greater benefit obtained by video recording over audio recording.

As research showed there was no benefit to using video recording but there was the possibility of more refusals by participants and greater bias in their self selection, audio recording was chosen. Kendall (1993) found it less intrusive than video recording and more suitable for use in the patient's home. The use of audio recording was therefore seen as beneficial to the overall aims of this study.

Secondary sources such as the patient's nursing notes, local protocols and guidelines, referral and appointment letters regarding assessment were read for contextual purposes. The use of nursing models and their relevance to the process were also noted.

4.3.5. Analysis and synthesis of the data collected

This stage of the study was designed to explore the remaining four research questions given above. The exploration was to be achieved by analysis and thereby making meaning of the data obtained from non-participant observation and audio-recording of interactions in the real world of practice. Additional contextual information, obtained by analysing secondary sources relevant to each assessment was also included to enable

evaluation of the macro and meso levels (see below) reflected within practice.

The analysis of the transcribed audio tapes and secondary sources undertaken was predicated upon the hypothesis that the interaction between nurses and patients during assessment constitutes a discourse: further, that an analysis of this discourse would reveal meaning. Discourse analysis (DA) comprises a careful search for meanings within talk and text that facilitate an identification of that meaning. Approaches to DA range from that of Potter and Wetherall (1987) who identify DA as intuitive and without any analytical method to the critical realist account (Bhaskar's 1998). Bhaskar ontologically proposes that there is one pre-existent reality that comprises groups of independently existing objects. Interactions between these objects instigate events to happen in the world and the connections between the action and the event can be revealed as causal processes.

Discourses are seen as specific objects that have knowable properties and are capable of revealing, through a systemised analysis, the forces that bring about their impact. DA allows the ways in which discourses change the material world to be identified through consideration of the underlying processes that make them possible. For example the use by the media of the discourses of economic processes makes possible the fluctuations of money markets within a free economy. These forces are identified by terms such as "a run on the pound" or obscuration of the action of printing more money within the term "quantitative easing".

4.3.5.1 Levels of analysis

As my research questions range across several levels of influence so do the discourses and therefore the analysis will include three levels: firstly those of the micro, by which I mean the immediate discourse and influence regarding the nurse, patient and carer in the specific interaction being studied. Secondly the macro that refers to the "bigger picture", the hegemonies pertinent to research question two that impact on assessment practice and the global and governmental policies that inform NHS practice. The meso level is between the micro and the macro and may yield information regarding the last research question.

4.3.5.2. Discourse Analysis theory

Howarth (2000) identified that DA theory is framed by one of three paradigms; the structuralist, Marxist or the hermeneutic traditions. Structuralists maintain that language is contextual, from Laclau (1993). Howarth cites the example “mother” the understanding of this word being dependent on the relational understanding of terms such as father, daughter. The meaning of mother is understood by recourse to the differences between it and the other associated terms. As one would expect the Marxist ontology sees language as ideological and predicated on notions of economic and political processes. The hermeneutic approach that is in concordance with the author’s method of making meaning challenges the positivist, behaviourist and structuralist approaches to epistemological theories. Drawing on Heidegger, Winch and Wittgenstein it is an interpretative approach to meaning making which eschews causal mechanisms.

In order to find a suitable approach to the analysis of discourse and answer the research questions for this study the following methods were identified and a critique made of their origins and processes:

- Linguistics
- Conversation analysis (CA)
- Dialogue analysis
- Discourse analysis (DA)
- Genealogical DA
- Critical discourse analysis (CDA)

4.3.5.2.1. A short genealogy of discourse analysis methods

1. *Linguistics* offers a non-social view of language and depicts language as a system of rules and categories. Following early twentieth century discoveries that nearly all European and many Middle Eastern and Indian languages (Hittite, Farsi, Hindi, Urdu) were members of one family of languages, connections and relationships between them were identified and studied and general principles of linguistics were developed. In 1903/04 Saussure (1974) added to his linguistic research on sound systems of Indo-European languages, questions regarding the fundamental “look “ and characteristic of language. In his *Course in General Linguistics* he differentiated synchronic and diachronic linguistics. The former considers systems of language, and the latter the development of language over time. Saussure (1974) further divided language into the

“*langue*” the systems of rules that govern meaningful speech and “*parole*” which consists of individual acts of speaking. With this division he also separated the social aspect of speaking (the rules) from individual acts of speech (conversation). As identified in the introduction he further named three basic elements of speech the *sign* that unites the *signifier* (the word used) and the *signified* (the concept designated by the signifier). For example the *sign* box can unite a concept of a cardboard container and the sound b-o-ck-s. However as Saussure identified the sign is arbitrary therefore the sound or signifier b-o-ck-s can also refer to the act of fighting in a ring, the act of putting something in a container or the name of groups of seats in a theatre. Linguistic analysis operates at the micro level of analysis which Gwyn (20020 describes as the specific means individuals use to “*express themselves in language*”.

2. *Conversational analysis* examines patterns that occur in dialogue and is both data driven and contextually reliant. The focus is on the empirical conduct of speakers within the surrounding dialogue. It is based on the ethno-methodological work of Garfinkel (1967) who suggested that individuals bring order to, or make sense of, their social world through a psychological process that he called “*the documentary method*”. Sense is made of a remark or action by reference to the context in which it occurred, referred to as “*indexicality*”. Ethno-methodological analysis ignores the information actually transmitted during conversations, concentrating instead on how an interaction was performed. Ontological acceptance of the proposition that reality is constructed in the minds of social actors and that social order is illusory, implies that all meanings are and can only ever be subjective. Garfinkel’s work on conversational analysis was advanced by Sacks et al (1973) and includes analysis of the rules and rituals of conversation:

body language

tone

gaze

the use of certain words which accompany turn-taking in conversation.

Garfinkel’s focus on contextuality and reflexivity emerged as a focus on the sequential aspect of the interaction. Turn-taking was produced with orientation to preceding talk as current actions project the relevance of subsequent speakers. Conversational Analysis is predicated on acceptance of

- Grasp of the next action that a current action projects
- Production of that next action

- Interpretation by the previous speaker.

These steps are methodologically achieved in conversation by means of socially shared practices such as the use of adjacency pairs - pairs of utterances produced by different speakers that are appropriately matched. Common examples include 'question/answer', 'statement/acknowledgement', and 'invitation/acceptance or rejection'. Conversational analysis also operates at the micro level of analysis.

3. *Dialogue analysis* is also concerned with the social order of talk, but it allows for a broader range of data, including interviews, documents, invented examples, and other non-naturally occurring talk. The analysis techniques employed are taken from conversational analysis and can be applied to the processing of non-naturally occurring language providing micro level analysis. Much research in dialogue analysis classification uses adjacency pairs to help determine a speaker's intentions in making an utterance. The circumstances of the dialogue, occasion of talk, and something about the immediate culture, language, and organizational context need to be known. Other considerations include

- Whether the participants have interacted before
- The outcomes of the most recent interaction
- Their relationships, obligations and agenda.

4. *Discourse analysis (DA)* accepts that all actions and objects are meaningful and DA questions the way social interactions construct and contest social reality through discursive forms. Discourse can refer to both linguistic and non-linguistic material for example a picture may be a non-linguistic discourse that can be read and analysed in an analogous way to the analysis of a speech, report, or manifesto. Drawing on conversational analysis, talk is recognised to be orderly and sequential. Dreyfus and Rabinov (1982), following Foucault, describe discourse as sets of "deep principles" which are integrated across "grids of meaning". These grids of meaning reflect construct and reference all that can be "seen thought and said". Foucault (1972) suggested that by careful study discourses can both reveal representations of culture and cultural practices and form those practices, "*the objects of which they speak*" (Foucault 1972 p. 49). DA facilitates macro level analysis that Gwyn (2002) has described as a style or representation specific to talk and thereby thought, within particular social and cultural

spheres.

5. *Genealogical DA*. Here the process of DA is facilitated by problematising or reactualising the virtual structure of an event. The linear historical view is dismissed in favour of a branching non-teleological approach and change is registered and analysed rather than stasis. Any event is seen as a sensory perception arising from a particular state of affairs in the world. Genealogical DA opposes the virtual/actual distinction with the possible/real leading to the notion of actualisation (the Christian/Platonic model of creation) (Deleuze 1998). Actualisation is where the virtual becomes different in the creation of something new. An analogy for actualisation is provided by the DNA code of an organism. The DNA is the virtual representation of the organism. Actualisation is the creation of the organism from the DNA. Through actualisation being and sensing are freed from the time continuum and the past exists as a disassociated set of events. Memory is conceived as a collection of preceding events that become part of the present through recollection. This constitutes the actualising of the virtual event that is held within memory. The actual is not seen as a representation of the virtual but a differential repetition of the virtual. In this way Foucault (1977, 1997b) located meaning in the practice of language claiming the event as outside the progression of past to present to future. Both Nietzsche (1886) and Foucault argue it is power, the will to power, knowledge or discourse and practice that fix an event in any particular actualisation. Genealogical DA provides macro level analysis.

6. *Critical Discourse Analysis (CDA)* is based on the notion that individuals have unequal access to linguistic and social resources and that these resources are controlled institutionally. CDA can generally be described as hyper-linguistic or supra-linguistic as it includes consideration of the social, political and economic contexts of language usage and production. CDA structures attitudes, dominance and power through the analysis of talk. In addition to operating at both the micro and meso levels of analysis, Speed (2006) has also postulated CDA can provide analysis at a third level, that of the meso. For example in the field of health care my perception of my pain is at the micro level. Macro level discussions could describe policy or institutional hegemonies regarding the provision of pain management. Meso level analysis can note local specific and cultural mores, perhaps reflecting an upbringing in which acknowledging pain was seen as a weakness. These may impact on the individual but not be represented by macro level findings.

Evaluation and critique

Howarth (2000) noted that ontologically, discourse theory is opposed by realists, Marxists and positivists since it is seen to reduce “*social systems to ideas and language*” p12. Thus it ignores factors that influence social meanings such as those that emanate from the state, institutions and economic and social divides. Allegations of methodological anarchy and conceptual and moral relativism are also made as discourse analysis does not claim to uncover truths.

However Feyerabend (1986) argued that “*science is essentially an anarchistic enterprise*” as new scientific discoveries are founded on the demise of the previously established and venerated dogmas. Further if this were not so and new hypotheses had to concur with established theories progress would be impossible as the criteria for acceptance would rely on agreement with what was established and not what is better or more fitting. In this way the allegation of methodological anarchy may not be seen as a damning indictment of DA.

Howarth (2000) dismissed the opposition as operating a critique based on “*the ontic rather than the ontological*” p13. By this I take him to mean that criticisms of DA as reductionist, because it denies the complexity of society by concentrating on speech, are unfounded. He argued that DA provides a link between the ways things are said and the position and understanding of the speaker within the social and cultural system.

4.3.6. Justification of the DA method chosen

Following this review a Critical Discourse Analysis (CDA) approach was chosen for this study. The justification for this decision is firstly predicated on the congruence of the ontological stance of the researcher and the method. CDA encompasses the thinking of Habermas (1986) who sees language as “*a medium of domination and social force*” and includes Foucault (1973, 1980) and Bourdieu’s (2007) accounts of the symbolism and actuality of power of institutions within discourses from micro to macro levels. CDA also considers the political, big and small P, the economic and the individual’s context of language usage and production. This provides an approach that is suitable for exploring the remaining four research questions all of which either implicitly or explicitly address questions of power. Specifically question 2 refers to *influences* which are imposed

through three channels - those of the nurse's profession, the institute for which a nurse works and the philosophical basis of this influence. It also contains implicit assumptions regarding the role of the patient as one who is to be assessed by a superior who will carry out the assessing. Questions 3 and 5 investigate notions of *impact* and Question 4 asks about *inclusion, involvement* and *empowerment*. I note that *influence, impact, inclusion, involvement* all imply responses to a force and that this force is social power that is constituted through the position of the nurse, as an individual professional and the hegemony of the institution in which s/he works.

4.3.6.1. Foucauldian theories of discourse formation

There are many approaches to CDA and each is formulated in response to a particular ontological approach. A Foucauldian analytic approach has been adopted for this CDA and this section will describe Foucault's approach to analysis and justify why his approach was chosen. In *The Order of Things: An Archaeology of the Human Sciences* first published in 1966 Michel Foucault embarked upon a voyage which set out how we accept at face value, the eponymous Order of Things. In his later work *Politics and the Study of Discourse: Ideology and Consciousness*, he referred to what is said. This deceptively simple objective is measured by the difference between what "one could say", correctly, grammatically, logically and what "is actually said". It is this difference that one is trying to discover when conducting a Foucauldian CDA.

In the *Archaeology of Knowledge* (1972) Foucault identified four basic discourse elements:

- Objects about which statements are made
- The places of speaking
- The concepts involved
- The theories and themes those concepts develop.

Foucault took the statement as the basic unit of discourse and differentiated statements from utterances and sentences. His analysis of statements was predicated on their construction as serious claims to truth that are dependent on who says them and when they are said. He examined the ways rules regarding these statements were configured. The first of these dispensed with the realist, positivist, accounts that confine discourse within a pre-existing reality (see *Critical Realists Methodology* chapter). Objects are

formed anew within the discourse around three sets of distinct but interdependent rules. Firstly the “*surfaces of emergence*” (Foucault 1972) that are the particular practices or symptoms that constitute the objects of scientific investigation; secondly the “*authorities of delineation*” that as the name suggests denotes those in power who are able to decide which objects belong within each type of discourse. Thirdly Foucault described a mechanism by which objects were classified depending on their properties that he called the “*grids of specification*”. Howarth (2000) noted that these rules can not be used independently from each other and for convenience I will refer to them as the surface of emergence rules.

4.3.7. How is it meaningful to speak of a discourse of nursing assessment?

The act of assessing implies a hierarchical position of the person who has the knowledge and therefore the power (Foucault 1980). The lay person or patient is subjected to the normalising gaze of the professional who is employed within the institution of the National Health Service (NHS). The patient is constituted by the discourse as an agent of pastoral power, as they are self-revealing, and an object of the normalising practice of the nurse and the governance of the NHS.

The term assessment distances the practice of nursing from that of medicine. As identified within the CA, assessment may contain elements of diagnosis that form part of the medical discourse; however nursing assessment emerged as a term as the emphasis of nursing care shifted from care of the sick and dying to health and palliative care (Besner 2004). Powers (2002) described health as a life goal and Illich (1990) as a moral imperative suggesting the state imposes a duty on us all to be healthy. This moves assessment from Nightingale’s notion of observation and reporting (1860) towards discourses manifesting power imbalances with social and moral dimensions.

Further surfaces of emergence are demonstrated through changes within the management of the NHS that continued throughout the 1990s and the first decade of the 21st century and are described within chapter 2. As accountability emerged as a panacea for all the ills of the NHS and in order to evidence clear lines of accountability in nursing there has been an increasing emphasis of the documentation of nursing care delivery within the process of demonstrating quality care delivery. Through this route the nursing discourse of assessment can additionally claim an element of auditable quality.

The authorities of delimitation are exemplified by the complex relationship between nurses and doctors. Baggott (2004) suggests the following model names that describe depictions of nursing within the literature:

Subservience model: where nurses carry out a doctor's instructions. This is compromised as nurses are accountable for their own actions and the defence of following orders does not hold professionally, legally or morally.

The doctor–nurse game: where lip service is played by nurses to “*minimise disagreement*”

The *opportunistic model* : where nurses have specific circumstances to exert direct influence. (e.g. specialist nurses)

Negotiated order: nurses' practical skills enable their influence.

Informal power: nurses are allowed by doctors to work independently (e.g. midwives)

Nursing power: where the nurse act autonomously (e.g. Nursing Development Units)
(Baggott 2004 ; 241-242)

Whilst the dynamic nurse / doctor relationship may embrace all or none of these models it can be argued that nurses do gain public status by their association with doctors.

4.3.7.1. Enunciative modalities of nursing

Foucault (1972) considers the need to investigate the ways in which individuals are awarded the right to speak (their social position, training or speciality and the position of being spoken to in a certain way). These he refers to as the “*enunciative modalities*”. Regarding nursing, the enunciative modalities encompass three distinct areas, the nurses' recognised and registered training, the hegemony of the institution in which the nurse is positioned and the “subject positions” from which valid statements can be made. District Nursing (DN) constitutes a subject position as any member of the DN team can interchangeably occupy the role.

In addition the choice of the word *assessment* implies certain structures and a hierarchy for the process of nurse assessment. Etymologically in the English language “*assess*” dates back to the 1420s where it was noted in the Rolls of Parliament. It had passed into English via the Anglo-French *assesser* derived from the Medieval Latin *assessare* - to fix a tax on. *Assessare* is a derivative of the frequentive form of Latin, *assidére*, to sit and

particularly to assist a judge or assessor, literally meaning to “sit beside another”. Use of “assess” + “ment” has been found in documents dating from 1548 (Chambers 2001). Interestingly the original roots are echoed in the findings of the CA of nursing assessment outlined in the previous chapter. As has been shown above there are few definitions given for the process of assessment and that leaves the exact meaning vague and relative to the practice.

The social and historical context of nurses undertaking assessments form part of the enunciative modalities and require consideration. Sweet (2003) noted that between 1917 and 1919 the role of the District Nurse (DN) became a speciality within the nursing profession. Following the 1919 *Nurse Registration Act* and the 1979 *Nurses, Midwives and Health Visitors Act*, their professional development culminated with the availability of a degree for specialist practice. This specialist practice degree grew to incorporate the speciality of Practice Nursing (PN) where numbers quadrupled between 1986 and 1990 (Ross et al 1994). Specialist nurses are also able to study at a post-graduate level and to earn accredited qualifications pertinent to their specialty. The acquisition of these qualifications has given nursing a right to call itself a profession however it has been argued that this status and its association with medicine has been a double edged sword (Rolfe 2002). During the 1960s and 70s nursing observation was to do with identifying needs and problems and seeking their solutions. However as we in the UK embraced the American model of nurse training and the implementation of Project 2000 the transition to the term assessment became widespread. It stopped short of the nursing diagnosis used as part of the nursing process in the USA (MacFarlane and MacFarlane 1993).

In short, District or Community Nurses (DN), Practice Nurses (PN) and Specialist Nurses (SN) have legal, professional legitimacy that is attained through their

- Education and qualifications

- Professional status

- Organised and institutional social power through alliances with the medical profession and the institutions of the NHS

- State Registration (legal legitimacy).

Powers (2002) identified the ambivalent relationship between nursing being seen as a

branch of medicine or as a separate but allied discipline. This flirtation is mirrored by the value placed within the appellation science. Most nursing degrees are deemed BSc or MSc and Rogers used the term *nursing science* in 1963. Nursing still seems unsure of whether it is a science or an art; however, following the three states of the Alchemist; that a thing can be *either, or* and *either and or*, perhaps we could postulate that it can be all three as the acceptance of one need not preclude the others. This position would accommodate healing, therapeutic touch and the use of intuition; concepts that cause tensions within a profession claiming an empirical science base.

4.3.7.2. Evidence of power and control within discourses

In the *Birth of the Clinic* (1973) Foucault identified both external and internal modes of control within discourse. The three external modes of control are:

- Social and political force where a subject is forbidden or suppressed. Mrs Thatcher's (1987) statement "*there is no such thing as society*" stifled debate regarding the fractures within society as a whole.
- That which is deemed reasonable or unreasonable. For instance it is unreasonable to complain about the proliferation of surveillance cameras as only the guilty fear this growth in surveillance.
- The will to truth as privileged over falsehood. Here Foucault (1973) noted the contingency of truth on constructs of historically specific systems of knowledge rather than its objective experience by the individual. For example the wall between Israel and Palestine both protects and excludes depending on which side of it you live.

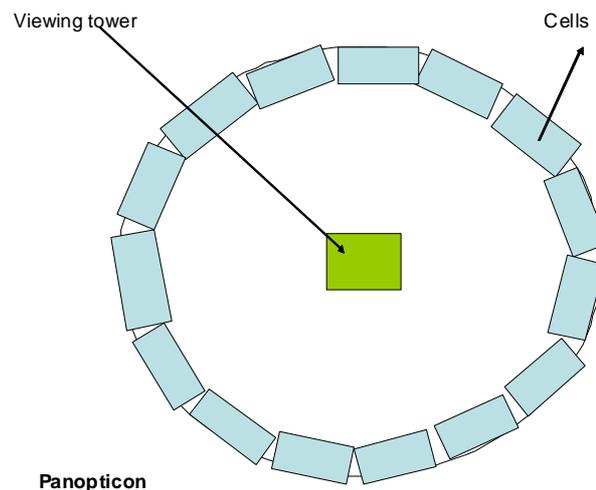
Foucault also identified internal constraints that were bounded by what is "sayable" at a particular time. Referring, in the *Order of Discourse* (1981), to Gregor Mendel's work on the inherited characteristics of the pea plant, Mendel, a nineteenth century monk, could not speak the *truth* of what he found because it was not reconcilable with the biological understanding of his time. Foucault (1972) also noted the constraints put upon statements by the authors' positioning, which contextualised problematisation. This in turn engendered docility and enabled subjectification and observation through the scientific or medical gaze and facilitated the manipulation, transformation, improvement or dissection of the body. A contemporary example is cosmetic surgery where both male and female bodies are the territory of a specific discourse of subjugation and are

controlled and exploited for commercial gain.

Foucault (1973, 1977) has written extensively on medical discourse and identified the dominant discourses of power and knowledge, which he argues imply each other. He also questioned everyday assumptions regarding language, for instance the concept of empowerment, discussed in chapter 7.

The words used within some DoH policy documents, for example DoH (2004a), align state policies with the concept of surveillance as exemplified in Bentham's (1789) Panopticon (figure 4.3). This facility was designed for institutions, schools, hospitals and Soviet factories in which the inmates, workers, or scholars were kept under constant surveillance, controlled, trained, corrected, and supervised. (Foucault 1977a). It constituted a central tower occupied by guards who watched the prisoners in their cells. The cells were arranged on multiple floors in a circle surrounding the tower. The guards were able to view the prisoners at all times as there was no part of the cell into which they could not see. Foucault saw the Panopticon as the "*mechanism of power reduced to its ideal form*". Research question 4 specifically looks at notions of empowerment of patients and this is the lens through which the assessments will be viewed.

Figure 4.3. Each floor of the Panopticon



Foucault's approach to discourse focused on whose voice is heard or excluded and the

rituals surrounding the management of discourse. Several procedures that control and organise the competing sets of ideas that constitute discourse have been identified from his collected writings:

- Truth - why and by whom is it attributed
- Conversational taboos
- Oppositions (e.g. madness /sanity)
- Doctrine
- Scientific discipline
- Power/knowledge/ influence
- Marginalisation of *other* ways of thinking and speaking about health care
- How speakers and listeners ascribe meaning
- Means of production of the discourse
- Social identities and relations
- Semiosis (e.g. doing the job of a nurse, or the genre of the discourse)
- Self-consciousness

Foucault (1970, 1973, 1978, 1980, 1981)

Howarth (2000) charts Foucault's journey through his "*archaeology of discursive practices*" as he moves from a structural to a later, Nietzsche-influenced, post-structuralist, "*genealogical*" account of discourse (Foucault 1977a).

The approach taken for deconstructing the discourses that comprise the transcribed assessments in practice, the field notes and the semi-structured interviews, will be to observe the differences between:

- what is said/ what is not said
- the ways in which it is said
- who is saying it

These aspects of the discourse were compared with what appeared to be happening. As Cheek (2004) indicated to identify instances where the:

"truth status of the medical/scientific discursive frames has shaped the dominant taken-for-granted understandings of what is appropriate.." p1143

Bio-power

As referred to above, instances are noted that portray Foucault's ideas of Bio-power,

which he describes as the

“ subjugation of bodies andcontrol of populations” Foucault (1981) p140.

An example of Bio-power is the condemnation of those who, following recent concerns regarding the triple vaccine and purported links to autism, chose not to have their infants immunised. Here a conflict arose between the government’s aim to create “herd immunity” by getting the largest possible uptake for the vaccines (governmentality) and the understandable concern of each parent for their child at a “micro” level within the infant’s body (pastoral power). Condemnation of those who refused the triple vaccine continued and spread to the private health sector where the vaccine was given as three separate doses. Although immunising the infant would appear to satisfy the Department of Health’s desire for a large population of vaccinated children their condemnation of those who chose separate immunisations continues.

Problematization

Howarth (2000) refers to *problematization* as a synthesis of

“his (Foucault’s) archaeological and genealogical dimensions of discourse analysis” p134

The Archaeological dimension refers to the examination of the forms of discourse themselves whilst the Genealogical explores how the “Archaeological” is constructed.

4.3.8. The process of CDA

Bearing in mind the aspects of discourse identified above. The process of identifying what Potter (2004) describes as *“the inner psychological worlds”* which influence the creations of reality within the transcripts takes place by a deconstruction of the text.

Each statement is regarded as the reframed answer to the questions;

- How else could this have been said?
- Who is saying it ?
- Why is it being said?
- What are the influences which could encourage the speaker to say it in this particular way?

The answers to these questions are framed within my experience of the world. For example as I child I knew I was in trouble if my mother called me by my full name rather

than the diminutive version. The power and control inherent in the established naming in full will always remain with me. Although the action took place in naturally occurring speech it is an example of what van Dijk (1993) calls "*jointly produced*" dominance. For a critical discourse analyst a cue to the recognition of this symbolic enactment of dominance is in the observation of the production and the reception of this practice.

The CDA process uncovers the social and cognitive process by which the discourses are enacted through interrogation of the statements, coupled with the observations recorded in my field notes e.g. posture, tone of voice, eye contact, gesture and the context in which the interaction takes place. As my research is not hypothesis led I will not be seeking out particular examples of, for instance, dominance but will look at statements made in this integrated way to see what they will reveal. The analysis will be a result of my interpretation based on evidence from the context of the interactions, the transcripts and my field notes. Returning now to the last two imperatives that provide ontological integrity for this study:

4.3.9. Congruence between the approach and the research method of a Foucauldian CDA

CDA is a poststructuralist theory that allows analysis and theoretically maintains that discourses operate laterally across local and institutional sites (Wodak and Meyer 2002). CDA will allow analysis over the micro, macro and meso levels (Speed 2006). Texts are seen to have a constructive function in forming, shaping and revealing human identities and actions (Davies and Harré 1990). Access to linguistic and written resources are unequal at all levels, for example the use of jargon by professionals that excludes those not in the *cognoscenti* (Gramsci 1971). Fieldwork observation and examination of secondary sources will yield data that when subjected to CDA may provide evidence of this type of exclusion, and relating to research questions 3 and 4 above.

CDA employs Bourdieu's (1991) theory that textual practices become "embodied" forms of "cultural capital" that have exchange values in particular social fields. Thus the context of language production is seen as an expression of political and economic forces (Fairclough 1992). CDA utilises Habermass' (1986) theory that language is also a medium of domination and social force serving to legitimise relations of organised power

(Foucault 1973, 1980). Grounded in an understanding of the use and abuse of social power, where one manifestation of power is seen to involve dominance that allows the exercise of control, CDA seeks to identify how discourses contribute to the reproduction and production of power and dominance (Van Dijk 1993). These controls may pertain to action, limiting the freedom of others, for example the police response to the 1984 miners' strike (Spence and Stephenson 2007). Or they may control cognition by influencing the mind, for example, persuasion, coercion, dissimulation or political spin (Fairclough 1989). The management of minds is perceived as a function of text and talk where contentious issues are presented as natural or acceptable and therefore avoid challenge (Gramsci 1971). For example the growth of state surveillance as a response to threats of terrorism is presented in this way. Dominant structures stabilise and naturalise conventions and the effects of power and ideology are obscured in the creation of meaning (Fairclough 1992). Illich (1990) has identified a cultural thrust towards responsibility of the individual for their health status that exemplifies this zeitgeist. CDA also exposes how power is exercised by institutions (Foucault 1973, 1980) through control of context: for example, in the making of an appointment with a health professional.

4.3.10. Justification that CDA is suitable for pursuing the research questions posed

CDA embraces Habermas (1986), Foucault (1973, 1980) and Bourdieu's (2007) accounts of the symbolism and actuality of power of institutions, within discourses from micro to macro levels. CDA also provides a suitable approach for exploring the patient, carer and nurse power imbalances pertinent to the four remaining research questions that direct this phase of the study.

Analysis of field notes enable observation and interpretation of micro areas such as body language, gaze, situation, framing, gesture and register to be carried out in order to provide contextual detail (Wetherall et al 2002). Examples of literature and records will be analysed in order to deconstruct text and reveal assumptions and ideologies at the meso level of analysis. Examination of policy drivers and documentation will facilitate analysis at the macro level.

Research questions 2, 3, 4, contain an inherent assumption of a power imbalance. Foucault's approach focuses on *whose* voice is heard, *whose* is excluded, and the rituals surrounding the management of discourse.

Foucault does not prescribe a framework for an approach to the discourse and it is antithetical to attempt to impose one in a post-structural, analytic paradigm. This exposes a tension between the accepted academic conventions of structured writing, rigour and objectivity, and the rejection of objectivity and "truth" that epitomises the post-modern, post-structural acceptance of multiple manifestations of reality.

4.4. Summary and Conclusion

Following this exploration of CDA the final practical justifications for the use of this method for this study are:

- as this is a non-participant study the researcher is distant from the data
- the data is embedded in its social context
- there is an explicit political stance
- there is reflection on self as a researcher.

4.4.1 Moral and ethical considerations

Submission of the study to the iRAS and R and D committees contribute to the protection of participants from harmful practice. This is further achieved as the researcher will have complied with the legal requirements of obtaining CRB check and Honorary contracts with each of the participating Trusts.

Non-participant observation will allow the researcher to be detached from the practice observed thus helping to keep clear the role boundaries between researcher and nurse and avoiding confusion.

Further following a Foucauldian inspired methodology that directs the focus of the researcher to consider whose voice is heard and who is not, will facilitate the representation of the participants own stories.

The recruitment practice for nurse participants ensures nurses do not feel coerced to

take part in the study as they contact the researcher only if they wish to volunteer. Patients and their carers will be further protected from either exploitation or compulsion to take part in the study as;

discussion regarding the suitability of participants is undertaken with the nursing team who deliver their care

the first approach to the patient is made by the nurse and not the researcher

the researcher is a registered nurse and must abide by the NMC code of conduct.

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This chapter has reviewed this studies design and identified and justified the methods employed. The following chapters will present the findings of this study in two parts. Chapter 5 will present Part 1 the literature review and Concept Analysis of the term assessment in nursing practice. Chapter 6 contains the Part 2 findings and will present the CDA of the transcribed audio recordings of assessment in everyday practice.

Chapter 5

Chinese encyclopaedia categorisation of animals:

“(a) belonging to the Emperor, (b) embalmed, (c) tame, (d) suckling pigs, (e) sirens, (f) fabulous, (g) stray dogs, (h) included in the present classification, (i) frenzied, (j) innumerable, (k) drawn with a very fine camel hair brush, (l) et cetera, (m) having just broken a water pitcher, (n) that from a long way off just look like flies” Foucault (1970) p xvi

5.1. Phase 1 findings

Having explored the epistemological and ontological basis for knowing and understanding and outlined the methods and fields of this research study I will now move to the findings sections of this thesis. This chapter will focus on the results of the Concept Analysis of nursing assessment that comprises a systematic process undertaken to identify and review examples of the use of the term “assessment” in the current health care literature (1990-2005). Analysis of the concept assessment, within the identified literature, was achieved by using a Glasarian Grounded Theory method (Glaser 1978).

5.1.1. Study selection data extraction and interpretation

In exploration of the first research question

How is nursing assessment defined in the literature?

the electronic data bases listed (Appendix 1) were searched using the search terms identified. This search yielded 32,304 records including duplicates. All identified papers were screened firstly by title, then by abstract and finally by full text with papers excluded at each stage (31,975 papers were excluded). Policy documents and nursing text books published since 1990 were searched for references to assessment and those that met the inclusion criteria were also included in the study. Following Glaser's (1978) rejoinder to look outside the professional literature the Lexis Nexis European data base was searched, 63 articles were closely read and the adjectives and adverbs used to qualify the term “assessment” when referring to assessments made by nurses of patients was compiled (Appendix 4).

Following the initial screening stages hard copies of 329 articles were read and a critical analysis of their research quality made and recorded on the data collection

forms (Appendix 2). After this initial analysis a full text review of 120 articles (0.36% of the total number of hits and 36.47% of those read in full), included in this study was undertaken.

5.1.2. Analysis and synthesis

Although all of the articles in the final sample discuss aspects of assessment of patients by nurses only eight articles and two Department of Health (DoH) policy documents gave working definitions of “assessment” (Crow et al 1995, Crow and Spicer 1995, Latimer 1998, Vernon et al 2000, Parry-Jones & Soulsby 2001, Lake and John 2001, Worth 2001, Birtwhistle et al 2002 and Department of Health 1989, 1990).

Birtwhistle et al (2002) in their study of the attitudes of 522 District Nurses (DN) to the care of the recently bereaved defined assessment as:

“ talking or asking specific questions about particular problems with the bereaved or close relatives or friends or using an assessment tool to measure any given problems” Birtwhistle et al (2002) p6.

And Vernon et al (2000) state:

“assessment of an individual can be seen as a diagnostic process leading to suitable medical and nursing interventions” Vernon et al (2000)

Birtwhistle et al’s definition demonstrates that the dimension of the process include information gathering and identification and quantification of problems. They do not make the link to solutions or possible outcomes included in the definition given by Vernon et al. Parry Jones and Soulsby’s (2001) longitudinal qualitative study of the opinions of health care staff who care for the older person also describe assessment as an outcome-focused procedure which:

“identifies and meets nursing needs that are free at the point of delivery”

They quote both the DoH (1989) para 3.2.3.

“The objective of assessment is to determine the best available way to help the individual”

and the NHS and Community Care Act (1990) that refers to needs-led assessment as part of the “ *corner stone of high quality care*”.

Worth (2001) offers a procedure and outcome focussed definition of assessment;

The “*means by which practitioners ascertain the needs of individuals in order to determine the most appropriate location of care and match services to need*” p257.

This explicitly identifies assessment as matching needs to services and develops the implicit suggestion “*best available way*” DoH (1989) above.

Latimer (1998) however refers to assessment as:

“*an alignment which helps managerial and clinical tasks to be carried out*”

reducing the process to one of organisational judgement echoed by Crow and Spicer (1995):

“*summary assumed to be an example of nursing judgement*”

And the,

“*relationship between the core property (of nursing) and the identification procedure*” p419.

Crow and Spicer’s (1995) study of twenty-four nurses’ categorisations of medical conditions suggested assessment was the critical evaluation or judgement of the “*status or quality of a particular condition*” and the “*situation of the object of appraisal*”.

Lake and John (2001), in their work on assessment using Fuzzy Logic, defined assessment as:

“*An intuitive process in that the expert uses inexact or imprecise information to make judgements based on nursing knowledge and practice wisdom.*”

and described five context-forming domains for assessment:

- “1. *Physical/medical condition*
2. *Complicating factors*
3. *Physical capability or ‘dependency’*
4. *Psychosocial domain*
5. *Clinical intervention*” p10

Already it has become apparent that ambiguity, complexity and tensions arise from the plethora of interpretations of the notion of assessment identified from the

literature. Much can be learnt about assessment from the apparent differences within its use and it was therefore important to find a way of synthesising all the studies' findings, whilst keeping the context and multiplicity of perspectives within the term.

Glaserian Grounded Theory.

Categories of assessment were collected to enable the breadth of aspects of the concept of assessment to be reflected and to avoid concentration on "pet" codes. Glaser (1978) refers to 18 coding families (table 5.1) and these were utilised to sort memos generated from identification of themes when reading the literature.

Table 5.1. Coding families used; from Glaser (1978) (pp74-82)

Coding Family		codes used
The six Cs	Causes Contexts Contingencies Consequences Covariance-connected variables Conditions	<ul style="list-style-type: none"> • Areas of nursing • Influenced by • Dependent upon • Identification of clinical cues and indicators • Social and functional cues
Process	A way of grouping together sequenced parts of a process. Glaser 1978 p74	<ul style="list-style-type: none"> • The nursing process
Interactive	Tries to capture interactions between variables	<ul style="list-style-type: none"> • Judicial
Cultural	To do with social identities	<ul style="list-style-type: none"> • Influences (cultural)
Mainline	Those exercising social control	<ul style="list-style-type: none"> • Influences (institutional)
Theoretical		<ul style="list-style-type: none"> • Post-modern
Ordering or elaboration	a. Structural b. Temporal c. Conceptual	<ul style="list-style-type: none"> • Institutional hegemonies • Date limited • Power
Models	Theoretical codes can be modelled pictorially	<ul style="list-style-type: none"> • Figure 1

5.1.3. Conceptual sorting

Classification of studies is unnecessary when using a grounded theory approach as comparisons are made at a conceptual level across different types of study (Glaser 1978). The themes identified from the copious memos taken whilst reading at the conceptual sorting stage were those of assessment as:

- Judicial /decision making
- Part of the nursing process
- Identification of cues and indicators in various realms

Subcategories:

- Physiological cues

- Psychological cues
- Social and functioning indicators
- Influenced by
- Dependent upon
- Conceptually related to

Noting Foucault's illustration of the arbitrary nature of categorisation, quoted at the start of this chapter, it is unsurprising to find large areas of overlap within the categories. For example the notion of assessment is influenced by the continuum from novice to expert. This continuum also fits within all the core categories identified above. Figure 5.1 illustrates how the conceptual themes have clustered to form the core category.

Following further reading, sorting, thought and noting Glaser's (1978) recommendation to "*promote one core variable to the centre and demote others to sub-core variables*" p122, the seven categories initially collapsed to form two (Judicial and Concepts). Crow et al (1995) offer a broad definition of judgement in this context as

"a statement which expresses the nurse's estimate of someone's condition or situation" Crow et al (1995) p207.

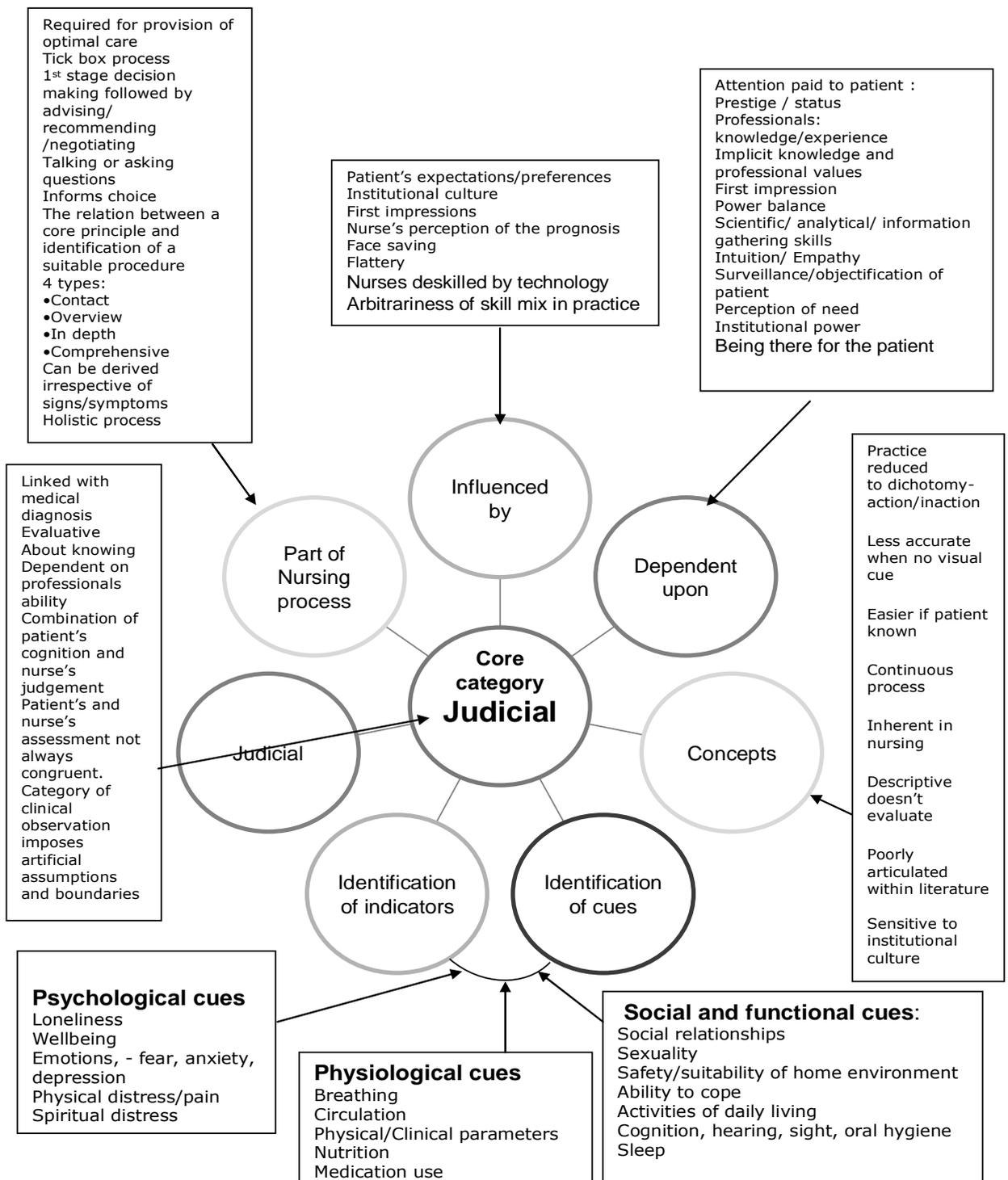
However judicial activities and decision-making are inextricably linked with things that "influence" the decision, which are the "cues and indicators" and the skills required for decision-making, the "dependent upon" category. Further judgements and decisions made are also part of the nursing process and are influenced and underpinned by the concepts identified. By this process of constant conceptual reference and comparison that Glaser (1978) calls "*theoretical sorting*" p116, and bearing in mind his advice to have only one core category, *Judicial* became the core category for this CA.

5.2. Core category: the Judicial

5.2.1. The mental processes involved in the Judicial

Identification of the thinking process involved in assessment decision making was core to fifteen articles reviewed. Harbison (1991) described two approaches firstly, the rationalist observation, analysis and logical response to data discovered and secondly a phenomenological perspective (Benner 1984). Crow and Spicer (1995) and Schmidt et al (1990) noted the concept of "illness scripts", causally linked categories that correspond to one illness or another

Figure 5.1. Diagrammatic representation of the relationship between conceptual themes, categories and the core category



This further suggests that nurses remembered an exemplar, or prototype, of any particular illness or condition and matched the patient cues they observe in practice to this memory. Crow et al (1995) also referred to nurses forming “*perceptual patterns which guide their internal search*” that enables illness recognition. This mechanistic approach of matching does not allow for the identification of individualised, diverse and complex manifestations of:

- disease processes
- illnesses
- specific health promotion
- lack of well being

all of which constitute assessment practice. It may however be the mechanism when assessing diagnostic cues, for example blood results, X-rays, ECG interpretation and other biomedical findings. Appleton and Cowley (2004) found that guidelines based on causative assumptions are only used by practitioners if found to have utility, and are often actively resisted. They referred to “professional judgement” that enabled the identification of those for whom the guidelines were appropriate. Niven and Scott (2003) also referred to assessment as making a professional judgement and similarly Lake and John (2001) suggested a “practice wisdom” that was used to underpin judgements.

Thommessen et al (1991) saw assessment as part of a screening tool and Green and Watson (2005) noted that although screening and assessment were often used interchangeably the hierarchy of skills involved in nutritional assessment were not needed for the less complex process of nutritional screening.

5.2.2. Diagnosis - a combination of inductive and deductive reasoning

The literature (Elstein et al 1978, Latimer 1998) indicates that both inductive and deductive reasoning (see Methodology chapter) were required to make a diagnosis. They identified four stages in hypothetic-deductive reasoning, firstly *cue recognition*, which they described as collecting information regarding the patient’s signs and symptoms. This was followed by *hypothesis generation* and *cue interpretation* where possible matches between the hypothesis and the assessed signs and symptoms were made. This process culminated in *hypothesis evaluation*.

Latimer (1998) looked at assessment as a cognitive process that combined information gathering, problem identification and diagnostic reasoning. This model

suggests the patient's needs were "out in the ether" waiting to be discovered when the nursing gaze was turned to them. Crow et al (1995) noted that the "nursing process" was based on the work of Elstein et al (1978) who included diagnostic reasoning as a part of the process. Crow et al concluded therefore that assessment, as part of the nursing process, must also be based on diagnostic reasoning. Their definition of assessment, above, suggested an evaluation or appraisal of the patient that falls short of a diagnosis. Hamers et al (1994) and Crow et al (1995) also linked assessment with medical diagnosis that contains a search for the evidence to support the hypothesised medical diagnosis as outlined above (illness scripts).

As has been discussed within the Methodology chapter, medical diagnosis combines surveillance that is driven by the search for evidence to support a particular model of illness, and a synthesis with knowledge gained through experience. Crow et al (1995) add to this "*domain-specific cognitive strategies*" which enable sorting of the information gathered. In medicine these domains equate with the medical specialties and are experientially developed. Luker et al (1995) referred to diagnosing as being a synthesis of scientific and analytical judgements that led to a diagnosis. This they state described the process by which nurses make an assessment. However they, and Lake and John (2001), noted that decisions were made despite a lack of available sufficient or precise information. Luker et al (1998) suggested nurses developed an implicit "*risk--benefit analysis*" to support their assessments. In contrast, Crow et al (1995) concluded that assessment was concerned with the patient's current situation and stated that the accuracy of decision-making depended on the quality of information gathered. Jordan (2002) noted that the categorisation required when making clinical observations and assessments imposed "*artificial assumptions and boundaries*" p422, on the nurse--patient interaction. McIntosh (1996) noted how difficult it was to uncover the thought process of caring, carried out by District Nurses (DNs), firstly because it cannot be observed and secondly when asked DNs found it hard to articulate how they had reached their judgement. Further Meerabeau (1992) found that, when questioned, DNs often re-interpreted their activities to make them appear more rational.

5.2.3. Combining practical and theoretical knowledge over time

Kennedy (2002b) saw assessment as a combination of practical knowledge, "*knowing how*" and theoretical "*knowing that*". She described assessment as a reflexive and cumulative process resulting in a decision, and taking place over several consultations. The best judgement was considered to be one that balanced

an individual's long- and short-term needs. This notion of getting to know the patient over time and the accumulation of information featured in several of the articles reviewed.

Hallett and Pateman's (2000) study of twelve community staff nurses found, regarding assessment, that the nurses do not assess officially but some felt that nursing involved constant assessment and re-assessment. Nurses were reported as referring to "*assessing in your head*", that Hallett and Pateman interpreted as continual unofficial assessment. The nurses also described doing "*invisible assessments*" and the authors took that to mean clandestinely. This gradual building up of a picture of the patient is also borne out in research by Griffiths and Luker (1994). However they reported that DN sisters, carrying out a first assessment as a locum for another DN, limited their assessment to the patient's immediate needs. Kennedy (2002a) concluded assessment has a

"complex and continual nature" p719

Castledine (1997) also asserted that an in-depth assessment may take days to complete, in keeping with Crow et al (1995) who identified assessment as a dynamic process requiring frequent review.

5.2.4. Complexity of "Need"

Fundamental to any standardisation of the approach to assessment is the perception of *need* which is discussed in twenty-seven of the papers. Johansson et al (2005) stated paradoxically the

"fundamental needs of every human being are of similar nature although each individual has in addition unique needs" p570

Further suggesting that the patient was best able to identify their own needs, Billings and Cowley's (1995) literature review of community needs assessment noted the complexity of the meaning of need. They offered Orr's (1985) interpretation of need as "*social, relative and evaluative*", also noting that health-care professionals evaluated need from their own standpoint. Further identifying the sociological view provided by Bradshaw's (1972) typology of need, where need is described as "expressed need", "felt need", "comparative need" and the professional judgement exercised as "normative need". They also found Bradshaw's influence in community nursing where need is realised as "*personal, subjective and variable*" p722. However they referred to Seedhouse's (1986) observation that health has a wide meaning and

it is better to keep the meaning of need vague since there are an infinite number of ways in which people can experience ill health. Exploring the epidemiological meaning of normative need as loss of lives, social function and morbidity, Billings and Cowley drew comparisons with notions of vulnerability based on census data.

Health economists offer a different interpretation, framing need in terms of cost-effectiveness and consumerism. The policy position on needs is that they are:

“the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life, as defined by the particular care agency or authority” Social Services Inspectorate (DoH 1991a) p12.

The sting is as ever in the tail as it is not the individual who decides on their quality of life.

Wright (2003) identified the following classifications as types of need assessed within her study of assessment for long-term care:

- breathing
- nutrition
- personal hygiene
- continence
- mobility
- transfer
- integrity
- sleep
- medication
- communication
- orientation
- emotional needs.

She did not discuss psychological, spiritual, social or sexual needs. She also identified the importance of government policy (DoH 2001b) regarding timing when assessing the need for long-term care, and noted as imperative that sufficient time is given for rehabilitation before making decisions. Further, the National Tracker Survey 1999/2000 (Wilkin et al 2000) found at that time 42% of chief executives were getting *“little or no support”* with interpreting health needs assessment.

Birtwhistle et al (2002) identified a need for bereavement support, and a combined approach to needs assessment was indicated in Brooks' (2002) study of the Rapid Assessment Support Services (RASS). RASS showed that the participants had needs that crossed social services and nursing boundaries. She further drew attention to the changes to DN practice in 1989 (DoH 1989) that resulted in the responsibility for patients' personal hygiene moving from nursing to social services (McIntosh 1996). This split may have a detrimental effect on nurses' opportunities to be close enough to their patients to establish the rapport necessary for making effective assessments. RASS also assessed the needs of carers and made recommendations for physiological and psychological support and respite care. Brook's (2002) evaluation of RASS reported that assessment involved accounting for patients' needs and wants but did not identify any differences between the two concepts. Cheyne et al (2006), reviewed midwives' decision-making and identified emotional and psychological needs for reassurance as many of the women were showing fear. Hignett's (2003) review of patient handling identified that some patients needed to be assisted from sitting to standing or lying positions. Jordan (2002) identified clinical needs and noted difficulties with meeting long-term needs in people with unpopular specialties living in remote locations. She referred both to the Inverse Care Law (Hart 1971) and Inverse Interest Law (Lewis and Wesseley 1992) as operating for these patients.

Bryan's (2000) case study of patient needs assessment indicated the importance of separating needs and goals and of identifying and prioritising needs when planning care to meet those needs. Darmer et al (2004) found that the positive evaluation of the VIPS¹ care planning model rested on the perceived ability to translate needs into nursing interventions.

Standardisation and tools used to assess need

Lockwood and Marshall (1999) in their study of standardised needs assessment for people with severe mental ill-health appreciated both the requirement for and the difficulty of defining what is meant by need. They stated that obstacles were practical and philosophical with the later caused by the differing perceptions of need exhibited by patients, carers, nurses or doctors. They also refer to Bradshaw's (1972) typology of need as above, however postulating that even if the philosophical difficulties were

¹ VIPS is an acronym, formed from the Swedish words for: well-being, integrity, prevention and safety.

overcome there were still practical problems in identifying and meeting need. They identified the use of a data base of local voluntary and statutory bodies that had services on offer to meet some needs as a practical solution. In Gormley's (1996) exploration of altruism he suggested a partnership between the state and community with needs initially met by family or voluntary services in the community. If the patient still felt their needs were not met they could then request help from the statutory services.

Blackburn (1991), Pearson (1991) and Mitcheson and Cowley (2003) all drew attention to the differing perceptions of need between professionals and their patients. Ruland et al (1997) concluded that assessments that included patients' preferences provided a greater congruence between patients' needs and nursing interventions. Labonte (1994) pointed to the futility of an assessment process when professionals had not identified the patient's perceptions of their condition and needs.

Bryan's (2005) qualitative study of HV domiciliary visits found clients were more likely to engage with the health promotional aspects of a visit after their "*personal and private*" needs had been addressed.

Mitcheson and Cowley (2003) identified that complex needs often had to be identified at the first visit and that using the tool piloted in their study, the pace and agenda of the assessment was often forced, resulting in a disempowered patient. Appleton and Cowley (2004) saw assessment of need as pivotal to health visiting practice and they described and evaluated a plethora of approaches and tools for the assessment of vulnerability and need. However they found in practice most HVs ignored guidelines and used professional judgement to assess need.

Appleton and Cowley (2004) also commented that if a family did not display any needs at the first visit they may not be assessed as requiring further visits. They also reported that the imposition of "core programmes" on HV practice had led to a reduction in their preventative work. Further that the core programme approach did not take into account the time required to build rapport and allow a reflexive unfolding of needs as the patient became more empowered and trusting, resulting in neither hope nor expectation that should *needs* arise, the client would contact them.

Birtwhistle et al (2002) identified that long-term contact between a nurse and a bereaved person may also have reflected the needs of the nurse.

5.2.5. Dissonance of experience between the assessor and the assessed

Five studies reported finding differences between the nurses' experience of assessing and the patients' experience of being assessed, both in the process and outcome. Sloman et al's (2005) study of post-operative pain assessment, using the Short Form McGill Pain Questionnaire developed by Melzack (1987), compared the pain ratings by 95 nurses of 95 patients' pain with the patient's own rating. Findings showed nurses' assessments significantly underestimated patient's post-operative pain and recommendations were made for research into the cognitive frameworks of both groups. Interestingly religiosity emerged as a variable in the approach to pain for this study whereas culture did not.

Ruland et al (1997) saw assessment as a combination of patient preferences and nurse's professional judgement. This was described as a clarification of mutual goals. Wright (2003) noted that assessment was often seen as a rubber stamp for decisions already made elsewhere or dictated by external constraints. Additionally that unnecessary assessments were sometimes performed in answer to a "*cry for help*" from a patient to a care manager who passed them on to the DN. Clough (2002) also identified that patients were passed around the system as joint assessment meant clients and patients were passed from one agency to another and "*multidisciplinary meant a quick word with a colleague*". Halfens et al (1998) noted a greater discrepancy between patient ratings and those of nurses when the nurses were unable to see what was being assessed, implying that nurses may need visual cues in order to be accurate and confident.

Cowley et al (2000) revealed how roles and expectations regarding DNs and assessments changed when an internal quasi-market was introduced under the National Health Service and Community Care Act 1990. Relative worth was ascribed to nursing activities, however conflicting views of this were held by health care managers, government, patients, the public, the media and nurses.

5.3. Category - part of the process of nursing

5.3.1. The nursing process

Assessment as part of the *nursing process* (Elstein et al 1978) featured implicitly in the majority of articles reviewed with forty-six papers using the nursing process as a framework for their discussion of assessment. As outlined above the nursing process

was imported from America some thirty years ago. However it does not seem to have facilitated the assessment and planning stages of nursing care, which are sometimes reduced to a check-list approach (Bryans 2000, Niven and Scott 2003). In contrast to Gormley's (1996) assertion that:

“the nurses should exhibit through practice the sincerity and conviction to understand and meet the unique needs of a patient through the medium of a truly caring relationship” p585.

Kerkstra and Bemster (1994) saw assessment as the first phase of the nursing process. Molony and Mags (1999) listed four phases to the nursing process:

- assess and identify problems/ needs
- plan interventions to engender expected outcomes
- implement interventions
- review and if necessary replace the interventions.

Darmer et al (2004) listed components of the nursing process as:

- assessment
- establishing a nursing diagnosis
- create and update nursing care-plans
- link assessment medical diagnosis and interventions.

Kennedy (2002a) described the nursing process as an information processing procedure and Griffiths (1998) listed assessment, planning, delivery and recording as the “problem-solving process” utilised by nurses in the UK. Crow et al (1995) also referred to the problem-solving nature of the nursing process.

Castledine (2004) questioned whether nurses have sharpened the assessment skills that have been a part of the nursing process for many years. Kennedy (2002b) noted that the linked action and feedback activities of DN assessments were often missed in descriptions of their processes. She identified DNs' areas of knowledge as encompassing physical, psychological and spiritual aspects of care.

Johnson and Webb (1995) ironically cited the accepted description of the nursing process as a benevolent activity that aims to render individualised and patient centred care. Further, that it will encompass the practices of “*mutual goal setting, openness and collaboration between patient and nurse*”. This they contrasted with

the reality where it is beset with conflict and struggle as patients acquiesce to the “*medical goals of care*”. They described the process as:

- assessing
- negotiation
- struggle
- acquiescence.

Similarly Frich (2003) suggested that assessment was followed by recommending and negotiating as part of the nursing process.

Johns (1994) criticised the nursing process for not ensuring individualised care delivery. Niven and Scott (2003) identified the obsession with the activities of daily living as detrimental to the nursing process as these were facilitated at the expense of identification of patient’s actual needs.

The nursing process embraced judgements regarding physiological, psychological and social and functional cue recognition (table 5.2). Eight papers implicated responses to cues as part of the initial phase of assessment. Cheyne et al (2006) found midwives’ decision-making was based on an adaptation of Elstein and Bordage’s (1988) work on psychology in nursing judgment-making (see above). Cheyne et al produced a diagrammatic scheme that elucidated areas under concern regarding different categories. Their information cues are listed (table 5.2) and it is of note that the general appearance of a patient proved to be an important cue both to the assessment of her physical signs and especially as to how well she was tolerating the pain of labour. This is reminiscent of the findings of Halfens et al (1998) above. Hamers et al (1994) study of pain assessment for children noted that a child’s expression and, unsurprisingly, crying may be an indicator of their level of pain.

Kennedy’s (2002b) work on DN assessment decision-making also linked cue interpretation and hypothesis generation. Darmer et al (2004) described the VIPS model, a system that comprised two levels of key words, the first corresponding to the nursing process:

- Nursing history
- Status
- Diagnosis
- Goals
- Intervention

- Outcome
- Nursing discharge notes.

The second level key words were linked to the categories: nursing history, nursing status and nursing interventions.

Table 5.2. Information cues and themes adapted from Cheyne et al (2006)

Category	Theme	Cue
Woman	Physical signs	Appearance Contractions Spontaneous rupture of membranes Show Vaginal examination History
	Distress and coping	Response to pain Fear Need for reassurance Appearance
	Expectations	Not knowing what to expect Media Antenatal education "Feels" in labour Conflict between midwife and woman's decision
	Social factors	Support Partner's anxiety Mother/mother-in-law Distance from hospital Transport

Lake and John (2001) saw the assessment process as the recognition and prioritising of patient need across the five contexts providing domains listed in this chapter's introduction. They noted that written and verbal nursing assessments often used a single sentence summary to convey the degree of patient need in one domain despite the fact the assessment had included all domains.

Dowding and Thompson's (2003) work on measuring the quality of nurses' decision-making described the Brunswick lens model as an illustration of how cue evaluation fed into judgements regarding the patient's "state".

Wolf (1999) states:

"The core value of the lens model consisted of its ability to utilize various starting points, to then use interchangeable paths, and to finally reach one goal by following various strategies."

Houston and Cowley (2003) indicated that cues may be verbal or non-verbal giving an example of a non-verbal cue taken from health visiting when a patient and her mother-in-law were observed sitting at either end of a couch.

The penultimate stage of the nursing process is the evaluation of outcome that is sometimes used as an indicator of the quality of the assessment (Donabedian 1976). Baron (2000) suggested that the best decisions were followed by the best outcomes. However this simplistic statement ignores the possibility of an outcome happening by chance, irrespective of the quality of the decisions made, or as a result of unanticipated patient actions. Dowding and Thompson (2003) described outcome used as a quality indicator regarding nurses' assessment of risk, (for example Moore (1996) study that considered nurses' estimations of a patient's risk of falling following their admission but which did not specify measures taken to avoid a fall)'.

The DoH circular HSC 2001/001 (DoH 2001a) stated the outcome of intermediate-care assessment

“a planned outcome of maximising independence and typically enabling patients/users to continue living at home.”

Frich (2003) noted that health care policy was one of increasing effectiveness but identified times when patients were discharged from specialist care into the community, where staff were found to be ill-equipped, both in time and knowledge, to deal with the specific needs of the patients, and this resulted in suboptimal outcomes of care.

Wright's (2003) quantitative study found that only 11% (n=3) of staff questioned regularly received feedback regarding the outcome of their assessments for long-term care. 30% (n=8) received feedback more often than not leaving the remaining 57% (n=16) rarely or never receiving feedback. This indicated lost opportunities to learn from and improve practice by using past experiences.

McKenna (1997) action research, regarding evaluation of the use of a Human Needs model for long-term psychiatric care, used outcomes as patient and nurse satisfaction indicators. They did not discuss the possibility of bias in their approach, as patients and nursing staff might positively skew results because they were included or those on the control wards might feel excluded and behave negatively.

Houston and Cowley (2003) studied the use of interpreters in Health Visiting assessment, demonstrating that outcome was significantly dependent on whether or not the patient/client was able to lead the assessment. Frich's (2003) study of seven articles on outcomes of nursing interventions for chronic conditions noted indicators in the three distinct outcome areas listed in table 5.3. She discussed probable category overlap with absence of depression being in both patient and clinical outcome categories.

Table 5.3. Indicators for three outcomes from Frich (2003)

Outcome category	Indicators
Patient outcome	Patient satisfaction Quality of Life Wellbeing Self reported adherence to regime Self efficacy Self care knowledge Skills
Socio-economic outcome	Hospitalisation Numbers and lengths of stays Nursing home admissions Use of health service Cost cutting
Clinical outcome	Mortality Disability Blood pressure assessment Cholesterol plasma level Blood glucose control Symptoms of depression

Kerkstra and Beemster's (1994) study of the quality of Dutch nursing assessment visits, using secondary analysis, employed a Donabedian framework looking at structure, process and outcome. They took community nursing intervention outcomes as improvement in patients'

- knowledge
- health
- physical functioning abilities
- satisfaction.

Lockwood and Marshall's (1999) study addressed whether the use of feedback resulted in a reduction in the numbers of unmet needs identified at assessment. They observed the first assessment and a further assessment six months later to reassess. Using a Wilcoxon matched pairs signed ranks test and Autoneed, a

Cardinal Needs Schedule assessment programme, they suggested that assessment could be divided into three stages:

1. identification of the problem/s
2. identification of those problems that need action
3. identification of needs from a list of interventions.

Stage 2 was predicted on three criteria:

- a. cooperation
- b. carers' stress
- c. severity criteria

The three main outcome indicators used were the number of needs, social behaviour and psychiatric symptoms. One of their findings was that feedback of evaluation led to a clinically significant reduction in unmet social and psychiatric needs.

Crow et al (1995) looked at influences on assessment and noted that knowledge of the medical prognosis influenced outcome. Similarly Crow and Spicer (1995) showed that medical prognosis or likely outcome of a condition provided attributes for which the severity of the condition was determined. Kratz (1978) noted that patients who were seriously ill received care appropriate to their observed needs whereas those whose condition remained unchanged, or chronic, received more diffuse care unspecific to their needs.

Bowers et al (2003) multidisciplinary reflections on assessment for compulsory admission revealed the importance of a speedy response from other healthcare professionals to enable the outcome of the assessment to be realised. Bryans and McIntosh's (1996) review of community nurse decision-making noted that decisions were formulated using a trade-off of predicted outcomes dependent on the nurse's ascribed values.

Johnson and Webb's (1995) study, in a ward setting, considered struggle and acquiescence as part of the nursing process. They highlighted the paradox that a patient may be manipulated into a course of action they do not want but which may be in their best interests. This raised the question of on what criteria, or which category of outcome, are the patient's interests being decided? In contrast Maher and Hemming (2005) asserted that in palliative care practice the process of holistic assessment facilitated mutual understanding. Patients were enabled to achieve control that was as important for the outcomes as technical and scientific knowledge. Posing the dilemma that by setting eradication of symptoms as an outcome, palliative

care patients may undergo procedures that prove intolerable or distasteful, just to meet the criteria. In these ways assessments may have far reaching financial and emotional implications.

5.3.2. Holism

The concept of holism was discussed by twenty of the studies reviewed and was also referred to as a dimension of assessment in many others. Maher and Hemming added ethnic, economic, intellectual and gender dimensions to Haworth and Duley's (2001) definition of holism:

"the relationship between the biophysical, social and psychological"
Haworth and Duley (2001)

Holism was identified as fundamental by Kennedy's (2002a) study of eleven participant observations followed by structured interviews with DNs who referred to *"building the bigger picture"* p716 . Maher and Hemming's (2005) indicated the need for holistic assessment as indisputable within the context of palliative care, in order that the nurse becomes both the director and producer and not merely an actor in the process.

Hopkins (2005) noted that the holistic approach brought added dimensions to leg ulcer assessment stating:

" a systematic and holistic approach may uncover mixed and unusual aetiology" Hopkins (2005) p78.

Within the context of care of the dying and the work of RASS, Brooks (2002) noted that hygiene care can often provide a platform for a holistic assessment. She attributed patient satisfaction with RASS to their holistic approach.

Bazian Ltd.(2005) systematic review of nurses' pre-operative assessments found core components to be:

- history taking
- physical examination
- ordering of necessary tests.

However a study (60 children pre-orthopaedic surgery) by Rushforth et al (2000) showed nurses to be better at history taking than senior house officers (SHO).

"Better" meant identification of 94% of detectable problems (identified by a senior

specialist registrar in anaesthetics) compared with 42% detected by the SHO. A second study by Staples et al (2004), reviewed by Bazian Ltd., found more people were “very satisfied” when assessed by a nurse than those assessed by a house officer. Although no reasons were postulated for these differences they highlight a disparity between patient perceptions of medical and nursing assessment practice.

Lockwood and Marshall (1999) stated that mental health care theorists asserted that patients’ outcome would improve with a more holistic assessment of their needs. Echoing this, the Chief Nursing officer (CNO), in her report on Mental Health Nursing (MHN) (DoH 2006f) added the recommendation that MHNs should take a holistic approach to patient care. Kneafsey et al (2003), in the ethnographic phase of their study into the role of District Nursing, contrasted the holistic approach with a task-orientated one, noting that the participating nurses classified their assessments as holistic if they included areas of health and social care - a much narrower classification than the one offered by Maher and Hemmings above.

Montford and Rosen’s (2001) London walk-in centre report for the Kings Fund, noted a tension between triage and the value the participating nurses placed on a holistic assessment. This was especially apparent when one nurse triaged and another carried out the care indicated by their colleague. The report did not state what the nurses meant by holistic or how many nurses had raised this concern. Ruland et al (1997) in their investigation into the inclusion of patient preferences within assessment suggested the holistic perspective was core to nursing philosophy.

Griffith’s (1998) study across two acute wards found a mismatch between the records of patient diagnosis in their notes, often listed as the reason for admission, and a holistic nursing assessment. They asserted that scant regard was paid to the nursing assessment. However they concluded that a nursing diagnosis, following from the holistic assessment, would be more likely to address the patient’s needs than consideration of the medical diagnosis. Although the first assertion is evidenced by the reported research findings the second is not.

Crow et al (1995), analysed the cognitive component of nursing assessment in their study - the probable outcome of a patient in cardiac shock. Likening the type of judgements made when nurses assess to a type of “holistic perception” (which they neither explained nor defined) Worth’s (2001) ethnographic study of assessment of older people identified that care managers, with a background in District Nursing, had

greater ability to carry out a holistic assessment. However only three care managers were recruited to the study and this would seem too small a number to support this generalisation.

Walker's (2003) study of the assessment of pain contrasted the positivistic paradigm of a pain assessment tool with the more holistic assessment of a patient's pain provided by nursing staff. Noting that by a combination of approaches a patient's pain could be better assessed. Following a literature review to discover the types and use of assessment tools for older people's needs, Slater and McCormack (2005) designed, piloted and tested a twenty domain holistic assessment tool to determine a person's eligibility for free nursing care. Focus groups, comprising nineteen assessors, agreed the assessment tool was more capable of giving a holistic assessment than other tools. This study is included as the large number of domains included in the tool reflects the complexity of holistic care assessment for the studies participants. Kennedy (2002b) identified a "*holistic*" element to assessment within her literature search, which she noted was antithetical to the practice of listing visits under tasks such as:

- wound dressing
- hygiene
- continence
- Doppler assessment.

Although she noted that the nurses seemed to be:

"making a general assessment of the situation" to `support their hypothesis' that "everything was alright". Kennedy (2002b) p719

If this is so judgements made in this way are based on the reductionist reasoning involved in making a medical diagnosis and are far from holistic. When evidence is gathered to support one position much of the patient's narrative may be overlooked or left unexplored.

5.3.3. Standardisation and checklists

The topic of standardisation or the implementation and evaluation of checklists were explored by twenty-five studies. Appleton and Cowley (2004) identified a policy thrust, dating from the Audit commission findings of 1994, towards a health needs assessment approach targeted to vulnerable families. This approach was charged with redressing health inequalities (DoH 2001a, 2003). These changes and the

resultant pressure on management to reduce spending and limit home visiting have resulted in a push for standardisation and a proliferation of guidelines. The specific need for a standardised assessment, vocabulary and tools has been identified by Ozbolt (1999), who noted problems of subtlety, hierarchy and degree when using an enumerated classification system. Lake and John (2001) also noted that scoring systems required the translation of nursing knowledge into numerical scores. Cautioning that despite the appeal of “*crisp linear*” p11 indicators, there could be a significant difference in patient assessment between an arbitrary score of 13 and one of 14. Crow et al (1995b) suggested the checklist approach excluded “*domain specific*” expertise that a nurse may have developed.

Appleton and Cowley (2004) also noted that problems arose when professional judgements indicated one course of action that was not suggested by checklists’ risk indicators. Dickinson (2006) reported staff perception that reducing assessment to “*a series of ticks in boxes*” p24, was not compatible with their working practice. Niven and Scott (2003) found patient-centred assessment core to a “patient-led” approach that is antithetical to the “*checklist approach*” identified by Bryans and Macintosh (1996). The call for standardisation was seen as stifling the creativity and artistry of nursing by CMHNs enrolled in Godin’s (2004) study. Houston and Cowley’s (2003) research into the HV’s use of a structured health needs assessment tool gave an example where an HV continued with a particular line of questioning until the client gave an answer that fitted the categories available on the form. They further concluded that using the Health Needs Assessment Tool (HNAT) did not discover deep-seated emotional and psychological needs for one third of clients enrolled in their study. Although acknowledging that only HNAT was used, the limitations demonstrated may extend to the use of other tools. If this is so, they asserted, far from achieving an equitable and standardised opportunity for patients the use of tools may prove to be detrimental to their well-being by restricting need identification opportunities. Parry-Jones and Soulsby (2001) also indicated the pressure on health care assessors to make the assessment fit within current resource provision. Jordan (2002) noted that using a checklist polarised assessment decisions into the binary of action or inaction.

However Frich (2003) noted the combination of a physical examination and checklist approach was used satisfactorily for the assessment of older people. Jordan’s (2002) study into nurse prescribing found the use of checklists beneficial, suggesting that in regard to some adverse drug reactions (ADRs) simple checklists were a

“most effective form of guideline for improving health care” Jordan (2002)
p438

Hatfield et al (2003) evaluated the Northwick Park Dependency score (NPDS), an ordinal scale comprising sixteen areas that were augmented with extra questions in order to assess dependency in the community. The extended scale “NPDS plus” was found to be sensitive to changes in patient levels of dependency during rehabilitation. Following comparison to other tools it was found to be reasonably reliable with the caveat that there would always be outliers when any tool was used.

Lockwood and Marshall (1999) postulated that the mental health needs assessment was inadequate as was also suggested by the RCTs conducted by:

- Muijen et al (1994)
- Ford et al (1995)
- Marshall et al (1995)
- Tyrer et al (1995)
- Holloway and Carson (1998),

The RCTs identified two main problem areas: firstly, when the patient’s needs fell outside the expertise of the assessor they were missed. Secondly, when needs were identified there were often difficulties in accessing the care required. These areas of concern were identified by several studies and I shall return to them below.

In contrast Mitcheson and Cowley (2003) found little evidence to show that risk factor checklists could accurately predict outcomes and Bryans (2000) showed nurses who utilised a checklist were not always responsive to patient mood or cues.

5.4. Category - identification of cues

5.4.1. Rapport

Establishing a rapport with patients was found to be especially important when asking difficult or taboo questions. Stenson’s (2005) qualitative study of twenty-one midwives’ experiences when asking women sensitive antenatal questions, specifically those regarding men’s violence against them, highlighted the importance of firstly building a good relationship with the women, which Stenson noted as vital for the questions “*to be able to ask at all*”. Kennedy (2004) found establishing trust and rapport were important aspects of “*knowing how*”, outlined above. In her 2002(a)

study of DNs' first assessment visits trust and rapport were seen as core to District Nursing describing them as key to "*making the visit work*".

Bowers et al (2003) research into assessment for compulsory admission identified "*clear honest communication*", as a way of establishing rapport with clients under these difficult conditions. In Maher and Hemmings (2005) exploration of holistic assessment in palliative care they noted that trust and rapport were necessary to differentiate between information gathering and a holistic assessment. They stated both were fostered by "*honesty, integrity and genuineness*" in the nurse's approach.

Niven and Scott (2003) case study of the experience of a patient with breast cancer described the difficulty of "*assessing and hearing the patient's voice*". They suggested that attending to the patient in this way "*may also cost both the patient and practitioner*" as it exposed nurses to the distress of patients without the defence mechanism of "*distance*". However they described this kind of listening as core to a "*patient-led*" approach to assessment. Johnson and Webb (1995) also noted that little attention is paid to the emotional cost of caring.

5.4.2. Social and financial implications

Wright (2003) found that inaccurate assessment had profound financial implications for patients regarding subsequent nursing input. Clissett and Kopp (2001) stressed the importance for nurses to realise that the transition from home to care was a painful and difficult time for patients when making such assessments.

5.5. Category - identification of indicators

5.5.1. Familiarity/ first impressions/prognosis

A group of nine studies included discussion of different influences on the process and outcome of assessment. Dowding and Thompson (2003) reviewed factors affecting nursing judgments, noting that assessment was more difficult if the patient was not known beforehand. Familiarity with the patient was seen as an asset. However the importance of the first impression of a patient's appearance was also noted.

Fagerberg and Kilgren (2001) found nurses felt that knowing the patient was important for their care delivery and MacLeod (1994) confirmed it as key to the delivery of high quality care.

Sbaih (1998) also reported that A&E nurses often made triage assessments and decisions before speaking to the patient. Nurses referred to this as forming a first impression that was sometimes made even before the patient got into the department. Interestingly Sbaih reported that the patient's story was used to corroborate these first impressions and if there was a mismatch the patient's motives were then doubted. Perhaps this is because of the specific nature of triage assessment, which is designed to answer questions such as how severe is the patient's condition, and how long can they wait. Similarly Hamers et al (1994) study of assessment of pain in children found nurses' decisions were influenced by their normative judgements of the children's parents.

Both Wahlberg et al (2003) and Richards et al (2004) quantitative studies of nurse telephone triage calls noted that assessment was more difficult if the nurse could not see the patient. Dickinson et al (2005) reported that maintaining eye contact during assessment was a factor in building a rapport with the patient

Crow and Spicer (1995) conducted a trial of 24 acute and community nurses who were given Multiple Sorting Tasks regarding conditions and categories of nursing interventions. Initially, cards representing the categories of nursing interventions for 35 medical conditions were prioritised by the nurses. The categorisation of conditions showed that the terms, for example long-term and chronic, had negative connotations bringing implications for nursing intervention. They showed that nurses identified a core category; they used the example recovering, and from this extrapolated what effect this would have on the patient's life. These findings have a resonance with the findings of Lake and John (2001) regarding the multi-facets of nursing language.

5.6. Category - influenced by

5.6.1. Intuition

Twenty-four studies identified intuition as an important pre-requisite for nursing assessment. Benner (1984) Yates (1990), Molony and Mags (1999) and Kennedy (2002a, b) noted that assessment contains a predictive quality. If a patient's condition is assessed to decide the amount of help they will need this decision is made on their future response to the help proposed. Crow and Spicer's (1995) study analysing nursing judgement showed both anticipated outcomes of interventions or "recovery" were core deciding factors in how the nurse viewed the patient's "*hold on life*" p419.

To explain this predictive quality; Pyles and Stern (1983), Benner and Tanner (1987), Jasper (1994), Eraut (1994), Bryans and McIntosh (1996), Dawson (1997), Sbiah (1998), Ellis (1999), Lake and John (2001), Walker (2003), Manais et al (2004), Godin (2004), Cader et al (2005) and Pancorbo et al (2006) all referred to intuitive assumptions or intuition. Bryans and McIntosh (1996) linked intuition to experientially gained knowledge and pre-decision activity. Whereas Dawson (1997) linked intuition, creativity and insight to the “intellectus”, which was the higher of the two medieval explanations accounting for the acquisition of knowledge, Jasper (1994) saw intuition as a form of tacit knowledge which allowed nurses to develop a “rule of thumb”, resulting from expertise or pattern recognition. Godin’s (2004) research demonstrated the importance of intuition or “gut feeling” in risk assessment for Community Psychiatric nurses. However questioning the exact nature of intuition he asked whether it could be discerned from “*whim or prejudice*”? Pyles and Stern (1983) referred to a “*nursing gestalt*”, a matrix linking knowledge, experience, identifying cues and “gut feeling” that they describe as; identification that the patient’s observable, but not necessarily clinical, condition significantly falls outside the usual pattern. Nurses in their study based this feeling on intuition, with one quoted as saying (despite the stability of the monitors):

“everything about the patient looks the same yet I just have the feeling something is going to happen.” Pyles and Stern (1983) p54

Pyles and Stern (1983) also referred to the patient’s intuitional decision that “*all is not well*” as a significant indicator for the critical care nurses in their study.

Sbiah (1998) reported Accident and Emergency (A&E) nurses as identifying “*normal cases*” through experience and “*having intuition*” p72. Some nurses in her study identified the need to back up their intuition with other evidence. Walker (2003) categorised aspects of assessment that could not be verbalised as intuitive. Manias et al (2004) refer to intuition as happening at an unconscious level, which I take to mean subconscious level, and included intuition as an adjunct to support other knowledge. They observed only two instances in their study, both of which were in connection with interpretations of patient behaviour. Ellis (1999) included intuition within her construct of caring and Pancorbo et al (2006) saw intuition as a skill resulting from experience. Cader et al (2005) included intuition, a rapid “*unconscious*” form of data processing, in their explanation of the Cognition Continuum theory of judgement making. Within this theory processes ranged from intuition to analysis and the theory refutes that these are ontologically rival forms of knowing. Eraut (1994)

also contended that professional deliberations consisted of both intuition and analysis.

Yates (1990) referred to the predictive quality of assessment as “*a likelihood judgement*” of the patient’s future performance following the provision of the identified treatment or support. Crow and Spicer (1995) saw intuition as the way nurses explained the cognitive skill of assessment and the process that enabled clinical skills to be categorised. Kennedy (2002a) referred to the “*determination of present and future needs*” as one of her five key categories and asked whether intuition is a mode of cognition or a form of knowledge?

Morse et al (1994) explored the notion of sensing a patient in need or “*reading the patient*” as part of the practice of nurse assessment and five of their seven concepts used to “describe the process of sensing” are metaphysical. These comprise;

- “Intuition”
- “Knowing”
- “Countertransference”
- “Embodiment”
- “Compathy”
- “Empathy”.

Morse et al (1994) also acknowledged the difficulty in discovering information about intuition by interviewing nurses. Benner and Tanner (1987) described intuition as “*understanding without rationale*” and Rew (1986) referred to “*knowledge acquisition without a linear reasoning process*”. Intuitive judgements were seen by Schraeder and Fischer (1987), in Morse et al (1994), as expert knowledge that is “*acquired and refined with experience*” p239.

Paley (1996) questioned Benner’s (1984) assertions regarding “expert” decision-making where the conscious “*highly intellectual analysis*” of the novice is replaced by intuition. He suggested her notion of intuition was just something that experts do and queried in what ways do novices’ actions differ?

5.6.2. Empathy

Six studies included empathy as a component of assessment. Morse et al (1994) defined empathy as “*the arousal or responsive component resulting in empathetic*

insight" p235. Rogers (1959) referred to empathy as a sharing of another's "psychological state." and Travelbee (1972) described a process shared by patient and nurse but that the nurse "stands apart from" the patient. Mitcheson and Cowley (2003) described empathy as central to the "empowering act that needs assessment should be". Walker (2003) saw empathy as crucial to the humanistic nursing skills involved in the assessment of pain but outlined difficulty in teaching or measuring an empathetic response. Carper (1978) and Baillie (1996) cited the therapeutic use of self and empathy as fundamental to the act of caring.

5.6.3. Countertransference

Morse et al (1994) used the word "countertransference" as essential for assessment defining it as:

"the emotional and physical reaction professional care givers give their clients." Morse et al (1994) p 237

Perhaps this has some overlap with the therapeutic use of self outlined by Carper (1978) and the notion of "being for the other" as the responsibility of the nurse in the work of Nortvedt (1998) p385. Griffiths et al (2000) also referred to a therapeutic component of care delivered by registered nurses which acted independently of other health care interventions. Maher and Hemming (2005) suggested that a holistic approach to patient care is, of itself, therapeutic.

Simington and Laing (1993) carried out a quantitative double blind study that examined the therapeutic use of touch. This process involved a compassionate concentration on the patient (centering) where it was claimed touch was used to restore the harmony of energy waves emitted from the patient's body. In their study 105 older people in four institutional care settings in Canada were randomly assigned to three groups. Group1 received "centered" therapeutic touch, group 2 a back rub, group 3 therapeutic touch but without "centering". Post test analysis showed group 1 had lower stress levels than the participants in the other two groups. Nortvelt (1998) suggested that to encounter a person's pain, as a nurse, is to share in their suffering. This takes the nurse's response beyond one of empathy and may have something of Morse's notion of "countertransference".

5.6.4. Training and education for the role of assessor

The topic of training and education was seen as fundamental to facilitate assessment by twenty-two of the papers. Wright (2003) found that only 36% (n= 10) of those

nurses who completed questionnaires regarding long-term care assessments had received any form of training and 46% (n=12) "*felt they had not had enough training*" p9. The training available was mostly "*on the job*", or a RCN workshop. She concluded that without proper training in assessment:

"there could be significant pitfalls in the system" Wright (2003) p14.

Niven and Scott (2003) advocated that a greater understanding of the decision-making process would inform, educate and challenge nurses. Kennedy (2002a) called for the need to "*uncover the knowledge base*" that informed decision-making in assessment and that research findings should guide education. McIntosh (1996) found DN learning to be mainly experiential.

Bazian Ltd. (2005) stressed the need for nurses to undergo the appropriate training to enable them to safely carry out pre-operative assessments. Read's (2005) commentary on the systematic review by Bazian Ltd stressed the need to enhance nurses' knowledge bases beyond what was taught for their initial registration in order to allow them to take on advanced practice. Jordan (2002) emphasised the importance of additional education in order for MHNs to competently prescribe for their patients.

In contrast Sloman et al (2005) found that the level of nursing education did not impact significantly on their underreporting of patients' post-operative pain. However (confusingly) they recommended better education for nurses regarding pain assessment. Hamers et al (1994) studies of nurses' decision-making when assessing pain in children suggested the requirement for more education directed at this form of assessment. Morse et al (1994) and Smith (1991) noted that both intuition and empathy could be taught in the classroom.

Hallett and Pateman (2000) research showed that D grade community staff nurses expressed a need for continuing education in assessing patients. The type of educational input was dependent on their prior levels of educational attainment. They also found nurses employed on higher grades received more education and opportunities to facilitate assessment. Frich's (2003) structured descriptive review of the literature regarding nursing interventions found positive assessment outcomes to be influenced by

- health care providers
- nurse education

- time spent with patients.

Communication skills were seen as a priority for nurse educators in a qualitative study of “patient labelling” by Johnson and Webb (1995). Kennedy (2004) advocated the “work based” learning approach supported by academic input for DNs to improve their knowledge. A Kings Fund report into patient involvement (Gillespie et al 2002) highlighted the need for all health professionals to be taught communication skills.

Birtwhistle et al (2002) noted specific post-registration training was required when caring for the bereaved although only 25% of nurses participating in their study reported it as a topic in their pre-registration training. Darmer et al’s (2004) prospective, quasi-experimental study into the use of VIPs (see above), concluded that use of this documentation improved participating nurses’ knowledge of the nursing process but raised implications for nurse education. Hugh et al (1995) found MHNs showed a reluctance to relinquish power to the patient. It was suggested this may be resolved by improved education. Francke et al (1996) reviewed twelve studies and concluded that continuing nurse education about pain assessment could be a positive influence for both patients and staff. Johansson et al’s (2005) study of night nurses found they had received less education than their counterparts on day-shifts. Further there were statistically significant differences between night nurses’ and patients’ perceptions of assessments in the fields of:

- observation and monitoring
- need for assistance.

These deficiencies indicated the need for tailor-made training for night nurses in order to improve patient care. Dowding and Thomson (2003) identified that “*you don’t know what you don’t know*”, drawing attention to available outcome measures that were essential in order to make an assessment judgement. Luker and Kenrick (1995) identified barriers associated with disseminating research findings and information to community nursing teams, resulting in an ill-informed workforce whose practice and knowledge base were static.

5.6.5. Skill-mix

Six studies explicitly referred to the effects skill-mix may have on the assessment process. Niven and Scott (2003) identified the arbitrariness of skill-mix and staff

allocation citing decisions made regarding care delegation by qualified nurses to non-qualified carers. They noted that these factors adversely impacted on nursing care.

Mountford and Rosen (2001) found that the problems of providing an optimal skill-mix impacted upon the care delivered by London walk-in clinics. Here less experienced staff took posts seen as developmental by the existing team but officially undifferentiated both in terms of grade and pay.

The Health Service Management Executive's (HSME) (DoH 1992a), value for money unit implemented changes within the skill-mix of community nursing teams, moving from the District Nursing Sister and health-care assistant teams of the early 90s to teams with a greatly increased numbers of community staff nurses (McIntosh 1996). Hallet and Pateman (2000) identified tensions and frustrations amongst the staff nurse grades regarding recognition of their assessment abilities. Problems of consistency arose as they were permitted to assess patients in surgeries but not in the patient's home. It was further noted that the role of the community staff nurse was blighted by a lack of educational and career opportunities exacerbated as those holding DN qualifications defended their monopoly of assessment practice with reference to their extra educational attainment and experience.

Niven and Scott (2003) and Dowding and Thompson (2003) raised concerns regarding the tasks of prioritisation and delegation that monopolised most of a registered nurse's time.

5.7. Category - dependent upon

5.7.1. Expertise and experience

Core to the discussions regarding intuition are notions of expertise and experience and these are explored by thirteen studies. Luker and Kennick (1995), Richards et al (2004) and Kennedy (2002a) referred to nurses' experiential knowledge base that underpinned nursing assessment judgements. However they did not differentiate between knowledge and experience. Crow and Spicer (1995), Hovi and Lauri (1999) and Richards et al (2004) all noted that expert assessments differed from novice assessments. Crow et al (1995) stated that experts solved problems faster than novices. In their study of subjective predictions of death made by nurses and doctors Marks et al (1991) noted that nurses were more accurate than doctors in these predictions. They suggested that "*experts seem to know what they are looking for*"

and “zero in” which they described as a cognitive response of “*seen it before and recognise it*”. This mechanistic process underpins medical diagnosis and its use fails to explain the reason for nurses’ accuracy in predicting death, as doctors would be using the same cognitive pattern recognition processes. Pyles and Stern (1983) noted nurses stressed the importance of experience in the development of “*gut feelings*” and intuition. Identifying the nursing “gestalt” (see above) as a process, the “*neophyte nurse*” learned from experienced critical care nurses. This process of mentorship of new staff, (Pyles and Stern 1983), has been further eroded over the ensuing twenty years as a result of additional reductions both in trained staffing levels and experienced staff retention.

Clough (2002) tracked thirty-nine referrals for community care assessment and noted the results were “*indistinguishable from assessment for a limited range of social care services*”. This type of assessment would fit into the pattern recognition noted by Marks but by implication is not the SAP intended. Clough concluded Social Services Departments were not translating assessment and care management into practice. Lake and John (2001) also noted the:

“*complexity of context and degree of acuity of nurse patient interaction*”p10

They identified aspects of “*holistic assessment*” while addressing a primary focus on “*physical/medical conditions or diagnosis*” further noting the ability of nurses to gather imprecise information and translate them into “*recognisable fragments of knowledge*”. Lake and John (2001) contrast the type of language used by nurses in assessment and handover to that which is normally used to convey information. They use the example “*stable*” which is not measurable in the same way as “*tallness*” yet has a precision when used in this context. These aspects of assessment offer an extra dimension when compared with a medical diagnosis.

5.7.2. Effective communication

Effective communication comprising speaking, hearing and listening were highlighted as characteristic of facilitative assessment by twenty-four studies. Communication ranged from Birtwhistle et al’s (2002) definition of assessment as:

“*talking or asking specific questions about particular problems*”

to the Lake and John’s (2001) observation, noted above, that the language used in assessment is very different from quantifiable language usually used to give precise

information. Giddens (1977) suggested that all social interactions, including assessment comprised three elements:

“communication of meaning, the exercise of power and the evaluation and judgement of conduct.” Giddens (1977)

Mitcheson and Cowley (2003) carried out ten in-depth conversational analyses of Health Visitor's (HV) health needs assessment visits. They identified good communication as the feature that characterised an empowering approach. The good communication skills identified were those who approached the client with a open agenda and a *“conversational style”*. The *“Exploring New roles in Practice Project”* included guidance on topics including that of effective communication (Read 2005). Mitcheson and Cowley and Read questioned whether or not the Health Needs Assessment (HNA) tool provided a support for empowerment of the patient through assessment or proved an obstacle to meaningful communication.

Clough (2002) concluded that the use of a joint assessment framework served only to *“introduce another barrier to seamless service”*. Richards et al (2004) noted a nurse's ability to make patients feel safe and to communicate clearly important adjuncts to assessment. Kennedy (2002a) identified good communication and putting patients at their ease as ways of establishing *“reciprocal trust and rapport”*. Recording one participant as saying *“once you start chatting with them they start to give you the information you need without even asking”*. Gerrish (2001) found a lack of communication impacted negatively on patient care and Boi (2000) outlined communication problems when using an interpreter. Houston and Cowley (2003) studied the use of a health needs assessment tool with non-English speaking families, highlighting difficulties in assessing this group especially if the HV was culturally unaware. Questions were raised during this study regarding the possibility that HVs were developing a two-tier service as they only addressed needs that were vocalised in a way health-care managers could count. This resulted in the least articulate and the most vulnerable, arguably the neediest, being ignored. An unexpected problem with semiotics occurred when the Edinburgh Post-natal Depression Score was translated for the use of Punjabi speaking women as some translated sentences had no meaning in Punjabi. Sloman et al (2005) found assessment disasters occurred when communication was poor.

Argyle (1988) suggested that non-verbal communication (NVC) was five times more influential than verbal. Mehrabian (2009) identified the following indices for NVC:

- Facial movements
- Gaze
- Touch
- Gesticulation
- Interpersonal spacing
- Posture

Chambers (2003) suggested that much of what we had learnt regarding NVC was learnt in childhood, impacting on the ways individuals interpret NVC cues. Routasalo and Isola (1996) described touch as a form of communication, drawing on the experiences of patients (n=25) and nurses (n=30) from long-term wards in Finland.

Morse et al (1994) drew attention to a nurse's ability to recognise an impending crisis before patients reported their feelings verbally or the monitors showed changes. This they partly attributed to picking up on non-verbal cues coupled with the experience and insight.

5.8. Category - conceptually related to

5.8.1. Self assessment

Griffiths (2005) noted the paucity of research within the area of self-assessment despite its inclusion within the following policy frameworks spanning over fifteen years:

- Community care in the next decade and beyond (DoH 1990a)
- Care Management and Assessment – Practitioner Guide (DoH1990b)
- NSF for Older people (DoH 2001d)
- SAP assessment tools and scales (DoH 2001b)
- Guidance on SAP for older people (DH 2002a)
- SAP for older people: assessment scales (DoH 2004c)
- SAP for older people: assessment tools and accreditation (DoH 2004d)
- Self care – A real choice. Self care support - A practical option (DoH 2005a)

Green and Watson (2005) noted that few assessments contained any degree of self-assessment. Doll et al's (1991) research into patient's responses when using postal questionnaires found evidence of systematic underreporting of problems in face-to-face contacts compared with self-evaluation questionnaires. Herbert et al's (1996) research into the use of postal questionnaires with the over 75 age-group did not find any attributable pattern of differences. However they noted that those who did not

complete the questionnaires were often those most in need. Griffiths (2005) questioned the unsupported use of self-assessment and noted this may involve more, rather than less, professional involvement. Playle and Keeley (1998) described the process undertaken by the patient prior to visiting their doctor as one that commenced with self-assessment of health need and lay consultation with friends and family. In contrast the 2005 DoH circular “*Self care - a real choice*” indicates:

- self-help
- self-diagnosis
- self-monitoring
- self-treatment

As part of the new approach to health, significantly, self-assessment was not included.

Griffiths (2005) cited the NSF for older people (DoH 2001d) that stated that self-assessment would impact positively on care management and outcomes. He also noted a correlation between self-report of global self-related health (GSRH) that measures responses on a Likert or visual scale and actual practice outcomes.

5.8.2. Evaluation of care

Regarding the neglected area of the review of assessment practice, Vernon et al (2000) stated that despite wide variations in the quality of assessment it is “*seldom monitored, and key parts are often missing*”.

Niven and Scott (2003) noted that evaluation of the quality of care was further compromised by the notion of “competent care” described as care of a sufficient quality. Patients however may perceive the quality of caring and interpersonal interaction as the most significant part of nursing practice. Bazian Ltd (2005) reported the notion of competence to achieve a task in their systematic review of four studies of preoperative assessment by nurses. Edwards and Staniszewska’s (2000) literature review into patient satisfaction research from 1990 to 2000 urged reflection on the implicit reasons behind the drive for user involvement and understanding the user perspective. They promoted furthering appreciation of patients’ perspectives over the race to accumulate quantitative patient satisfaction assessments.

5.8.3. Power

Seventeen studies focused on the power imbalance between the health care professional’s repository of expertise and advice, and the patient seeking help. The

knowledge that one group has, and the other seeks, forms the basis for exercising power within the health-care arena. Mohr (1999) noted jargon could be intimidating to patients as the speaker appears pretentious and authoritarian. Johnson and Webb's (1995) covert study of nursing identified the four areas where judgemental labelling of patients took place as:

“*assessing, negotiation, struggling and acquiescing*”. Johnson and Webb (1995)

They noted that assessment was disempowering following “*surveillance*” or information gathering. In their article on non-compliance, Playle and Keeley (1998) coined the term “*benevolent coercion*” applicable to doctor—patient interactions. Mohr's (1999) deconstruction of the language used in the assessment records of twenty-six psychiatric patient found that only 1% recorded anything positive and that over 20% of the recordings were:

“*pejorative 9%, punitive 5%, inane 8% or nonsense 1%.*” Mohr (1999) p057

She concluded that many of the statements made as a result of the assessments were value judgements, often lacking evidence of thought or reflection, and they were of a different order to judgements made for a cardiac assessment. Johnson and Webb's (1995) study involving overt participation and subsequent interviews, suggested there was little evidence to support the notion that nursing is a benevolent process. They saw it as a power struggle and conflict. They noted that nurses “label” patients as a way of exercising normative judgements and once one group has “labelled” another there is an expressed power hierarchy between the judge and the object of judgement.

Niven and Scott (2003) indicated that the structure and culture of the organisation in which the nurse worked influenced all levels of nursing practice. This influence reached beyond resource allocation and was inclusive of moral perceptions and decision-making (Bristol Royal Infirmary Inquiry 2001). Hallett and Pateman (2000) revealed a power imbalance within the nursing teams with assessment seen as a high prestige task associated with power and authority. Bryans and McIntosh (1996) identified that when working with one patient other patients within the DN's case load exercised demands on their time and energies even when absent. Kennedy (2002a) spoke of working within the constraints of DN practice.

The constraints on decision making within assessment exercised by the institutional culture is a thread running through much of the literature (DoH 1989 and 1990, McIntosh 1996, Worth 2001 and Clough 2002). Wright (2003) noted one nurse's comment that assessments would be ignored if they didn't fit in with the care manager's preconceived plan. Kennedy (2002a) stated that DNs needed to know the resources available and encourage patients to pay for care when possible. Gillespie et al's (2002) report for the Kings Fund highlighted the lack of progress towards:

“empowerment, increased choice and patient centred care”. Further they drew attention to the *“intransigence and persistence of medical paternalism”*.

Shattell's (2004) literature review of nurse--patient interaction noted that not wanting to complain caused delay and avoidance in communicating need for some patients. Further that when adopting the sick role, a patient is:

“ a willing passive recipient of care provided by a knowledgeable health care provider. The patients freely give up their power to professionals because they have specialized knowledge that the patients do not have;” Shattell (2004)

Shattell also noted *“professionals willingly accept this power”*. The patient is sometimes attempting two incompatible positions by trying to retain autonomy and self-esteem whilst at the same time appeasing the nurse.

The study of proxy symptom assessment in advanced cancer patient care by Nekolaichuk et al (1999) noted differences between the ratings given to symptoms by patients, physicians and other health-care professionals. However reference is made to:

*“patients' **subjective** expressions of symptoms”* p321 (my emphasis)

The use of the word assessment within the European papers (Appendix 4) and the qualifying adverbs and adjectives used within these articles give a further sense of the range, diversity and ambiguity of its use.

5.9. Summary

This chapter has reported the findings from the Glasarian grounded theory analysis of the literature identified for this study. This analysis of the literature has been presented under the arbitrary headings of the categories identified through the BSP

and theoretical sorting. The core category of the Judicial has been identified and is conceptually represented in all the other categories.

I have made the case that there is little consensus in the nursing literature regarding understanding of term assessment within nursing practice. There are few definitions and fewer standards – and this has become significant as we move towards joint assessments with other health care disciplines and providers

Chapter six will report on the findings from the field work phase of this study.

Chapter 6

Phase 2 findings

Language is the fabric that weaves individual lives in and out of the lives of others.

Hovey and Paul (2007) p58

6.1. Critical Discourse Analysis using a Foucauldian approach.

The CA explored in chapter 5 has exposed the complexity of interpretations of the term *assessment*. As justified and described in chapter 4, a Foucauldian approach to Critical Discourse Analysis (CDA) was used to analyse the data.

Table 6.1 Patient (emboldened) and informal carer participants' demographics

Code	age	sex	marital status	left school	employment	house	pseudonym
C1	62	♂	m	16	white collar	ho	Tom and Babs
B1	84	♂	m	14	retired print compositor	ho	Fred and Mary
B2	81	♂	w	16	retired insurance agent	ho	Mark
B3	67	♀	m	16	book keeper	rents	Linda and Mick
B4	40	♂	co habit	16	manager	ho	Steve and Vanessa
B5	72	♀	w	16	housewife	rents	Ursula
C2	83	♀	s	16	cared for parents	sa	Dorothy
A1	65	♂	m	14	carpenter	ho	Richard and May
A2	52	♀	S	18	lab technician	with parents	Carol Carol's Mum
A3	68	♀	w	14	retired cook	rents	Marjory
A4	62	♂	m	16	driving instructor	ho	Bruce
withdrew							

Key: ♂=male; ♀= female; m=married; s=single; w=widowed; s=separated;
co habit=cohabiting; sa=sheltered accommodation; ho=home owner.

A background to the areas in which the fieldwork was carried out and a vignette of each of the participants is included in Appendix 6. The transcription conventions

used and an extract from one transcription are included in Appendix 7. Table 6.1. shows the demographic details and the codes for each of the transcripts presented within this chapter.

This chapter will present the data and the CDA of the transcriptions of the field work including analysis of secondary sources, such as patients' notes and local and national guidelines pertaining to the observed assessments.

Each extract from the data will be labelled with the code (Table 6.1) and to enable the extracts to remain contextually bound each has a brief description and the line number in the transcript.

Interpretations of the data and commonalities between the findings will be presented. Whilst acknowledging that all of the extracts contain examples of differing discourses, to facilitate their presentation and to give structure to this chapter they are grouped under the headings that represent higher and lower level interpretations.

6.1.1. Surfaces of emergence

Following Foucault (1972) and as discussed in chapter 4, discourse not only relates to the narrative of practice, it also constructs practice itself. The surfaces of emergence identified describe the social relations that constitute the interactions comprising particular aspects of practice. Two main surfaces of emergence have been identified from the data, firstly that of "social power and dominance" and secondly "empowerment" of the individual.

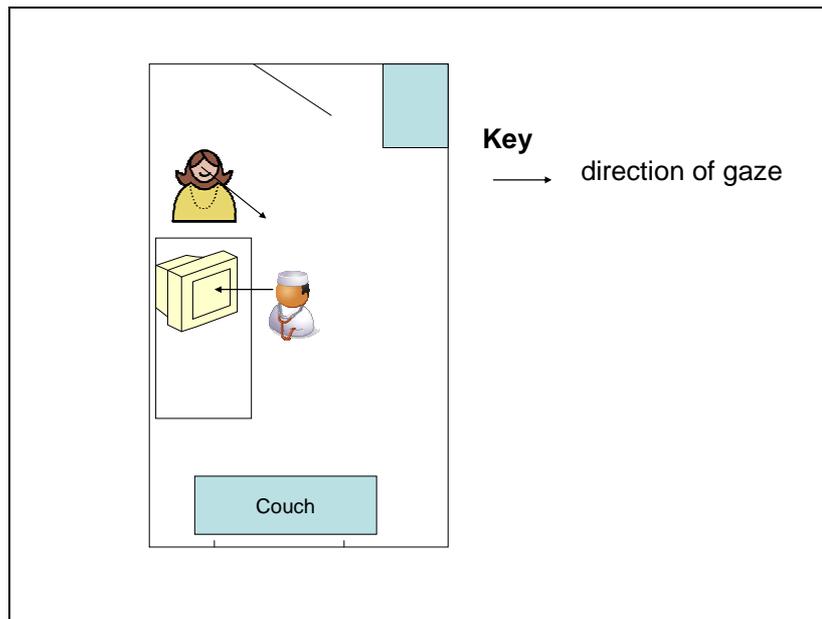
6.2. Social power and Dominance

6.2.1 Discourse of discrimination

Social power is enacted as the nurses in this study are in control of the time, place and the environment of the clinical encounter. Practice and specialist nurses exert control over the setting for the assessment by arranging their consulting rooms or electing to see the patient elsewhere. In the two assessments that took place in NHS surgeries (B5 and C2) both nurses faced and used their computers during the assessment and the patient sat adjacently to their left, facing in the opposite direction

(Figure 6.1). One nurse (B5) deliberately removed her reading glasses and turned to look directly towards the patient whenever she spoke to her. The other nurse (C2) continued scrolling up and down the screen and turned to address the patient only when lifting the patients clothing to see if she was wearing stockings or socks.

Figure 6.1 Position of practice nurse and patient in the consulting room C2



6.2.1.1. Reification

Reification is the changing of social interactions from relations between individuals to a relation between things. In this study objectification of the patient resulted in their discrimination as “other”. Watson (1990) has noted the discourse of nursing knowledge encourages the view of patients and health care problems in this reified way. This practice neither empowers nor includes patients in care delivery or decision-making but constructs patients as labile recipients of care. Examples of reification were found both within the transcribed data and the nursing notes.

The biomedical perspective privileges biological changes within the patient’s body above those of social and environmental factors and this has provided the focus for the software proforma and questionnaires used for many of the assessments. An example of this is taken from assessment C1 where analysis reveals engagement at the micro level, immunisations and blood results and the macro level of the government policy that underpins the Quality and Outcomes Framework (QOF).

Context: C1, interview with the Practice Nurse (PN) immediately following the assessment.

437-**Nurse:** *yes and it is the fact of it that it is QOF tick box as well has she-*
438-*had her flu has she had her pneumonia have we sent off the urine for it*
439-*have- we got that back is it ok umm because the blood results we do*
440-*them 2 weeks before they come in we look at them if there's a diabetic*
441-*issue and it is not something that the nurses can deal with we then feed it*
442-*into our lead GP for diabetes*

Dorothy was objectified as the recipient of immunisations and investigations (lines 438 and 439). This discourse typified a dividing practice (see below) as in the phrases, “*we do them/we look at them*”. “*We*” refers to the staff at the surgery and not to the patient and the nurse. The computerised notes reflected the QOF agenda and did not include patient-directed input.

Micro level analysis of the following extract carried out in the patient’s home provided further examples of objectification.

Context: B4. First visit by the District Nurse (DN) to a terminally ill young father (Steve).

418- **Nurse:** *the category you fall into you’ve got some physical umm*
419- *...needs at the moment OK and this asks us to categorise you*
420- *um.....cos at the moment... where um.. how can you if we can just look*
421- *at the physical issues you’ve got your pick line you’re flushing*
422- *everyday ?*

Steve was reified through the use of “*categorise you*”, and his reduction to an expression of physical and clinical needs “*your pick line*”. Steve was not asked if he understood nor was this categorising explained to him. This objectification, within the discourse, of a human being as “*physical issues*” and a clinical procedure “*your pick line you’re flushing*” demonstrated a nursing judgement based on scientifically derived reductionist categories. This practice exemplifies objectification and problematisation, allowing domination of the patient through emphasis of the disease model. This allowed the nurse to retain knowledge and expertise and, following Foucault, power.

Further examples of reification are provided in the micro level analysis of the data from assessment C2.

Context: The PN continued to look at her monitor as she scrolled down the screen to find a suitable appointment slot. The PN did not look at Dorothy who appeared pale and agitated, as she clasped and re-clasped her hands.

Nurse: *right I think we need to get you to see him only because some of your blood test results have come back as slightly abnormal now it is nothing to worry about but it is just because of some of the medication that you are on the BP tablets can just affect the salts and electrolytes*

Dorothy: *oh yes mm*

Nurse: *in your blood and I think we just need to have a little look at those to make sure that you are back on track again*

Dorothy: *oh (leans forward to try to look into the PN's face.)*

125. Nurse: *I'm saying you don't have to run around the garden waving red flags getting all excited it is just that ...hang on a minute we need to be looking at this*

Dorothy: *mm (Lines 118-128)*

The nurse had noted the changes in Dorothy's blood chemistry results and understood their significance for her long-term health. She followed the protocol precisely, noting the need for changes to Dorothy's blood pressure (BP) treatment regime and made an appointment with the doctor to facilitate the change, "*we need to get you to see him*". Her use of the terms "*we need*", can be interpreted to show that she is using the power of her position within the practice, she has used *we* rather than *I*. Secondly she has used *need* which denies the patient the legitimacy of a refusal as this is an imperative rather than a preference. Dorothy is excluded from the discourse as "*get you*" reduced her to a passive object that can be framed as a recipient of care. The final words "*see him*" can be interpreted to show a familiarity, as the nurse has said this rather than see the doctor. Within this short statement the nurse has demonstrated her power through, her social identity as a nurse, her knowledge as a skilled person able to decide Dorothy's options and her influence as a team member able to facilitate her consultation with the GP.

The reason given for Dorothy to see the GP, "*only because some of your blood test results have come back as slightly abnormal*", are significant. "*Only*" implies that if Dorothy's blood tests had remained "*normal*" she would not see the doctor whose

role was delineated as the expert who will rectify this abnormality. However the objectification of Dorothy's position, someone with slightly abnormal blood results, has framed her as the subject of the discourse of abnormality, not as a person with anxieties regarding their investigation results. The assertion that they are "*nothing to worry about*" served to further entrench Dorothy as a passive recipient of decisions made by professionals and inhibited her from raising concerns at this stage.

Later in the assessment the nurse proceeded through the proforma:

Nurse: *okhow have you been feeling in yourself not just diabetes wise but generally*

Dorothy: *oh fine except I'm um hmm very tired*

Nurse: *right*

Dorothy: *I sit down and sort of go to watch television and ...um ½ hour later I think um oh what was that all about ha ha*

Nurse: *and is that something new or has that just been a progressive thing*

Dorothy: *I think it has been progressive*

Nurse: *because as I say it is not anything drastic it is just that the salts and electrolytes are slightly out of kilter, your BP is absolutely fine so what he may want to do is just to change your BP tablets slightly*

Dorothy: *oh*

Nurse: *and just see if we can get those blood tests back on an even keel and he will more than likely... get you to come back in a week or 2 weeks to have another blood test done to see if the changes so let me just ... (Lines 133-151)*

The nurse's agenda was defined by the proforma provided by her computer programme. This had her gaze and her attention. The interaction with Dorothy was confined to noting some responses. During the 28 minute appointment Dorothy was never invited to ask questions and her anxiety regarding feeling "*very tired*" was dismissed by the nurse with the comment "*because as I say it is not anything drastic*". The nurse did not explicitly explain that Dorothy's tiredness was probably linked to changes in her blood chemistry.

It may be argued that the nurse was disempowered by the attention she was required to give to gathering "official knowledge", which was prompted by the computer software. The attention given to the computer screen and the intrusion of entering data is an example of the privileging of written discourse over the oral discourse. The

NMC (2009) emphasises the requirement for nurses to engage with the written culture, either paper based or electronic, that they see as core to the delivery of “safe and effective care”, further enabling the audit of nursing practice and the provision of evidence of care delivery. However, by raising the status of the written discourse nursing’s predominantly oral culture is denigrated.

The nurse’s incomprehensible statement (Line 125 penultimate extract above) was given in response to the patient’s facial display of anxiety (*the field notes indicate Dorothy looked pale, leant towards the nurse trying to look into her face*). The metaphor of *red flags* and their association with danger is misplaced as Dorothy is already concerned because of her “*slightly abnormal*” blood test results. This obscuration within the discourse may be interpreted as a device to distance the encounter from engaging with the implications of the test results. However they allow the patients’ anxieties to be acknowledged but dismissed without discussion. This may be partly due to the constraints imposed by keeping to set appointment times.

6.2.1.2. Normalising judgement

Normalising judgements exercise power over those who are judged by creating, as their objects, the standards against which categories are measured and found acceptable or in need of correction. For a patient to be examined or any investigation performed implicitly there must be a set of cultural or clinical parameters that define normality for a given population. Comparisons made between the patient and what is accepted as the norm extend beyond clinical parameters to include institutional expectations of behaviour and deportment. Authorities and their agents discriminate against individuals who are “other” than the norm, for example in Foucault’s (1977) binary divisions of mad/sane; normal/abnormal. Once identified as being “other”, sanctions, instruments of disciplinary power, are applied to correct the aberration and examples of these were found within the observed assessments.

Context: A3. The DN visited Marjory, at her home, to dress her leg ulcers. On arrival Marjory was watching television in her lounge/dining room and the DN asked if we might move to the bedroom to change her dressings.

Nurse: *so it was 21 ½ stone wasn’t it cos they needed the weight in order to order the chair didn’t they and weight is always a good guide line obviously and you are quite good with your diet now aren’t you*

Marjory: *yes*

Nurse: *so you do eat quite wellso that is lovely rightwe will go back to your wound your wound isn't quite so macerated as certainly it was it is drying up there it is a little bit macerated there but not too bad* (Lines 344-347)

Eating and drinking have become part of a moral discourse constructing meals as *diet* and dividing good from bad foods and good from bad diets. In extract (A3) the DN made a normalising judgement that Marjory's was "*quite good*" with her diet despite her weight being reported as 21 ½ stones.

Context: A3 later the nurse referred to Marjory's un-ulcerated leg.

Nurse: *see that piece here that is your previous leg ulcer*

Patient: *right yes*

Nurse: *and that damage will always be there and you need to sort that out*
HYDRATE IT (nurse raises her voice and then sighs) (Lines 608-610)

The normalising judgement regarding Marjory's healthy leg demonstrated an extension of the nurse's agenda. Her remit moved from treating the ulcerated leg to a proactive agenda following surveillance of a healthy limb. This showed power exercised through surveillance and correction with the emphatic advice, containing the technical term "*hydrate*", contrasting with the vernacular expression "*sort that out*". This is an example of intertextuality, an instance of using scientific or medical discourse to add gravitas to the vernacular message "*sort it out*". Further it was implied that it is Marjory's responsibility to prevent further ulceration by hydrating her skin. Other instances of intertextuality will be identified and interpreted later in this chapter.

A further normalising judgement was made regarding the type and amount of exercise reported by Ursula.

Context: B5 Ursula's appointment with the practice nurse was for a routine assessment of her asthma.

Nurse: *yes and do you take exercise?*

Ursula: *well I clean my daughter's house every day*

Nurse: *well that is good exercise*

Ursula: *and look after all 4 children*

Nurse: *you do very well*

Ursula: *do the cooking, cleaning and washing*

Nurse: *yes yes yes you're VERY active*

Ursula: *ride my bike* (Lines 34-41).

The nurse's normalising judgement regarding exercise contains the moral imperative "good". Perhaps here "good" was used to indicate where housework would be placed on a continuum from exercise that has little effect on the body to beneficial exercise.

Both the nurse and Ursula repeatedly cut across each other's speech which demonstrated both parties' attempts at controlling the interaction. This could be because there were conflicts of expectations regarding these agency pairs. The nurse prompted, by the on-screen proforma, could expect a "yes" or "no" to her questions. This is suggested by her attempt to move the discourse forward by responding "*you do very well*", whereas Ursula was keen to individualise her answers and described the extent and type of her exercise. These interjections and normalising judgements are overt displays of power and assertions of authority. Freidson (1970) suggested that lay health professional interactions could be typified as a conflict because they comprise this "clash of perspectives".

Context: A2. The nurse answered the researcher's interview question regarding Carol's pain and the adequacy of her prescribed analgesia.

Nurse: *she desperately does and it is something I am going to have to tackle at the surgery cos they are not always...[] well I was thinking in the past in C (area the nurse worked in before) we would have used [...] and I was thinking they would be brilliant for Carol cos again the GPs they are not here they are not seeing what we are seeing and Carol is not the kind of lady that cries for nothing* (Lines 747-752)

The nurse, new to the area, stated the need to "tackle" that suggested she was anticipating a problem getting effective analgesia for Carol. She made a normative judgement regarding Carol's reaction to pain by asserting that Carol was "*not the kind of lady that cries for nothing*". This suggested both that in the nurse's judgment there were some "*ladies*" who do cry for nothing but in this case Carol was deserving of pain relief. Although she had misgivings regarding the GPs' assessment as she noted, "*are not seeing what we are seeing*". This exemplified reliance on surveillance and observation that was indicated in much of the data will be explored later in this chapter. This extract raised issues of patient advocacy since the nurse was interceding with the GP about pain relief for the patient. The discourse of patient

advocacy has both moral and practical dimensions that will be discussed in the following chapter.

The third research question for this study explores the impact that assessment has on patients. The data suggested the nursing response to normalising judgements regarding social class and educational attainments of their patients would seem to be of significance to their practice and thereby to the impact felt by patients. This example comes from assessment A2;

Context: Interview with nurse following the assessment.

Nurse: *Carol is a very educated lady* (Line 765)

It is significant that the level of Carol's education was seen as relevant and deserving of comment. The adjective "very" has been added to emphasise Carol's attainments. This can also be framed as a dividing practice, with those deemed by the nurse as educated to be distinguished from those not seen as educated. This begs the question in what way do perceptions of education levels influence care?

This next example could be interpreted as indicating that the patient was aware the DN would pass normalising judgements regarding his financial status.

Context: A4. Bruce talked about his quandary regarding compensation from the institutions for what he perceived as poor and detrimental treatment.

Bruce: *but of course we are all short of money more or less but if a bill comes in I don't need to worry about it...*(Lines 386-387)

Bruce made the case that he was not in need of money and therefore his primary reason for making a complaint was not financial compensation. Later he explained that he wanted acknowledgement of his grievances and an apology although using "probably" suggested he did not rule out a financial settlement.

Bruce: *I feel really I have always felt that if ... whoever it was that was in charge just admitted that they had made a mistake ...and they was in charge and itwas a huge mistake andcan I be forgiven and I will try my hardest for it never to happen again then I'd say probably yeah* (Lines 663-666)

In the first statement Bruce established his financial status and thereby his capability of not having financial motives for raising the complaint.

From assessment B 3, Mick, who had given up work to care full-time for his wife Linda, tried to establish status based on his former employment.

Context: Mick described his problems when helping Linda to use a female urinal in the prone position. The nurse and Linda gently laughed at his predicament as he suggested the female urinal was ill designed.

Mick: ***SHUT UP**..... I've been an engineer for some 50 odd years...* (Line 938)

Mick called upon the power he felt explicit within his previous status, as opposed to his status as a carer, responding with aggression to shout “**SHUT UP**”.

Both Mick and Bruce needed to establish status and thereby respect by the establishment of a persona other than their present framings of patient and carer.

Assessment C1 provided an example of a normalising judgement regarding class behaviour.

Context: The DN asked if Tom had stayed in the respite-care facility describing why he might like it.

Nurse: *that's fine and that's fine and I mean they have um they have like a drinks trolley and stuff over there you know*
(Lines 853)

The normalising judgement that Tom would enjoy socialising and having a drink was offered as an inducement to stay at the hospice in order to achieve the nurse's un-stated agenda of giving Babs a break. By not listening to Tom (Line 851) the nurse had incorrectly judged him to be a man who would be attracted by the offer of alcohol in an institutional environment.

Tom: *I tend to be a bit of a loner, myself* (laughs) (Line 851)

6.2.1.3. Physical geography

In addition to the power relationships manifest within the discourse other factors served to reinforce the domination of the nurse. Figure 6.1 illustrates the seating

arrangement used by both participating practice nurses. At the meso level the ritual of assessment consultations and the formats in which they were carried out have roots within medical practice. The practitioner taking the dominant position, seated at the desk, whilst the patient had a subordinate position to one side. Both practice nurses were able to turn to their right to make eye contact with their patients. However the one nurse (C2) chose rarely to do so, with the patient at one point leaning forward in an attempt to catch the nurse's eye. I will return to the significance of eye contact below.

In assessment C1 Tom's wife Babs asserted her power as the householder welcoming visitors to her home and offered tea or coffee. She also directed the nurse to a specific seat enabling her to sit between the nurse and husband, a physical metaphor of her role as intermediary throughout the assessment.

Each of the extracts given have a multiplicity of influences that can be uncovered during CDA and in the next section a selection of those displaying the biomedical model, the dominant paradigm of the discourse of natural science (Kuhn 1962), are explored.

6.2.2. Discourse of natural sciences

6.2.2.1. Standardisation of approach

The standardised approach through the production and use of questionnaires and proforma, owe their premise to practices within the natural sciences. As discussed the intention of using a standardised tool is to enable a novice to carry out tasks in the same way as a more experienced practitioner. A standardised proforma was used as the nurse recapped Dorothy's situation.

Context: C2. The nurse read aloud as she entered the data.

Nurse: *um nowlet me just ... mmmso (inputting into computer)
oops ...so you are feeling more tired recently*

Dorothy: *mmand I am so slow*

Nurse: *ha ha*

Dorothy: *I can't walk it is terrible*

Nurse: *is that because it is painful or just because... ?*

Dorothy: *no ...the legs won't go*

Nurse: *ha ha the mind is working quicker than the legs**

Dorothy: *yes*

Nurse: (inputting into computer) *-no more hypos .. main meal at lunch time....so you are* (Lines 194-203)

Dorothy again expressed her concerns regarding walking and fatigue; however she remained unheard as the nurse received prompts from the proforma regarding hypo and meal plans. There are two interpretations of the nurse's phrase in line 200* firstly that it is to reassure Dorothy by down-playing her concerns by using humour. Or that it is dismissive of Dorothy's concerns and enabled the nurse to avoid discussing them. Additional examples of the uses and significance of humour and laughter are given under the heading *Interactional devices*.

6.2.2.2. Nursing notes

In C1, B4, and A1 the nursing notes contained references to the use of the national Gold Standard Framework (GSF) (DoH 2005b) as a designation for the standard of care delivered to people with cancer. This lists the 3 processes of the GSF as:

"- all involving improved communication, are to:

- 1. **Identify** patients in need of palliative/supportive care towards the end of life*
- 2. **Assess** their needs, symptoms, preferences and any issues important to them*
- 3. **Plan** care around patients' needs and preferences and enable these to be fulfilled, in particular support patients to live and die where they choose"*

www.goldstandardsframework.nhs.uk/ accessed 22.07.08

Macro level analysis of this secondary data leads to consideration of the lexical power of the designation Gold which erroneously implies silver and bronze standards. Without this hierarchy the standard could just be called the Service Cancer Plan. Gold is an example of a simulacrum as it implies that this is the highest level with no other levels.

Further, using standardised models as a substitute for knowledge and experience remove treatment from the specificity of individualised care to the norm of standardised care.

At the micro level, information recorded in the nursing notes during the assessment are repositories of power, as patients are objectified within the discourse and the

notes themselves can be seen both as an aide memoir for the present but are also a record for the future. Foucault (1972) noted written records were:

“ no longer a monument for future memory but a document for future use” p191.

The power within nursing notes is established as they are legal documents and their format and contents are prescribed by the NMC (2009), relevant Trust and national guidelines. They are written from a point of view that problematises ordinary aspects of daily life framing the status of everyday events as part of the medical or clinical discourses. Foucault wrote that all the mechanisms of power are highly ritualised because:

In it are combined the ceremony of power and the form of experiment the deployment of force and the establishment of truth. At the heart of the procedures of discipline it manifests the subjection of those who are perceived as objects and the objectification of those who are subjected.
(1985: 184)

Roper et al (2000) “*Activities of daily living*” model was used in all of the hand written nursing notes. This model ranges over five domains:

- physiological
- psychological
- socio-cultural
- environmental
- politico economical.

Once identified within one of these domains clinical significance is given to everyday activities. For example everybody eats and drinks but patients have diets and fluid intake. This formulaic approach with objectified responses is exemplified in the notes from assessment C1. The entry statement for the box commenting on the patient’s sexuality read:

“has two grown up sons”. Patient’s nursing notes C1

This epitomised a lack of nursing engagement with the lived experience of the patient. Suggesting that once a person becomes a patient they are normalised as “other”. Their behaviour and appetites are noted, controlled and became a part of a medical discourse. Their body is reduced to the habitus of their disease and is a matter for clinical regulation, correction, treatment or cure. Sexual or other appetites are for the well. Food and drink become nutrition; exercise and social activity are no

longer for pleasure and fun but to lower cholesterol or blood pressure or avoid depression.

An example of user inconsistency, mitigating the intention of standardisation, was identified in the interview following assessment C2. The nurse explained her rationale for missing parts of the QOF.

Context: Interview with the practice nurse who justified her approach to the assessment

Nurse: *...I didn't ask the depression questions of this lady because she has had them asked before but we make there is just a mental tick box that you that's been done already don't need to do that with her feet I just took the decision that I wasn't going to fight with her stockings. I'll pick a more opportune time so. but it is those kind of things we just have to be sure that they have actually been ticked off as well and because the lady is on insulin we want to talk about injection sites and how much insulin is she actually taking. (Lines 455-461)*

The practice nurse made the decision that if Dorothy was not depressed before there was no need to ask how she was feeling now and so this aspect of the assessment was missed. However depression in older people, and people with diabetes, is more prevalent than in the whole population (Anderson et al 2001). Also although the proforma prompted the nurse to assess foot health and injection sites she chose not to as this would have involved extra time while the patient took off her stockings, "*I wasn't going to fight with her stockings*". Timely treatment of ulceration, soreness and redness of the feet of a person with diabetes can avoid amputation (National Institute for Clinical Excellence 2004). Visual examination of injection sites is also essential to avoid frequent use of pain-diminished areas where there is a probability of depots of insulin collecting which cause sub-optimal glucose control (National Institute for Clinical Excellence 2004). For these reasons the prompts are put into the QOF with the expectation that they will be carried out. When they are not patient care can be compromised.

It could be interpreted that the nurse was trying to individualise the proforma and felt that Dorothy would have raised these issues if they were important to her. However there are implications as any audit of care following an assessment would presume

these areas had been covered. This could result in the next assessment missing these topics as it was felt they had been covered a few months before.

6.2.3. Discourse of repression

6.2.3.1. Body language

Passivity may be interpreted through verbal and body language and it was noted as expressed through body language on 43 occasions as patients:

- sighed (C1, B5, C2, A4),
- shrugged (C1, A4, B5, A2, B1)
- looked down (C1, B4, B1, C2)
- avoided eye contact (C1, B1)
- crossed their arms (B1, A4, A3)
- looked away (B3, C2, A3)

6.2.3.2. Eye contact

The significance of eye contact at the micro level is two fold. Firstly it has been shown to encourage the patient to ask questions (Heritage and Maynard 2005). Secondly the Foucauldian (1973) notion of the “gaze” implies assessment or examination made through visually or olfactory attention or by touch.

This was evident within the practice of the district nurses who visited patients’ homes. As they carried out procedures patients were sitting or lying on low furniture that necessitated the nurses kneeling on the floor in front of them, a subordinate position. The nurses frequently looked up to speak to the patient making eye contact (field notes assessments – A1, A2, A3, B1, and B4). Judgements made regarding their patient as a result of this sensory assessment were based on expert nursing knowledge and therefore power that reasserted their authority.

Body language can also be empowering and instances are reported later in this chapter.

6.2.3.3. Biopower

Foucault (1977a) used this term to designate surveillance of bodies and populations. Biopower focuses on the body as a machine and contains elements of observation,

discipline or correction. Foucault (1977a) noted the techniques used were not overt oppression but the production of the “docile body” was achieved through “improvement”, self-examination and self control that equates in UK healthcare with making the “right choices”. Instances of bio-power are given as part of the discourse of repression.

Following Foucault “*power and knowledge directly imply one another*” (Foucault 1977a p27), and therefore the withholding of knowledge by the nurse keeps the power balance in her favour.

6.2.3.4. Missed opportunities

The following four extracts provide instances of missed opportunities. Firstly the DN’s first visit to Steve since his diagnosis with advanced carcinoma.

Context: B4. The nurse completed the documentation regarding Steve’s medication.

1. **Steve:** *and with the chemo it is like steroids isn’t it*

Nurse: *ok*

Steve: *and so you’ve got the 2 fighting each other... terrible*

(Lines 102-105)

Later when the nurse asked about Steve’s employers, Vanessa answered;

2. **Vanessa:** *so they just want him to sit back and get well* (Line 401)

Further the nurse asked about their domestic arrangements;

3. **Vanessa:** *we’ve lost the chef*

Steve: *mm*

Nurse: *you’re on the sick are you ha ha*

Steve: *mm*

Vanessa; *hurry up and get better* (Lines 586-590)

And towards the end of the assessment Steve again expressed his concern regarding his dramatic weight loss;

4. **Steve:** *I’m sure I’d be able to do something if I could put some weight back on*

Nurse : *mmm*

Steve: *cos this is you know what I mean this is getting me down*

Nurse: *mm has anything changed*

Vanessa: *last night*

Steve: *I've lost 3 stone*

Nurse: *OK (Lines 642- 648)*

Throughout these interactions Vanessa and Steve made it clear that they did not fully understand Steve's prognosis or treatment. Steve was under the impression his symptoms were due to the interaction of chemotherapy, which he described as a type of steroid, and other medication. He did not understand the reasons for his weight loss as evidenced in extract 4. Excerpts 2 and 3 demonstrated that Vanessa was under the misapprehension that Steve would make a recovery. The nurse did not challenge these errors or suggest that this was an area they might discuss in a subsequent visit.

In the interview following the assessment, the nurse acknowledged Steve and Vanessa's need for information:

Nurse : *I think it's a forum to come out with the emotional things that went on with the initial diagnosis and treatment and I think that that is something that needed fielding then at the time and I don't think you can focus on the patient and the holes in the patient it is the whole patient isn't it .(laughs) no I mean I was under the impression it was going to be quite a complex and involved ...situation anyway um...yea they flitted about a bit didn't they he was talking about this and talking about that but um I just felt very sorry for him I mean the um loss of the role it just came across really clearly um I mean that is something that we will probably have to put a bit of time into and that is possibly something you can talk about when you have the diversion of doing a dressing(Lines 1058-1069)*

The nurse was clearly sensitive to Vanessa and Steve's situation; she noted their confusion remarking that they "*flitting about a bit*" but focused on Steve's loss of role as breadwinner. She indicated in the first 4 lines that she regarded explanation of Steve's diagnosis, prognosis and treatment as something that should have already been done. However she observed that the family demonstrated their need for information in order to make sense of their situation. In a visit lasting over an hour there was no reference to cancer, tumour or diagnosis. It is of note that the nurse offered only monosyllabic responses to the Steve and Vanessa's statements regarding their misunderstanding of their situation. By withholding her expert

knowledge the nurse retained power and failed to empower her patient and his family.

An alternative interpretation could be that the nurse felt it inappropriate to discuss topics of prognosis or to directly answer Steve and Vanessa's questions. She spoke of using the "*diversion of doing a dressing*" whilst covering difficult topics. However the visit had included a dressing that she had not used as a diversionary technique.

Evident within this interview was the emotional input the nurse made in everyday practice when she said "*I just felt very sorry for him*". The concept of emotional labour is something I discuss in chapter 8.

Another missed opportunity is taken from assessment B3.

Context: Linda, now paralysed from her chest down, was left alone when Mick went shopping. Mick taped a microphone and mobile phone to Linda's nightdress and an earphone to her ear. She could depress the button of her phone, which was programmed to ring Mick, and call him home. Both were adamant that there was no-one to stay with Linda:

Nurse: *time and there's no one else you can ask*

Mick : *no*

Nurse: *just for that time*

Linda: *no ..no.....everybody we knew*

Nurse: *yes*

Linda: *won't come*

Nurse: *right*

Mick: *were in the position again even if there was someone here*

Nurse: *yes*

Mick: *I do not think they could get her up*

Nurse: *right NO no that's right (Lines 1091-1100)*

Mick showed on several occasions that he was reluctant to involve others in Linda's care. Further the nurse missed an opportunity to suggest that it would be helpful to have someone with Linda despite their not being able to lift her, as they could call Mick. It was important other people became involved in Linda's care as there were several instances, given below, when the tensions, exhaustion and disappointment felt by Mick influenced his relationship with Linda.

Context: Mick outlined the problems he had with helping Linda.

Mick: *If you're feeling rough and she says she wants to go to the toilet and you're getting her and she keeps saying quick quick oh wait wait quick quick wait wait OH Jesus*

Linda: laughs

Mick: *oh shut up and get on with it I even tried it upside down do you know that that is more(Lines 931-934)*

Mick described the urgency of response demanded as Linda became more and more dependent on him for all of her needs. He sometimes did not feel able to respond to her, "*if you're feeling rough*". He raised his voice and shouted at Linda in response to her laughter. Although the tension between them built throughout the assessment the nurse did not address this with them on any level during the assessment. She stated in the interview:

Nurse: *I was very worried that umm you know she might find it distressing so um I felt that some questions were may be a little bit irrelevant at this moment in time but on the whole I felt the interview did go well (Lines 1394-1397)*

And later;

Nurse: *they are coping admirably they are such an inspiration to the nursing team (Lines 1410-1411)*

6.2.3.5. Value-laden words

Words in everyday use can convey inherent meanings of repression or passivity. In the data *obviously* was used 73 times in 9 of the assessments and *actually* was used 113 times in all 11 assessments. The power inherent in these words comes from the contexts in which they are used. Lexically the use of *obviously* can be seen to exclude patients or carers from the discourse as it is very difficult for them to question any assertion that is framed within the discourse as obvious. To do so would suggest they were ignorant or being awkward as they would be questioning something which is beyond question, obviously. In assessment C1 *obviously*, *actually* and *as you know* are being used to demonstrate the nurse's power by association with Mary as they are both members of the same team.

Context: The nurse is trying to re-establish herself as Tom's nurse in place of Mary who was withdrawn for macro-political reasons.

Nurse: *It's funny actually because Mary did say something to me about that because obviously we very much communicate with the team as you know.*
(Line 162-163)

This statement framed the patient and carer as passive recipients of care delivery within their own home. It deliberately failed to engage or include them in any discussion of the changes. Later in response to questions regarding Mary's travelling to visit Tom the nurse dissembled.

Context: Babs asked if the reason Mary was being replaced was the distance she travelled.

Nurse: *Oh absolutely we work as um, we very much work as a locality, so obviously we've got the Ambridge surgery there's.....(Lines 654-656)*

Again knowledge and power regarding the planned changes and the macro political manoeuvres were denied to the patient and carer who were unable to comprehend the reason for the changes and yet were intimidated by the language used and did not raise an explicit challenge.

Context: In assessment B3 the nurse questioned Mick and Linda regarding respite care provided by the Motor Neurone Association (MNA).

Nurse: *... is that right have they actually started that for you?* (Line 111)

Mick had cancelled the respite care for financial reasons. The nurse used *actually* to indicate whether the respite care had progressed from a proposal for the future. Passivity was indicated with the use of the words "*started that for you*" as if Mick and Linda had no part to play in this.

Context: In assessment A3 the nurse (*blushing*) responded to the patient's observation that her blood test results were three weeks overdue;

Nurse: *right we need to chase that up really I think obviously we hope that it is all OK* (Lines: 230-231).

The use of *obviously* and *really* form a smoke screen in order to reduce the patient's annoyance that the test results have not available and that there is a potential for sub

optimal treatment. The nurse used *we* to distance herself and leave Marjory in a passive role waiting for her results.

Context: Assessment C4, the nurse gave reasons why a patient's medication might be stopped when transferred between hospitals.

Nurse: ...*something will happen to them like an acute episode of something and they will admit them and the hospital just stops all medications straight off because they have got them there and they can monitor them 24 hours a day and see because I don't think it is anybody's fault but quite often a doctor will see you and he will put you on medication and then 18 months later he might see you for something else and put you on something different* (Lines 504-509)

Patients were described as "*having something happen to them*" and "*put you on medication*" emphasising their labile role. The normalisation of the cessation of his medication was achieved as the practice was framed with reference to "*they*" and "*them*".

The use of *we* and *they* in the last three extracts are examples of excluding and dividing practice and I shall move on to discuss this as an example of the repressive discourse.

6.2.3.6. Excluding and dividing practice

Micro-level analysis of *we* or *they* demonstrate objectification of the patient, nurse, or carer, locating them within a specific social situation or subject position, as part of a group of individuals understood in a particular way. The group once constituted can be subjected to specific discourses and practices. Examples are available from all of the transcribed discourses when, for instance, nurses refer to themselves as "*we*", as in the extract from A3 above where *we* indicated membership of a group privileged and distinct from patients and members of staff from other disciplines or other parts of the institution who are objectified as "*they*". This further example is from assessment B4;

Context: The nurse struggled to remove a dressing put on at the local hospital.

Nurse: *they've really put this on to stay didn't they* (Line 171)

The nurse distanced herself from responsibility regarding the struggle and subsequent discomfort as she removed Steve's dressing by indicating that someone other, "they", put the dressing on.

In B5 the practice nurse identified herself with the group with expert knowledge by using a medical discourse.

Context: The nurse corrected the patient's description of her symptoms;

Nurse: *when you're having what we call an exacerbation* (Line 46)

This problematised breathlessness, described by the patient, by framing it within the medical discourse as "an exacerbation" which the group of experts "we" understand and name.

In A2 the nurse assessed Carol's analgesia:

Context: Carol's leg ulcers caused her excruciating pain that had interrupted her sleep.

Nurse: *"Is it because it has helped you sleep (slight laugh) is it because it makes you drowsy or is because it is actually helping the pain"* (Lines 32-33).

Actually is used to differentiate between the side effect of drug or the analgesic properties of the drug. This begs the question that if the pain was keeping the patient awake and now she is sleeping (which she associated with the medication) does the technical reason matter. The nurse is exercising power through her professional expert knowledge of pharmacodynamics and pharmacokinetics.

The construct of the patient as someone outside the norm of the general population was highlighted in C1.

Context: Babs told the nurse that she had a heart attack the year before Tom's diagnosis with cancer.

Nurse: *are you still having any sort of regular checks or do you have a sort of clean*

Babs: *No*

Nurse: *slate* (Lines 754-756)

The use of the value laden descriptor “*clean slate*” is associated with being in debt. This revealed the nurse’s pejorative discrimination between the ill who have things recorded about them and are indebted, and those who are well or have recovered.

Further exclusion was found regarding the nursing notes, which in eight of the eleven assessments remained in the patient’s home, although in assessment B4 a second set of notes was held at the office, and in two cases sets of notes were taken away to be “written up”. The computerised records were not shared with the patient.

Context: B4. Having completed the dressings the nurse commenced the assessment paperwork.

Nurse:*this is our basic paperwork now this one’s quite new but this basically what it covers all your background details OK just about you, your family things like that um so I’m going to use this as a starting point to go from and um we will just go through and as it goes on this... this is a nurse model we just use that to see how things are and we just talk around that OK?*

Steve: *yep*

Nurse: *well we leave the notes in your house... so these are obviously all about you so there is nothing secret there or private...the front page is... all about contact details and I am sure they told you that when they discharged you OK so that gives everybody on our team*

Steve: *right yep*

Nurse: *because if you ever rang for a referral you might end up seeing one of them and OK but we all do work as a team so and we hold some notes at the office as well so this is just a copy and then anyone should be able to either answer any questions or... or hand pass them on to us so (Lines; 254-268)*

It is of note that the nurse used the words “*secret*” and “*private*” regarding the patient and his care. Information recoded in the notes is of course private and confidential. I interpret that the nurse referred to the patient’s access to the nursing comments and any differences in the notes kept back at the office. Analysis of the statement “*hold some notes*”, suggests that by using *hold* she implied a legitimacy for this practice which both the Data Protection Act (1998) and local Trust policy precludes. *Some notes* may suggest that these are different to the notes left with the patient, as, “a copy of your notes”, would be more applicable. The nurse “repairs”, (corrected her statement, realising what she said was not what she intended to say), at *hand* ..

pass. *Hand* has finality whereas *pass* suggests a sharing between the members of the nursing team.

It is also significant that in all areas the notes are referred to as “nursing notes” rather than “patient notes” or “patient records”. They are the patient’s property and it is excluding, and following Foucault where knowledge equates with power, disempowering, to keep information at a place where patients cannot access it.

The nurse made the point regarding continuity of care when she stated that the notes held at the office would be useful for a member of the team who was to visit a patient they did not know, although the nurse could read the notes when she visited the patient’s home. However this would suggest that she knew less about the patient than others did which may have implications for the nurse’s confidence and the patient’s trust.

In assessment C1 all nursing notes were kept at the nursing office and were never seen by the patients. The nurse reported, in the briefing preceding the assessment, that this was because the notes might contain:

Nurse: *“things the nurses wouldn’t want the patient to see”*

However Tom’s notes contained little he and Babs would not already know. The differences were in the tone and language in which they were written; for instance the notes contained comments recording nurses’ normalising judgement about the degree of support offered to Tom and Babs by their adult sons. Such comments were not made in any notes that remained with the patient.

6.2.3.7. Intertextuality

Intertextuality describes where a discourse specific to one area appears in another. It is seen as interdiscursivity and is of significance within CDA (Wodak and Meyer 2002). Intertextuality may be described in three ways:

- Sequential, when language from different discourses alternate within the same text
- Embedded, when one type of discourse is within the matrix of another.
- Mixed intertextuality, where different discourses merge and are difficult to separate.

It is of consequence to identify which genres, styles or discourses are juxtaposed with each other and why they may be used in that way.

The data provides 35 instances of significant intertextuality, for example as identified in C2, the nurse sequentially interchanged between colloquial speech and the medical discourse of assessment;

Context: The practice nurse informed Dorothy that her last blood test showed some changes in her blood chemistry.

Nurse: *it is not anything drastic it is just that the salts and electrolytes are slightly out of kilter, your BP is absolutely fine so what he may want to do is just to change your BP tablets slightly*

Dorothy: *oh*

Nurse: *and just see if we can get those blood tests back on an even keel and he will more than likely... get you to come back in a week or two weeks to have another blood test done to see if the changes so let me just ... (Lines 143-151)*

Colloquial phrases such as “*slightly out of kilter*” and “*on an even keel*” are at odds with “*salts and electrolytes*” which are from the medical discourse. Out of kilter means out of alignment and the sailing reference regarding an even keel is a metaphor for balance. The significance of this sequential intertextuality as using the vernacular may be a device to lessen Dorothy’s anxiety. The nurse may identify that Dorothy can better understand terms outside the medical discourse. However it could be interpreted as showing the nurse’s anxieties regarding Dorothy’s blood chemistry results and the implications that these may have for her health and prognosis. This intertextuality also demonstrated the hierarchy within the assessment process as the nurse showed her ability to use both the clinical and vernacular discourses.

This example of embedded intertextuality is taken from C1.

Context: The nurse (Kay), who it was proposed would take over Tom’s care, incorrectly identified Oromorph as his main analgesia, which he corrects.

Nurse: *Oromoph is it?*

Tom: *it's a different thing all together you take 4ml... with a syringe you put it into a drop of juice.....* (Lines 204-206)

During this tense assessment which had a meso political sub-agenda of replacing Mary, Tom's usual and much admired nurse, with Kay. Kay tried to establish this change as natural and normal and justify her position as having been involved with Tom's care through meetings and briefings. By correcting her "*it's a different thing all together*" Tom made the point that he had more knowledge of his current care regimen, and following Foucault, the power balance swung towards him. He embedded the descriptor "*4 ml syringe*" within the colloquial matrix of a recipe format to demonstrate that he also had technical expertise and knowledge of his analgesic preparation.

In assessment B4 Steve embedded a discourse from drug abuse culture into his vernacular use of language.

Context: During the assessment Steve and Vanessa are discussing his reaction to chemotherapy.

Steve: *yes that's when it all kicked together* (Line-76)

Steve and Vanessa were both traumatised by the sudden change in their circumstances brought about by Steve's illness. He used the phrase "*kicked together*" to try and show that he understood the effect the chemotherapy was having on him and through demonstrating knowledge to exert some control over his situation.

6.2.3.8. Patient's expectations

It is important to remember that some people have no previous experience of serious illness or dealing with the health service. In assessment A4 Bruce demonstrated outrage at what he felt was the antithesis of care. Whilst severely ill with hospital acquired infections and opiate allergy reactions he described the nursing care he received.

Context: The district nurse assessed Bruce following his discharge from a local rehabilitation unit.

Bruce: *yea with the pain and the nurse thought I was joking I mean deliberately awkward but I wasn't I was in ...they used to turn me over to change the sheet ...I'd peed the bed and I couldn't turn over to change the the sheet and I was in the screaming agony they rolled me about like a piece of pastry (Lines 475-478)*

Bruce's statement implied his expectation that he would be believed when he said he was in pain and that he would be treated kindly, with care and dignity. His candid description of his situation was highlighted by his metaphorical dehumanising description "*like a piece of pastry*" which emphasised the discrepancy between what he expected and what he experienced.

In assessments A1 and B3 both Richard and May and Linda and Mick respectively expected to play a part in the training of health care professionals.

Context: In Richard's interview following A1 he gave his reasons for allowing students to observe his condition and treatment.

Richard: *...like when the nurses bring a young student in it is far better if they see me as I am than try and read it from books (Lines 967-968)*

Although coping with his terminal illness Richard demonstrated altruism by his readiness to play his part in training those who will treat future patients.

Linda's decision to have students observe her seemed to be based on a desire for a cure for motor neurone disease.

Context: Linda's interview following B3.

Linda: *it fascinated them and theyin groups of 2 and 3 one group of 15*

Researcher: *right*

Linda: *...at one time I got to make a ??? of something coming and they've got to learn*

Researcher: *yes absolutely*

Linda: *somebody's got to do it and one of them may find a cure they're all young (Lines 1175-1180)*

Linda was the only participant to speak of cure.

6.2.4. Discourse of resistance

Foucault's (1977) early analysis has shown that the medical discourse subjugates and nullifies voiced resistance. It may be argued that opportunities to discuss delicate issues may have been missed unwittingly, however the antithesis may be evidenced when nurses abruptly changed the subject and actively resist addressing concerns which patients' voice. Twenty one instances were noted within four of the assessments. This example of subject avoidance is taken from assessment B 4. The nurse changed the subject when Steve again remarked that he had abdominal pain.

Context: The nurse had just changed Steve's abdominal drainage bag. Steve leant back his face twisted with pain (*field notes*).

Steve: *it is sore*

Nurse: *I'll just change this bag for you so that it doesn't catch* (Lines 147-149)

The nurse did not respond to Steve's statement or his physical manifestation of the pain. She changed the subject to indicate a drainage bag that had got folded over. It may be that she felt unable to help with his pain; however by not acknowledging it she subjugated his voice.

Later in the same assessment;

Context: The nurse knelt on the floor to the patient's right hand side. She spoke quietly and reassuringly, making frequent eye contact with Steve.

Nurse: *no that's fine actually you can see the bottom of the wound bedthat's good... and it is healing up quite nicely....that's good and um its pink on there that's healthy and there is some gooo (pause while she changes gloves) it's like a button hole now isn't it 2 belly buttons yes OK then that is definitely going in the right direction and we can see about that* (Lines 119-123)

It is possible this information was shared in an attempt to lighten what was a very bleak situation. However the patient returned to his concern regarding his weight loss and inability to eat anything. In the context of this situation where, as noted above, both Steve and Vanessa seemed to be expecting a recovery it is of concern that opportunities were not taken to discuss their expectations. Further it may be that

Steve and Vanessa might draw erroneous hope from the nurse's description of his wound healing. The nurse may have focused on the complex task of dressing Steve's abdominal wounds, to the exclusion of all else, and therefore not picked up on their cues.

In assessment C1 the nurse tried to avoid addressing Tom and Babs' disappointment that Mary would no longer be involved in delivering Tom's care.

Context: Towards the end of the visit Tom and Babs were again seeking clarification of why Mary would no longer be delivering Tom's care.

Tom: *She said she's still ...*

Babs: *She said she still wanted to come*

Nurse: *Oh yes and she certainly said that to me*

Tom: *She's back at work this week or*

Nurse: *Um I think it's next week she's on holiday (Lines 646-650).*

The nurse cut across Babs and Tom's comments retaining control of the conversation by displaying knowledge and power.

6.2.5. Discourse of surveillance

6.2.5.1. Panopticism.

Foucault's description of the extreme form of observation, constant supervision and examination, offered by the panopticon (chapter 5) and the medical gaze has been used as a metaphor for the imbalance of power between the observer and the observed. The practice of assessment can be constructed as a way of constituting power by amassing information and thereby knowledge of the person being assessed. The data showed instances of nursing language regarding surveillance using statements such as "**see** patients" or questions of "where are you being **seen**" or "who is **seeing** you". Following Foucault, elements of the judgement of appearance or actions followed by correction to normalise behaviour, can be interpreted as a consequence of power imbalance. It is the nurse who exercises the power derived from expertise and authority and decides what is normal and what is not. .

In assessment B5 Ursula was asked to demonstrate how she used her inhalers so that the nurse could judge/ assess her technique.

Context: The nurse outlined the agenda for the assessment.

Nurse: *goodanother thing I would like to check is how you take your inhalers (Line 10)*

It is of note that the nurse elevated Ursula's everyday inhaler use by using the value-laden word *take* rather than *use*. The nurse checked both the amount of the medication Ursula took and observed the way in which she used her inhalers. She used the value laden word *check* implying verification of a norm against which Ursula would be judged or assessed.

In the interview following this assessment (B 5) the nurse revealed her surveillance of Ursula extended to include checking the amount of prednisolone dispensed to her.

Nurse: *yes I thought before she came in when I saw the amount of prednisolone she was having and although she was saying that she has a lot of salbutamol . She wasn't having a lot of salbutamol it err she is not having it it is partly education isn't it and not getting people's backs up because if they felt caught out. (Lines 33-37)*

The statement “ *not getting people's backs up*” implied awareness of the manipulation she was employing as she corrected the situation by using “*education isn't it*”. In this way the nurse is hoping to empower, by imparting knowledge through education, without making the patient aware or resentful. The use of the words *caught out* implied a policing role for the nurse.

A similar example of surveillance was provided in assessment B1;

Context: DN's interview concerning Fred's leg ulcers.

Nurse: *Yea we do, each time I come I check both of the dressings and we change it um as needed . He does tends to have a little fiddle and stick things down there. (Lines 626-627).*

The word *check* was used again and the patient was described as complicit in the need for his ulcers to be redressed as he had interfered with them, “*have a little fiddle and stick things down there*”. At no time during the visit did the nurse raise her

suspicions that this had taken place. She used the word *tends* that implied the normative judgement that Fred was the type of person who would be likely to do this.

In assessment C3 the practice nurse extended her surveillance to cover the minutiae of Dorothy's meals.

Context: Dorothy a slim 83 year old had managed her type 1 diabetes for over 25 years with few of the long term complications.

Nurse: *an occasional treat isn't the end of the world*

Dorothy: *no*

Nurse: *but I don't know how good you are at an occasional treat I'm pretty much an all or nothing kind of person myself but*

Dorothy: *occasionally if they have fruit pie or crumble*

Nurse: *yes*

Dorothy: *I say can I have some and put down D in mine (Lines 53-54)*

The nurse made the normative judgement that Dorothy would be like her “*an all or nothing kind of person*”. This degree of surveillance and advice regarding Dorothy's food intake was an inappropriate exercise of power for which the nurse offered no clinical reason. Dorothy was being encouraged to confess her enjoyment of food and this degree of self-disclosure is also an example of pastoral power (see below)

The data demonstrated that assessment involved:

- policing
- manipulation
- target achieving
- education
- training
- making judgements based on nursing expertise.

This shows an inherent paradox regarding the change in semantics from patient compliance to concordance that will be discussed in the next chapter

6.2.5.2. Pastoral power

As discussed previously, in contrast to the external observation, indicated by observation and surveillance, pastoral power (Foucault 1988) refers to self

governance and self examination, as in Dorothy's case above. This is expected of patients as nurses gather both official and unofficial information. Statements that privilege "pastoral power", the self-regulating and self-governing passive patient and the constituting field of power and knowledge, speak this construct into being.

The arena of confessions regarding eating, diet and food was significant in eight of the assessments and extended in assessment C1 to the carer's activities as well as the patient.

Context: The nurse was assessing how Babs, a well rounded and active person, was coping with caring for Tom.

Nurse: *had you been dieting or*

Babs: *Well I think . Well I'm glad I had yes I've lost 2 stone*

Tom : *She hasn't, she hasn't done it purposely because I couldn't eat (Lines 737-739)*

Babs was defiant as she confessed that she was *glad* that she had lost weight. Tom came to his wife's defence stating that she had not intentionally lost weight , "*she hasn't done it purposely*". This revealed that Tom understood the nursing function within this interaction to be one of sanction or criticism. The nurse had extended her remit from surveillance of the sick to surveillance and control of the well.

Ursula gave an insight into how she felt about treating asthma in assessment B5.

Context: The practice nurse told Ursula the maximal doses of medication taken by other un-named patients.

Ursula: *I am pleased to realise that I am not as bad as some people (Line 209).*

Ursula demonstrated the importance, for her, that she used less medication than others. The use of the term "*bad*" shows the moral connotations of illness in Ursula's mind. It is also another example of a dividing practice that separates the good from the bad and which implies culpability of the patient in their ill health. "*Realise*" displayed evidence of self examination in comparison to others and the normalising erroneous judgement that "*bad*" can refer to using large doses of prescribed medication.

Assessment C4 illustrated critical self examination regarding behaviour and the role of being a patient within an institution.

Context: Bruce described the beginning of his stay in his local acute hospital. He had transferred there by train, a journey of three hours, from the intensive care ward of a specialist hospital following a severe reaction to morphine, unsuccessful spinal surgery and hospital-acquired bacteraemia.

Bruce: *yea I was in this ward with this bloke and sharing and I has already had a horrendous day already and travelling on the train and all that carry on and this patient just kept shouting and screaming all night and ahh I just said I mean it was impossible for me to do it but they knew this bloke they all knew him and I just said if you don't shut up I am going to come out over there and give you a good dent in the head if you don't shut up*

Nurse: *who said that you did*

Bruce: *I did and I was absolutely jumped on not far off a straitjacket*

Nurse: *oh dear*

Bruce: *yeayea .. don't talk to him like that and all this carry on*

Nurse: *and who told you that*

Bruce: *all the staff did ...the night staff and I was all ... what have I done wrong and I couldn't think what I had done wrong (Lines 811-823)*

Bruce articulated the passivity required when being an in-patient that is in contrast to the norms of behaviour in situations in everyday life. For example if one were in a hotel an assertive reaction to someone who is making a noise and keeping us awake is acceptable. Interactions between patients are often mediated by the nursing staff and this extension of patient advocacy has ramifications that will be discussed later.

Bruce demonstrated his self-examination, pastoral power, with his use of the words *I couldn't think what I had done wrong*. He is accepting that there must be fault and blame but he has no frame of reference regarding why his behaviour had been met with such condemnation. He could not see that his threat could be taken seriously and decided the other patient was privileged because *"they knew this bloke they all knew him"*.

6.2.6. Institutional hegemony

The data revealed instances of the power of the institution of the National Health Service (NHS) influencing the discourse. For convenience I will divide these into expressions of NHS policy and economy at a macro level and the notion of sanctioned care and support expected of the NHS at a meso and micro, level. These will be considered as discourses of:

- health economy
- health care delivery,

6.2.6.1. Discourses of health economy

It is imperative that the NHS is run on sound economic footings and that avoidable waste is eradicated. A GP surgery is a business and Practice Nurses have to be mindful of the links between targets and funding for the practice. However when economic drivers lead to an increase in patients' feelings of powerlessness in the face of a bureaucracy, or their care is compromised, this further disempowers both staff and patients. There were 83 instances that revealed that economic sanctions had been detrimentally placed on practice. I will divide this section into those that show powerlessness in the face of the bureaucracy surrounding funding and those that demonstrate the unintended consequences of cost cutting.

6.2.6.2. *Bureaucracy of funding*

Assessment B3 provided examples regarding living expenses, provision of a hoist, a chair lift and respite care. Mick and Linda had fallen foul of government funding policy as they were too young to qualify for the aid they needed and yet Mick had given up work to care for Linda. Their situation demonstrated that age, class and income have an influence on care delivery. Excerpt (1) below demonstrates that although having assessed their need and referred the couple the nurse was unaware that respite care carried with it a significant cost implication. This couple had also experienced problems regarding funding for a now unusable stair lift (excerpt 2).

Excerpt 1. Context: The nurse tried to understand the position regarding the provision of respite care for Linda.

Nurse: ... *right have they actually started that for you*

Mick: *Nope*

Linda: *well*

Mick: *cancelled them*

Nurse: *you've cancelled them*

Mick: *cancelled them Friday we got a letter through stating we would have to pay £85 per week rising to £117*

Nurse: *Really oh gosh*

Mick: *for 5 hours*

Nurse: *oh goodness me*

Mick: *I think that's not..#*

Nurse: *#I didn't realise that (Lines 109-122)*

The use of *them* shows a dividing practice between us and them. Mick cut across Linda's explanation with "*cancelled them*", having dismissed the first question with "*nope*" asserting his power in this discussion. He gave compelling financial reasons for cancelling the respite care.

Excerpt 2. Context: Mick's interview following the assessment about a chair lift.

Mick: *right well someone would come round to see if they could finance it she said I will get someone to come round and she will assess you she did and when they came back we got a letter from them the following day stating again our contrib....., our contribution, not to buy... our contribution towards it would be almost 2 ½ thousand poundsnow you can buy them new for 1,500 and I said why is it costing us almost 2 ½ thousand when you can buy one of 1 ½ thousand pounds well Sally (social services) couldn't under...couldn't answer that but she did say we will, look around and what she did come up with was the solution was someone will pay for the installation and the removal and another person another CHARITY will pay for (Lines 1332-13348)*

In excerpt 2 Mick used the epithet *someone* to denote an impersonal faceless entity who would assess and decide what help this couple could have. The financial burden impacted on their daily lives and added to their feelings of alienation and entrenchment. Mick said : "*Sally couldn't under.. couldn't answer that*". His conversational repair from *understand* to *answer* showed a shift in his mind set, he had moved from thinking that Sally was as bemused as he was, to perhaps that she did not have an answer because there was no answer. He also corrected "*another*

person” and raised his voice showing his offence at the word “CHARITY”. He noted the professionals had been wrong footed by the bureaucratic system inherent within the NHS.

Assessment B4 illustrated the complex procedure required to apply for a prescription exemption certificate.

Context: Steve required a plethora of prescribed items in addition to his medication.

Nurse: *right that's good so when the exemption thing comes through I think there is an option that you can actually be refunded as well just keep everything that you have been charged for*

Steve: *yea we will*

Vanessa: *yea*

Nurse: *cos it will be backdated*

Vanessa: *yea*

Nurse: *backdated then it was Dr G who filled it in wasn't it and whatever he*

Vanessa: *Dr S*

Steve: *Dr S*

Nurse: *Dr S it got passed around a bit didn't it? Dr A is your GP isn't he or have you swapped so have you got Dr H?*

Steve: *it is all over the place (Lines 461-473)*

The power of the institution dictated whose signature was acceptable to sanction the prescription exemption and the delay caused had real implications for Steve and Vanessa's budget. Later during Vanessa's interview:

Context: Vanessa cited their lack of control over booking transport, as an example of the worst aspect of their present situation.

Vanessa: *the only thing that annoys us is the transport there are 2 lines and I've been given one that I can phone to book and they say oh no we ...we can't do that we don't come back after a certain time and the hospital's got to do it. So I just find that annoying that I can only do half that when we've got a million other things to do (Lines 1027-1032)*

Vanessa highlighted the misapprehension that patients and those who care for them have endless time and energy to carry out organising care. Vanessa's experience, “ *I can only do half*” displayed a controlling attitude towards resources on behalf of the

NHS. Steve and Vanessa were entitled to have transport provided for their hospital visits and yet an intermediary was required in order to authorise this each time. The power and authority lay with the institution who considered the minutiae of every decision.

Avoidance of incurring cost delayed the provision of a support stocking for Marjory. Assessment A2.

Context The nurse was aware that Marjory required new support stockings and was clarifying the information regarding who prescribed the last pair and therefore whose budget could be used to support their replacement.

Nurse: ...I have tried to find the prescription and I couldn't find it so again did tissue viability order that how did you get that stocking initially

Marjory: umm

Nurse: through?

Marjory: I think you people ordered it

Nurse: yes

Marjory: but you see I had a prescription for this lot and they took the prescription down

Nurse: right

Marjory: and they reckon they have never had itbut that is how

Nurse: I tell you what if you don't mind I will measure your leg

Marjory: right

Nurse: and then we will order up cos it is a lymphoedema stocking isn't it
(Lines 153-162)

And later;

Nurse: you could do with a new one because it is worn the elastic a bit
(smiling and laughter in her voice)

Marjory: yes

Nurse: I have been trying to sort it but they couldn't find a prescription

Marjory: oh

Nurse: so I was a bit confused over that so I thought I will speak to you about it .. so if (Lines 577-582)

The ongoing need for treatment to reduce Marjory's lymphoedema was demonstrated as her leg was considerably swollen.

Nurse: 23 (cms) *at the ankleso I will do the top now the top bit dear me now .. do the top bit 53 ...* (Lines 583-584).

However ordering and providing this essential equipment was delayed due to the loss of the Acute Trust prescription. If the DN replaced the prescription the charge would be made to the Community PCT budget. This remnant of the internal market resulted in delay in the care and recovery of this patient.

6.2.6.3. Assessments based on availability

The ritual of a nurse identifying a problem and then suggesting a solution is a part of the routine of care. However the data showed that sometimes the solutions had more to do with what was available rather than meeting the patient's needs. The first example is taken from assessment B3 where the nurse responded to Linda's concern that she was losing control of her voice.

Context: The nurse suggested the existing referral and long awaited visit by a speech therapist would help Linda.

Linda: *but I don't see how I can do anything (when) I can't speak at all*

Nurse: *yes yes they can um um there is um a sheet they can give you with symbols and you can point to which*

Linda: *I can't do that as I can't move my fingers.*

Mick: *she can't move her arms*

Nurse: *of course yes yes yes I see OK that's going to be followed up anyway* (Lines 457-462)

The nurse's irritation, evidenced by *yes yes yes*, seemed misplaced and yet she still did not address Linda's very real concern that when her voice failed she will not be able to communicate. Further the nurse continued with the speech therapist referral although time was short and it was unlikely to help as it was evident that Linda's paralysis would preclude her from pointing at an icon on a board.

A further example from assessment B 4 was the nurse's response to Steve's concerns regarding his weight loss and exhaustion.

Context: Steve was taking all his nourishment through his PEG tube. He had already reported that he experienced severe pain whenever he tried to eat.

Nurse: *Ok ...well just take what you can when you can don't put yourself in a tizzy for not being able to eat plate of fish and chips or whatever so just whatever takes your fancy appeals to you then just go for it and umm.....OK ...mm what about ...your bowel then any problems* (Lines 802-805)

The phrase “*put yourself in a tizzy*” can be seen as an attempt to downgrade Steve’s anxiety as an overreaction. This ignored the severity of Steve’s condition that was at odds with her later comment regarding his weight loss:

Nurse: *umm you're not eating and drinking a lot the skin is not as robust as it would normally be OK all your bones on your side are sticking through your skin... OK ...mm what about ...your bowel then any problems*

Steve: *no problem at all no*

Nurse: *no problem at all you have a sort of regular habit and everything*

Steve: *yep* (Lines 862-817)

This example indicated the extent of the nurse’s assumptions regarding what it is to be a patient in that she felt able to make these comments to Steve regarding his plight and his appearance. These statements were not couched in the professional language that one would associate with nursing practice and did not empower, include, or involve Steve’s concerns. The nurse returned to the formulaic approach of her questionnaire and again asked Steve about his bowel movements. She was on safer ground because if Steve was constipated she could offer practical help. A further problem solving example, framed only from the nurse’s perspective, is from A 2 where the nurse suggested ways in which Carol might shower despite her heavily bandaged legs.

Context: The DN knelt in front of Carol washing her feet and hydrating them with an emollient.

Nurse: *you know when you are in the shower*

Carol: *yes*

Nurse: *can you get down with the flannel*

Carol: *I don't have a shower*

Nurse: *you don't have a shower do you have a bath*

Carol: *no* (Lines 301-306)

When Carol said she did not shower the nurse presumed she must take a bath despite the impossibility of her being able to keep her heavily bandaged legs dry. Carol could not shower because her parents' bungalow did not have one. However the nurse offered the advice anyway.

6.2.6.4. Examples of the unintended consequences of cost cutting

Instances of NHS economic constraints extending to the provision of equipment, dressings and support stockings were observed and their impact can be seen at the micro level. For example the statement made by the nurse in B1 regarding Fred's dressings.

Context: Fred asked the nurse if it was helpful that every time his dressings were changed tissue stuck to the dressing resulting in his ulcers bleeding.

Fred: *it's just that ... Is this a different one then*

Nurse: *it's a cheaper version of*

Fred: *ohh?*

Nurse: *of the same dressing really Fred but the problem*

Fred: *I thought you were going to put a different one*

Nurse: *the problem is it's sticking it doesn't come off nicely it sticks on*

Fred: *yea*

Nurse: *so we might go back to A*** that we used before*

Fred: *yea yes*

Nurse: *These cheaper versions don't work for everybody.*

(Lines 153-162)

The practice of using the cheaper dressings indicated by the Trust Formulary until they were proved unacceptable, concealed the information that each time the nurse removed Fred's dressing, because it stuck, it took a layer of healing tissue from the ulcer. This is a false economy as it prolongs healing time, increasing the number of dressings required, district nursing hours, resultant travel expense and Fred's pain which diminishes his quality of life. Decisions made regarding the suitability of dressing are predicated, where available, on an evidence base that shows:

- efficacy
- value for money

Although both these are important considerations the nurse doing the dressing is disempowered because she cannot use her expertise to select the appropriate product from outside the formulary until she has proved the cheaper one is

detrimental. In these cases the hegemony of the NHS or Trusts exercises power over individual practice.

Differences in approach between Acute and Secondary care was found in the data from assessment A3. The Tissue Viability Sister, (Acute Trust employee) had visited Marjory and recommended specific dressings to enable the contour of her legs to be improved whilst still applying supporting bandages and stockings to reduce the lymphoedema.

Context: The nurse knelt on the floor in front of the patient building up layers of gamgee to a specific thickness that she checked again and again with a tape measure.

Nurse: *so we put on lots of padding now initially we was putting 12 rolls on but we use cos it was a bit of a cost issue we use gamgee initially and put bandages on the top cos it was a lot but gamgee that builds it up but that was tissue viability that was fine about it wasn't it (Line 455-458).*

Consideration of the budget had resulted in the use of a compromise dressing. The nurse referred to a *"bit of a cost issue"* clearly indicating the change in product was solely predicated on cost of the original prescriptions. The statement *"tissue viability that was fine about it"* also indicated that the nurse was concerned regarding the change as she had consulted with the Specialist Tissue Viability nurse. *"Fine about it"* infers the process of sanctioning a decision made rather than using the product of choice.

The nursing notes also contained the discourse of health economics. The notes for assessment C 1 identified issuing a disabled parking permit as a problem to be resolved and problems with the process of obtaining surgical support stockings were included in the notes for assessments B1 and A 3.

6.2.7. Discourse of healthcare delivery

6.2.7.1. Complex packages of care

This discourse revealed examples of governmentality, and pastoral power. Foucault suggests governmentality is achieved through different sanctions of power; the law socially prescribed rituals and disciplinary power. This model of power enables the

state's surveillance, the creation and examinations of norms and standardisation to be carried out without coercion.

Looking now at what constitutes the delivery of care within the NHS, policy has driven a more integrated approach to complex care delivery with the expectation that teams of doctors, nurses and social workers will liaise and discuss and thereby optimise patient welfare as evidenced in the aspirations of the Single Assessment Process (DoH 2002a).

The assessments studied revealed the many different services involved in the delivery of care to all of the patient participants (Table 6.2). This is belied by the term “complex package of care” which implies something with discrete boundaries, “a package” and homogeneity.

Table 6.2. Complexity of care delivery

involving	C1	C2	B1	B2	B3	B4	B5	A1	A2	A3	A4
GP	√	√	√	√	√	√	√	√	√	√	√
DN	√		√	√	√	√		√	√	√	√
SN	√	√			√	√		√	√	√	
PN		√					√				
Hospice doctor	√							√			
Hospice nurse	√							√			
Acute Trust consultant	√			√	√	√		√	√	√	√
Occupational therapist			√		√	√		√		√	√
Physiotherapist					√			√		√	√
Dietician		√							√	√	√
Phlebotomist		√	√		√	√		√		√	√
Social Services			√		√	√		√	√	√	√
Third sector	√			√	√	√					√
Audiometrist				√							
Podiatrist		√							√	√	
Mental health Services											√
Speech therapy					√						√
Research nurse						√					
Medical equipment service			√		√	√		√		√	√

Complex liaison would seem to be a prerequisite between “teams” who are working together to deliver care to patients. However in the areas where assessments B and C took place nurses reported that there were few or no joint meetings. Liaison with Social Services was minimally recorded and the DNs in two areas expressed difficulties with approaching them, because they

- did not know the procedure
- could never get to speak to anyone directly
- did not know how to use their forms requesting interventions and support.

Meetings with doctors in the same trust happened rarely and meetings with others involved in care delivery did not occur at all.

The Single Assessment Process (SAP) enables either social workers or nurses to assess patients’ needs. The nurse in assessment B1 commented on nurses’ and social workers’ knowledge of each other’s practice.

Context: Nurse’s interview following the assessment.

Nurse: *We could do more the other way around thank you*

The nurse suggested that nursing teams have a greater knowledge and understanding of the social services practices than social workers do of nursing procedures. The use of the phrase “*thank-you*” adds a note of petulance and dissatisfaction. The data from assessment B3 provides another instance.

Context: In the interview the nurse described the *ad hoc* approach to interagency working with regards to Linda’s case and the problems that this caused.

Nurse: *with um I mean I can get on the phone and talk to them and they will get back to me but I feel we pick on the gold standard team that obviously ,... once a month we have a discussion with the doctors and the Macmillan nurses and but I think maybe it would be a good idea to maybe suggest that maybe with patients such as Linda once in a while to be able to get together with all the different agencies such as OTs, physios, social workers so that we could all come together and share our fears and which is the best way forward... to help them so we can draw from each other and obviously give them the best possible help and support that they need at this moment in time (Lines 1421-1430)*

Despite Linda being cared for by the nursing team for over two months the DNs had not had regular meetings with the other agencies involved with her care. The DN described the model of care outlined in the Gold standard for cancer care that involved district nursing liaison with the Macmillan nurses and the doctor as one they could use “*we can pick*”. The nurse knew the benefits derived from team working that she itemised as “*share our fears and which is the best way forward... to help them so we can draw from each other and obviously give them the best possible help and support*”. She indicated that this *approach* would improve care and support to Linda, Mick and those involved in care delivery; however it had not been used.

Further problems regarding inter-agency contact were evidenced in the nursing notes in A3. Here the nurses stated they were trying to “*chase up*” the dietitian and the occupational therapist and in A2 the nurse tried to get “*social services involved*”. These attempts had been made by repeatedly leaving messages on the each other's answer-phones and had sometimes been ongoing for weeks without either party ever speaking directly to the other. This lack of effective liaison also resulted in patients having to reiterate their stories many times for example Linda disclosed the extent of this repetition.

Context: B3 In Linda's interview she responded to the researcher's question regarding repetition of information.

Researcher: *'cos there seems to be quite a lot of repetition*

Linda: *oh ha ha*

Mick: *yes an awful lot yes*

Linda: *yea a dozen times easily mm*

Researcher: *mm*

Linda: *we've been through it they do not communicate*

Researcher: *no?*

Linda: *so you have to tell each one (Lines 1160-1167)*

It is of note that in order to speak at all Linda had to put a supreme effort into pitching her voice and to have told and retold her story must have been both a physical and mental strain.

Following Foucault, the lack of formalised knowledge-sharing on a regular basis between the services involved could serve to enhance the perception of power one

group has over another. Exclusion of social services from primary care meetings again fosters the dividing practice of the “us” and “them”.

The problems and frustrations incurred when trying to make the system work resulted in nurses becoming disempowered and I shall consider this aspect of the data next.

6.2.7.2. Disempowered staff

It has been shown above that budgetary constraints left nursing staff unable to use their experience and expertise to decide which treatments were most appropriate for patients (B1, B3, A3). In A2 the nurse expressed frustrations that they were disempowered when working with other agencies.

Context: DN’s interview following the assessment. Fran is Carol’s teenage daughter.

Nurse: *.....but it is so complex they have been through...we almost feel as district nurses we are in the middle of an ongoing family dispute...Carol was in a quite a psychologically abusive relationship ended up coming to her Mum and Dad’s had no money and we ended up having to get the social services involved to get her some funds and we are now pushing social services to get Carol and Fran their own place to live because we actually feel lovely as Mum and Dad are it is not right Carol and Fran are not being able to live there ...*

(Lines 757-762)

This statement described liaison with other agencies using the terms “*having to get*”, “*having to push*”, “*we are in the middle of an ongoing family dispute*” and, “*pushing social services*”. These suggest both reluctance and resistance within this partnership. The statement “*lovely as Mum and Dad are*” revealed the complexity of Carol’s situation and demonstrates the DN’s representation of the interests of all parties, by recognising that the situation was also hard for Carol’s parents whose circumstances had also been profoundly altered.

6.2.7.3. Brokerage

Table 6.2 lists the many agencies and departments involved in delivering complex care to the patients seen by the nurses in this study. In order to facilitate the timely provision of this care nurses tried to move the individual’s care forward, using mainly telephone messaging, to make the case for the provision of a professional’s time or products for their patients. Dickinson (2009) has described this process as brokerage

and there are many instances of this role within the assessments. In the extract immediately above the nurse in assessment A2 stated that the team felt as if they were “*in the middle of a family dispute*”. They needed to broker inter-agency action to help Carol, her daughter and her parents.

Further in A4 the nurse spent the first five minutes of the assessment attempting to put Bruce in touch with those best able to deal with his concerns.

Context: Bruce was angry and resentful regarding his treatment as an inpatient.

Nurse: *there are PALs that are are patient they come to your assistance and will discuss things with you - PALs they are called Patient Assistance Liaison I think they are*

Bruce: *right*

Nurse: *and they deal with the likes of complaints and any concerns you have got and they come and they will come and point you in the right direction and come and tell you ...what your options are all that kind of thing and be there as your backup and support. (Lines 43-49)*

A further example of brokerage is from assessment A3;

Context: The nurse questioned the patient about any long-awaited responses from the dietician, social services about re-housing, the OT, and the local agency with regard to the construction and provision of a rise and recline chair.

Nurse: *.....so that is another thing we need to chase up and what about your OT as well*

Marjory: *no I haven't heard no more about that either*

Nurse: *I left a message on the answer machine last Friday*

Marjory: *mm mm*

Nurse: *about your reclining chair cos obviously D (the tissue viability specialist sister) would like to get you into a reclining chair and get your legs up*

Marjory: *yes*

Nurse: *cos they need to be elevated so I haven't heard anything since and we need to chase that up as well (Lines 241-250)*

Here the DN included driving the care delivery forward, by liaising with all the agencies involved with Marjory, as part of her role.

Nurses were also involved in referrals to voluntary agencies, for example the Motor Neurone Association for respite care in assessment B3 and to PALs in A4. In assessment B4 Steve and Vanessa remarked that the nurses had listed the contact numbers for the agencies involved in Steve's care delivery, in the nursing notes.

Context: Steve's interview following the assessment.

Steve: *yes we from day one we have had all the contact numbers out of hours in hours um and we could and I mean the Chemo this Chemo thing because I has this abscess that bursteverything just went out the window and it's changed and I'm with the third lot and the nurses have been available from day one and they've changed and moved things for us (Lines 994-998).*

Again the data showed the nurse's pivotal role in the co-ordination of the complex care delivery.

6.2.7.4. Choice

At a macro level the rhetoric of NHS policy makes much of patient choice. The discourse of morality, questions of right and wrong, can be seen in this excerpt from this secondary source "High Quality Care for All" DoH (2008)

"We want patients to make the right choices for themselves and their families. So we will empower them to make informed choices." DoH 2008 p 39

This portrayal of empowerment as a means to make health choices is an example of the power and authority of the voice of natural science and the hegemony of the modern NHS. At the micro level of patient decision-making B4 gives an example where making a choice involves coping with the status quo.

Context: Steve's interview.

Researcher: *about the assessment - nothing you didn't expect - anything you want to add?*

Steve: *no I don't think so I must say I had the opportunity to go to BUPA and I was advised not to because of where we were you know and I have found that that advice has probably paid off yea because I did have the opportunity and umm ...and the surgeon and I think it was the Consultant said to be*

honest we canbut I wouldn't because you've got... at the moment you've go 10 people behind youyou'll still have me behind youbut you will have other people and at the moment these people are already umup to speed with what's going on so I think that you would... (Lines 1038-1047)

Steve showed his concern that he had made the right choice which he justified as being based on the conversations he had with people in authority. However he did not seem at all clear what his alternatives would have been had he elected to be treated privately. The following extract showed his uncertainty;

Steve: *... .. I mean I've chosen to go on a - or I was given the offer to go on a research programme and I suspect without sounding facetious that I am probably getting a bit better treatment because I am on a research programme but having said thatthey are excellent.....The um there's one guy when ever seen I think the registrar makes absolutely certain that every time I go up there he sees me (Lines 1003-1008)*

Steve's used of the words "*probably*" and "*a bit*" and his uncertainty regarding who he was seen by displayed his insecurity regarding his position. His lack of knowledge of the system and the advanced state of his cancer diminished Steve's power and ability to make choices.

Having concluded this section concerning examples of social power and dominance I will now provide evidence of empowering nursing practice.

6.3. Discourse of empowerment

6.3.1. Interactional devices

6.3.1.1. Body language

Previously in this chapter examples of body language that portrayed passivity have been reported. Body language can also empower and include patients in care delivery and decision making. At a micro level exclusion can be necessary and this was indicated by the body language observed and noted in assessment A2. Carol's mother kept speaking for Carol, interrupting and interjecting observations.

Context; The nurse knelt on floor facing Carol who was seated. Carol's mother was standing to her daughter's right and faced the nurse. Carol's mother was in a dominant position as she was standing over both her daughter and the nurse.

Nurse: *ok what's your diet like at the moment are you managing you know the whole government thing about your 5 a day 5 fresh fruit 5 veg which I never manage*

Carol's Mum (Mum): *(is talking over the nurse) she has fruit and some veg but um...you don't eat a lot lately but it is because you are not getting out and about which is the problem*

Nurse: *no so it is almost not*

Mum: *problem*

Nurse: *not building up an appetite ...(Lines 561-570)*

And later in the assessment;

Context: The nurse still kneeling has moved from making a note of Carol's weight to her smoking habits. Carol's Mum was keen to share her experiences of the Slimming World system.

Mum: *but it is a very easy diet to follow*

Nurse: *yes (talks loudly over Mum) I think different things Mum: you have just got to go along and get weighed*

Nurse: *(turns her head to address Carol's mum) different things work for different people and you have obviously found something that that works for you which is really good..... (pauses and turns to face Carol) Just a final question and then I am going to stop shining a light in your eyes and torturing you ..do you still smoke?*

Carol: *yes*

Nurse: *yes how many roughly do you smoke a day*

Carol: *(draws a deep breath in) I wouldn't say a lot more but between 5-10*

Nurse: *between 5 and 10 a day depending on the day*

Carol: *yes*

Nurse: *Ok*

Mum: *you have just changed your brand haven't you she has gone to menthol cigarettes because she thought they were healthier*

Nurse: *(to Carol) now with regards you smoking is that something you want to continue doing or is that something you'd like to try and give up ?*

Carol: *(draws a breath in) everybody wants me to give up so I suppose I want to try and give it up*

Nurse: *yea but really at the same time it has got to be you*

Mum: *(talking over nurse) it is her only pleasure its her only you know*

Nurse: *yea... *** but I am just thinking back to your past history and it is obviously you know one of the bigger side effects with regards to your arteries, your circulation but at the same time it is alright saying everybody wants you to give up yes as one as one of your nurses I would love you to cos I can see the benefits of that but I want you to feel comfortable doing that as well you know and again if it is something that you want to pursue and give up I am quite happy to liaise with the GPs at the surgery and see if we can get you some support or something to help you do thatso perhaps have a think over this weekend (Lines 631-644)*

During these interactions the nurse had remained courteous and for the main part ignored the interruptions made by Carol's mum. At *** the nurse turned her body towards Carol's Mum and acknowledged her comment with a nod of her head and "yea". She then paused and turned her back towards Carol's Mum whilst leaning forwards directs her gaze towards Carol. She delivered the rest of her remarks to Carol making continuous eye contact. In this way Carol was empowered, by the nurse's body language and eye contact, to speak for herself. Whilst her Mum was politely, silenced.

6.3.1.2. Touch

Nurses were observed to touch patients as an attempt to reassure or comfort. For example in assessment B3 when Linda was crying quietly

Context: Linda had just been asked questions regarding her religion that had made her cry.

Linda: *tearful and indistinct*

Nurse: *yes*

Linda: *carry on*

Nurse: *I will carry on sorry right (touched Linda on the arm) Ok um well what I will put her is here um wellyou've got motor neurone disease*

The nurse leant forward to touch Linda on the arm however this physical manifestation of sympathy did not extend to considering the phrasing or timing of the next question. The nurse withdrew from her empathetic response to Linda's distress and turned to the unthinking and unfeeling prompts of the assessment documentation.

In A1 whilst checking that Richard was warm enough whilst draining his chest the nurse rubbed him gently on the shoulder expressing tenderness (field notes).

Context: The nurse knelt on the floor changing the redivac that drained Richard's chest. He had removed his pyjama top whilst the dressings were changed. His chest tumour was now so large that he had to sit with this arm raised above his head.

Nurse: *are you warm enough there*

Richard: *I'll struggle*

Nurse: *you look like you are striking a pose*

Nurse, Richard, May and researcher: laugh

May: *he usually has his blanket over him I am surprised he has not put it over himself... You are thinking of flashing your body off are you today (Lines 532-537)*

I will discuss the delicate nuances of touch and intimacy that epitomise care of the body as a corner stone of nursing practice in the next chapter.

Although assessment B2 did not involve technical procedures the nurse sat adjacent to Mark throughout the assessment. She often lent forward and touched his arm, as he displayed distress regarding his wife's death, as a gesture of reassurance or compassion (field notes).

Nurses also assessed their patients' physical wellbeing by touch, for example in assessment A2 whilst speaking to Carol and removing her dressings the nurse touched each of Carol's feet with the back of her hand (field notes) to assess temperature, which would have been elevated had Carol's ulcers become infected.

Touch was sometimes used to metaphorically bring patients back to engage in the discourse. For example, in assessment C4 ;

Context: Bruce was seated in a wheel chair and the nurse sat opposite him some two yards away. There was a low coffee table between them. Bruce was responding to the nurse's questions regarding his sleeplessness:

Bruce: *yea or bad dreams it usually is ... very horrendous well I was driving a train last night do you remember it*

Nurse: *right*

Bruce: *and these people were trying to get across the railway track....and instead of the train stopping for them it was just running them all over ...*

Nurse: *oh dear*

Bruce: *and I was dreaming this and I was driving the train yes uh some of them are quite difficult to live with as I can remember them so well the next day*

Nurse: *so they are really vivid and real seeming*

Bruce: *nods distressed and tearful*

Nurse: *yea*

Bruce: *quite often and I still get hallucinations which is .. not very pleasant..and the two things that I am not there and people are not there*
(Lines 599-572)

Bruce became more and more distraught and distracted as he told the nurse of his nightmares and his confusion regarding what was real and what imaginary. The nurse moved towards him and sat on the edge of the coffee table directly in front of Bruce. She took hold of both his arms and looked straight into his face from below. In this way she brought him back into the agenda of the assessment and into reality.

6.3.1.3. Laughter

Both as I observed the assessments and perhaps even more as I transcribed them I was aware of the amount of laughter and the many different types of laughter that took place during the assessments. Laughter ranged from the polite response to an attempt at humour for example this from assessment B3.

Context: The whole of the tiny two bed house was full of equipment. Mick had been talking about the fact that he could hardly use the bathroom as it was a storage place for pads and sheets. The nurse asked if there was anything else he needed.

Mick: *if you can get a skip for us that 'd be handy*

Nurse: *ha ha um* (Lines 503-504)

An example from the same assessment demonstrated derisory laughter.

Context: The nurse worked her way through the new assessment documentation checking that information was correct before re-entering it.

Nurse: *right no children you don't have any children do you*

Linda: *no*

Mick: *hey hey you do*

Linda: *ha (derisory laugh)*

Mick: *we have a daughter*

Nurse: *I beg your pardon you have a daughter but you don't see her as she is grown up*

Linda: *noNO*

Mick: *yep*

Linda: *39*

Nurse: *39 right*

Linda: *no we are on our own*

Nurse: *does she live in the area or is she*

Linda: *yes I think so*

Mick: *yes the last time she lived with*

Linda: *speech slurred mumbles something*

Mick: *pardon*

Linda: *she likes the lower life doesn't she... (Lines 322-339)*

Linda denied the existence of her daughter.

Laughter was also identified as a release of emotion in 37 instances during the assessments. This example is from assessment A1 where the patient commented on where he wanted to be as he died.

Context: In the interview following the assessment Richard and May were discussing their interactions with the district nurses.

May:..... (the nurse) *said to him well where, where do you want to go from so he looked like that and he said what are you on about where do I want to go from? and she said well when you die you it is a horrible question well Richard says well we haven't really thought about it so then we discussed it didn't we*

Richard: *yes*

May: *and then and then they got the package all ready and when the time comes so if Richard does deteriorate he can go into the hospice so it has all been all discussed and everything and they have been brilliant*

Richard: *well one good thing my eldest son commented on you should have said Hawaii*

Richard, May and Researcher: *laugh* (Lines 953-961)

This extract demonstrates the use of humour as May retold the story regarding the discussion of whether Richard preferred to die at home or in the hospice. Further Richard's son added the humorous comment that he should have elected to be in Hawaii when he died. Humour and laughter rendered contemplation of the location of Richard's death bearable.

Another example is from B4 where Steve is in considerable pain.

Context : The nurse worked her way through a series of closed demographic questions dictated by the documentation.

Nurse: *that's alright OK (nurse is filling in assessment form head down occasionally looking up at Steve) you sound Londony is that right ?*

Steve: *that's more like it*

Nurse: *that's right you certainly sound London – which part*

Steve: *Hexham actually*

Nurse: *Hexham and how long were you there for then when did you leave?*

Steve: *Bloody hell ummmm*

Nurse, Vanessa, Steve and Researcher: *laugh* (Lines 312-319)

Steve's spontaneous reaction to the nurse's relentless and intrusive questions diffused the situation with the release of laughter.

Laughter as a response to anxiety was identified on 26 occasions. In assessment C2 Dorothy repeated her concerns regarding her weakness and tiredness.

Context: The practice nurse followed the proforma on the monitor.

Nurse: *okhow how have you been feeling in yourself not just diabetes-wise but generally*

Dorothy: *oh fine except I'm um hmm very tired*

Nurse: *right*

Dorothy: *I sit down and sort of go to watch television and ...um ½ hour later I think um oh what was that all about ha ha* (Lines 133-138)

Dorothy's anxiety about her deteriorating health was not being addressed by the practice nurse and this caused her nervous laugh.

Bruce was in considerable pain that was not controlled by the cocktail of strong analgesics, including ketamine, which he was prescribed. He tried to appear quite sanguine about his condition however his anxiety often showed through as laughter or attempts at making light of his situation

Context: The nurse was assessing how much pain Bruce experienced and how much sleep he had.

Bruce: *the thing is It is just the inclusion of everything and it has been just horrendous and I just can't get over it that it is finished if you like*

Nurse: *what your spell in hospital or*

Bruce: *pain it s???? I can't forget it*

Nurse: *no*

Bruce: *it is all I think about all the time*

Nurse: *yea*

Bruce: *and the psychiatrist said oh do this that and the other, and I said to him will it do any good and he saidin your case probably not*

Bruce, Nurse and researcher: *laugh (Lines 1020-1028)*

Bruce also laughed and he meant this to be funny but the hopelessness of his resonated in the line- "*in your case probably not*".

However on several occasions laughter reflected the genuine warmth that the nurses and their patients felt for each other and the fun they were having in a relaxed and informal way during the assessment process. An example of this is from A1

Context: As the nurse prepared to undertake a technical procedure she was aware that Richard's breathing was laboured and he was not using his nasal oxygen

Richard: *I have just taken it off (indicates the oxygen mask) then I can stoke up you see ...I have just been I've been to the bathroom and er I don't like dragging it all the way round dragging it to the hall and*

Nurse: *cos the old lips are err looking a little bit er bluey so if I rig this up do you want it on again or would you rather have keep it off while we are chatting and you will put it on afterI would rather wait*

Richard: *I will put it on while you are talking*

Nurse: *(laughing) that might not be such a bad idea* (Lines 57-61)

The nurse gave Richard the power to decide whether or not to recommence using oxygen but made light of the fact that he was very cyanosed with the remark “*cos the old lips are err looking a little bit er bluey*”. They both realised the severity of the situation and the nurse joked that putting it on “*might not be such a bad idea.*”

During the interview both Richard and May (A1) commented that laughter was vital for establishing rapport.

6.3.1.4. Rapport

Rapport was mentioned by six of the nurses and although stressing its importance for effective patient care few clues were given as to how it could be established. The nurse in B1 referred to banter.

Context: Nurse’s interview following the assessment.

Nurse: *It’s also the kind of knowledge you build up - is, I know I know Fred well and as soon as he is unwell I can tell for a start you don’t get all the banter.* (Lines 628-629)

The nurse said she could tell, through her experience and “*knowledge*” how well Fred was as when he was unwell he no longer bothered to joke with her “*banter*”. The nurse repeated *I know* indicating that she has been nursing him for a long time.

Following assessment A1 the nurse described rapport in a similar way.

Context: Nurse’s interview.

Nurse: *just now and again you do build up a rapport and you do notice when things are changing even if nothing is said you do notice* (Lines 837-838)

This seemed to indicate a deep level of knowing and *being with*, by which I mean an authenticity that enabled the nurse to detect changes which were not spoken about.

Additionally following assessment B3,

Context: Nurse's interview.

Nurse: *I've got a good a fairly good rapport with Linda and with her husband and they are very happy to to tell me things and I think it is important that we give them that opportunity (Lines 1397-1399)*

The nurse described rapport as something that enabled patients and carers to *tell her things* that I interpret to mean subjects that they otherwise might be reticent to share. Rapport here is a means to get the patient to open up and be at ease.

In assessment A1 May referred to banter describing when the nurses came to drain her husband's lungs the relaxing and beneficial time they spent together.

Context: Carer's interview following the assessment.

May: *.....when you drain you sometimes get ½ a bottle of and they are sat there for an hour with you and they always have a cup of tea or a cup of coffee and have a bit of banter they are not rushing (Lines 1198-1200)*

Richard commented in his interview;

Richard: *we can make it... we can have a laugh and joke about it so it is no good going an flinging your arms up in the air and going oh woe is me and telling you all my woes don't get me wrong you have got enough of your own you don't want to hear my woes (Lines 975-978)*

Later Richard and May commented:

Richard: *yes I couldn't wish for a more helpful band of ladies who come round to look after me dedicated too we always have banter don't we with Jenny different banter with different ones and you have know because some are much younger*

May: *well we are alright we just have a laugh with them all I think there is quite a few of them only in their 20s but we can have a laugh (Lines 883-887)*

It was clear that both Richard and May (A1) thought very highly of the team that delivered Richard's complex care and described an ethos of laughter, banter and dedication that Richard expanded on below.

Context: Patient's interview following the assessment.

Richard: *well it is all the loving care isn't it you have got people like Jenny coming round and you couldn't ask for more love than that could you she is dedicated to her job isn't she and while she is here you are number one - nothing about somebody's ingrowing toe nail next call down the road - like focus on me* (Lines 1094-1097)

In response to a question regarding the nursing care he received Richard identified love, undivided attention and dedication as the indicators of nursing care that he most valued. I will discuss the idea that good nursing involves love, as agape, in the next chapter and will now move on to discuss other aspects of Richard's comment the notion of being "*number one*" which I refer to as authenticity of approach.

6.3.1.5. Authenticity

As discussed in chapter 4, Sartre (1954) regarded the ultimate authenticity of existence, of being the *thing in itself*, an act of pre-reflective being. Authenticity of this intensity was identified and comprised exclusively dedicating time, continuity and the sharing of knowledge.

Mark (B2) identified the amount of time the nurse was able to spend with him as one of the most valuable assets in having her deliver his care

Context: Mark's interview following the assessment.

Mark: *....Valerie has much more time to discuss and to go through things in greater depth* (Lines 1056-1057)

Ursula valued the knowledge Sonia had shared as part of the assessment process.

Context: Ursula's interview following the assessment.

Ursula: *well now every time I see Sonia I learn something else* (Line 617)

Richard and May (A1) appreciated the unhurried approach and their familiarity with the whole nursing team.

Context: May spoke about being one of the team in her interview following the assessment.

May:*Jenny, cos she was the first one that came in and we all had the video and the other nurse followed I and we all knew what to do they had trained me up so I knew how to do it ...*(Lines 1109-1111)

6.3.1.6. *Empowering language*

Language that *empowers, involves and includes* was noted in eight of the assessments. The three extracts from the assessment coded B2 demonstrate where the nurse listened, reinforced what Mark said and praised his efforts towards self care.

1. Context: Mark described an episode of sudden hearing loss and what he had done.

Nurse: *you are absolutely right*

Mark: *yes?*

Nurse: *That's been a big thing you have sorted out and are coping with* (lines 118-120)

Later;

2. Context: In this excerpt the nurse asked Mark about his breathlessness.

Nurse: *it's a subtle change isn't it*

Mark: *that's right*

Nurse: *that only you really would know the difference* (Lines 233-235)

The nurse explicitly acknowledged the patient's expertise regarding his condition.

3. Context: In his interview Mark described having initial misgivings regarding the change from seeing his doctor, being admitted to hospital, to seeing his nurse, Valerie, a Community Matron, when he was ill.

Mark: *when I was first told it was going to be operative um I was a bit dubious becauseI wasall my life I was used to seeing a doctor if I was not feeling well and I had great faith in doctors.*(Lines 1037-1040)

[]*but you see Valerie has much more time to discuss and to go through things in greater depth she could organise the antibiotics for me and it also meant that I wasn't going down and sitting in the surgery amongst other people who were coughing and sneezing and I could pick up something else* (Lines 1054-57)

After initial misgivings, (Mark said he has been “ *dubious*”, which suggests uncertainty or suspicion) he now appreciated his nurse's involvement. He saw the advantages of having close contact with his nurse and she was able to foster his independence by his instigation of meetings that saved him from going to the surgery. This appealed to Mark's enlightened self interest.

During assessment A2 the nurse asked Carol if she had seen the ulcer on the back of her leg. Carol said she had not but would like to and so a mirror was used to enable her to see the ulcer.

Context: Carol was visibly shocked at the extent and depth of the ulcer on the back of her left leg.

Nurse: *yes that is what I thought - I have got you this stuff when you were trying the boot with the calliper because it was rubbing wasn't it?*

Carol: *yes(8 seconds) I am quite depressed about that*

Nurse : *Oh I am sorry about that Carol I didn't realise it would be such a shock (Lines 249-251)*

At first Carol had said nothing, her gaze was towards the floor and her shoulders hunched (field notes) but after reflection she shared her feelings with us. The nurse acknowledged Carol's honest statement of shock without attempting to lighten the blow with platitudes. Acknowledgement that the condition of her leg was shocking began the process of empowerment that allowed Carol to speak about her experiences.

6.3.1.7. Nursing notes

Empowering practice was noted when the nursing notes were written during the visit and in three cases read back with the patient. The notes for assessment A3 contained Polaroid photographs of the patient's leg ulcers and both patient and nurse looked back through the records to discuss which had been the most or least effective treatments. When asked in the interview whether the patient and carer participants ever looked at the notes all but one said that they did. Typical responses were from interviews B1 and A3:

Context: Interview with Mary.

Mary: *I have glanced at them*

Fred: *You've forgot to put it away haven't you Mary?*

Mary: *I don't scrutinise it as soon as they have gone or anything like that*

Mary noted what was recorded but not to verify "*I don't scrutinise*" what was written out of interest. This was in common with Marjory's approach in assessment A3

Context: Interview with Marjory.

Marjory: *oh I sit here sometimes and I think oh I will go through the notes a minute and have a read* (Line 7773)

Marjory described "*having a read*" which again intimates looking out of interest and not scrutinising.

Steve (B4) as noted above he had found the notes useful as they contained all the contact numbers he needed for help and advice.

Following Foucault the knowledge provided by access to the notes gave both patients and their carers power. However in both the assessments which were carried out in the doctors surgery the notes were computerised and the patients were neither able to see the screen nor were their records shared in any way.

6.3.1.8. Institutional practices

The data revealed examples of the NHS hegemonies that facilitate *empowering* and *inclusive* practice. For example the Gold Standard framework for cancer care delivery, which despite the shortcomings noted above (C1), gave patients' wishes priority. The caveat being that their wishes need to be within the confines of the services which are being offered to them, such as .

- free prescriptions
- help with transport to and from hospital
- provision of bespoke recliner chairs, hoists, stair lifts.

However in the examples of practice observed for this study delays in the sanctioning of these provisions militates against the intention to provide needed and effective services.

The *empowering* exceptions were in assessments B5, B2, B3 and A1. In B4 the carer and patient found it noteworthy that:

- direct contact with both the hospital car service and the medical equipment team could be made when needed
- the nurses kept them informed and responded speedily to their needs .

Context: Steve's interview

Steve: *yea but yea I mean that and like the phone call we had earlier is from the research nurse and I know what it is about cos we made the appointment yesterday and it was just to confirm that we have transport and the times and that sort of thing []and that was 4pm yesterday afternoon (Lines 1020-1024)*

In B2 the patient had directly contacted the nurse regarding the concordant management of his chronic condition.

Context: Mark's interview

Mark: *...er last October I think it was err..... we were going to start doing the flu injections and I went down there to book in and they were already booked up and the only time they can see me was sort of late afternoon and the traffic gets horrendous at that time (laughs) and I didn't fancy it at all but I suddenly thought well Valerie comes to see and oh he said I will just go and check and he said oh yes it is all arranged she's going to come up and see you and give you your injection (Lines 1065-75)*

Mark had been able to arrange that his flu injection be given at his home at a time convenient to him. His relationship with the nurse had empowered him to take control.

Mary, in assessment B1, remarked regarding the nurse's provision of an air cushion and pressure relieving mattress for Fred that neither she nor her husband would have been able to ask for them, as they did not know they existed.

Context: Mary's interview.

Mary: *she's done all that for us ... and we hadn't a clue they existed (Line 918)*

6.4. Summary

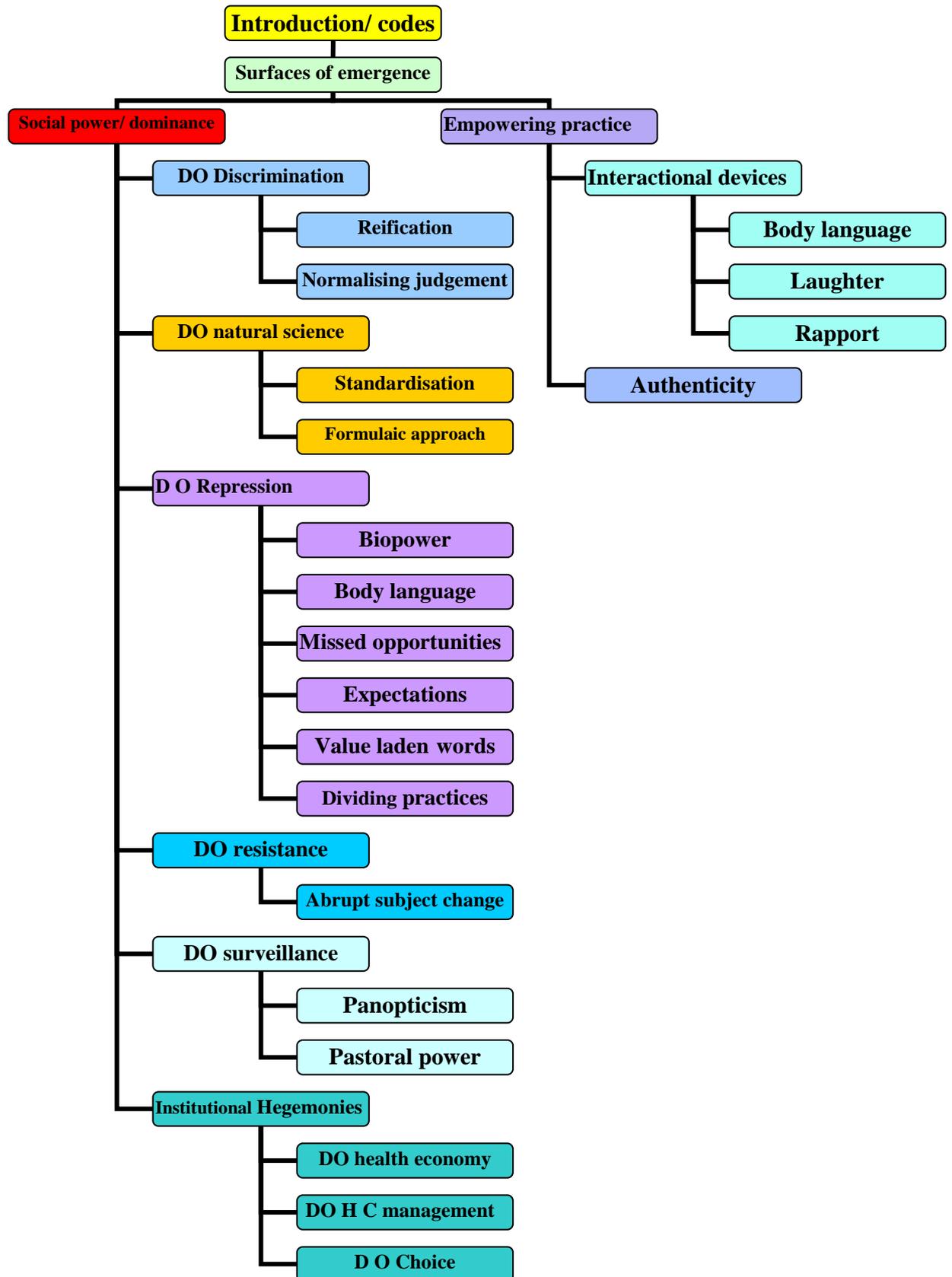
In summary the findings of this second phase of the study have revealed the complexity of the interlocking components that comprise the interaction between nurse and patient constituting nursing assessment. These are illustrated in Figure 6.2 where DO represents “discourse of” and HC represents “health care”.

This analysis has raised further questions and in the next chapter findings from both phases of this study will be compared and discussed in addition to data generated by considerations such as:

- emotional labour that constitutes both practice and research
- establishing of rapport
- agape
- patient advocacy
- authenticity

The formulaic approach engendered by the QOF led to consideration of the possible paradox inherent in achieving both a concordant agreement with a patient and reaching health care targets.

Figure 6.2 Map of Phase 2 findings



Chapter 7

Discussion

“It is in our idleness and our dreams that the submerged truth sometimes comes to the top.” Virginia Woolf. (1983) p32.

7.1. Introduction

The aim of this study has been to explore the factors that constitute the practice of nursing assessment. The literature review undertaken highlighted a paucity of comprehensive definitions of assessment and the subsequent Concept Analysis (CA) disclosed the many different and competing concepts for which assessment is a cipher. The previous two chapters have reported the findings from the CA of the literature reviewed and the Critical Discourse Analysis (CDA) of the field work data. This chapter will conceptualise and discuss these findings in the light of current nursing literature within a post modern philosophical paradigm. Practical, professional and political implications for practice will also be discussed in relation to the findings identified.

It is acknowledged that it is not the intention of this qualitative study to provide specific examples that can be extrapolated to form universal rules regarding nursing assessment. However it does provide instances of commonalities, contradictions and anomalies, both between the assessments studied and the analysis of the literature. The focus of this non-participant observational study was the everyday work of district nurses (DN), practice nurses (PN) and specialist nurses (SN). This chapter will commence with a consideration of the misapprehensions that arise from the use of the catchall term “assessment” and the implications this has for nursing practice accountability and evaluation.

I will review the findings of Phase two of this study with regard to the Judicial, the core category of assessment identified by the CA process. As identified in chapters 3,4 and 5 and following Foucault’s (1980) statement that knowledge equates with power; I will elucidate the particular aspects of nursing’s unique body of knowledge that support the

right to be heard and contrast this conceptually and philosophically with that of the medical discourse. I will also explore the tensions within nursing practice caused by the duality of their holistic approach to patient care coupled with the nurses' role in servicing the science of medicine (Hovey and Paul 2007).

The concept that underpins four of the five research questions for this study is that of empowerment and this will be analysed and discussed with regard to the findings of the CA and the CDA undertaken. The chapter will close with a reflection on the limitations of the researcher and the inception, process and outcomes of this study.

7.1.1. Issues arising from the use of the term *nursing assessment*

Chapter 5 has listed the categories identified by the CA. It is of note that only eight of the one hundred and twenty articles reviewed for this study offered formal definitions of assessment and that there was a divergence in scope over time between the concepts underpinning these definitions. For example Lake and John (2001) identified a range of considerations comprising assessment that offer a broader view of the process than that proposed by the DoH (1989), that restricted assessment to nursing needs only.

7.2. The assessment process as the identification of need

7.2.1. The assessment process

The UK government has responded to demographic and economic challenges to health care by expanding the responsibility of nurses to encompass the requirements of the single assessment process (SAP) (DoH 2002a). This has extended both the range of assessments made by nurses and the domains they cover, resulting in nurses assessing areas previously assessed by social workers and vice versa. This assumes that the knowledge bases of different healthcare domains have common aspects, a position contradicted by Clough (2002) who noted that "*workers assess primarily for the services provided by their own agencies*" and that joint assessment meant clients and patients were passed from one agency to another. Further that "*multidisciplinary meant a quick word with a colleague*". Clough's observations were confirmed in instances within the practice observed and audio recorded for this study. For example the nurse participant in assessment B1 noted that nurses had a greater understanding of the services provided

by social workers than social workers had of nursing services. Other nurses noted that they were unsure how to use referral systems and documentation designed by other branches of health care. Further when the nursing participants referred to team meetings it was in a narrow ambit comprising only members of the nursing team and perhaps the patient's GP. These practices challenge the perception of the seamless and integrated care pathways envisaged by policy makers (DoH 2007). This study has identified instances of professional tribalism and an unawareness of the roles of other professions. These attitudinal and practical barriers to the success of both the SAP and the integrated care pathways have profound repercussions for the effective delivery of patient care. For interagency working to function well these divisions must be overcome through mutual understanding whilst retaining respect for the zeitgeist of each of the agencies.

7.2.2. Conflation of contrasting terminology

Twenty-seven of the articles reviewed conflated the terms “*assessment*” and “*needs assessment*” and eight of the eleven assessments observed focused on assessment of need as the major part of the process. There are examples of the unintended consequence characterized by Worth's (2001) statement “*match services to need*”. This study further evidenced Appleton and Cowley's (2004) observation that rather than record unmet needs nurses' assessments may restrict identification of needs to those which have concomitant services available. This view of health needs assessment is in direct opposition to that of the Health Care Commission (DoH 2006) who regard the remit of SAP as addressing:

“*the whole range of needs and aspirations of older people*”. Commission for Health Care Audit and Inspection (DoH 2006) p37

I will return to discuss the implications of unmet need below but will firstly briefly elucidate some of the complexities identified within the concept of need itself.

7.2.3. Need

The concept of need is multifaceted and I offer this brief illustrative overview to demonstrate the confusion caused by the taken for granted assumptions implied with the everyday use of these deceptively complex terms. The following descriptors were identified from the literature reviewed for the CA and identify that the notion of need ranges in scope from the totally unspecified to highly specified types of need including;

- health needs (Audit commission 1994, Houston and Cowley 2003)
- nursing needs (DoH 1989)
- long or short term needs (Kennedy 2002b)
- psychological needs (Cheyne et al 2006)
- fundamental needs (Johansson et al 2005)
- clinical needs (Jordan 2002)
- physical needs (Hignett 2003)
- patient needs (Bryans 2000)
- personal and private needs (Bryans 2000)
- human needs (McKenna 1997)
- needs assessment (Mitcheson and Cowley 2003)

Further, Wright (2003) classified the types of need assessed within her study of assessment for long term care as; breathing, nutrition, personal hygiene, continence, mobility, transfer, integrity, sleep, medication, communication, orientation and emotional needs. The work of assessment is predicated on the assumption that all nurses have the experience and training to be able to identify the many different needs which any one patient manifests.

At a conceptual level if we deconstruct the noun *need* it can be used to imply:

- requirements
- prerequisites
- essentials necessary

Need also conveys a sense of a deficit, for example, poverty is the *need* of money and in the sense of neediness it implies dependence. Following Foucault, the term *need* may carry with it a hierarchical division between the person who has the *need* and is therefore needy and the person who identifies that *need*. Resulting from these pejorative connotations of the concept and the problematising nature of the process a tension is noted in the statement “a concordant assessment of *need*”. Concordance implies an interaction where the nurse and patient are equals denying the hierarchical process inherent within the language used to describe that process.

In addition to signifying a deficit, syntactically the verb “need” is also used to refer to the specific provision of the service required to rectify that particular requirement. For example “*identifies and meets nursing needs*” (DoH 1984) implies that it is the needs of a patient that can be met by nurses that are identified. This limited view of the scope of assessment begs the questions as to what nurses should do when they encounter needs requiring input from other agencies? The SAP should address this tension; however in practice it has been shown that barriers to inter-agency working still exist.

This brief exploration of *need* is used to identify the complexity, unintended consequences and confusions within our understanding of nursing assessment. It could be argued that this is merely semantics however in defence I would suggest that, following Foucault, it is through our use of language that we construct the object of our discourse. Further, our perception of the subject/object is dependent on its framing - a construct of our use of words which are experientially influenced.

Consequentially careful consideration is required when using descriptors for assessment based on a classification of types of needs. Primarily descriptors could presuppose an agenda driven and specific approach that could be detrimental to the nurse’s ability to respond to individual patient’s requirements that fall outside this remit. Proforma driven assessments evidenced that the patient’s agenda was lost because it failed to conform to the format used. Additionally Meredith (1993) has identified the paradox between the position where nurses defined and identified a user’s needs in a system that claims to be user led. This further reinforces the power hierarchy between nurse and patient. Raising questions regarding the implausibility of a practice, assessment, which can combine compliance, part of an ideology of control, and concordance its supposed antithesis (page 189).

7.2.4. Self-assessment of needs

Disparity has been noted between the literature that supports the concept of self-assessment and the CDA findings. According to Griffiths (2005) self-assessment, as recommended by the NSF for Older People (DoH 2001d), will impact positively on care management and outcomes. Conversely both patient and carer participants in phase two of this study, identified that nursing knowledge had provided them with equipment,

techniques and treatments of which they were previously unaware (assessments A1, B1, B3, B4, B5).

Further the question of the patient's perception of their health impacts on their self-assessment. The observation of practice and the CDA of the data highlighted examples of a disparity between the professional view of health and patient's view. One such instance was assessment B1. Prior to the assessment visit the nurse had described Fred in terms of his case, his diagnosis and clinical status, describing him as; a chair bound 84 year old, on BD morphine for pain from his leg ulcers that had required treatment for over forty years. Fred had recently been discharged from hospital following surgery for a fractured hip. He took anticoagulants, hypotensives and antidepressants. However Fred's self perception was not of a person who required additional interventions to restore his health. He described his health as apart from problems walking "*otherwise I'm fit enough*".

Further confusion was caused as Fred was reluctant to "*put his feet up*" as his recent bed rest in hospital had helped his ulcers heal. It became clear in the interview with Fred's that his reluctance was caused by a misunderstanding as he thought the nurse meant rest in bed, which he found isolating, when she said "*put your feet up*". Further Fred was unaware he could be provided with a recliner chair to enable him to stay downstairs and elevate his legs and he therefore would not have been able to self assess for this.

7.2.5. Unmet needs

The potential for identification of needs that cannot be met is acknowledged within the literature (Lockwood and Marshall 1999, Appleton and Cowley 2004). Evidence that documentation following assessment was constrained by the reluctance of practitioners to either discuss unmet needs with users and carers, or to record them for fear of legal ramifications was noted in the studies by Ellis (1999), Bryans and McIntosh (1996), Kennedy (2002a), Niven and Scot (2003) and Appleton and Cowley (2004).

This study has confirmed from practice observation and the literature that there is a disparity between the rhetoric of a needs assessment process that address and meets all of an individual's needs and one that only identifies needs for which there are

services available. Further that, because we “do not know what we do not know” self-assessment by patients may fail to identify all their needs that could be met. Lastly the use of conflicting terms for assessment results in a presumption that it refers to any one of many diverse and specific practices whilst at the same time providing an holistic overview. The process of assessment is detrimentally influenced because of this confusion coupled with the pejorative connotations of the term *need*.

False assumptions regarding understanding of what is meant by needs raises implications for nursing practice, as the confusion engendered only serves to obscure the necessary practice of the timely direction of funded resources to those who require and will benefit from them. This is in opposition to the unaffordable rhetoric of a desire to meet all “aspirations” (Health Care Commission (DoH 2006) now the Care Quality Commission). This statement confuses the responsibility of the NHS to meet patients’ necessary clinical requirements with provision for their *wants* and *hopes*.

7.3. The “know how” of nursing knowledge: intuition, empathy and prediction

In addition to clinical skills and scientific knowledge, both CA and CDA have shown assessment to have a phenomenological aspect, a question of perception. With some of the essential prerequisites required for making an assessment characterised as having the metaphysical dimension of intuition. Lake and John (2001), Pyles and Stern (1983), Jasper (1994), Eraut (1994), Dawson (1997), Bryans and McIntosh (1996), Ellis (1999), Sbiah (1998), Walker (2003), Manais et al (2004), Godin (2004), Cader et al (2005) and Pancorbo et al (2006) all included intuition as a necessary part of their theories regarding the process of nursing assessment. Intuition has been described in the nursing literature as “*understanding without rationale*” (Benner and Tanner 1987p23) and as a use of “*the sudden perception of a pattern in a seemingly unrelated series of events....Beyond what is visible to the senses*” (Gerrity, 1987 p65). Dawson (1997 p.286) described intuition as “*creativity and insight*” a part of “*intellectus*”, the higher of the two medieval explanations for the acquisition of knowledge.

7.3.1. Intuition

In chapter six the CDA demonstrated the importance of intuition as a part of the

assessment process. For example within the discourse of empowerment, intuition was seen as fundamental to the establishment of rapport with patients (assessments A1, A4, B1 and B3). Rapport was indicated by the CA as significant especially if assessments were of a sensitive nature (Kennedy 2004, Maher and Hemming 2005, Stenson 2005). The essential position of rapport as a facilitator of assessment, through improved communication, was noted in nine of the papers critiqued and by eight of the participants in the assessments observed. Analysis of these sources identified the following prerequisites for building of rapport:

- the provision of personal care (McIntosh 1996, Twigg 2000; Niven and Scott 2003; Appleton and Cowley 2004) (assessments A1, B4),
- time spent getting to know the patient (Anderson 2008; Appleton and Cowley 2006) (assessments B1, A1)
- nursing experience (Richards et al 2004, Appleton and Cowley 2008) (assessments B3, A1)
- building trust (Stewart 1995; Fallowfield & Jenkins 1999; Twigg 2000; Niven and Scott 2003; Appleton and Cowley 2004) (assessment B3)

It is of note that state policy has brought about changes in composition and skill mix of the community nursing teams (Health Service Management Executive [HSME] DoH 1992a). These changes have reduced the numbers of DNs at Sister grade working in the community from the levels of the 1990s (McIntosh 1996) and increased the numbers of staff nurse and health care assistant grades. This practice has been mirrored in acute nursing teams for policy, demographic and managerial reasons. In the community this has resulted in the delegation of some of the intimate care previously delivered by nurses to untrained social care staff. In consequence opportunities for nurse and patients to establish rapport have been reduced and, in the light of the evidence from the literature reviewed and the field work observation (assessments A1, B2) this can have a detrimental impact on assessment practice and patient care.

The CDA also showed patient's making intuitive judgements for example Richard and May (A1) spoke of tailoring approaches when establishing rapport with individual nurses.

7.3.2. Prediction

A further example of this phenomenological perspective of assessment practice was the

predictive quality of the process. Predictions identified within the literature and the CDA were of two kinds: the predictions of requirements and those of events. Benner (1984) Yates (1990), Molony and Mags (1999) and Kennedy (2002a, b) all noted that the assessment of a patient's condition included judgements regarding the amount of help and type of service they would require in the future. Observation and analysis of practice also showed that nurses based their decisions on the predicted outcome of tasks and on anticipated needs of patients. For example the provision of a recliner chair for Marjory (assessment A3) was seen as a precursor to improvements in her leg ulceration and lymphoedema because it would enable her to elevate her legs and thereby reduce the swelling. These types of judgement were predicated on the nurses' prediction of the patient's response to the options under consideration. Crow and Spicer's (1995 p419) study analysing nursing judgement showed the anticipated outcome of interventions or "recovery" were a core deciding factor in how the nurse viewed the patient's "hold on life" that in turn biased their judgements regarding treatment options.

Nurses were also reported as predicting events, for example death, as a part of their assessment practice (Marks et al 1991) or deterioration in the patient's condition (Pyles and Stern 1983). Similarly the participating nurse in assessment A1 stated that having built rapport with her patients she was able to notice changes even if "*nothing is said*".

Further, the CDA of the field work data, showed examples where nurses predicted the outcomes of actions. These were reported within the discourse of discrimination which contained examples of normalising judgements based on an individual's constructed expectations of what constituted normal behaviour by a patient in any given situation. These expectations were shown to be either empathetic, where the nurse intuitively tried to put herself in the place of the patient. Or they can problematise patients and their behaviour as "other". Some judgements based on expectations were predicated on anticipated attitudinal changes over time as patients adapted to their new situation, for example the nurse who undertook assessment A4 expected that in time Bruce to be less fixated on the treatment he received whilst an inpatient, as he would "*move further on*".

7.3.3. Empathy

Empathetic responses to patients' situations were identified as a part of the assessment process in both the CA of the literature and the CDA of the field data. Empathy was first

used as a scientific term to describe care delivered by nurses and others, in a clinical psychology study by Carl Rogers (1959). Mitcheson and Cowley (2003) refer to empathy, and Rodgers and Knafl (2000) drew on Morse et al's (1994) list of seven metaphysical concepts that include, intuition, inference, knowing the patient, countertransference, empathy, compathy and embodiment.

They noted that an overlap of these terms had led to misinterpretation of assessment practice and they suggested the

“appropriate concept has not yet been developed” Rodgers and Knafl (2000)
p350

I will return to this discussion of the *“appropriate concept,”* and the implications for accountability of accepting the use of metaphysical concepts as a part of nursing practice.

7.4. Misapprehension caused by the conflation of assessment with other concepts

As was noted above the literature reviewed often used the term assessment interchangeably with others such as nursing diagnosis (Crow et al 1995) screening (Green and Watson 2005) and clinical judgement making (Thompson and Dowding 2009). Drawing on the evidence from the CA and CDA I would argue that the terms are not synonymous but may indicate aspects of assessment practice. For example screening implies simple judgements regarding the binary: *A* or *not A*.

7.4.1. Nursing diagnosis

Nursing diagnosis is a contested term that has not been fully adopted within the UK but is used throughout the USA. Gordon's (1994) book, originally published in 1983, developed a nursing diagnosis typology in order to standardise American nursing diagnostic assessment formats. Interpretations of nursing diagnosis range from simple cue recognition and matching, as with screening through to the medical model of hypothesis generation and justification. At one extreme Carpenito-Moyet's (2008) book on *Nursing Documentation and Care Planning* suggests that problems are raised if a nursing diagnosis does not differ from medical diagnosis. For example according to Carpenito-Moyet the medical diagnosis *“asthma”* equates to the nursing diagnosis

“impaired gas exchange” (p4). In contrast to a holistic diagnosis where the purview is wider than the biomedical parameters of gaseous exchange this concept of diagnosis presents a reductionist approach. Both the Carpenito-Moyet approach to nursing diagnosis and the biomedical model that underpins medicine fail to portray the patient, or address holistic patient care, as recommended by the Nursing and Midwifery Council (NMC) (2007).

“The emphasis must be on the provision of holistic care” NMC (2007) p5

Holistic care offers an integrated approach that facilitates care for whole people within their social relationships and circumstance. The practice of holistic nursing extends care beyond the physical to include consideration of a patient’s mental and spiritual state. Holistic nurses construct the concept of healing as the journey to a position of holistic balance or well-being (Erickson 2007). Conversely the medical discourse of which diagnosis forms a part can be viewed as a construct that concentrates on specific parts of people or their disease processes and takes a causative approach. For example A causes B, therefore stop, change or alter A, and B will no longer be present.

Nettelton (2008) noted that the medical profession have maintained their dominant position in healthcare because they have retained *“control over certain technological procedures”* and I would argue that diagnosis is a case in point. An example of this is the response by doctors, following the advent of nurse prescribing, which threatened their monopoly of diagnosis. One instance was the statement made by Professor Hugh McGavock (2007), Visiting Professor of Prescribing Science at the University of Ulster, who was reported as voicing his *‘serious concerns’* about the nurses’ new prescribing rights citing their *“pathetically poor skills”* in diagnosing. Conversely Radley et al (1995) found that nurse participants in their study prescribed more appropriately than their junior medical staff counterparts. Appropriate prescribing is dependent on the demonstration of accuracy in diagnosis.

As noted above there are tensions in the nursing role when it tries to serve the reductionist medical agenda of symptom specific, task facilitated, cure or treatment since this is antithetical to a holistic, concordant agenda that dictates the approach of caring for the mind, body and spirit of a patient, who as an individual is a part of a wide social and cultural network.

Until the connotations of incompatible terms used interchangeably to express the notion of

assessment are challenged, nursing assessment cannot be accurately defined, primarily because, as has been shown, it has several meanings and is therefore a composite activity where each meaning is contextually bound. This position raises several concerns since without a definition it is difficult to standardise, audit or assess the quality of the process. However assessment is a process that is an integral part of the activity of nursing and permeates every nurse--patient interaction. For example, whilst undertaking a complex dressing which entailed utilisation of their clinical assessment skills, the nurse participants in assessment A1, A2 and A3 also assessed

- the patient's mood
- were they depressed
- their general well being
- any influences from housing, work, or family causing concern
- any anxieties regarding their condition
- how the patient was relative to their last meeting
- what anticipated improvements there may be in the condition
- their biological parameters:
 - infection,
 - dehydration,
 - skin condition,
 - reactions to dressings,
 - blood pressure,

The case I am making is that assessment is an intrinsic part of the nursing process and this was identified by forty-six of the papers reviewed and observed in practice.

Therefore what constitutes nursing practice also constitutes nursing assessment.

However this simplistic assertion relies on universally accepted definitions of nursing and fundamentally, what it is to be a nurse. Consideration of the two descriptors below challenges the perception that these are well understood terms. Both are from influential bodies; the first, from the Royal College of Nursing (RCN), defines nursing practice as

The use of clinical judgement in the provisions of care to enable people to improve, maintain and recover health, to cope with health problems and to achieve the best possible quality of life whatever their disease or disability until death. RCN (2003)

The second from the NMC describes the core requirements for a nurse within their code

of practice:

The people in your care must be able to trust you with their health and well-being. To justify that trust, you must

- *make the care of people your first concern, treating them as individuals and respecting their dignity*
- *work with others to protect and promote the health and well-being of those in your care, their families and carers, and the wider community*
- *provide a high standard of practice and care at all times*
- *be open and honest, act with integrity and uphold the reputation of your profession NMC (2003)*

There is a disparity between these positions as the use of the limiting term *clinical* in the RCN definition precludes aspects of holistic nursing that are found in the NMC code, for example the second bullet point and also the notion of well being in the opening phrase. This inconsistency of approach to the concept of what constitutes nursing and nursing practice from two pre-eminent professional bodies within nursing identifies profound implications that need to be addressed as we enter the second decade of the twenty-first century.

7.5. The Judicial

Bearing in mind Foucault's (1970) reference to the arbitrary nature of categorisation illustrated in the opening quotation for chapter 5, I will move to discuss the core category identified by the CA and implicated in the opening sentence of the RCN (2003) definition above, the concept of the Judicial or judgement making.

This search to broaden understanding of the process of assessment in everyday practice is predicated on the dispositional theory of concepts that arose from the work of Wittgenstein (1953). As discussed in the methodology chapter this holds that in order for a person to have the use of a concept they must have an understanding of that concept. Ryle (1971) proposes that the grasp of a particular concept facilitates a range of cognitive and practical tasks that share characteristics with the concept. The

archaeological and genealogical analyses of the discourses of nursing assessment, following Foucault (1972), were reported in chapter 4. I now move to discuss the core concept identified through the CA, that of the Judicial or judgement making with regard to the both the CDA findings and the relevant nursing literature.

Thompson and Dowding (2009) consider judgement as “*the assessment of alternatives*” which they describe as the core of all nurses’ clinical decision making. However they note that it is often a tacit process, drawing on experiential knowledge, and not open to scrutiny or challenge. This has profound implications for practice as it is necessary for nurses to be accountable (NMC 2008) and for this to be achieved the process by which nurses reach their decisions must be clear and justifiable. Further Meerabeau (1992), Morse et al (1994) and McIntosh (1996) have noted difficulties encountered by nurses when asked to express or validate the process of intuitive and empathetic models of judgement making.

7.5.1. Nursing knowledge

Appleton and Cowley (2008) assert that “*knowledge is the basis for making judgements*” citing Carper’s (1978) work that identified four domains constituting ways of knowing:

- ethics (questions of morality),
- empirics (the scientific basis of clinical knowledge),
- aesthetics (the emotional feeling of experience)
- personal knowledge (self-awareness)

Examples of judgements made by nurse participants across all four domains were observed following the CDA of the data. For example ethical considerations of honesty were noted in assessment B4, although the nurse’s statement is somewhat ambiguous as she asserts that “*nothing secret and private*” is included in the notes. Following careful consideration and the context in which the statement was made it was interpreted that the nurse was speaking from her perspective referring to the fact that the notes give an open and honest reflection of the elements of the care given.

An illustration of knowledge based on the domain of empirics is taken from assessment A3 where the nurse used complex calculations to determine the pressure being applied to the patient’s leg by the pressure bandaging.

The domain of aesthetics has been illustrated by the data regarding intuition and empathy in the previous section. It is significant that the emotional component of nursing practice has been cited as a domain and I will return to the concept of emotional labour later in this chapter.

Self-awareness as a component of assessment was also noted and this example is taken from the interview following assessment A4 where the nurse discussed Bruce's anger at his treatment whilst in hospital. She demonstrated awareness of her own "rule of thumb" when dealing with emotionally charged situations when she stated "*First keep an open mind is always a good one*". This also revealed a tacit acceptance that personal bias may influence any judgements made.

7.5.2 How do nurses know what they know?

In addition to the theoretical domains (Carper 1978) in which judgements are made there is also the questions of how they are made. The literature regarding knowing reveals a polarised split where some theories echo Heidegger's notion of pre-theoretical understanding that stands in sharp contrast to the ontologically positivist theories of rationality. Both Harbison (1991) and Thompson and Dowding (2009) describe these two approaches to the process of nursing judgement making. The first is the theory of rationality, epitomised by a reasoned response to observation, analysis and a logical assessment of data. This is grounded in the systematic positivist ontology of the hypothetical-deductive model of an assessment process. This was attributed to Elstein (1978) and Carnevali (1984) and cited within the works of Appleton and Cowley (2008) and Thompson and Dowding (2009).

The second approach is based on the hermeneutic or interpretivist paradigm. This offers a phenomenological perspective to our understanding of the world where meaning is made through conscious awareness (Draucker 1999) that is embodied in the individual (Merleau-Ponty 1945). In nursing this approach is attributed to Benner (1984) who built on the work of Dreyfus and Dreyfus (1980).

Thompson (1999) identified a third position, that of the Cognitive Continuum theory, a combination of deduction and intuition that does not hold these two ontologies as oppositional but considers them as at either end of a spectrum of cognition. Table 7.1

below presents these three theories and their components in addition to six further theories that were identified following the CA of the literature undertaken for this study.

Table 7.1. Reasoning process theories in nursing judgement making

Reference	Theory	Theory components
Elstein et al (1978)	Hypethetico-deductive rational process	<ul style="list-style-type: none"> •1 Cue acquisition •2 Hypothesis generation •3 Cue interpretation •4 Hypothesis evaluation.
Carnevali et al (1984)	Hypethetico-deductive rational process	<ul style="list-style-type: none"> •1 Exposure to the pre-encounter data •2 Entry to data search fields and shaping the direction of data gathering •3 Coalescing of cues into clusters or chunks •4 Activating possible diagnostic hypotheses •5 Hypotheses and data directed search of data field •6 Testing diagnostic-directed search hypothesis for fit.
Hamm (1988)	Cognition Continuum theory	<ul style="list-style-type: none"> •1 Acceptance or rejection of cues observed •2 Familiarity with task and implementation of experiential knowledge •3 Evaluation of evidential and intuitively obtained information.
Hammond et al. (1967) Panniers &	Bayesian and/or probability theory	<ul style="list-style-type: none"> •1 Beliefs are held to differing degrees based on:

Kellogg-Walker (1994)		<ul style="list-style-type: none"> ○ Scientific theories ○ Outcomes ○ Phenomena ●2 Beliefs are adjusted in response to new or probable evidence.
Aspinall (1979)	Decision tree	<ul style="list-style-type: none"> ●1 Structured decision making based on calculated probabilities.
Benner (1984)	Phenomenological: Intuitive--humanist	<ul style="list-style-type: none"> ●1 Expertise enabling intuitive judgements ●2 The expert no longer relies on analytical principles to make decisions
Gobet and Chassy (2008)	Phenomenological: Template theory (TempT)	<ul style="list-style-type: none"> ●1 The unconscious retrieval of information caused by: <ul style="list-style-type: none"> ○1 Intuition ○2 Emotion ○3 Pattern recognition
Lake and John (2001)	Phenomenological: Fuzzy Logic	<ul style="list-style-type: none"> ●1 Mathematical concept ●2 Accommodates ambiguities ●3 Intuitive method

7.5.2.1 Examples of the hypothetical-deductive model of knowing

The CA identified the hypothetical-deductive model within the concept of “illness scripts”. These are causally linked categories that correspond to one illness or another (Schmidt et al 1990, Crow and Spicer 1995). It is suggested that nurses remember an exemplar or prototype of any particular illness or condition and match the patient cues they observed in practice to this memory. Crow et al (1995) also refer to nurses forming “*perceptual patterns which guide their internal search*” and recognition of disease. This process has been identified in Cianfrani’s (1984) information processing model, which has as its central premise that the human decision system is divided between the short and long term memory. In this model the short term memory responds to cues and stimulates the

utilisation of episodic knowledge stored in the long term memory.

Instances of this type of reasoning were also identified following the CDA of the data obtained from practice observations. For example, the use of proforma or documentation which prompts questions as part of the assessment process. The QOF proforma was described by the practice nurse in assessment C2 as a “*mental tick box*”. I interpreted this statement to imply that the on screen proforma provided the cue prior to her formulation of possible hypotheses. These hypotheses were based on her experience and memory of similar patterns recalled from guidelines or the presentations of other patients.

I would argue that this approach of matching internal patterns stored in memory with external observations does not give sufficient scope to allow for the diversity and complexity of all assessment practice. Bergen’s (1996) study has highlighted the complexity of the practice of assessment when carried out by community nurses noting that it included “*ethical* “ components and required practice wisdom. The CDA of the field work data has shown that when carrying out an assessment, in addition to clinical judgements nurses have to consider the many different manifestations of disease processes that are affected by

- the patient’s perceptions of their relative health or illness (A1, B1, B4),
- health promotional activity (A2, B2, A3)
- broader notions of well being (B2, A2)
- the comparative use of medications and treatments (C1, B5)
- the use of equipment including medication delivery equipment, (B5 B1)
- life style considerations such as diet and exercise (C2, A2, A3)
- travel (A3, B2)
- housing (B3)
- family relationships (A1, B3, B4, C1, A3)

Matching external cues to memory may however be the approach that is used when appraising diagnostic cues such as abnormal blood results, X-rays, ECG interpretations and other biomedical findings. As noted above assessment was often conflated with this type of screening in the literature reviewed. Screening may also be facilitated through the use of checklists and proforma-led assessments. These are provided to aid

standardisation and thereby audit and to help the novice carry out new procedures. Conversely, both the literature reviewed, for example Niven and Scott (2003), Dickinson et al (2005), and the CDA of assessments C1, C2, B3 and B4 demonstrated that this approach was far from universally successful. Examples were observed in practice where the nurses adapted and edited these processes. By these examples this study has shown that dependence on the use of tools such as proformas to facilitate standardisation and audit does not provide an accurate picture of practice.

7.5.2.2. Theories of the phenomenological perspective on knowing

Heidegger's (1889-1976) tutor Husserel (1895-1939) saw experience as the ultimate basis for knowledge. Husserel described the world of enquiry as one populated with subjects directed towards objects, the epitome of Cartesian dualism. In contrast Heidegger portrayed individuals as inseparable from the world of objects. Identifying much of our daily lives as being spent in pre-theoretical understanding of "*being-in-the world*" or Dasein. Heidegger's phenomenological position requires that experiences can only be understood in terms of their cultural, social and historical contexts, further, that the goal of hermeneutic or interpretative research is to increase an understanding of human experiences.

7.5.2.2.1. Benner

This phenomenological approach to judgement making was identified by Thompson and Dowding (2009) and found in the nursing theory of Benner (1984) that was influenced by the work of Dreyfus and Dreyfus (1986). Thompson and Dowding and Benner's shared theory of knowing is based on the shaping force of an individual nurse's experience, expertise and the metaphysical concept of intuition. They describe decisions made by experts as being made without recourse to rules or maxims - these are only considered when a new situation is encountered (Thompson 1999).

I would argue that this last stance does not constitute an example of Heidegger's pre-theoretical knowledge as it is post-theoretical. Because at one time each experience must have been new and therefore hypothetical-deductive logic would have been used at this first encounter. This would infer that all nursing knowledge was primarily based on the hypothetical-deductive model. If this position is accepted the range of nursing knowing is limited to what can be inferred or deduced. As a consequence philosophically

antithetical metaphysical concepts such as intuition would be excluded from the process of judgement making.

7.5.2.2.2. *Template theory (TempT)*

Gobet and Chassy (2008) have shown a link between intuition and emotion, reporting Bechara et al's (2000) experiments with neurological patients, which demonstrated that intuitive decision-making was more difficult without an emotional component. Critical of Benner's explanation and the work of Dreyfus and Dreyfus, Gobet and Chassy (2008) propose the Template theory (TempT) originally proposed by Gobet and Simon (1996.). TempT accepts that experts and novices have the same cognitive limitations and use the same problem solving methods, while asserting that experts have however learnt a larger repertoire of "chunks" (Simon and Chase 1973), perceptions and meanings, than have novices. Complex aggregations of chunks become templates consisting of a core of stable information and slots that accommodate changeable information. Core and slot knowledge when frequently accessed, as with each experience, become more quickly accessible for the expert than for the novice. The novice has to retrieve knowledge through a slow process of explicit problem solving each time. TempT accepts intuition as just one more method of seeking solutions to problems. Gobet and Chassy (2008) use DeGroot's (1978) study of chess masters as evidence of the complexity of templates as compared with chunks and the ability that the expert has to rapidly process complex information. Gobet and Chassy conclude that the evidence from chess will be transferable to nursing and that expertise in nursing will yield the same rapid access of stored knowledge as it does for chess masters. Although allowing that TempT may be the function that facilitates our acquisition and storage of knowledge chunks I am not sure that the evidence from chess masters is analogous to nursing. Chess is a game with fixed rules consisting of the movement of pieces in proscribed ways, whereas the manifestations of disease and disease process are unique to each individual and every individual reacts differently to their situation. Further chess pieces themselves are unable to interact with each other, react or influence the game.

7.5.2.2.3. *Fuzzy Logic*

Lake and John (2001) observe that assessment comprises variables such as

"imprecision and intuition" p11

"uncertainty and vagueness" p14

They construct assessment as a process exemplified by fuzzy logic, a mathematical concept that can accommodate the ambiguities of real-world human language and logic. Fuzzy logic accommodates the positions, “either”, “and” and “or” which is reminiscent of the medieval approach of the alchemist. It provides both an intuitive method for describing systems in human terms and automates the conversion of those system specifications into practical and effective models. Fuzzy logic has been embraced by architecture and engineering (Hess J 1992, Yager and Filey 1994). For example it forms the design and control system for the Sendia subway system in Japan designed and built in 1987. Bates and Young (2003) proposed its use for computer-aided medical diagnosis in Intensive Care Units, in order to reduce inconsistencies in medical diagnosis. Examples of experience, intuition, prediction and holism in the data regarding the assessment process have shown that both the fuzzy logic system and the human process of knowing may be based on similar processes.

7.5.2.2.4. *Cognition Continuum theory of knowing*

Eraut (1994) contends that professional deliberations consist both of intuition and analysis, and research by Lauri et al (1995), using a factor analysis approach, found evidence to support the utility both of the hypothetical-deductive and the phenomenological approaches to judgement making. The Cognition Continuum theory places judgement making somewhere between the two poles of these positions. This model takes into account the influence on judgements of the shared knowledge of the wider team, the institutional hegemony and an individual’s knowledge base (Hamm 1988). Pyles and Stern (1983) refer to a “nursing gestalt”, a matrix linking knowledge, past experience, identifying cues and “gut feeling”. Within the Cognition Continuum theory unsupportable intuitive decisions made by junior colleagues were rejected and decisions made by other individuals were utilised, dependent on what those individuals were judged to know.

Unfortunately this combined approach although recognising a spectrum of cognitive approaches and identifying nursing as a social interaction influenced by cultural, institutional and historical pressures does not escape the criticisms made about its component parts. Thompson (1999) claims that the power of this combination allows transparency, however he does not say how this will be brought about. He relies on an evaluation of the process provided by Hamm (1988) whose review of the practical use of

Cognition Continuum theory was based on observations of medical practice. Thompson (1999) asserts this work is transferable, but as outlined in earlier chapters, I contend that unlike medicine where the doctor approaches the patient with a hypothetical theory of what is wrong and then seek evidence to support their theory, in contrast, nursing decisions are made through interactions with the patient. The patient's understanding of their condition is gauged and then interpreted in the light of nursing knowledge, experience and expertise.

The Cognition Continuum theory as described by Hamm and Thompson utilises decisions made about the knowledge base of other practitioners before deciding if advice is taken. It is difficult to see how a nurse who needed advice about practice would know whether or not to trust the advice of others. This position will not accommodate the requirement for accountability since if an error is made nurses cannot use the defence that they were following orders. Further, if intuition is accepted as a part of nursing judgement-making, it is difficult to construct criteria for judging the reliability of the intuition of others. Lastly by describing a linear continuum for this theory they have denied the complex combinations of the theoretical positions between the two poles.

7.5.2.2.5. Bayesian and/or probability theory and Aspinall's (1979) decision tree

The Bayesian or probability theory suggests that a practitioner will adjust their hypothesis in accordance with new evidence as it presents itself. Aspinall's (1979) development of this theory led to his design of a tool, a decision tree, which is based on calculations of predicted outcomes to actions that enabled nurses to reach decisions.

There are three main problems with these approaches; firstly, as discussed above the approach is that of medicine rather than nursing, as a basic hypothesis is justified by empirical evidence rather than information gathering and dialogue which would result in a holistic assessment of the patient. Secondly real life rarely, if ever, follows the linear sequences implied by the models and in practice nurses may not sequence their activities in the ways dictated by the models. Lake and John (2001) note that there is not always sufficient or precise information available on which to base the decisions that nurses make. Thirdly nurses are conservative and risk averse (Slevin et al 1990), described by Thompson (1999) as "*cognitively cautious*", and this is reflected in their judgement making. In practice this may restrict their use of the decisions these models

would promote.

Synthesising these theories regarding nursing knowing and knowledge elucidated through the literature, and the findings from the CDA, the complexity of the process indicated by the term *assessment* emerges. The evidence provided by this study shows that the process of assessment comprises making judgements using knowledge obtained from the domains indicated by Carper, above. However there are components within the domain of aesthetics that raise implications of verifiability and accountability for nurses. For example if as Benner (and others identified by the literature review) suggest, intuitional and empathetic judgements are based on experience (Pancorbo et al 2006), it is hard to show how the original exposure to situation can have been evaluated. If it is accepted that intuitive judgements are based on the experiences of what worked and what did not, how can nurses defend themselves when they have tried a response based on intuition, that didn't work? Additionally if intuitive judgement is solely based on the observation of efficacious practice carried out by others, then nursing practice will become stultified and unresponsive to external pressures and advances. Ling and Luker (2000) suggest that intuition decisions are only taken if they are confirmed by "*more tangible*" information. This notion of a combination of using the clinical evidence observed, the experience gained from encounters of previous similar sets of situations, and the metaphysical feelings and emotions a nurse may have regarding a situation may indicate the process undertaken to make judgements.

This may go some way to answer Paley's (1996) question regarding Benner's (1986) assertion that intuition is just something that experts do. Paley specifically asks, then what do non-experts do when carrying out the same functions and in what ways does it differ from intuition? Perhaps as described by Gobet and Chassy (2008), non-experts have to go back to basic principles and using induction and deduction construct their response whereas experts are using a combination of clinical evidence, experience and intuition. The data supports this position regarding an expert, for example Niven and Scott (2003) identified "*practice wisdom*" which can be interpreted as underpinning predictions such as the assertion that changes could be discerned even if "*nothing was said*" (nurse participant in assessment A1).

This discussion of assessment has raised several more interesting themes, those of the building of rapport and the importance of banter. Although both are cited in the literature

as important adjuncts to nursing assessments (Appleton and Cowley 2008) and evidenced through the CDA, there is little evidence of the processes involved.

7.6. Empowerment

The concept of empowerment within health care explicitly underpinned the third research question for this study, and in addition, through the concepts of impact and influence was implied in questions two, four and five. Before discussing the instances and effects of empowerment on nursing assessment, following Foucault, it is useful to identify in what way it is meaningful to speak of a discourse of empowerment.

7.6.1. Archaeology and genealogy of the discourse of empowerment

7.6.1.1. Surfaces of emergence

The origin of the word *empower* dates back to the early 1650s and it was used by William Penn as a legal term to legitimise his founding of the state of Pennsylvania in 1654. The *Dictionary of Etymology* (Chambers 2001) suggests the modern use of *empower* dates to 1986 and is a conflation of *em*, to give to and *power*. This definition semantically suggests the transfer of power from one person to another. Traditionally, power has been considered in terms of the 'juridico-discursive' model where proponents see power as an oppressive force that dominates as it flows down from the top to the bottom of society. Foucault (1980) criticised this model as representing only one form of power. He described a construct of power that is both constituted and constituting; that is exercised and not possessed.

Following from this Foucault's construct of power is seen to be free from egalitarian connotations and able to flow throughout society operating across macro, meso and micro levels. Foucault's construct perceives a manifestation of power free of repressive and oppressive connotations; that is liberating and empowering in the sense that it is emancipating, enabling individuals to challenge the status quo. Because this manifestation of power cannot be possessed it cannot be seen as a commodity given by one person to another but perceived as something that circulates, visualised as moving across a net or as links in a chain -- not leaving one person without power in order to empower another but transferring power by linking across interactions (Foucault 1980).

Not all power found in health care is of this emancipatory kind. Foucault raised a distinction between the extravagant ceremony of the panoply of state power and the invisibility of disciplinary power described as enforcing visibility on those it subjects to its influence. It is disciplinary power that is manifest within the clinical examination and the discourse of surveillance identified from the CDA, where the patient's body is scrutinised and compared with a normalising ideal. He describes these examinations as the "*ceremony of this objectification*" (Foucault 1991) p198. This is the manifestation of power that was most frequently observed in assessment practice that accords with Giddens' (1977) description of all social interactions as comprising three elements, "*communication of meaning, the exercise of power and the evaluation and judgement of conduct.*"

Following the exercise of disciplinary power, the assessment, a nurse then documents the event. Foucault describes documentation as;

" a meticulous archive constituted in terms of bodies and days" Foucault ed.
Rabinow (1991) p201.

Foucault identified the objectification of the person through their records as the creation of a "case". He contrasts these "clinical cases" with those of law or casuistry where a case comprises a "*set of circumstances defining an act*". Cases created following medical examination become the individual as he or she is to be compared, measured or judged. There are many examples of the documented case from the literature analysed for this study and perhaps one of the most telling is Mohr's (1999) findings regarding the deconstruction of language used in assessment records of twenty-six psychiatric patients. Mohr found only 1% recorded anything positive and over 20% of recordings were "*pejorative 9%, punitive 5%, inane 8% or nonsense 1%*" p1057. She concluded that many of the statements made as a result of the assessments undertaken were value judgements, often lacking evidence of thought or reflection, and of a different order to those of perhaps a cardiac assessment. The CDA identified the exercise of documentary power through the discourses of the natural sciences, discrimination, repression, care delivery management and surveillance. This was achieved through such mechanisms as excluding and dividing practices and the use of value-laden words reported in chapter 6.

Foucault (1980) noted the intimate relationship between power and knowledge and also between power and resistance. He described resistance as ever present as it permeates the power network. Green and Thorogood (1998) also suggest that whilst semantically having credence, the notion of power as a commodity that is passed from one to another is probably not the meaning intended within health care and following Tones (1986) suggested:

“Self-empowerment, on the other hand, would be concerned to use only those methods which preserve the principle of voluntarism.” (p11)

This is echoed by Mitcheson and Cowley (2003) who date this modern use of empowerment to the feminist and radical socialist struggles of the 1970s, perceiving it as a result of involvement of patients within healthcare practice. This meaning has resonances with that of Kendall (1993 and 2007) who notes the importance of patient participation in the production of an empowered patient. The CDA of field data also found patient empowerment was achieved through the interactional devices used by nurses to include their patients in the assessment process.

Additionally NHS policy documents also contain the rhetoric of empowerment. Malin and Teasdale (1991) suggest that the 1989 Government white paper *“Working for Patients”* was an early example of policy that championed empowerment. However rather than empowerment it featured giving patient’s *“choice”* that was equated with a *“grassroots desire for empowerment”*. The term empowerment is also used in *The NHS Plan* (DoH 2000) where it is suggested the NHS service:

. “be based around the key themes of patient empowerment and education of the public” p42

and that changes will be made when:

“community health councils will be abolished and funding redirected to help fund the new Patient Advocate and Liaison Service and the other new citizen’s empowerment mechanisms” p95

Further the Nursing and Midwifery Council’s standards for Public Health Nursing (2004a) give the following adaptation of the WHO (1998) definition of empowerment in their glossary of terms

***Empowerment** is a process through which people gain greater control over decisions and actions affecting their health. It may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs. p21*

Deconstructing this “matter of fact” statement the discourses of repression are manifest in the first line where “greater control” not total control is set as the goal. This implies both that at this time people had less control over fundamental decisions than was envisaged as desirable (which implies someone else was making decisions on their behalf). This discourse constructs the acceptance of a shift of responsibility regarding enabling people to identify and express their own needs from the healthcare professional to *individuals* and *social groups* as referenced above. The CDA of the field work data has demonstrated that individuals can be unable to identify their needs and are unaware of ways in which needs may be met.

Further the construct that individual service users should *devise strategies for involvement* is redolent of the attitude identified in phase 2 findings, where nurses did not regard the patient—professional interaction as one in which they were there to meet patient needs. It is significant that the final line of the statement limits the inclusion of patients to a group of actions that do not specify those of a medical or clinical nature. As with the extracts from the DoH policy documents (1998 and 2000), again empowerment of care users is constrained by the power of the professions who describe and prescribe its range and extent.

The use of the empowerment within these policy documents raises questions of choice and advocacy identified within the discourse of discrimination as part of the CDA of the field work data (chapter 6).

7.6.1.2. Advocacy

Patient advocacy presents us both with moral and practical dilemmas. Porter (1992) has drawn attention to the increase in domination of patients and carers by nurses as a consequence of speaking for them. For example in assessment A2 the nurse is denying

the patient their voice by interceding with the GP on their behalf. This practice normalises barriers between doctor and patient, and requires the interception of nurses in order to be circumvented. The nurse in assessment A2 tacitly acknowledged this when she stated, during the interview, that the doctors may be reluctant to prescribe additional pain killers as “*they (the doctors) don’t see what we see*”. Further Mallik (1997) has drawn our attention to the probability of conflict as the nurse tries to represent the needs of the patient by either direct or indirect means.

Hewitt (2002) argues that in order to empower patients, nurses themselves need to be empowered. Further, Hewitt notes the imbalance between the aspirations of nurses to empower, for which she claims there are compelling humanistic arguments, and the obstacles that result in nurses’ need to use covert means to achieve their ends.

Further the NHS Plan (2000) proposes that patients be given “*real powers*” as a form of empowerment:

- *letters about an individual patient’s care will be copied to the patient*
- *patients’ views on local health services will help decide how much cash they get*
- *patient advocates will be set up in every hospital*
- *if operations are cancelled on the day they are due to take place the patient will be able to choose another date within 28 days or the hospital will pay for it to be carried out at another hospital of the patient’s choosing*
- *patients’ surveys and forums to help services become more patient-centred.* DoH (2000) *NHS Plan* summary p6

These modest examples of the *real power* listed above give evidence of the limited conception of empowerment. The first bullet point, regarding the right of a patient to see letters that have been written about them was not found in any of the practice observed eight years later. In assessments A1, A2 and B2 the nurses paraphrased letters that they had received but of which the patient was ignorant. This practice serves to reinforce the hegemony of the institution.

7.6.1.3. Condition of possibilities

Taking as their starting point the limitations of constructs of empowerment within healthcare, Green and Thorogood (1998) suggest that if empowerment facilitates decision making and decisions imply choices, then the relationship of how these choices are “constructed and constrained” is at question. Empowerment through public health education is a discourse predicated on a natural science rationale that it is sensible to make healthy choices. This excludes choices such as pleasure seeking, hedonism or risk taking that are not only seen as irrational but immoral (Illich 1990).

Choice

Examples of the constraint of choice, identified by Green and Thorogood (1998) above, and the discourse of morality, questions of right and wrong, can be seen in this excerpt from the policy document “*High Quality Care for All*” DoH (2008).

“We want patients to make the right choices for themselves and their families. So we will empower them to make informed choices.” DoH (2008) p 39

Ignoring the social questions of inequality of resources that impinge on patient actions that portray “empowerment” as a means to “*make informed choices*”, this is an example of the power and authority of natural science and the hegemony of the modern NHS.

“*High Quality Care for All*” DoH (2008) also portrays the 'juridico-discursive', top down, model of empowerment as it refers to “*we will enable this to happen*” .

“Professionals need to be empowered to make the daily decisions that improve quality of care and we will enable this to happen.” DoH (2008) p61

Thus policy takes the position that in order to empower patients to have “*more control and influence*” staff require power. The CDA of the data demonstrated how without power/knowledge the nurses were unable to empower their patients. However domination was observed through the withholding of power/knowledge and the negativity of this approach was noted. Conceptually, from Foucault, nursing practice is empowered because nursing, as a profession, is accepted, legally and ethically by the state, by its association with the medical profession and the hegemony of the institution of the NHS.

These constitute the “enunciative modalities”, described in chapter 4, which give nurses the right to speak and be heard. However in practice institutional hegemonies and inter-professional rivalries militate against their voices being heard. “*High Quality Care for All*” DoH (2008) recognises some of these constraints.

Foucault (1981) described the power relations constituted within the discourse of repression as a combination of pastoral power and governmentality. Pastoral power is exercised through a melding of the Christian modification of the Hebraic priest figure, whose role incorporated those of guardian and guide, with practices derived from the Greco Roman aesthetic of self-government through self-examination. Thus an individual has responsibility to accept rules, obey and possess the self-knowledge in order to “mortify” through confession and thereby be immune to the consequences of temptation. In this way it is assumed that the 21st century patient, when given the evidence will have the self-knowledge to understand the normalising framing of their own needs and make the “*right*” choices.

Foucault suggests that governmentality is achieved through different sanctions of power, the law, socially prescribed rituals and disciplinary power. It is this latter model of power that I would suggest interfaces with pastoral power and enables the state’s surveillance, creation and examinations of norms, and standardisation. The link between governance and the individual is provided by biopower. Foucault uses the example of sexuality which is a target of the legal system and is subject to the power of government through the disciplinary model. Thus following this analysis it can be suggested that power, knowledge, morality, resistance, psychology, and participation construct the contemporary discourses of empowerment.

7.6.2. Implications for assessment

Four main themes emerge from this exploration of the concept empowerment when applied to the nursing practice of assessment. Firstly, confusion of approach within health care delivery and policy has been identified, with some policy documents (see above) proposing a ‘juridico-discursive’, top down, model of empowerment, whilst those charged with implementation of policies are attempting a bottom up, “*grass roots*” approach.

Secondly the notion evidenced from the CDA, that in order to empower, nurses need power themselves. However barriers to nursing empowerment have been implied within the DoH (2008) policy document "*High Quality Care for All*" and observed within practice, and these require identification and circumvention.

Thirdly the role of advocacy within nursing *per se* and its' effect on patient empowerment merits consideration. Specifically the need to reconcile the mandate for advocacy as a part of the professional role of nurses (NMC 2008) and the limitations placed on their success in this role by other professionals and the institutions of healthcare delivery. Within this debate are considerations regarding rivalry in professional status.

Nettleton (2008) identifies four cornerstones of professionalism:

- Specialised knowledge and a lengthy training
- Altruism (to ensure the professional acts in the best interest of a vulnerable client/patient)
- A monopoly over practice (because there is a legal mandate which precludes those other than nurses to carry out designated tasks)
- Autonomy

Whilst acknowledging that these characteristics are open to refutation if we accept that nursing has a degree of professional autonomy based on the remit of the NMC who confer registration or strike nurses from the professional register, should this autonomy not be extended to nursing practice? Observations during the field work for this study and the CDA, noted nurses' ambivalence when having to approach their GP colleagues to provide patient referrals, investigations, changes in treatment or medications. The two exceptions to this were the practice nurses who referred directly to their GP colleagues where changes were identified following their assessments. This raises the question how has the process of assessment been detached from the outcome that it indicates? Is it a decision based on good stewardship of funds or the retention of power? If the former is there evidence that shows our medical colleagues are more careful with funding than nurses or does it remove decisions regarding the rationing of resources from those who are in direct contact with patients?

If it is a response to feelings of power loss, the long fought battle for nurse prescribing or non-medical prescribing is a case in point. However even within this constraints are placed on the training of non-medical prescribers who have to undergo supervision in

practice by doctors, despite the evidence that doctors prescribe expensively. For example the PACT data for methadone prescribing (Strang and Sheridan 2003), and dangerously (causing 5% of hospital admissions, 18,820 patients, related to mainly avoidable adverse drug reactions [ADRs] which costs the NHS £466m a year) (Pirmohamed et al 2004).

Lastly, consider the constraints placed on the limited areas of empowerment envisaged within policy, specifically those of patient choice. Conceptually empowerment to make choices within healthcare continues to intrigue and at present I am enthralled by the notion that it is a simulacrum (see chapter 3) as by limiting the range and scope of empowerment we are only ever empowered to take the accepted path. So choice is restricted to the option offered or no choice. This does not offer choice in the widest interpretation of the word but offers selection from the permitted options outlined, the “*right choices*” (DoH 2008 p 39), or an exit from the system.

Is this a pragmatic response to the question that if we as individuals choose a life of dissipated degeneracy should the NHS help us deal with the consequences of our actions? If so, where do we draw the line and who decides what is degenerate or dissipated? The rhetoric is that health funding is a finite resource and fiscal controls are therefore required as demand would grow and grow (Vetter 2002). But I would argue that it is a defensible position to only offer care to people who have genuine requirement for healthcare resources. However if we are to assume that the growth of demand is made by people who are not ill or in need of healthcare, who are they? For we have diagnoses for this group under the umbrella of Munchausen’s which by definition makes them unwell. If all the people who are demanding healthcare are then ill or able to benefit from healthcare, then the NHS and by implication the Government of the day, are failing to meet their obligations of providing health care free at the point of need for all. I would suggest that the notion of an exponential rise in the demand for NHS resources is based on models of supply and demand taken from other sectors (in which the goods demanded are more attractive than those offered by the NHS). If we were to consider removing the gate-keeping role, identified from the data regarding referral and budget identification, which currently filters patient access to specialist services and equipment. Is there any evidence that this would increase the number of people erroneously seeking advice? In short would having open access make more people think they were ill and waste valuable time and resources?

7.7. Commonalities and anomalies between the findings phase one and two of this study

7.7.1. Emotional labour

As stated above both the literature the CA and the CDA recognised the emotional component of assessment, for example Morse et al (1999) referred to;

“the emotional and physical reaction professional care givers give their clients.”

Johnson and Webb (1995) and Niven and Scott (2003) both referred to the “*emotional cost*” of caring. According to Nettleton (2008) this can be referred to as “emotional labour” and although she was initially considering James’s 1989 study of doctors working in a hospice setting, there were similarities across the assessments observed for this study. For example Nettleton notes the need for comfort and support at times of bewilderment and confusion that were observed in five of the assessments. Oakley (1984) noted that women, and all the nurses in this study were women, serve others and derive satisfaction from these acts of service.

Hochschild’s (1983) study of flight attendants in America identified three characteristics that typified jobs where an employee is expected to support and control clients in order to earn their salary. The characteristics of this employment were that they involved:

- Face to face or voice contact with members of the public
- The worker was required to engender an emotional state in the client.
- The employer exercises control of the emotional activities of the employee through training and supervision.

Hochschild’s (1983) definition of emotional labour states

“The induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial, safe place”.(p7)

All the characteristics listed and Hochschild’s definitions have huge resonances with the

work of nurses as observed in this study. Hochschild's descriptors of emotional labour were observed and for example when the nurse and patient connected as in assessment A1 and B2 the interaction transcended any superficiality. I would describe this as authenticity as the nurse's empathetic response appeared genuine and real, redolent of Maher and Hemming's (2005) description of holistic nursing as "*honesty, integrity and genuineness*". The expressions of empathetic caring were not a means to an end but an end in themselves. The emotional cost to nurses who practice at this level needs to be acknowledged as an essential component of nursing practice.

This position contradicts that of Fineman (1993) who suggests that nurses should maintain a "*benign detachment*", because as Hugman (1991) articulated

"by failing to construct and defend clear boundaries the professional becomes too closely linked with the service user" Hugman (1991) p133

However I would contend that the skill required by nurses is to be empathetic, authentic and genuine and this does not preclude their ability to carry out necessary clinical work. The ability of nurses to create analogous limitations is required and accepted when they deliver physically intimate patient care, despite this crossing the social taboo regarding exposure and touch of genitalia by strangers. In this way nurses have demonstrated their ability to develop skills that enable them to care for the body in whatever way is necessary, whilst maintaining the context of a nursing interaction. Skills of empathetic communication and care giving are often referred to as "*soft skills*" that would intimate that they are less valued than the technological skills. I have noted in the methodology chapter the gendered connotations of the use of terms such as hard and soft. Since 1983 the UKCC, the forerunner of the NMC started to classify nursing skills in terms of competencies defining it as:

'. . .the skills and ability to practise safely and effectively without the need for direct supervision' (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1999: 35).

Demonstrating competencies in the "soft" skills requires the nurse to develop strategies with which she or he feels comfortable and which are effective. In a curriculum that is crowded with the need to teach technical skills there is little time to teach these skills (Smith 1991). Also the absences of the soft skills from the competency frameworks

render them of lesser importance during nurse training. This hierarchy of skills then spills over into perceptions of what constitutes good nursing practice *per se*.

7.7.2. Face to face contact.

Firstly taken from the literature there are indications that nurses find it easier to assess patients if they can physically see them (Wahlberg et al 2003 and Richards et al 2004).

The CDA was silent with regards to the importance of observing the patient. This may be because the strictures put in place by the Ethics committee prescribed the type of assessment observed. The assessment had to be a planned appointment to enable the 24 hour delay to give patients time to consider participation. The procedures observed and talked about during the interviews were all regarding face to face encounters. The use of NHS Direct would be a field in which further investigation of assessing patients who were not visible could be pursued.

7.7.3. Continuity of care delivery

Both the CA and the CDA highlighted the benefit of knowing a patient well when assessing their needs (Millard et al 2006, assessments B1, A1) and this was implicated in the section of establishing rapport. The importance of knowing the patient raises questions of continuity and the team approach to caring. Problems with this approach were observed in assessment C1 where one nurse was taking over the delivery of care to a patient. Both the patient and carer were resistant to these changes. Kennedy (2002b) notes the importance of continuity in assessment practice, which she described as a combination of "*knowing how*" and theoretical "*knowing that*". This she sees as a reflexive and cumulative process that necessitates the assessment to be made over several consultations and this is also evidenced in Appleton and Cowley's (2004) study. Observation of practice showed this to be aspirational but not always achievable as whoever was available visited and added to the assessment process. The CDA data showed the importance of continuity for building rapport that was at odds with the team nursing approach employed in eight localities. The team approach to nursing care delivery also raises questions of skill mix, which was prominent within the influences on assessment identified from the CDA. For example in assessments C1 and B3 the nurses expressed their lack of knowledge regarding the procedures required to involve other agencies. Further the nurse in assessment A2 was diffident regarding the success of

approaching her GP colleagues.

Birtwhistle et al (2002) suggested that long-term contact between a nurse and a person who had been recently bereaved may also reflect the needs of the nurse. Five of the participating nurses spoke of an attachment to particular patients.

Policy changes (Department of Health 1992a) which reduced the numbers of DNs have reduced opportunity for preceptorship offered to newly qualified nurses. This has reduced both the mentorship and apprenticeship model of learning from more senior staff. Skill mix was identified as a factor influencing judgement making within the observed assessments. Attitudinally one nurse proudly boasted that other nurses said she was more like a GP in approach than a nurse (C2). It is unlikely that these changes can be reversed in the present financial climate. They do raise profound implications for nursing including the need to articulate the complexity and vitality of their practice and unlike the nurse in assessment C2 be proud of their specialist nursing skills within the panoply of health care delivery.

7.7.4. Diversity of approach

Both the CA and the CDA demonstrated the diversity of approach in what was referred to as an assessment. For example Vernon et al (2000) state;

“the quality of assessment varies widely, is seldom monitored, and key parts are often missing”.

This was also observed in assessments C1, C2 and B3 where proformas were not fully followed and therefore parts were missing. Each of the eleven assessments observed focused on agendas pertinent to their specific and individual interactions. Seven of the assessments A1, A2, A3, A4, B1, B2 and C2 also included a more holistic approach in addition to gathering specific information prompted by their Trust protocols, for example demographic or known allergies, and assessment practice models.

7.7.5. Evaluation

The notion of monitoring assessment raised by Vernon above could be extended to evaluation of all practice including assessment. In all the eleven practice settings visited patient evaluation of care was never mentioned nor was there any paperwork to suggest

that it was done. This is supported by the literature with Wright's (2003) study which found only a small proportion of those questioned regularly received feedback with the majority rarely or never receiving feedback. As noted in chapter five this indicates lost opportunities to learn and improve practice using past experiences. Baron (2000) noted the importance of evaluation, asserting that the best assessment decisions are followed by the best patient outcomes. However this simplification does not take into account several possibilities. Firstly that of an outcome happening by chance or as a result of unanticipated patient actions irrespective of the quality of the decisions made. Dowding and Thompson (2004) indicate that when outcome is used as a quality indicator, for example Moore's (1996) study that looked at nurses' estimation of a patient's risk of falling following their admission, it is difficult to know what measures had been taken to avoid the fall. Lockwood and Marshall (1999) provided evidence that feedback reduced the proportion of unmet social and psychological needs.

Policy drivers are equally vague on the procedures for evaluation for example the DoH circular HSC 2001/001 (DoH 2001c) states the outcome of intermediate care assessment to have:

“a planned outcome of maximising independence and typically enabling patients/users to continue living at home.”

This document does not include any explicit systems for evaluating or advice as to how this aspiration could be achieved. However despite the limitations patients should be given the opportunity to offer anonymous feedback regarding their care and the service performance. If the NHS is truly to be a listening service it must not neglect this valuable area.

7.7.6. Location of the assessment

There were differences between assessments carried out in the patients' homes compared with the two assessments that took place in the GP surgery and were facilitated by practice nurses (PN). Assessments undertaken in the surgery were both shorter in duration and proforma led. However it would be unsupportable to claim the location was solely responsible for the differences observed. Both of the PN assessments were to ascertain how well a patient with an enduring condition, in these cases diabetes and asthma, had been over the six preceding months. Although several of the other assessments embraced the health education brief, with reference made to

“5 a day” fruit and vegetable intake and healthy eating (A2) and the nurse undertaking assessment A3 made recommendations regarding skin care and the prevention of ulceration. Health promotion and education issues were fully addressed by the practice nurses in both C2 and B 5 with references made to mental state and the importance of regular exercise.

The proforma-led approaches comprised direct closed questions to elicit short responses from the patient. Little reference was made to social events or the individual lives of the patients, that were not discussed unless they had a direct bearing on the questions prompted by the proforma, for instance diet and exercise. The assessments observed in the patients' homes had a more vernacular syntactical style where nurses engaged with life events discussing grandchildren's birthdays (B1), a planned wedding (A3) and events in the lives of other members of the DN team, such as the birth of a baby girl to one of the nurses (A 3) and a nurse's retirement (B1).

It is also of note that there were differences in approach between the two Practice Nurses. For example in assessment C1 the PN was completely proforma led and rarely looked at the patient keeping her gaze towards her computer monitor as she entered data. The second practice nurse assessment B5, although also proforma led and involving data entry into the computer, always turned from the monitor and removed her reading glasses before she asked each question of the patient. This may be partly due to the different type of assessment agendas underpinning the assessment types and gives further evidence of the problems associated when a portmanteaux term such as assessment is used for diverse practice events.

7.7.7. Privileging the written over the oral

Audit of practice is carried out by measurements of results. These are obtained through the written discourses comprising letters, investigations, reports, patients' notes and hospital statistics. There is an absence of systems in place to measure the spoken part of nursing practice. This results in the majority of nursing practice remaining silent as it is not identified and is often undervalued, as it cannot be measured by numerical data audit tools. It is of note that almost all of the assessments observed contained many instances of laughter; sometimes this could be interpreted as a release or through nervousness but in many cases I would interpret it as having fun. Where appropriate

having fun is an aspect of nursing practice that is significant and yet under-researched.

7.7.8. CDA findings not found in the CA

There were three main omissions from the CA, evidenced in the majority of the assessments observed. The first was the use of abrupt changes of subject to avoid patients persisting in asking questions that the nurse did not want to address. This may be a device used to avoid overloading people when they are grappling with huge changes in their expectations of their life course and indeed a reappraisal of how they see themselves. There were occasions when it was used repeatedly, for example in assessments B3 and C2. The patient's reaction ranged from annoyance as evidenced in their persistence, the assertive tone of their voice, their interruptions and their body language. The second reaction observed was one of heightened anxiety and eventual quiescence.

In addition to subject changes, which were a reactive ploy, some of the nurses actively missed opportunities to share their knowledge and address any misconceptions the patient or carer may have. This withholding of knowledge and therefore, by Foucault, power, was not noted in the literature on assessment reviewed for this study.

There were also instances within the CDA where the patient was using emotional labour in the form of flattery or the expression of gratitude. Nurses engendered these responses on occasions for instance in assessment C1 the nurse tried to manipulate the patient into praising the service she had provided. The CA did not identify this as a part of assessment although Shattell (2004) spoke of times when a patient felt they needed to "appease" the nurse.

7.8. Unexpected omissions

It was of note that neither the CA of the literature nor the CDA or observations of field work found examples where nurses were openly addressing the topics of:

- cure and expectations
- spirituality
- sexuality.

Although Kennedy (2002b) noted that the spiritual aspects of care were an area of

knowledge required by nurses I would have expected these subjects to have been meaningfully discussed. I accept that each of these eleven assessments formed only one interaction between nurses and their patients. However on looking through the patient's nursing notes, in the eight assessments where they were available, none of the three topics listed were recorded as having been addressed. The nurse who took part in assessment A1 discussed with the patient where they wanted to die that demonstrates a tacit acceptance that there was no cure for his condition. Further as reported earlier where there was a prompt to consider sexuality the response was superficial as demonstrated the notes merely recorded the phrase "*has two grown up sons*" (assessment C1).

7.9. The right terminology

As was noted above in the section on empathy Rodgers and Knafel (2000) observed that amongst the metaphysical skills the appropriate concept of assessment was yet to be developed. The nursing practice I observed for this study held both physical and empathetic intimacy without compromising the nurses' ability to skilfully perform tasks or carry out the procedures necessary to maintain well-being, comfort and safety of their patients. The CDA for this study identified within the discourse of empowerment instances of empathy, authenticity and love in the sense of agape (assessment A1). Agape is a word of Greek derivation that distinguished altruistic love from filial, platonic or sexual love. C. S. Lewis (1960) describes agape as "*a selfless love*". A love which focuses on the well being of others. I would suggest that love, in this sense, could be the appropriate term to express the caring interaction between a nurse and his or her patient. In order to identify the needs of others I suggest a loving response to their situation is required. Heaton's (1999) study of informal carers referred to care being given out of "*love and filial piety*" (p765). Further Nortvedt (1998) and Griffiths (2008) refer to registered nurses being able to deliver a specific therapeutic component of care that acts independently of other health care interventions. However Maher and Hemming's (2005) suggest that an holistic approach to patient care is of itself therapeutic. Although the terms agape, love or authenticity were absent from the literature reviewed for the CA. I contend, through my observation of practice and the CDA of the data, that they are expressions of the activities included in concept of

delivering nursing care.

One patient, Richard (A1), within the interview identified the reason for his well-being as the “*loving care*” provided. Richard characterised this as being the focus of the nurse’s undivided attention and dedication.

7.10. Interpretative bias

I acknowledge the bias I inherently bring to the interpretation of the discourses studied in both phases of this work. It is impossible to be other than I am and to avoid reflecting my age, gender, education and cultural mores. However I have tried to approach the analysis acknowledging these influences and I have deliberately not developed any hypothesis nor have I tried to make the data fit with any pre-conceived ideas. This has been a journey of exploration and there have been amazing surprises at every turn.

I also acknowledge the bias of self selection within the assessments observed as only those participants who volunteered to take part were recruited. But as this is an interpretative post modern study where universals cannot be extrapolated from individual instances the assessments observed were illustrative of their own individual situations.

The time spent with the participants varied depending on workload and availability of the participants, however all the observations and audio recordings could hope to provide was a snap shot of ordinary everyday practice, albeit with an observer and audio recorder in the room. Most of the participants said that they forgot about the recording and felt that the assessment was what they had expected based on their prior experience.

7.11. The research process

7.11.1 Phase 1: the Literature Review and the Concept Analysis

Literature review

Although my approach to the literature was systematic, in order to minimise bias my reasons for inclusion or exclusion of papers were defined before the review started. This was not a systematic review of the literature as exemplified by the approach taken by

Egger et al (2005), who although they claim superiority for their process over the narrative approach, predicate their work on the assumption that the review will evaluate the outcomes of the research in a quantitative paradigm. The literature research for this study evaluated the research methods when they were recorded in a paper, but did not exclude studies where this area was not covered providing the conclusions reached followed the evidence and arguments produced.

This clearly demonstrated bias as the reason for their inclusion is predicated upon my subjective desire to include the information they contain in this study. I have tried to limit this by the use of the grounded theory approach that deconstructs the narrative and permits retrieval of conceptual notions rather than complete theories and arguments. These are then reassembled and sorted before being reconstructed into theories. However it would be an act of self delusion to deny that every decision made regarding selection, attention and reinterpretation is influenced by who I am and what I think. For example I have made a conscious effort to overcome my dislike of managerial tasks, agendas and attitudes by including any effects these have on assessment within the review. However in this desire to be inclusive and to surmount my bias against these areas I may have given them greater prominence than they deserve.

Publication bias is also inherent within the literature review process as the reviewer is drawing on articles that are published within journals which have their own agendas. In an attempt to reduce this bias a broad spectrum of data bases were used and Lexis Nexis the European news, business and legal information data base provided examples of the use of the words assessment which did not originate from the healthcare literature.

Whilst acknowledging concepts change over time, the time span for this literature search was 11 years but this was extended as earlier papers and books were identified from the reference lists and included in the review. Further time lag bias, the time taken between submitting for publication and articles actually appearing in print, lengthens the time frame. Although concepts are reflective of different populations and nuances in the epistemological ethos of the studies the congruencies identified are still noteworthy.

Criticisms of the literature review process have been levelled by Jensen and Allen

(1996). They have suggested that as reviews circulate interpretations of others' findings, they may inadvertently increase bias. Further Evans and Pearson (2001) have added that reviews may produce "third level interpretations" of descriptions of phenomena. They describe the first level as when an individual encounters an event or phenomenon. This is then interpreted by the primary researcher, the second level of interpretation, and finally there is a third level where the reviewer reports findings which may now be so far removed from the original phenomena as to be meaningless.

Despite these apparent problems the process of reviewing the literature offered a comprehensive, transparent and reproducible protocol to enable the quality of published research to be evaluated and the synthesis of findings to be carried out. This gave a broad spectrum of uses of the term assessment in order for the CA to be carried out.

7.11.1.1. Glasarian Grounded theory

Following the critique of commonly used CA frameworks, Glasarian Grounded Theory was chosen as this favoured the principle of theory development rather than that of theory testing. The main weaknesses of this approach are in the iterative nature of categorisation, as it is hard to justify when interpretation is complete. Also Glaser claims that concepts emerge from the data without selection. However as Popper (1959) has argued, as it is impossible to record everything, there must be selection of what to record. Therefore to decide what is germane suggests some kind of underlying theory and the presence of this theory and data selection implies theory verification or refutation. Despite these practical and theoretical criticisms Glaser's model was chosen as it avoids the imposition of verification of a preconceived hypothesis forcing the data into the binary of accepted and unaccepted. Grounded theory is the obverse of the models outlined in Appendix 5 which identify instances of the concept fitting their research hypothesis and then use this as evidence to support or refute their theory.

The identification of concepts at the Basic Social Process (BSP) level, the prototype or the basic unit of category or concept (Rosche 1978) allows great transferability between incompatible studies (Glaser 1978). Grounded theory also avoids elimination of evidence that does not fit with a preconceived general theory.

7.11.2. Critical Discourse Analysis (CDA)

Discourses can be seen as comprising, “*function, construction and variation*” (Potter and Wetherall in Wetherall et al p199). The strength of the CDA approach for this study was that it recognised both that individuals have unequal access to linguistic and social resources and that these resources are controlled institutionally. CDA facilitates consideration of the political, social, cultural, institutional and economic, context of language usage and production.

This decision to choose a Foucauldian approach to CDA is based on its congruence with the ontological understanding of the researcher and the four final research questions. CDA embraces; Habermas (1986), Foucault (1973, 1980) and Bourdieu’s (2007) accounts of the symbolism and actuality of power of institutions within discourses from micro to macro levels. Foucault challenges everyday assumptions and promotes “thinking differently rather than legitimising what is already known” (Foucault 1981).

Foucault is criticised because he has asserted that “*nothing exists outside the discourse*” this is taken to mean that things have no material reality. Following Foucault, I understand that discourse as the process that gives everything meaning and that we cannot frame the objects of our existence without thought which is primarily constructed through language. However, as with the incident of Alan Bennett’s Mum, it is possible to think of things without naming them. Laclau and Mouffe argue that every “*social configuration is meaningful*” to which I would add that every social configuration produces a discourse.

There are two main weaknesses to the use of this Foucauldian approach: firstly the absence of a framework. It is impossible to expect poststructuralists to provide this type of structure but it would help silence the inner critic as to whether or not Foucault would have recognised what I was doing. Secondly I chose to use a Foucauldian CDA approach where each statement is considered and the difference between what was said and what could have been said were noted. I collected and analysed more data than could be represented in one thesis. Therefore I have only been able to present and discuss a small part of the findings from this study.

7.11.3. Reflection

It is hard to comprehend that this study, that has been my purpose for the last four years, is now coming to an end. With hindsight I can see that I have constructed many unnecessary problems. The research questions for this study were too numerous and the terms used in their construction required further exploration in preparation. The questions are predicated on assumptions I made four years ago that I now challenge. A case in point is the notion of empowerment during this study I have vacillated between the positions that empowerment is a chimera, it is a commodity that the individual needs to possess in order to give to others and that it is a link in a chain or a mesh of possibilities. I now take the stance that it is all of these and more. Within health care and health promotion, like choice it is a simulacrum.

In addition to the opportunity to read and grapple with academic concepts this study has enabled me to understand more about myself and my relationship with nursing practice. I have found it difficult to be in contact with a patient for the few hours involved in their recruitment, the observations of their assessment and the interview and then leave. On several occasions I have wanted to impose my views and make my suggestions to bring about changes in approach and practice. In fact on some occasions I have done just this and have discussed aspects of care with the nurses after the interviews were completed. I carry with me 11 cases that will never be resolved as I will not see them again. There are 11 families with whom I shared an interaction for a few brief and troubled hours. This has left me with a sense of loss that I was unprepared for. I have also learned the subtle distinctions between what is sub-optimal, what is acceptable, what is helpful and what is interfering on the part of the researcher. Decisions that were made in seconds will resound for my lifetime.

There have been huge frustrations caused by the workings of the system that formalises the research process, involving delays that were outside my control. I also note the capricious nature of mandatory process that had to be undertaken in order to get permission to undertake a study based on non-participant observation within the NHS. The decision that participants had over 24 hours to consider their participation in this study was imposed by the Ethics Committee and seriously hampered the recruitment of patient and carer participants. This did not pose a problem for recruiting staff. However it would have been unethical to delay the provision of needs-led care to patients and as

many are referred and assessed on the same day it was impossible to recruit them to the study. In practice once the study had been explained to the patient those who wished to take part said they were happy to go straight ahead and they could not understand why I was going away for a day and then coming back.

Despite all the frustrations I have an overwhelming feeling of gratitude and privilege that people have let me into their lives, often at times of crisis, so that I can carry out my research. My ethical and moral obligation is now to disseminate my study in order to raise discussions about the nursing roles of the present and the future.

7.12. Summary

In summary the research study has located similarities and differences between the findings revealed through concept analysis of the literature and observations and critical discourse analysis of the data collected from real life assessments. There is concordance regarding the core category of judgement making identified from the CA, observations and CDA of the every day interactions between nurses and patients during these assessments.

Examples of observed practice not included in the CA were noted above as:

- the use of abrupt subject changes to avoid addressing sensitive issues,
- missed opportunities to address topics judged to be a priority by the patient
- the emotional labour of patients expressing gratitude and flattery.

The CA also drew attention to the importance of being able to see a patient in order to assess them but this was not noted from the field work.

The assessments that appeared to be the most empowering included approaches where the nurses' language, both syntactical and body language, showed that they were totally engaged with the practice they were undertaking. Where nurses were empowered by their knowledge, experience and confidence they were able to empower their patients. The converse was also observed which has political and professional implications regarding nurse training, availability of further education, skill mix and the provision of

suitable mentors.

This research has shown that the formulaic approach is not always an effective substitute for experience and confidence as it is open to different interpretations by each nurse. This further demonstrated the importance of skill mix within teams, the need for a period of preceptorship for newly qualified staff and ongoing advanced training and updating for qualified staff.

I have argued that the notion of choice within the healthcare arena is a simulacrum and this includes patient choice within nursing assessment. The debate regarding the purpose of the health service in the twenty-first century has to address the friction caused by the juxtaposition of the freedom of the individual and the hegemony of the state and the NHS in particular. We need to have systems in place that acknowledge the differences between services predicated on care, such as nursing and social work, and those predicated on the ability to cure such as medicine.

Chapter 8

Conclusion

It was still snowing as he stumped over the white forest track, and he expected to find Piglet warming his toes in front of his fire, but to his surprise he saw that the door was open, and the more he looked inside the more Piglet wasn't there.

Milne, (1974) p.1.

This thesis has introduced the topic of assessment and examined what is known and written about the subject. A discussion and appraisal of research methodologies has been presented and it was noted that the perception of nursing as either an art or science may prove problematic to ontological discussions of nursing practice. Within the methodology chapter I proposed that it can be both, a position that facilitates accommodation of scientific notions of nursing such as observation and cure, in addition to nursing theories regarding healing, the use of intuition, therapeutic touch and authenticity or “being there” for the patient.

8.1 Strengths and limitations of using two approaches

This study has used two approaches to analyse the data. Firstly a Grounded Theory (GT) Concept Analysis (CA) of the literature followed by a Critical Discourse Analysis (CDA) of the data provided by observation and recording of the action that constitutes assessment. This provides the advantage of utilising the appropriate tool to uncover and explore meaning in different ways. Congruence of philosophical approach has been provided as both discourse analysis (DA), of which CDA is an example, and GT are approaches to “*qualitative analyses*” (Gerrish and Lacey 2006 p418). They further note that GT belongs to the canon of qualitative research, “*Grounded theory is a systematic qualitative approach*” p 192

Ontologically nursing, GT and CDA share the underpinning assumptions that human behaviour is complex and responsive to the externals of culture and environment (Wodak and Meyer 2002, Reed and Runquist 2007). Epistemologically GT has a reflective approach which contrasts with the quantitative, positivist, reductionist

approaches that employs a speculative and emergent method providing only one point of view. Further it has been argued that Glaser's critical realism may be placed within a constructivist paradigm (Lomburg and Kirkevold 2003, Corbin and Holt 2005). Corbin and Holt (2005) acknowledge the many realities facilitated through different interpretations of the data in a constructivist account and this is a characteristic of postmodern enquiry.

Foucauldian CDA aims to uncover the relationship between discourse as a way of interpreting social practice and as a method of social construction. Semiosis may be seen as the core of the interrelated networks which constitute social practice (Fairclough 2003). CDA aims to analyse the relationship between semiosis and the shifting elements which constitute the activity and practice of discursive events.

The function of the literature review for this study was to identify how the term nursing assessment was defined in the literature. However the review revealed a dearth of definitions of this interaction despite the term *assessment* being widely used. As argued earlier an approach was necessitated that would generate a theory regarding the conceptual use of the term *assessment*. Gerrish and Lacey (2006) give theory generation as one of their key points for GT and Rodgers and Knafl (2000) note GT was used in nursing research by Chenitz and Swanson (1986) as early as 1986 as a tool to produce abstract concepts. Theory building or "*theorisation*", was noted as a "*primary goal of research*" by Gerrish and Lacey (2006 p418). Silverman (2004) reminds us that in Glaser and Strauss' (1967) original work there was a chapter regarding using GT to "*develop grounded applications of qualitative knowledge*". GT was therefore seen as a suitable approach to generate theory regarding the concept *assessment* from examples found in the literature. GT employs a constructivist approach as understanding is gained through familiarisation with the discourses that constitute the literature. From this process basic concepts are identified, collected, revised and collated at an abstract level and then rebuilt into a construct or theory.

In contrast CDA deconstructs the discourses and enables the identification of instances which constitute genres, for example, the discourse of surveillance. CDA reflects a postmodern approach which challenges ideas of certainty and truth and offers exploration through uncertainty and ambiguity. CDA does not generate a theory as to what assessment is but facilitates the classification of the discursive practices which both demonstrate and describe it. CDA generates meaning and

identifies the significance of that meaning rather than offering a theoretical understanding of the process. DA is seen as an accumulative process with new works building on predecessors as they identify and offer theories (Wetherell et al 2002).

By using both GT and CDA as methods of data analysis many facets of the practice of assessment have been identified. Firstly facilitated at the theoretical and conceptual level through the use of GT and secondly using CDA at the social, political and historic levels through which the discourses of assessment are produced. The strength of this combination gives a comprehensive interpretation of the many layers which constitute the process of assessment. These two approaches can be considered as complimentary. As CDA interprets and critiques socio/political and historical influences on the function and constructions achieved through discourse at the micro, meso and macro levels. This to some extent ameliorates the criticism of GT, that it fails to reflect the cultural or social influences on practice (Gerrish and Lacey 2006).

The main limitations of the use of more than one approach to analysis are threefold. Firstly to demonstrate a coherent approach to the overall processes of analysis, secondly the synthesis of the analytical outcomes. Thirdly the resultant differences in the style of presentation of the findings. For example GT requires the researcher to promote one category above the others, whereas CDA facilitates multiple interpretations to be presented without the need for a hierarchical evaluation in their presentation.

Further it has been argued that GT provides a tension within a postmodern enquiry as it rests on assumptions which reflect a symbolic interactionist approach (Gerrish and Lacey 2006). Symbolic Interactionism (SI) may be briefly characterised as the enlightened conduct of human beings who have agency and interpret their experiences in the light of their insight. SI does not seek to ask why but how is an experience is structured, lived and given meaning? This method could be seen as limiting exploration however I would defend the use of GT for an exploration of the nursing literature on the grounds that the CA seeks primarily to show *how* the term assessment is used in order to identify the conceptual components of the term.

In addition the use of more than one method of analysis adds to the already contested ground of how to provide evidence of quality in qualitative methods.

8.2 Why CDA was not used throughout.

As stated above the choice of using both a GT facilitated CA and a Foucauldian inspired CDA raised difficulties in both the synthesis and presentation of results and in the justification of the quality of the research. As argued above each method analyses within a different frame Discourse Analysis (DA) does not :

“recover events, beliefs and cognitive processes” Potter and Wetherell (1987) p 198

CDA seeks to analyse the dialectic relationships between different but interwoven elements of discourse (Wodak and Meyer 2002). These elements encompass:

- a. The activity and means of production of the discourse
- b. The social relations and identities of the agents
- c. Cultural values
- d. Agents experiences and interpretations of those experiences
- e. Semiosis (all forms of meaning making including body language and visual images).

CDA draws on hermeneutic methods of enquiry in order to interpret meanings and explore actions in order to discover rules and conventions that structure discourse and the practice it produces. There is a particular emphasis on looking at the power imbalances which influence those rules and conventions. It does not uncover meanings (Howarth 2000) and had CDA been use to analyse the literature it would not have answered the first research question:

How is nursing assessment defined in the literature?

CDA of the literature would have provided insights into ideological concepts such as social inequality, dominance, power, control and discrimination that were revealed manifest within the written discourses.

8.3 A critical reflection on the strengths and limitations of a post-modern account in light of the studies findings.

Postmodernism embraces a range of expressions. Primarily it constitutes a reaction against the rigidity of modernism or structuralism exemplified for Foucault (1981) within the “repressive hypothesis”. Foucault not only identified the abuse of power through constraint and repression but also through the insidious ways society is

organised and regulated. For example biopower which entails the acceptance of certain types of bodily control and subjugation for greater utility of the many. An example of this would be the medicalisation of the natural process of health childbirth. Here Obstetricians exercise control over aspects of an individual's life often outside their need for restorative medical treatment.

Lyotard (1984) implies that postmodernism rejects meta-narratives and transcends the traditional inequalities of value judgements regarding the inherent superiority of one narrative over another. This allows for the acceptance that the researcher will demonstrate bias based on her life experiences and the influence they have over her interpretations. This facilitates the interpretation of the data collected and collated from the CA and CDA within this study and permits a unique viewpoint to be expressed.

Baudrillard (1994) takes an even more anarchistic approach to postmodernism. He pushes interpretation to the extreme by blurring the image and the reality of a thing, for example suggesting that TV and cinema are reality in the USA (Baudrillard 1988). This challenge to the perceived essentialism of the structuralist gives way to a world of indeterminacy. This theory supports the notion of the simulacra identified and utilised within the reflexivity section of chapter 3. Further postmodernism denies the notion of the existence of the one single route to truth which has been the scientific search. This allows the qualitative exploration of the many interpretations of the term assessment and enables the inclusion of non-scientific notions such as intuition and empathy to be analysed.

Cheek (2004) notes that language:

“does not “have” universal meaning”

and postmodernism allows the demise of universality in favour of discontinuity and difference. A postmodern approach facilitates this study's aim to question naturally occurring assumptions regarding the nursing practice of assessment and the position of the nurse and patient within this interaction. Primarily the researcher's intention is to draw attention to the pragmatic acceptance of events and practices. This is achieved by questioning the use and limit of the linguistic constructs within each interaction. The identification of these practices is seen as engendering debate, providing theoretical universalism by identification and comparison of commonalities, rather than seeking to impose solutions to problems. This creates a tension with the

accepted expectation that research aims to produce universal procedural recommendations for practice.

At the heart of this study has been a postmodern approach to questions of who is the expert? Postmodernism dispenses with the hierarchy of knowledge (Howarth 2000, Nettleton 2008) disputing the perceived valuing of expert knowledge above lay knowledge. This study intends to forefront the participants' voices often marginalised in other approaches. The use of a free approach to semi-structured interviewing has enabled participants' interpretations of practice to be recorded and analysed. For example the revelation in A1 that Richard identified love as a major component of the effective assessment and delivery of care was not influenced or prompted by a line of questioning. Further May's identification that seniority and experience of nursing staff led to effective support and the provision of necessary equipment. Or Mary (B1) who noted the importance of nursing assessment to determine effective interventions as the nurse knew of things which she did not. Each participant could have revealed their insights in response to open questioning regarding aspects of care. However their answers would have been influenced by the agenda inherent in the researcher's questions and may not have been purely a reflection of the participants own priorities.

However postmodernism has significant limitations. Firstly it is open to the question of whether by writing this I am creating a new meta-narrative which I must reject? Further by drawing attention to the historical, social and political constructs which shape nursing practice does the postmodern author need to deconstruct their own work? I would suggest the answer to both of these questions is probably yes and the price that needs to be paid is a continually reflexive approach to the analysis and the realisation that all views are contestable. As Baudrillard (1990) suggests "*history is over*" and we now inhabit a two minute "*depthless culture*" free of authoritarian arbiters.

Postmodern projects such as this study expose and deconstruct the hegemonies within institutional practice. However in daily practice the interactions between nurses and patients still need to take place. It is imperative that they take place between people who have confidence and ownership of the processes. It is for that reason that solutions to some problems identified within this study need to be developed by

practitioners themselves and not imposed or suggested by the researcher. This study has demonstrated that there are areas which need significant attention. The dissemination of the study's findings are intended to promote debate and effect change.

Postmodern authors often offer an exaggerated view regarding the difficulties we have in communicating with each other. I have argued that there are times when individuals are sure of something and we can share this certainty with others (Lyas 1992). However Lyas's analogy demonstrates this by the degree of conformity of sensory perception between individuals when observing the colour changes of traffic lights. Accepting shared certainty in this type of observation does not preclude the multiplicity of linguistic meanings and the insight into the internal worlds of participants provided through the study of discourse. For example this study found the use of certain words, e.g. "obviously", allowed a nurse to exert power and effectively close discussion or questioning regarding a certain topic.

8.4. An explicit account of the implications of a postmodernist approach for accommodating and developing evidence-based practices.

There are certain tensions that are created by taking a postmodern approach to the subject of nursing which espouses an evidence-based approach to care delivery. Evidence based practice (EBP) aims to give greater emphasis to the reasoning process when making choice regarding health care delivery. The American evidence based medicine working group (EBMWG) notes the following components of an evidence based approach to medicine;

Evidence-based medicine de-emphasizes intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision making. (EBMWG 1992, p. 2420)

Postmodernist thinking poses a challenge to the claimed objectivity of EBP (Rolfe 2002, Griffiths 2005). As has been noted postmodernism eschews grand narratives as they are seen to bolster those in power who attempt to define ways of knowing and thereby marginalise dissenting voices and stifle exploratory debate. For example the objectivity claimed through the use of the RCT the results of which are seen as

the pinnacle of evidence provision. In chapter 3 I argued that the RCTs' privileged status is achieved through the promotion of science as the source of "*legitimate knowledge*" because of its reliance on numerical quantitative data.

EBP is driven by the findings of the influential Cochrane Collaboration which undertakes systematic reviews and collates research evidence from RCTs. This evidence is then used by institutions such as NICE to develop guidelines for practice. EBP is open to criticism on many levels. Firstly there is an undefended discrimination against qualitative research findings through the acceptance of the primacy of the RCT. This view is opposed by many including Feyerabend (1986) whose extreme philosophical stance is that;

"The only principle that does not inhibit progress is: anything goes" p28.

Nettleton (2008) has noted that EBP fails to pay sufficient attention to the distinction between the science of health research and scientific research per se. Buchannon et al (2008) also noted that:

"A vastly disproportionate share of the world's research resources is now allocated to studies on diseases that affect only a minority of the global population"

The Global Forum, an independent international research foundation set up in 1998, noted a 10/90 gap in health research in their 2004 report. This refers to the 90% of "preventable mortality" in peoples who live in the developing world and which attracts only 10% of the funding for research. Whereas 90% of the funding and therefore the research focus is spent on illness in the developed world such as the "obesity epidemic". The majority of scientific research in healthcare is therefore driven by an agenda that ensures a return on the pharmaceutical shareholders' investments. This marginalises research which tests independently considered hypotheses or builds on existent knowledge across all areas of international health care. In this way the evidence underpinning EBP is provided by studies which have received funding. In order to obtain funding areas for research are limited to those lucrative to funders, be they drug companies looking to profits or health care providers looking for savings.

Nettleton (2008) has further suggested that although EBM may not reinforce the medical model, the positivist focus on man as machine divorced from his socio-political environment may bolster the medical mentality. In order to develop EBP will

need to move towards the more integrated approach indicated by Sacket (2000) who has defined EBP as

"the integration of best research evidence with clinical expertise and patient values."

Sacket's view provides a more balanced approach to what constitutes the evidence promulgated by EBP. The challenges lie firstly in how to create a consensus as to what constitutes evidence and how to obtain, integrate and weight these three sets of findings. Secondly, how to retain individual choice in a system based on utilitarian universal recommendations for practice. Thirdly how to ensure dissemination and utilisation of the evidence gathered. Black (1997) and Nutley et al (2003) noted that there were many barriers to the implementation of research findings into either practice or policy.

Finally Kendall (1997) highlighted the complexity of what constitutes evidence which include the provision of some;

"objective truth about the efficacy of therapeutic interventions" p 27

However Kendall recorded the response of the singing man who had been freed from the pain and social repercussions of having an unhealed leg ulcer through the expertise of his nurse. She noted that in addition to the biometric evidence of the ulcers reduction in size and depth an indication of his healing was his move from depressed isolation to singing constituted additional evidence. In this way evidence can be enriched by embracing both the technical and scientific findings of an RCT and the nursing observation of manifestations of healing and humanity.

The data from phase two of the study has shown that the most effective and empowering practice took place where the nurse and patient shared decision-making along a path guided by the nurse (B2 and A1). Nursing power is implicit within the nurse/patient therapeutic relationship, as without power (therefore by Foucault knowledge), the nurse would bring little to the interaction. However a tension arises if the nurse does not respect the expertise of the patient regarding how their condition makes them feel and what is important to them.

Further, both in the literature reviewed and in the CDA, the notion of establishing rapport was commented on by nurses, patients and their carers as of significance for the assessment process. .

8.5. The findings in relationship to the research questions.

Accepting the caveat that this is an exploratory study and the findings do not discreetly relate to specific questions as some findings provide insights across several questions. There follows a summary of the research findings which explore the five research questions. The first research question,

1. *“How is nursing assessment defined in the literature?”*,

was explored using an adapted systematic review process to identify the relevant literature and to offer an appraisal of its quality. The concept of assessment was interpreted from the identified literature which met the inclusion criteria. A Glasarian grounded theory process was utilised and *assessment* was found to be a complex and multifaceted term. Through the iterative process of coding and recoding the core conceptual category of the judgement making was identified. This category was inherent in the other competing categories which contextualised or directed the nursing judgements. Böhm (2004) notes that the;

“core category is characterised by it’s formal relationship with the other important categories” p274

The competing categories were:

- factors which influenced judgements
- factors upon which judgements were dependent
- conceptual factors which influenced judgements
- factors which were reliant on cue or indicator identification
- factors which are intrinsic to the nursing process.

The findings related to the second research question:

2. *What professional, philosophical and organisational influences affect the nursing role regarding patient assessment?*

Were the results of exploration using both concept analysis (CA) and critical discourse analysis (CDA) methods. Nursing practice was found to be influenced by a

professional ethical code and an understanding of the importance of an holistic approach to patient assessment. In addition the nurse has legal requirements which direct practice. These ethical and legal requirements are allied with each individual nurse's moral values and the status of nursing within society. Power imbalances prejudiced by the institutional hegemony of the NHS, in addition to the culture and location of each individual team, were also found. Department of Health policy decisions regarding skill mix, nursing management and the levels of work loads were also established as exerting an influence on the nursing role regarding patient assessment.

The CDA of the transcribed audio recordings of the assessments and the semi-structured interviews with patients and their carers explored research question three and four;

3. What impact does nursing assessment have on patients?

and;

4. Does patient inclusion, involvement and empowerment happen as a result of a nursing assessment?

Examples of both empowering and disempowering practice were identified. Patients and carers were able to identify and valued the expertise of individual nurses and saw them as essential in the management of their complex requirements. Core to empowering practice was the notion of the authenticity of the nurse within the interaction and their use of empowering language. The discourses of repression, surveillance, discrimination and the primacy of the approach of natural science to the body were observed and interpreted as influential on the processes and impact of assessment on patients.

The final research question;

5. Does the location of a nursing assessment have an impact on the assessment?

considered the effect that location may have on the process of assessment. Phase 2 findings showed that the two assessments which took place at the GP surgery were proforma-led and driven by the medical discourse. Both aspects of empowerment and disempowerment were found when assessment took place in the patient's home and on surgery premises. Patients were observed to be less assertive when assessed in a clinical setting.

8.6 Possible revisions to the research questions with the gift of hindsight.

The five broad questions which have underpinned this exploratory research have remained unchanged during the four years it has taken to complete this study. They reflect the areas identified from personal professional practice and, in my opinion, are of importance to nursing practice. In addition their derivation reflects policy decisions and theoretical considerations. On reflection and as indicated above questions three and four could have been conflated and still sought to explore all extremes of practice. The motivation for question five was the perception of and anecdotal assumptions that patients are more empowered when nursed within their own homes. As posed question five has proved to be too broad and on reflection should perhaps have been limited to consider any differences regarding empowerment in specific clinical settings.

With hindsight it would have been enlightening to have canvassed each participant's opinion, prior to the assessment, into the aspects of this interaction that were of interest to them. These questions could have been included and would have further reflected individual patient and carer priorities.

8.7. Commonalities and implications

Reflection on these questions and the findings of parts one and two of the studies have revealed confirmation that although assessment is a taken-for-granted term there is little clarity as to what it means in practice. There is a further confusion posed by the notion of informal and formal assessments. The literature review revealed that both are intrinsic within the nursing process (Elstein and Bordage 1998). Nursing maintains the ritual of observation of cues and indicators followed by recording and reflection on changes in the wellbeing of our patients. The area of judgement-making, the core category of the CA, involves deciding on the significance of the changes noted. The relevance and efficacy of these decisions are predicated on the experience and expertise of the individual nurse.

Deficits within interagency working have been identified as a result of the findings of phases one and two of the study and the resultant power imbalances have a detrimental effect on patient care and nursing confidence.

Observation and data have shown that when assessment is carried out well it facilitates inclusion and involvement of patients in decision-making regarding their care and treatment. Proforma or checklists have been shown as poor substitutes for these assessments.

The notion of empowerment within health care continues to intrigue and at present I am enthralled by the notion that like choice within healthcare, it is a simulacrum - since we are only ever empowered to take the accepted path.

8.8. Areas for further research

Some of the areas for future research raised by this study are

- Self-assessment – for whom is it appropriate? Griffiths (2001) found little work regarding this topic, which seems a fundamental area for research.
- The effect of the organisational culture of different institutions on assessment practice. If the SAP is to function well there needs to be a mutual understanding of the zeitgeist of each of the health and social caring professions.
- How can effective evaluation of nursing services be provided by patients?
- How can the loss of opportunities to utilise the therapeutic practices of touch, listening, and establishing rapport, caused by the delegation of care, be overcome?
- Is there mistrust and suspicion between different health-care professionals and how does this impact on patient care? Clough (2002), Dickinson et al (2005), Worth (2001) all show dissonance and insularity in their approaches to the SAP and assessment in general, and the CDA of the assessments within this study demonstrated barriers to acceptable levels of inter-professional liaison.
- How common is the response to a mismatch between the assessment made by the health-care professional and the patient's own assessment one of suspicion of the patient's motives?
- Are notions of pride and face-saving barriers to communication in general and assessment in particular?
- Do nurses find it more difficult to assess things they cannot see as suggested in the literature (Hamers et al 1994, Sbiah 1998, Birtwhistle et al 2002, Dowding et al 2003, Richards et al 2004)?

- What additional training do nurses require to enable them to ask difficult questions and to eliminate the tactics of “abrupt subject change” and “missed opportunities” identified within the CDA for this study?

This thesis is the report of an adventure that has kept me captivated for the past four years. The research detailed in this thesis broadens and adds to the debate regarding the role of the nurse in the 21st century.

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Appendix

Appendix 1. Data bases searched, search terms used, results before and after screening for duplicates

Search terms	Data bases	Initial results	After screening for duplicates
<i>Nurs* "and" "assess* Assess * 1 Patient "and" "nurs* "and" "assess* Nurs* "and" "appraisal Nurs* "and" "patient appraisal Nurs* "and" "evaluation* Nurs* "and" "judgement" Nurs* "and" "review Nurs* "and" "measure*</i>	o1 Age Concern	4	4
	o2 Allied and Complementary medicine (AMED)	136	100
	o3 ASSIA		2
	o4 BIDS	2	
	o5 British Nursing Index (BNI)	1,4678	
	o6 Cumulative Index for Nursing, Allied health literature (CINAHL)	0	
	o7 Database of Reviews effectiveness (DARE)	25	4
	o8 Diabetes UK	0	
	o9 Economic evaluations	0	
	o10 Expert patient groups	5,907	
	o11 Health Technology Assessment (HTA)	15	15
	o12 HMIC	5,001	63
	o13 Kings fund data base		
	o14 LexisNexis	103	
	o15 Medline] 190
	o16 National Research data base	129	
	o17 National Research register	129	87
	o18 PROQUEST		
	o19 Psychinfo	22	22
	o20 Pub Med	197	144
	o21 RCN included in OVID		
	o22 SIGLE	11,897	124
	o23 Social services Citation index. In web of science		
	o24 Zetoc		

Appendix 2. Draft data collection form:

Areas	Details to be collected:	Why collected	Findings	Date
Study citation	Author/s Date Title Journal	For identification of study and authors		
Philosophical stance	Positivist Interpretivist Ethnographic Sociological Anthropological Semiotic/linguistic Hermeneutic Other	To aid with synthesis and analysis and enable appropriate comparisons to be made and heterogeneity/homogeneity to be assessed.		
Research methodology	Interviewing/ questionnaires Focus groups Delphi study Consultation Participant observation and ethnography Documentary analysis Conversational analysis Discourse analysis Biographical approaches- life histories Other	To aid with synthesis and analysis		
Quality appraisal outcome	See Table 8	To check for reliability and validity		
Inclusion criteria		To aid with synthesis and analysis To enable comparisons to be made and heterogeneity/homogeneity to be assessed		
Exclusion criteria		To aid with synthesis and analysis To enable comparisons to be made and heterogeneity/homogeneity to be assessed		
Setting for the study		To provide a context and aid with generalisation To enable comparisons to be made and heterogeneity/homogeneity to be assessed		
Intervention and process		To provide a context and aid with generalisation To enable comparisons to be made and heterogeneity/homogeneity to be assessed		
Intervention		To provide a context and aid with		

outcome		generalisation To enable comparisons to be made and heterogeneity/homogeneity to be assessed		
Procedure and process		To provide a context and aid with generalisation To enable comparisons to be made and heterogeneity/homogeneity to be assessed		
Procedure outcome		To provide a context and aid with generalisation To enable comparisons to be made and heterogeneity/homogeneity to be assessed		
Main findings	Study's findings and any caveats regarding the findings.	Needed for comparison to enable synthesis and analysis		
Subsidiary findings	Any subsidiary findings and caveats associated with them	Needed for comparison to enable synthesis and analysis		

Appendix 3. Table of included studies -Core Theme : Judicial

Themes	Author and country.	Method	Identifies	Comments (mine in italics)
Judicial: based on rationality 19 studies	Harbison (1991)		Two approaches to decision making: <ul style="list-style-type: none"> • the rationalist observation, analysis and logical response to data discovered • a phenomenological perspective 	
	Crow and Spicer (1995)	Literature review	Both note the concept of “illness scripts”: these are causally linked categories that correspond to one specific illness. Both papers further suggest that nurses remember an exemplar or prototype of a particular illness or condition and match the patient cues they see in practice to this memory.	<i>illness scripts</i>
	Schmidt et al (1990)			
	Crow et al (1995)	Literature review. Discursive	A component of “ <i>domain specific cognitive strategies</i> ” p207. for sorting the information gathered. Concerned with the patient’s current situation. The accuracy of decision making depends on the quality of information gathered. (Refer to nurses forming “ <i>perceptual patterns which guide their internal search</i> ” and recognition of disease p210)	
	Appleton and Cowley (2004) (UK)	Case study guided by constructivist methodology. Purposive sampling informed by previous study.	<ul style="list-style-type: none"> • Guidelines, which are based on causative assumptions, are only used if found to have utility, and are often actively resisted. • They refer to “professional judgement” which is used to identify those for whom guidelines are appropriate. 	
	Niven and Scott (2003)	Case study.	Assessment, as in making a professional judgement.	
	Lake and John (2001)	Literature review	“practice wisdom” underpinning judgement. There is not always sufficient or precise information available on which to make a judgment.	

	Latimer (2000)	Polemic	Assessment as a cognitive process combining information gathering, problem identification and diagnostic reasoning.	
	Thommessen et al (1999) (UK)	Experimental & evaluative. 6 nurses and 37 patients were assessed using a screening tool.	Assessment as part of a screening tool.	
	Green and Watson (2005)	Literature review.	Screening and assessment are often used interchangeably.	<i>Noted that nutritional assessment is more complex than nutritional screening.</i>
	Hamers et al (1994) (Netherlands)	Literature review Grounded Theory analysis. Observation Examination of patient records Semi-structured interviews of 10 subjects.	Link assessment with medical diagnosis, based on diagnostic reasoning, containing elements of a search for the evidence to support the hypothesised medical diagnosis as outlined above (illness scripts).	
	Bazian Ltd's.(2005) systematic reviews of pre-operative assessment by nurses Both in the UK	1. RCT 60 child participants. 2. RCT 339 patient participants	1. Rushforth (2000) (60 children pre-orthopaedic surgery): showed nurses to be better at history taking than senior house officers (SHO), with detection of 94% of the problems identified by a senior specialist registrar in anaesthetics, compared with 42% detected by the SHO. 2. Stables et al (2004): more people were "very satisfied" when assessed by a nurse than when assessed by a house officer.	<i>Although no reasons were postulated for these differences in outcome they do highlight a difference between medical and nursing models of assessment</i>
	Luker et al (1998) (UK)	Mixed approach Literature review Pre and post prescribing interviews with 49 nurses, GPs, practice managers, FHSA advisors and pharmacists.	<ul style="list-style-type: none"> Refer to a diagnosis as being a synthesis of scientific and analytical judgements and this, they state, describes the process by which nurses make an assessment Suggests nurses develop an implicit "risk/benefit analysis" to support their assessments. 	

	Jordan (2002) (UK)	Experimental. Observation of 40 nurse/client interactions with and without check lists for assessment.	<ul style="list-style-type: none"> • Categorisation is required when making clinical observations and assessments. • This imposes “<i>artificial assumptions and boundaries</i>” p422 	
	McIntosh (1996) (UK)	Case studies using Schon as a framework	<p>Difficult for DNs to uncover the thought process of caring since:</p> <ul style="list-style-type: none"> • Thought processes cannot be observed • DNs find it hard to articulate their feelings. 	
	Meerabeau (1992).	Discursive polemic	Nurses often re-interpret their activities to make them appear rational.	
Judicial based on: Intuition as “gut feeling” 2 studies	Godin (2004) (England and Wales)	Probabilistic sampling of subjects; 20 Community Mental Health Nurse (CMHN) interviews (6 forensic CMHNs)	Research demonstrates the importance of intuition or “gut feeling” in risk assessment for CMHNs.	<i>Questions the exact nature of intuition, and questions whether it can be discerned from “whim or prejudice”</i>
	Pyles and Stern (1983) (USA in 8 large urban hospitals in Louisiana)	Qualitative study. In-depth interviews. Analysis and comparison of findings using Grounded Theory.	<ul style="list-style-type: none"> • Refer to a “nursing gestalt” a matrix linking knowledge, past experience, identifying cues and “gut feeling”. • “gut feeling” the identification that the patient’s observable, but not necessarily clinical, condition significantly falls outside the usual pattern. <p>Nurses in their study based this feeling on their intuition: one was quoted as saying that despite the stability of the monitors <i>“everything about the patient looks the same yet I just have the feeling something is going to happen.”</i> p54</p>	
Judicial based on Intuition as a “subconscious”	Walker (2003)	Polemic	aspects of assessment which cannot be verbalised since events are categorised as examples of intuition.	

Response. 7 studies	Manias et al (2004) (Australia)	Participant observation of 12 graduate nurses each over a 2 h busy period on an acute surgical ward.	<ul style="list-style-type: none"> • Intuition occurs at an unconscious level. • That intuition is used to reinforce other knowledge. 	<i>? subconscious level.</i> Observed two instances in their study: both possible interpretations of behaviour
	Cader et al (2005)	Fawcett's framework used to analyse and evaluate Hammond's Cognitive Continuum Theory.	<ul style="list-style-type: none"> • Intuition - a rapid "unconscious" form of data processing • Cognition Continuum Theory of judgement making • Within this theory processes range from intuition to analysis 	<i>The theory refutes the hypothesis that these are ontologically rival forms of knowing.</i>
	Eraut et al (1995) (USA)	Textbook	<ul style="list-style-type: none"> • Contends that professional deliberations consist of both intuition and analysis 	
	Benner and Tanner (1987) (USA)	Textbook	<ul style="list-style-type: none"> • Intuition - "<i>understanding without rationale</i>" p23 	
	Rew (1986) (USA)	3 phase study: 1, Scale items were generated from the published nursing, and a management Content Validity Index (CVI) of 0.96 was computed on responses from a panel of five experts. 2, The scale was pilot-tested on a random sample of 106 psychiatric mental health nurses. 3, The revised scale was presented to a convenience sample of 112 nurses	<ul style="list-style-type: none"> • Refers to "<i>knowledge acquisition without a linear reasoning process</i>" p 37 	

	Kennedy (2002a, 2002b)	1. Literature review and semi-structured interviews with 11 DNs 2. Participant observation of 11 DNs carrying out first visits; In-depth interviews; Analysis using Caroll & Johnson's (1990) framework.	<ul style="list-style-type: none"> Refers to the "determination of present and future needs" (p716) as one of her five key categories. 	<i>Questions whether intuition is a mode of cognition or a form of knowledge.</i>
Judicial based on Intuition as a component of the assessment process. 4 studies	Crow and Spicer (1995)	Literature review	<ul style="list-style-type: none"> Intuition: the way in which nurses explain the cognitive skill of nursing assessment How clinical skills come to be categorised 	
	Morse et al (1994)	Polemic	<ul style="list-style-type: none"> Explore the notion of sensing a patient in need or "reading the patient" as part of the practice of nurse assessment Five of their seven concepts used to "describe the process of sensing" are metaphysical. <ul style="list-style-type: none"> intuition, "knowing", "countertransference", embodiment empathy. 	<i>Morse et al (1994) acknowledge that it is difficult to discover information regarding intuition by interviewing nurses</i>
	Schraeder and Fischer (1987).	Polemic	Intuitive judgement is expert knowledge which is "acquired and refined with experience"p239.	<i>Links with experience</i>
	Paley (1996)	Discursive	Questions Benner's (1984) assertion that intuition is just something that experts do.	<i>Questions what non-experts do when carrying out the same functions and in what ways does it differ from intuition?</i>
Judicial based on intuition expertise and experience. 13 studies	Richards et al (2004): N England - 3 GP surgeries	Quantitative - 200 consultations recorded and independently rated by assessors regarding the quality of information gathering and accuracy.	<ul style="list-style-type: none"> All refer to an experiential knowledge base regarding assessment that underpins the judgements made by nurses 	.

Luker & Kennick (1995) (UK)	Literature review Pre and post (6 weeks on) information pack - test questionnaires. 12 nurses in pilot study; 171 in full study		
Kennedy (2002a)	Literature review and semi-structured interviews with 11 DNs		
Crow & Spicer (1995),	Literature review	All note that expert assessments differ from novice assessments.	
Hovi & Lauri (1999) (Finland)	Experimental: 51 pairs of patients with cancer, and their nurses. Semi-structured interviews for the patients and structured questionnaires for the nurses. Analysis of nurses' knowledge and congruency of pain assessment, with patients' self-assessment.		
Crow et al (1995a)	Literature review. Discursive	State that experts solve problems faster than novices	
Marks et al (1991) (Australia)	Prospective study: 568 patients in ITU ward assessed using Apache 11 Severity of Illness score. Outcome predicted subjectively and independently by doctors and nurses on admission.	<ul style="list-style-type: none"> • Study of subjective predictions of death made by nurses and doctors. • Nurses are more accurate than doctors. 	<i>That "experts seem to know what they are looking for" and "zero in". This they suggest is a cognitive response of "seen it before recognise it" .</i>
Pyles and Stern (1983) (USA)	Qualitative study. In-depth interviews. Analysis and comparison of findings using Grounded Theory.	<ul style="list-style-type: none"> • Noted: nurses repeatedly stressed the importance of experience in the development of "gut feelings " and intuition. 	<i>Identifying the nursing "Gestalt" as a process the "neophyte nurse" learned from experienced critical care nurses</i>

	Clough (2002) (Northern England)	3 year study, participant observation of case conferences, meetings and visits to clients. Separate interviews with professionals and service users (n = 65)	<ul style="list-style-type: none"> Tracked thirty-nine referrals for community care assessment and noted the results were “<i>indistinguishable from assessment for a limited range of social care services</i>” p 2 	<i>Social Services Departments were not translating assessment and care management into practice</i>
	Lake and John (2001)	Literature review	<ul style="list-style-type: none"> Note the “<i>complexity of context and degree of acuity of nurse patient interaction</i>” p10 Identify the aspects of “<i>holistic assessment</i>” whilst addressing a primary focus on “<i>Physical/medical conditions or diagnosis</i>” p10 Noting the ability of nurses to gather imprecise information and translate it into “<i>recognisable fragments of knowledge</i>”. p10 Contrast the type of language used by nurses in assessment and handover to that which is normally used to convey information. eg the word “<i>stable</i>” which is not measurable in the same way that “<i>tallness</i>” is and yet has a precision when used in this context. 	<i>These aspects of assessment, the extra dimension as compared with diagnosis and the particular use of language are commented on in other works within the study.</i>
	Morse et al (1994)	Polemic	<ul style="list-style-type: none"> An ability to recognise an impending crisis before patients verbally report their feelings or physical parameters of monitoring are showing changes. Partly attributed to picking up on non-verbal cues and having the experience and insight to decipher their meaning 	<i>Links with non-verbal communication below</i>

Judicial: based a combination of practical and theoretical knowledge over time	Kennedy (2002b)	Participant observation of 11 DNs carrying out first visits. In-depth interviews. Analysis using Carroll & Johnson's (1990) framework	<p>Assessment - combination of practical knowledge, "knowing how" and theoretical knowledge "knowing that"</p> <ul style="list-style-type: none"> • A reflexive and cumulative process. • Combination may be made over several consultations. • Identifies the best judgement as one which balances long and short term needs for a particular individual. 	<i>This notion of getting to know the patient over time and the accumulation of information features in several of the articles reviewed</i>
	Hallett and Pateman (2000) (2 UK NHS Trusts)	16 semi-structured in-depth interviews with D grade community staff nurses	<p>Interviews with twelve community staff nurses regarding their role in assessment.</p> <ul style="list-style-type: none"> • Some felt that nursing intrinsically involved assessment and re-assessment. • Nurses reported that they did not assess but referred to "assessing in your head" p 756 and "you do invisible assessments" p756 	<i>These nurses do not officially assess patients</i>
	Griffiths and Luker (1994) (UK)	Participant observation of 130 home visits by 16 DNs followed by in-depth interviews.	<ul style="list-style-type: none"> • Identified the gradual building up of a picture of the patient. • DN sisters who normally carrying out a full first assessment limit their assessment to immediate needs when acting as locum. 	
	Kennedy (2002a)	Literature review and semi-structured interviews with 11 DNs	<ul style="list-style-type: none"> • Concludes assessment has a "complex and continual nature" p719 	
	Castledine (2004)	Polemic	<ul style="list-style-type: none"> • An in depth assessment may take days to complete. 	
	Crow et al (1995b)	Literature review. Discursive	<ul style="list-style-type: none"> • Identify assessment as a dynamic process which has to be frequently reviewed 	

Appendix 4. Words used frequently as qualifiers of “assessment” in European press (Lexis Nexis) .

General qualifying terms	Specific qualifying terms
Appropriate	Adaptation
Care	Blood chemistry
Combined	Clinical
Common	Dental
Comprehensive	Disease
Detailed	ECG lead
Effective	Economic
Emergency	Early Pregnancy
Essential	Legal
Face to Face	MAU
Fair	Mental health
Fast	Medical
Formal	Needs
Full	Pain
Illness	Pain levels
Independent	Pathology
Initial	Performance
Intense	Pre-op
Latest	Post-op
Meaningful	Physical
Multi-disciplinary	Psychological
Needs	Risk of
Outpatient	Risk
Proper	Self
Rapid	Single
Realistic	Social services
Reasonable	Surgical
Simple	Telephone
A single	Visual
Special	X-ray
Standard	
Thorough	
Uniform	
Upbeat	
Wide ranging	

Appendix 5

The “con” of concept analysis

A discussion paper which explores and critiques the ontological focus, reliability and antecedents of concept analysis frameworks

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Abstract

This paper draws on the work of Paley and Duncan et al in order to extend and engender debate regarding the use of Concept Analysis frameworks. Despite the apparent plethora of Concept Analysis frameworks used in nursing studies we found that over half of those used were derived from the work of one author. This paper explores the suitability and use of these frameworks and is set at a time when the numbers of published concept analysis papers are increasing.

For the purpose of this study thirteen commonly used frameworks, identified from the nursing journals 1993 to 2005, were explored to reveal their origins, ontological and philosophical stance, and any common elements. The frameworks were critiqued and links made between their antecedents. It was noted if the articles contained discussion of any possible tensions between the ontological perspective of the framework used, the process of analysis, praxis and possible nursing theory developments.

It was found that the thirteen identified frameworks are mainly based on hermeneutic propositions regarding understandings and are interpretive procedures founded on self-reflective modes of discovery. Six frameworks rely on or include the use of casuistry. Seven of the frameworks identified are predicated on, or adapt the work of Wilson, a school master writing for his pupils. Wilson’s framework has a simplistic eleven step, binary and reductionist structure. Other frameworks identified include Morse et al’s framework which this article suggests employs a contestable theory of concept maturity.

Based on the findings revealed through our exploration of the use of concept analysis frameworks in the nursing literature, concerns were raised regarding the unjustified adaptation and alterations and the uncritical use of the frameworks. There is little evidence that these frameworks provide the necessary depth, rigor or replicability to enable the development in nursing theory which they underpin.

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Keywords: Casuistry; Concept; Concept analysis; Discussion paper; Nursing theory; Ontology

What is already known about the topic?

- There has been a huge proliferation of concept analysis papers in nursing journals in the past decade.
- Several apparently different methods are commonly used to carry out these analyses.

- There is evidence to show that nursing theories are developed from the outcomes of the concept analysis process.

What this paper adds

- An exploration of the origins and inceptions of 13 concept analysis frameworks identified from the nursing literature between 1993 and 2005.

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- This paper reveals the ontological and epistemological basis of the identified concept analysis frameworks.
- Theoretical examples are cited to demonstrate the complexity of the term “concept”.
- A case is made that the majority of frameworks used are based uncritically on methodologies which are fundamentally flawed in their inception or application.

1. Introduction

Paley (1996) and Walker and Avant (2005) have identified an increase in the numbers of concept analysis (CA) articles in nursing publications over the preceding decade. Much is claimed in nursing literature regarding the facility of CA frameworks to clarify and define concepts (Watson, 1991; Chinn and Kramer, 1995). Modernist philosophy of language expounds the theory that concept clarification elucidates meaning and that meaning provides rules for correct use (Wittgenstein, 1953). Nursing theories are often developed using definitions identified from CA explorations (Watson, 1991 and Chinn and Kramer, 1995).

The purpose of this paper is to engender debate regarding the utility and probity of the use of 13 identified frameworks. The paper provides a description and critique of the pedigree, credibility, and reliability of the origins of the CA frameworks identified from a review of health and social care literature between 1993 and 2005 (Table 1). It is not possible in a journal article of this length to adequately explore the notion of “concept”, to critique the identified frameworks and to create and justify a new CA framework. Therefore the focus of this paper will be a consideration of the assumptions which underpin the frameworks used in the nursing literature over the time frame indicated.

Duncan et al. (2007) identify the paucity of internationally published works which discuss the ontological (study of being) and epistemological (how do we know?) taxonomy of concept identification. Additionally Paley (1996) argues that there is a lack of consensus within the nursing literature,

regarding the nature of the term “concept”. Before moving to critique the CA frameworks identified in this study it is important to acknowledge that the term “concept” has a variety of interpretations. Theories range from the Platonic construct of conceptual perception as a combination of sense perceptions (aesthesis) and judgment (Plato in Plato Buchannon (ed) 1997). Through Frege (1884) (in Baker, 1986) who distinguished concepts from objects allowing a conceptual hierarchy with first and second level concepts. This allows the discussion of abstract notions such as types of concept which display type difference.

Within the twentieth century, Wittgenstein (1953) developed the notion of type difference within his work on taxonomy and the probability notion of concepts. Here he used the idea of family resemblance by suggesting family members equate to category members of a concept sharing some characteristics and attributes with each other but not needing to display them all. For example a penguin and a robin can conceptually belong to the category *birds*, providing flight is not a prerequisite for category membership.

Saussure (1960) limits our understanding of concepts suggesting we require the associative mental connection to appreciate them. Contrastingly Derrida’s (1978) deconstructionist methods countered the acceptance of fixed linguistic meaning and conceptual understanding evidencing this from word play, for example the old joke:

Dog owner “My dog has no nose”

Respondent “How does he smell?”

Dog owner “Dreadful”

This relies on the ambiguity of our connotations regarding the word smell, meaning both to “sense an odour” and to be an “odour”. Further Derrida suggested that concepts displayed a hierarchical lexicon having pure expression only within an individual’s mind. Spoken words, he argued, captured the

Table 1

Main frameworks used for concept analysis identified from a review of the nursing literature (1993–2005)

Named framework	Citation of an example	Philosophical paradigms critiqued
Aristotle’s (350 s) five predictable of logic and four causes	Goddard (1995)	Reductionism containing <i>a priori</i> statements
Wilson (1963)	Thompson (2005)	Reductionism, Casuistry, Causality
van Kaam (1966)	Pang et al. (2004)	Reductionist
Hardy (1974) (adapted and integrated with others)	Öhlén and Segesten (1998)	Reductionist
Glaser and Strauss (1967)	Walton (1999)	Inductive
Norris (1982)	Browne (1993)	Reductionist
Walker and Avant (2005)	Speros (2005)	Reductionist, Casuistry, Causality
Rodgers (1989)	Brilowski and Wendler (2005)	Relativist, Casuistry
Glaser (1992) Theoretical sensitivity	Coyle (2002)	Inductive
Schwartz-Barcott and Kim (1993)	Sung OK Chang (2001)	Reductionism
Chinn and Kramer (1995)	Dalton and Gottlieb (2003)	Reductionist
Morse et al. (1996)	Fasnacht (2003)	Reductionist
Penrod and Hupcey’s development of Morse (2005)	Hupcey et al. (2001)	Reductionist

mental concept's essence imperfectly and written words were further removed by being reinterpreted through text.

The relationship between a concept and the context in which it is displayed is assumed by several of the frameworks. Silverman (2000) describes this as a relationship where concepts are arranged within theories to define phenomena. For example he argues that "death" is situationally dependant on the model of "death" under discussion. Contextually a death can be an execution or a mercy killing, giving the concept different resonances and demonstrating a link between a "concept" and the context in which it is manifest.

Berard (2005) develops this contextual determinism identifying the importance of particular categorisation in the understanding of concepts. His example distinguishes the contextual influences on the concept of "institutional racism" as opposed to the previously used term "racial discrimination". Both refer to a similar set of actions, a modification of behaviour towards others of different races, however racial discrimination is a criminal act and requires the identification of an accountable perpetrator. The behaviour remains the same but the action has been re-classified as "institutional racism" for contextual reasons, which it may be argued, are legal, political and societal.

Understanding what is meant by the term "concept" is therefore revealed as complex, contested, temporal, indistinct and, some may argue, contextually bound (Silverman, 2000; Duncan et al., 2007) In the articles identified from the literature review which informs this paper, scant acknowledgement or discussion of this underpinning complexity was identified. If alluded to at all, authors offered only semantic taxonomies, with Morse et al. (1996) describing concepts as "abstract representation of a phenomena" and Chinn and Kramer (1995) referring to them as "a complex mental formulation".

2. What is concept analysis?

Concept analysis (CA) may be considered a branch of empirical linguistics, as it contains the assumption that a definition of a term may be found which pertains to its representation in natural language. Winch (1958) referred to CA as an "uncommitted inquiry" suggesting it should be a disinterested description neither politically, morally or agenda driven.

Wittgenstein (1953) makes reference to conceptual analysis, writing of "a grammatical investigation" to identify subject matter. One Oxford University school of analytical philosophy, proposed that if the analysis of one concept, the *analysandum*, was made in terms of another concept, the *analysans*, the nature of the analysis was made with regard to the relation between them both (Moore (1942) in Körner, 1986). This suggests that the relation is of the same order as that between the following statements: "X is a sister" and "X is a female sibling". That is, although both concepts must be in some sense the same, in order for one to refer to the other, the phraseology must differ as the *analysans* must contain explicit

reference to different concepts from the *analysandum*. It is important to note that when considering a concept, in this example "sister", the use of this term has broadened over time from referring to a genetically or related sibling to mean someone with whom we have a closeness, e.g. the lyrics of "Sisters are doin' it for themselves" (Stewart and Lennox, 1985). Here we may understand sister as referring to all other women and perhaps some transvestite and homosexual men. This illustration demonstrates the importance of considering the temporal context when undertaking a CA.

The practice of CA can be seen to be problematic as it is operating in territory where the subject of analysis, "the concept", may be disputed and the methods used to analyse are influenced by the skill, knowledge, culture and understanding of the analyst and the framework being used.

3. Use of concept analysis in nursing theory development

Developments of many nursing theories are based on concept analysis and clarification (Chinn and Kramer, 1995; Blegden and Tripp-Reimer, 1997; Walker and Avant, 2005). Walker and Avant identify CA as one of three approaches to concept development from which nursing theory follows. They describe four levels of nursing theory development:

- "Metatheory", focusing on methodological and philosophical questions pertaining to nursing theory development.
- "Grand nursing theories", identifying conceptual frameworks underpinning the science and artistry of nursing.
- "Middle range theory" "become reference points for further refining grand nursing theories" p. 16
- And also direct the recommendations for practice theories.
- "Practice theories" theories relating to practice issues.

The development of "grand nursing theory" has promoted and aided fundamental debate regarding the nature of nursing and conceptual differences between nursing and medicine. However it has been argued that many theories of nursing contain only vague generalisations couched in terminology with indistinct and unclear meaning (Levine, 1995; Blegden and Tripp-Reimer, 1997).

4. A critique of the philosophical theories underpinning the identified concept analysis frameworks

4.1. Heidegerian hermeneutics

Thirteen named CA frameworks were identified from the nursing literature search between 1991 and 2005 (Fig. 1) all of which are based on the Heidegerian hermeneutic proposition

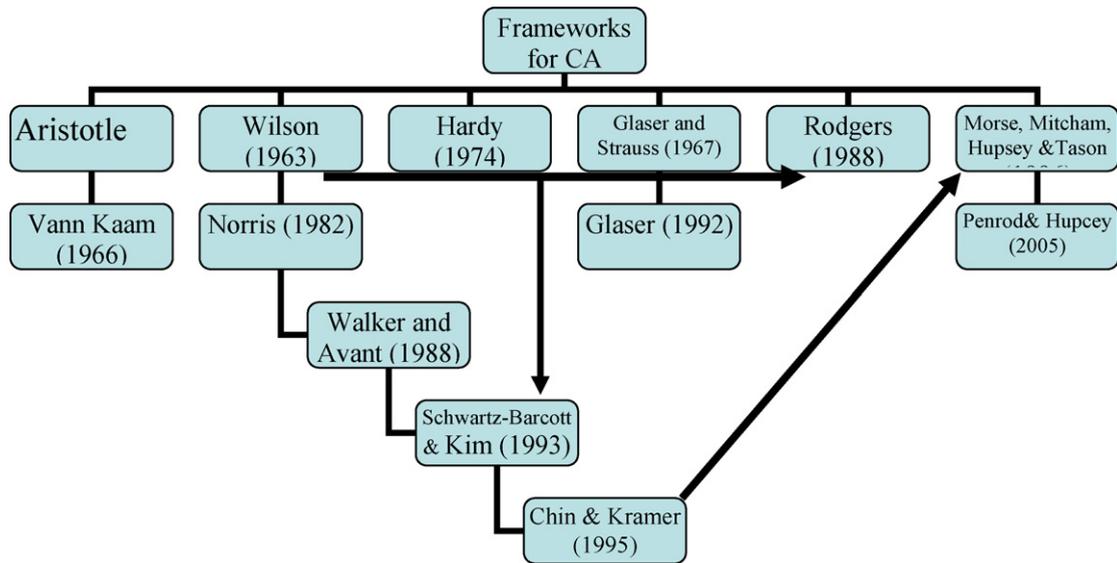


Fig. 1. Concept analysis (CA) frameworks showing antecedents.

that we are “thrown” into a world of meaningful discourses and practices which we are able to understand by drawing on our experiences of what it is to be human (Heidegger, 1962). Rather than standing outside as an objective observer hermeneuticists are already in a world of recognisable practices which they aim to make more easily intelligible. Heidegger saw the past and future as being as real as the present with existence accessible and apprehended through an “understanding of being” Heidegger (1962) p. 32 (Dasein). This process of human understanding is facilitated through; interpretation, identification, reflection on rules and patterns, implicit premises and modes of meaning, which culturally contextualise our experiences (Watts, 2001). Hermeneutics may be criticised as a metaphysical theory which oscillates between self-understanding and understanding of the world. Here understanding is facilitated by retrieval and reconstruction where sense is made from the hidden but knowable logic which it is claimed may be revealed and clarified (Dreyfus and Rabinow, 1982).

Understanding through interpretation is open to the criticism made by Wittgenstein (1953) that it is difficult to know when to stop interpreting to ensure relevance and sufficiency. This uncovering of existing knowledge is exemplified in the philosophical tenet of Casuistry which is utilised in the form of case studies or reconstructions and offered as a basis for many of the frameworks identified.

4.2. Case studies, case reconstructions or case inventions

The frameworks developed by Wilson (1963), Norris (1982), Rodgers (1989), Chinn and Kramer (1995) and Walker and Avant (2005) (Fig. 1) all include case studies or reconstructions in which identified rules are made expli-

cit. Rodgers and Knaf (2000) broaden and compromise this by suggesting case invention for instances when the

“scientist cannot discover a sufficient number of differing instances to exemplify the concept. . . it is often helpful to take the concept outside one’s own experience.” p. 61.

Reliance on case reconstruction, invention or description raises concerns regarding the proposition that truths are revealed as a result of a causal explanation of the effects of a social action within the “pure case” and the distance and difference between it and other cases. This proposition is based on two philosophical theories, casuistry and causality.

4.3. Casuistry

Casuistry, like hermeneutics is borrowed from the religious lexicon having been originated to explain religious rule setting by Jesuit monks in the sixteenth century. Casuistry was used to justify their claims regarding the probity of the rules their order set. Justification is based on an internal structure of verification and is still employed within our legal and medical systems and within the field of ethnography (e.g. Levi-Strauss, 1970: *The Raw and the Cooked* in Sim, 1992). Within the legal profession, as with the religious rule setting, outcomes are arbitrarily agreed by members within these elite groups and case or religious law decisions are adjudged against the outcome of similar previously agreed cases (precedents). In other words, outcomes of one case set a precedent for judgements involving other like cases. This does not reveal or discover anything new but identifies that one particular outcome may be discussed and evaluated in the light of a previously agreed decision. Commonalities and not universals are being used and claims are made regarding their applicability rather than any uncovering

of any principles. Beauchamp and Childress (2001) describe casuistry as not applying principles to cases but moving up from cases to principles.

Casuistry is supportable where there is consensus about rule making and outcomes, but is less useful within other spheres and has practical limitations in a health care setting. For example, if the lowest set of nursing standards are accepted and practiced. The use of precedents based on case studies from this arena to make judgments in other analogous cases could drive down standards overall. Secondly any guidance from the example of one case is sensitive to problems arising if the example case is inappropriate for the setting of the case it will inform. Further extrapolation from the principles which underpin a particular case to claim a universal rule, as used in the CA frameworks identified, is problematic. These limitations require acknowledgement and consideration when constructing or describing cases as part of a CA framework.

4.4. Reductionism and positivism

Many of the frameworks adopt a reductionist or positivist philosophical stance. For example, those based on the work of Aristotle (350 BCE translated 1979), Wilson (1963), van Kaam (1966), Walker and Avant (2005), Schwartz-Barcott and Kim (1993) and Chinn and Kramer (1995). Positivists, with regard to study of society, hold that causal relationships can be found within human behaviour and that observations of this behaviour can be reported free from theoretical interpretation. Thus positivists claim, observations of behavioural patterns will lead, empirically, to the discovery of objective truths. However nursing, in addition, requires both interpretative skills to uncover the patient's conception of their situation (Benner and Wrubel, 1989) and ethical considerations (Nursing and Midwifery Council, 2004) implying a moral dimension to nursing practice. Neither the

ethical or interpretative facets of nursing are adequately explained within a positivist or reductionist paradigm. CA frameworks based on these stances cannot therefore reflect the breadth and complexity of alternative interpretations and are unable to produce a complete account of these aspects of the concepts which define nursing practice.

4.5. Causality

Causality, the theory that one action or outcome can be identified as a consequence of another, subsumes empirical events into universal laws, as with the critical realists (Bhaskar, 1978) and the natural sciences. Although at first this may seem appealing, in nursing practice it is often difficult to define the exact link between two events. Without a clear-cut identification of the particular cause and effect relationship, a CA framework will lack the analytical qualities it claims. For example, consider an individual who successfully attended smoking cessation classes. A causal inference may be made that this outcome is predicated on the information and support offered by the classes. However, those making that inference may be unaware of other motivational forces, perhaps a new relationship with a partner who insists they stop smoking. Accepting the initial causal inference that the smoking cessation sessions have been the motivator is an error which would be compounded if the findings of this case were extrapolated to other like cases.

4.6. Wilson's method and those using it

Examination of the frameworks found that Norris (1982), Walker and Avant (2005), Schwartz-Barcott and Kim (1993), Chinn and Kramer (1995) and Rodgers (1989) were all using uncritical and unjustified adaptations of Wilson (1963). Morse et al. (1996) further modified Chinn and Kramer's (1995) adaptation of Wilson (1963) (Fig. 2).

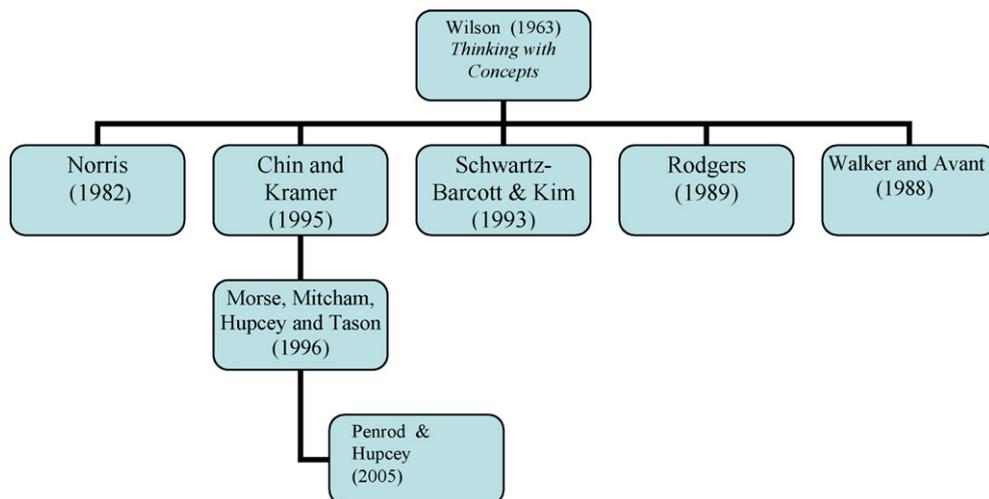


Fig. 2. Concept analysis frameworks (adapted from Wilson's (1963) model).

Wilson's method, proposed in his book "*Thinking with concepts*" and referred to by Duncan et al. (2007) as a "seminal work" was originally written with the intention of enabling his school pupils to pass their "Oxbridge University Entrance Exams". Wilson describes an 11 step iterative process (Fig. 3) referred to as

"*The method of choice for...the discovery of idea testing*" Wilson (1963 p. 42). In Wilson's framework (Fig. 3), steps 3–7 recourse to casuistry and therefore raise questions of universality and sensitivity, as outlined above. Step 8 identifies the importance of identifying the social context in which the concept is utilised. However, Wilson does not suggest consideration of other contextual influences such as political, financial, or historical. He suggests that by recog-

nising essential elements the "best meaning" of the concept will be found. By use of "best meaning", he implicitly introduces subjectivity and choice as to which meaning is "best". Further, this acknowledges the proposition that there may be a range of conceptual meanings which is at odds with his essentially reductionist framework.

Although highly appropriate for his target audience, Wilson's method lacks the depth and rigour required for use as part of a CA framework which aims to produce a definitive statement regarding a particular concept.

Norris (1982) refers to "Wilson's technique" which he claims is the "*method of choice*" for "*discovery and idea testing*" (Norris, 1982 p. 42). Norris and Walker and Avant have reduced and simplified Wilson's eleven steps without

1. Isolate questions implicit within the concept- What are the facts, the values?
 2. Find the correct answers to 1. By examination of multiple use of the concept.
 3. Describe a clear cut, **model case**, from real life, that illustrates the concept.
 4. Describe a clear cut, **contrary case** that does not illustrate the concept.
 5. Describe **related cases** in which it is possible to identify which aspects of the concept are essential and which are not.
 6. Describe **borderline cases**.
 7. **Invented cases** may be used when there are insufficient real life examples.
 8. Identify **Social Context** in order to determine the context in which the concept is used.
 - who uses the concept
 - in which manner and environments.
 9. Examine **underlying anxiety**.
 - Able to expiate underlying feelings and discussion surrounding the concept
 10. **Practical results**.
 - Identify results brought about by understanding the concept's essential elements.
 - Make use of in every day practice.
 11. **Results in Language**.
 - Defines the concept and its essential elements
- Identifies the *best* meaning of the concept.**

Fig. 3. Wilson's 11 steps.

explanation, justification or critique, using only five or seven steps, respectively. All the identified frameworks listed in Fig. 2 are based on an uncritical simplification or unjustified adaptation of Wilson and do not discuss, identify, or address any of the problems associated with the causal and reductionist ontological positions which underpin Wilson's work.

Rodgers' (1989) CA framework employs an evolutionary approach which considers changing perspectives and acknowledges mutation in conceptual language over time. For example the concept "gay", has moved from meaning being happy and carefree to now mainly referring to same sex relationships and culture (The Concise English Dictionary, 1990).

Both Rodgers (1989) and Morse et al. (1996) place emphasis on the identification of concept boundaries. To this end Rodgers' search strategy involves a random sample, in excess of 20% of the total literature identified over a long-time frame. Exclusion criteria are utilised in order to reduce the sample size. Rodgers claims this facilitates examination through an iterative process exposing concept evolution through use and application. Although the initial literature review sample covers a long-time frame, the final sample is randomised, creating problems as the reviewer cannot ensure their final sample contains examples from the entire time range and diversity of concept use in the initial sample. Thus having emphasised the need to consider changes in meaning over time the randomisation of the selection procedure precludes this aim.

Rodgers also includes the researcher's construction of a real case model and the identification and recording of frequently occurring attributes, boundaries, references, antecedents, consequences and related concepts. These steps are attributed to Wilson by Rodgers and are open to the same criticisms regarding the use of casuistry and reductionist approaches.

Rodgers' framework raises questions of how the attributes, contextual features and related and surrogate concepts are identified and categorised into themes. Her attempts to be "scientific in approach" result in analysis at a descriptive level lacking evaluation and interpretation. Noting instances of particular words only empirically demonstrates the number of those words present. In order to rank them and deduce their relevance, interpretation and context appreciation are required. As Lyas (1992 p. 360) puts it:

"there is no way of deducing conclusions about values from neutral descriptions".

Schwartz-Barcott and Kim (1993) propose a "three phase hybrid framework", adding a field element to that of the theoretical phases found in other frameworks. Initially based on Hardy's (1974) theory development and concept clarification work the hybrid framework involves using findings from the theoretical phase to justify the findings of field research. The fieldwork, comprising small focus groups in the sample identified, is suggested as an empirical element which will enhance the theoretical findings. Their

theory phase includes a literature review, using either, Walker and Avant's or Rodgers' frameworks, to support their fieldwork findings. Imposing this agenda may arbitrarily compromise the comprehensive nature of their literature review.

Chinn and Kramer (1995) state that the creation of conceptual meaning provides the foundation for developing theory. Advocating a systematic approach, which draws on the work of Wilson and Walker and Avant for their concept clarification process their framework, is in a positivistic, reductionist paradigm. Using either constructed or remembered case studies they are also open to the criticisms cited of casuistry. A further area of concern is their prescriptive and pragmatic advice given to the researcher when formulating criteria:

"for the expression of both qualitative and quantitative meaning of a concept": "as you develop criteria you will naturally refine them so that they reflect the meaning you intend" Chinn and Kramer (1995 p. 88).

Chinn and Kramer stress the importance of clarifying the context in which a theory is to be analysed. However, they do not extend consideration of the effect of these contextual considerations to the concepts themselves.

4.7. Less commonly used frameworks identified by the literature review

The literature review identified three rarely used CA frameworks and methods which were used either alone, or in combination with each other, or with the others listed in Table 1:

- Aristotle's four causes and five predictables of logic theory (in Madigan, 1999),
- van Kaam's (1966) controlled explication following an adaptation of Aristotle (350 BC),
- Glaser and Strauss (1967) Grounded Theory Method.

In the interest of completeness as they were found in the sample we will briefly identify the stances which they espouse. Aristotle's four cases are the defining parts of his theory of causality of knowledge of an object. The four cases comprise the material, formal, efficient and final causes. When applied in CA frameworks their use was analogous to *a priori* (given) definitions of the concept under review. It is hard to imagine how else they could be used as the notion of a cause is intrinsically linked with the outcome. The criticisms of causality also apply to the use of this framework.

Van Kaam's (1966) "explication" theory claims to make explicit that which is implicit in human behaviour by a discussion of the fundamental structure of phenomena. A precise formula is proposed and used in order to describe the necessary and sufficient conditions required to determine

whether a particular aspect of behaviour is present or not. This reductionist method relies on finding evidence in the literature to support a hypothesis regarding one particular way of seeing the world which is then claimed to be definitive. Problems arise when claiming an individual instance can be extrapolated to form a universal law.

Although usually used for concept clarification the remaining CAs identified (Table 1) used Glaser and Strauss (1967) process of grounded theory to clarify and thus analyses the concepts they reviewed. Grounded theory (GT) was developed as a contrast to the positivist use of a logico-deductive model of inquiry into human behaviour. Those working within a humanist paradigm saw grounded theory as a tool to re-establish the connection between theory and practice. Many felt this focus was becoming lost as the positivist (reductionist) approach had become removed from the social phenomena of practice which was the object of the research (Layder, 1982).

Grounded theory may be criticised as it is conceptually akin to “Baconian inductivism”. Bacon’s 1620 work *Novum Organum*, in Rees (2004), promotes an approach for developing theories iteratively from unbiased observation. Bacon’s approach comprises continual collection and inductive systemisation through which he sought to eliminate human interference in the process, and thus subjectivity in the outcome. Many doubt if the elimination of human subjectivity is either possible or always desirable. Similarly Glaser and Strauss’s (1967) method employs observation followed by stages of constant comparison until categories and theory properties emerge and the theory is delineated. Predicated on the notion that actions and interactions are theory-rich sources and any behaviour observed can be understood as a process of “symbolic interaction” (SI) (Glaser, 1992 p. 16). Grounded theory accepts that human beings, engaged in discourse, respond to the interaction they have with each other and interpret or “define” this interaction calling on symbols which are embedded within the interactions structure (SIs). These SIs are culture and time sensitive and a mediating influence on the discourse. From close examination of prototypes or “Basic Social Processes”, themes which display “fit”, “work” with the theory, are “relevant” to it and can allow its “modification”, are discovered. Using “conceptual sorting” (p. 116) relational properties or conditions under which the action categorised may be minimal or maximal are gathered into a theoretical outline. From examination of themes a “core category” emerges and an integrated theory is constructed. Rooted within the data under review the theory has not been forced to fit either in rebuttal or support of a postulated hypothesis. Glaser (1978) acknowledges there may be competing categories within the data but non-core categories must be realised in later works. This process will not result in the production of one definitive definition of a concept if that is the stated aim goal of the CA.

The conceptual process by which concepts emerge from the data remains elusive. Popper (1959) critiques claims

regarding the use of induction and its role in limiting subjectivity. Popper asserts that when using induction methodologies, decisions must be made as to what is germane to be observed. These decisions presuppose an underlying theory which together with the selection of data involves notions of theory verification or refutation. It is at the theory development stage that this process is vulnerable to accusations of subjectivity.

A split between Glaser and Strauss in the 1960’s has resulted in different interpretations of grounded theory being promulgated, resulting in confusion regarding which GT method has been followed to analyse the concept.

5. Morse et al.’s 9-step framework

Morse et al.’s (1996) 9-step framework has “concept maturity” as the prerequisite for analysis. Morse et al. assert that determination of

“the level of maturity is an essential task early in the research process” (p. 387) and further, that concepts which are identified as immature require development in order to be “operationalized and defined” (Morse et al. 1996 p. 387).

Their criteria for evaluating the maturity of a concept is dependent on the degree of development of; definition, characteristics, boundaries and the preconditions and outcomes associated with that concept.

This begs two related questions:

- (i) How will we know when a concept is fully mature and no longer needs development?
- (ii) If concepts “mature over time” and have an “indefinite range of maturity” (1996 p. 387), can there ever be criteria to show a concept is mature?

Although Morse et al.’s (1996) delineation of concept boundaries is interesting; their criteria for concept maturity, that its meaning becomes distinct from other concepts, is open to the following refutation. Morse et al. offer the example of WISHING as a mature concept, with firm boundaries which delineate it from other, similar concepts, such as HOPING. They further state WISHING has the characteristic that there is the implications of a realistic chance of attaining the wished for goal. Whereas HOPING, they assert, does not:

“as the form of “hope” moves towards the boundary delineating “hope” from wishing the characteristics of “hope” are less well represented until they are no longer present.” (Morse et al. 1996 p. 389).

However, I suggest HOPE is also said with expectation of attaining the hoped for end. Evidenced in everyday phrases such as “hope against hope”, “feint hope”, “hope springs eternal” and “where there is life there is hope”. Thus the HOPED for outcome is also believed to be attainable, as

there would be no point in having HOPE if a situation were hopeless. Therefore the boundary between HOPE and WISHING is not clearly delineated. Further, Morse et al.'s criteria indicate that a mature concept does not have to “*compete to explain the same phenomena*” (p. 387). Wishing and hoping are by this description both immature concepts as they both infer the same phenomena.

Morse et al. further assert that concepts require evaluation. They propose this should be done in a similar way to judgements made regarding the logical construction of arguments. However, having identified the lack of criteria for evaluation of concepts, they propose the notion of maturity as the analytical tool to facilitate these judgements. No further evidence is offered to advance their particular model of concept maturity. They only offer what seems to be the syllogistic argument,

- (a) No tool has been found for evaluating concepts,
- (b) A tool is needed for evaluating concepts,
- (c) We have a tool for evaluating the maturity of concepts.

Therefore the tool for evaluating concepts is that of measuring them against our criteria for evaluating concept maturity.

The logic is clear but the premise in line b is an assertion and may not be true. In order for the conclusion of a syllogistic argument to be true the premises must be true.

Morse et al. (1996) propose additional criteria for concept maturity which they describe as being when the research literature provides

“*a clear description of the defining characteristics*” (p. 388) of a concept.

This suggests that the criterion for judging the characteristics and thence the maturity of a concept are already preconceived by the reviewer. This second position is supported with the assertion that a concept may be considered mature when it has a

“*consensus and constituency of use among theoreticians, researchers and practitioner*” (p. 387).

Morse et al. also present a confused position regarding the relationship between concepts and context. Contradictory statements about context are made within their work: firstly, that concept can be defined without regard to their context,

“*strong enough to define the concept regardless of the context in which it appears*” (p. 388),

secondly, that a concept has a relationship with its context: “*the characteristics have maintained contextual relevance*” (p388)

and thirdly

“*Concepts are not manifest in different contexts in the same pattern.*” (p. 389) The second and third statements imply a

link between the concept and context and contradict the first assertion.

Penrod and Hupcey's (2005) development of the work of Morse et al. (1996) exclude concept advancement from CA without explaining why. Acknowledging the relationship between CA findings and the method used and in an attempt to standardise the results obtained from the use of Morse et al.'s (1996) framework, they suggest the addition of a four principle-based “scientific” development to their analysis:

- Epistemological,
- Pragmatic,
- Linguistic,
- Logical.

They also assert that,

“*probable truth is the foundation of concept analysis*”

and regard the nature of truth as one which,

“*transcends conceptual experience in human existence*” (p. 404).

This metaphysical notion that truth exists out in the universe as a given and is not subject to judgement challenges their later assertions that judgements regarding concepts can be made. These judgements regard qualities of concepts which may be divided into scientific concepts, which are worthy of analysis, and everyday concepts which are not.

6. Conclusion

On exploration of the nursing literature, 1993–2005, 13 CA frameworks were identified. Rather than providing a wide choice of methods which this plethora suggests, many frameworks are unjustified, hybridised or adapted versions of each other.

All of the frameworks identified assume the notion “concept” to be a well-understood term which required neither discussion, nor the provision of a working definition or explanation of its use within the paper.

There is absence of any critique or discussion of the core of contestable philosophical tenets including Aristotelian causality, Baconian inductivism, hermeneutics, reductionism and casuistry which underpin the CA frameworks identified.

Five frameworks are based wholly on the simplistic work of Wilson (1963), a school teacher writing a primer for teenage school boys to help with their University entrance examinations. Wilson's method was not intended to provide the sufficient depth for the analysis of complex concepts claimed by those who use it. Adaptations and simplifications of his framework are carried out in an unjustified and *ad hoc* way. Wilson's ontological stance is reductionist, binary and his use of case studies is reliant on casuistry. Those using Wilson fail to discuss any limitations of his approach with

regard to the analysis of concepts which underpin the complexity of nursing practice.

Of the remaining seven CA frameworks there are three sets of developmental work, one of which is predicated on a further adaptation of Wilson.

The hermeneutic stance which forms the basis for seven of the frameworks raises questions as to utility of case studies within this area. Morse et al.'s (1996) framework is based on two challengeable assertions, firstly that "concept maturity" exists and secondly that is required in order to analyse concepts.

The CA frameworks identified are adapted without justification and used uncritically in the nursing literature. This paper does not suggest that nothing can be learned through examination of concept use within discourses. Further work regarding the congruence of terms such as concept clarification, development and analysis need to be undertaken and relevant framework development is required. The underpinning theories which position new frameworks need to be robust, replicable, clear and justifiable and to be used with acknowledgement of defensible adaptations, ontological limitations and the contextual caveats required when operationalising findings (Paley, 1996; Duncan et al., 2007).

This study revealed little evidence to show that the CA frameworks discussed add rigour to our research or facilitate deep enough understanding of concepts to enable and justify the theory developments which they underpin.

Conflict of interest statement

This is to state that there are no potential or actual conflicts of interest that could inappropriately influence or be perceived to influence this work.

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Appendix 6

Description of the “field”.

Having set out and justified the methods used for this research study in the previous chapter I will now move on to outline the areas in which the field work was carried out. This chapter will include an account of the physical sites, the relevant organisations involved, those from whom permission was required to undertake the study. The history of the nursing roles and the types of nurse who participated will be summarised. The relevant social and economic background to the patient participants and the reasons for their referral to the nursing service will be described.

The sites.

The research was carried out in three distinctly different physical sites. Site B, was a thriving affluent cosmopolitan city site with an unemployment rate of 1.1% (██████ Mail February 24th 2009). Site A was a deprived rural county with growing unemployment which has increased by 33% since November 2007 as compared with the overall UK rise of 26% and average earnings in 2002 at 25% below those of the rest of the UK. www.economicforum.org.uk. Site C was an affluent commuter belt setting.

Negotiating different levels of gate keeping

The institution of the National Health Service (NHS) of Great Britain is divided into two spheres of influence, Primary and Secondary care. As described in chapter 2 the understanding and therefore standardising of the nature of the interaction referred to as assessment was proving problematic in the Primary care areas. It was therefore in this area the research study was to be set. Primary Care delivery takes place in patients’ homes, including institutions, nursing and residential homes, General Practitioner (GP) surgeries and Primary Care Trust (PCT) hospitals.

In order to make initial contact with the nurse participants in this study a number of obstacles had to be overcome. Primarily this began with gaining approval from the institutions involved. At a national level, through submission of a written standardised application to a designated NHS Research Ethics Committee who considered Qualitative research. The next stage was to obtain consent from the Research and Development Committees (R and D) of each of the PCTs for the areas in which the recruitment was to be carried out. Application was made using a standardised written format. Lastly consent was sought and obtained from the University’s Ethics Committee. The problems and constraints resulting from encounters with the Research Ethics Committee will be discussed

Once the relevant parties had agreed that the research could take place Honorary contracts were required from each of the PCTs. To obtain these, references and current enhanced Criminal Record Bureau (CRB) checks were sent along with the confirmation of the requisite Ethical and R and D committee approval to the Human Resources departments of the relevant

Trusts. Honorary contracts were issues between four and 20 weeks later. It took over five months to obtain the necessary consents and contracts to enable the researcher to gain access to the field.

The next stage required negotiation with more gate keepers at several different levels throughout the institutions. As the NHS is centralised for policy and major decision making and decentralised for individual accountability and responsibility it was necessary to negotiate with the strategic nurse managers and nursing team leaders throughout the different levels of the organisations.

Each of the areas where participants were recruited worked in very different ways. In the city locality (site B) the initial approach was by contacting the nurse manager who had the responsibility for research and arranging a meeting to explain the aims, objectives and methods to be employed. Following her agreement that this was a research area that had merit, an appointment was made in January 2008 to address the senior nurse managers at the PCT headquarters and the process was repeated. After reassurance regarding any impact the research would have on work load the area managers readily agreed to ask the locality managers to contact me by email. Following these contacts appointments were made to talk to nurse groups and individual nurses regarding the research aims purpose and methods. Information sheets and contact details were left for colleagues who were not able to attend these meetings. Individual nurses who were interested in volunteering to take part then made contact and a mutually convenient meeting was sent up. This meeting comprised a discussion of the nurse's involvement, the consent forms and the eligibility criteria for patients. In addition a method by which the nurses could obtain interested patient's consent to pass their contact details and the preferred method of making contact was developed.

In area A after first approaching the PCT board nurse manager an agenda slot was arranged for me to address the next county-wide Nurse Forum. A presentation was made and information sheets and contact numbers left for both those attending the Forum and for team members who were not present. Locality nurse managers were also approached and meetings were arranged to outline the project to them. Individual nurses who were interested in taking part then made contact with me and further meetings were arranged.

In area C a presentation was made to the nurse locality managers who distributed the information sheets throughout their teams. Interested nurses then contacted me by phone or email and a meeting was arranged. This was the least effective recruitment strategy.

To recruit the practice nurses (PNs) an approach was made through the Trust manager with a responsibility for practice nurses. She approached the individual practices and any interested nurses arranged to meet me by email. Initially the three PNs, each from a different practice, agreed to take part but all three felt it was necessary to seek and gain approval from the the lead GP in their practice. One GP refused to give consent and therefore only two PNs took part in the study.

As discussed in the last chapter contact with the participants varied from locality to locality and was predicated upon the needs and preferences of the individuals. The one constant was the constraint imposed by the Ethics Committee that at least 24 hours elapsed between participants receiving the information sheets and the assessment taking place.

The nurse participants.

All the nurse participants were female and were Registered General Nurses. Some of them had additional qualifications as District Nurses (DNs), Specialist Nurses or Practice Nurses and four were team leaders band 7 and above and nine were band 5 or 6 District or Practice Nurses. The nurses' age range spanned late 20s to 50s.

A brief history of nursing in the Community.

All the discourses studied are situated within nursing interactions with patients either in the patient's home, or their GP surgery. The participating nurses are community nurses, previously referred to as District Nurses, or Practice Nurses or Specialist Nurses working in the Community. Although there have always been people within communities who cared for the sick arguably the first District Nurse, Mary Robinson, was employed in Liverpool in the 1860s by the pioneering philanthropist William Rathbone (Stocks 1960). Her role was to work with the "*sick and poor*" and since that time nurses have worked within the community as the main providers of professional nursing care and support in people's homes. Sweet (2003) notes that between 1917 and 1979 the role of the District Nurse became a speciality within the nursing profession and Community health care team. Following the 1919 *Nurse Registration Act* and the 1979 *Nurses, Midwives and Health Visitors Act*, their professional development culminated with the availability of a degree for specialist practice. DNs may be employed directly by the NHS, or by private companies offering care in the community.

Following their inception in the late 1970s Practice Nurses (PNs) and Specialist Nurses (SNs) are more recent sub-sections of the nursing community. They comprise registered nurses who have developed particular skills for specific roles. PNs are employed by General Practice surgeries and their roles, pay and conditions are decided by the practices. SNs are employees of the NHS and their pay and conditions depend on the grade awarded to their post, which varies in different areas.

Patient participants

All the patient participants were NHS patients and were selected on the criteria that they spoke English well enough to be able to give their consent to take part without the aid of an interpreter. Of the final eleven participants who have remained in the study five were female and six male and their ages ranged between 40 and 84 years. There was a range of education and employment histories and a mix of homeowners and those living in rented accommodation. (Table 1). This data was collected as signifiers of patients' educational and economic attainments, which are relevant to research question two. Nine of the patients were cared for by their spouses, one by her

parents and two lived alone. One patient employed a carer to help him get up in the morning and get dressed, and again in the evening.

Table 1 Patient participants' demographics

Code	age	Gender m/fm	marital status	school leaving age	employment	home ownership (ho)
C1	62	male	married	16	white collar	ho
B1	84	m	married	14	print compositor	ho
B2	81	m	widowed	16	insurance agent	ho
B3	67	female	married	16	book keeper	renting
B4	40	m	living with partner	16	manager	ho
B5	72	fm	widowed	16	housewife	renting
C2	83	fm	single	16	cared for parents	sheltered accommodation
A1	65	m	married	14	carpenter	ho
A2	52	fm	separated	18	lab technician	with parents
A3	68	fm	widowed	14	cook	renting
A4	62	m	married	16	driving instructor	ho
withdrew						

The reasons for the patients' contacts with the nurses reflected the breadth of expertise and experience of the participating nurses. (Table 2) . Patients were referred to the nurses by GPs , hospitals on discharge, out patient clinics and social service personnel.

Some of the patients were well known to the nurses whilst others were visiting for the first or second time. The practice observed varied from fact finding and gathering, through observation to carrying out technically complicated procedures and dressings.

Table 2. Reasons for nursing contact, new referral and where seen.

Reason for referral	Known or not known to the nurse	Where seen	Code
Palliative care assessment	Known to the nursing team for over a year.	Patient dressed and seated in a recliner chair in their bungalow.	C1
On discharge from acute hospital following a fractured hip and for chronic leg ulcer	Known to the nursing team over many	Patient dressed and seated in the lounge of their house.	B1

dressings and assessment.	years.		
Assessment of Chronic Obstructive Airways Disease and depression following bereavement	Known to the nurse over the past year.	Patient dressed and ambulant seated in the lounge of his own house.	B2
Assessment of skin care in a patient with advanced Motor Neurone Disease.	Known to nurse over previous months.	Confined to bed paralysed from her neck down.	B3
Assessment of a palliative care patient and change of dressing following exploratory surgery and care of a percutaneous endoscopic gastrostomy line (PEG) and central line following the administration of chemotherapy.	First visit by the nurse	Patient prone on the sofa in the lounge of their house.	B4
Yearly asthma assessment	Patient well known to the nurse	GP surgery	B5
Six monthly diabetes assessment	Patient well known to the nurse	GP surgery	C2
Assessment of palliative care patient, dressing and pressure drainage of abdomen,	Known to the nursing team for over two years	Patient in bed in their own house.	A1
Care following a cardio vascular accident (CVA) and for assessment of extensive leg ulcer and pressure sore dressings,	Patient known to the nurse over the preceding two weeks	Patient dressed and seated in the lounge of her parent's house.	A2
Assessment of chronic leg ulcers and renewal of dressings.	Patient well known to the nurse.	Patient dressed and in the bedroom of her own flat.	A3
Following discharge from rehabilitation hospital following spinal surgery, post operative bacteraemia, morphine reaction allergy /overdose. New patient.	Not known to the nurse	Patient dressed and seated in a wheelchair in the lounge of their own house. A hospital bed and commode were also in the room which was used as the patient's bedroom.	A4

Vignettes of the patient and carer participants

In order to give a little more context regarding the people who participated in my research the following vignettes provide a small snap shots of how their situations appeared to me. Pseudonyms have been used throughout to safeguard anonymity.

The first patient participant (C1) Tom, was a family man with two grown up sons. His younger son worked in the Gulf States and the other lived and worked a few miles away from his parents. Tom's illness had forced him to retire early from a white collar job. His wife Babs had also taken early retirement from her position as a secretary/ administrator for a group of research biochemists to care full time for Tom. Babs was a car owner and driver. Tom had been diagnosed with cancer of the prostate and the oesophagus the previous year. Tom's demeanour was quiet and unassuming in sharp contrast to his wife who was very insistent on telling Tom's and her own stories. Pale and tired Tom seemed beleaguered, closing his eyes and folding his arms on several occasions during the nurse's visit. His speech became more laboured and slurred as the visit progressed.

Fred (B1) had been retired for nearly 20 years from his job as a print compositor. He and his wife Mary lived in the house they bought together in the 1950s. They have two grown up children and several grandchildren. Their daughter had recently moved to a house in the same road as her parents, so she could be of more help. Their son lived a few miles away and regularly visited. Fred had suffered with persistent leg ulcers all his adult life. This he attributed to his work when he was on his feet for many hours and the fact that his father had also had leg ulcers. Fred had recently been admitted to the local hospital following falling from a ladder resulting in a broken hip. Typically he had been up on a step ladder to check thieves had not stolen the lead flashing from his garage roof as this had happened twice before that year. Fred's enforced bed rest while in hospital had enabled his leg ulcers to begin to heal. Mary was Fred's full time carer and had retired from a secretarial post she had taken up after their children had left school.

Mark (B2) had lived with his wife, now deceased in their bungalow on the outskirts of the city since the early 1960s. He had grown up on his father's farm but as the second son there was insufficient income for his parents and older brother so he had to move away. He moved to his present address just after the 2nd world war and worked as an insurance salesman. Mark's son Derek lived less than 10 miles from his father and he and his family visited often. As Mark was hard of hearing Derek always accompanied his father for hospital appointments. His mother-in-law, now over 100 years old, also lived locally. Mark had suffered with bronchial asthma for as long as he could remember. But since the traumatic proceedings surrounding his wife's death he had been clinically depressed and had required several admissions to hospital for his chest condition over the past year.

Linda (B3) first noticed problems climbing stairs when she was on a walking holiday in the Lake District six months before we met. She was still able to walk and feed herself eight weeks before the observed assessment took

place but now had only limited use of arms. Linda was stoical, accepting and calm and did not express any resentment towards her worsening condition. She was now confined to bed upstairs as she had insufficient lower limb strength to manoeuvre onto their newly installed stair lift. A year before Linda's illness Mick had been treated for carcinoma of the bladder using Tb bacillus. He had unfortunately contracted tuberculosis, according to his doctor a 1:1000 chance, necessitating surgery and chemotherapy. Tom's ill health had forced him to give up full time employment as a tool maker and take a job as a part-time storeman which he had now given up to be Linda's full time and sole carer. Mick looked pale, tired and a little dishevelled. The couple had a daughter and two grandchildren but had chosen not to have any contact with them as they disapproved of her life style and partners. Several rooms of the small house were full of supplies and equipment for Linda. The small bedroom in which she lived is dominated by the electronically controlled hospital bed and hoist that Mick required to help him lift Linda on and off the bedpan. Linda was reluctant to be catheterised until there was no choice but was also aware of the consequences on her carer of her decisions.

Steve (B4) lived with his partner and three children, two boys and a girl, the youngest were still at school and their eldest son had just started working. He had been diagnosed with cancer two weeks earlier and had received chemotherapy the previous week. Steve described himself as working from home as a multi-million pound project manager for an air-conditioning company. His partner, Vanessa, interjected that his company was trying to get along without him. Vanessa was registered as disabled and whilst awaiting a second hip replacement a few months previously she had surgery for the removal of an abdominal mass. Vanessa required a walking frame and could only stand for short periods of time. Steve's main aim was to eat something so he could put back some of the weight he had lost. He felt he would then be able to do more. He was being fed and hydrated through a PEG line.

Ursula (B5) lived alone but cycled three miles each day to her daughters to cook, Clean, and care for her grandchildren after school. Ursula also has a son who lived in London and another daughter who lived 5 hours away by train in a seaside area where Ursula would holiday twice a year. She also belonged to a club and went away with the other members on holidays at least three times a year. She was attending a routine appointment with her Practice Nurse (PN) to assess her asthma and has suffered with angina for over 17 years. Ursula engaged with the assessment process and avidly listened to the PN when she showed her some new techniques for using her inhaler spacer.

Dorothy (C2) was also visiting her PN for a routine appointment to assess her blood glucose levels. She had been diagnosed with diabetes for over 25 years and also has mild hypertension. Although living in very comfortable sheltered accommodation she has a lively social life and took an active part in the management of her blood glucose levels. As a young woman Dorothy had cared for her father helping him with his diabetes care and was impressed at the advances made in the treatment over the many years that had ensued.

She had developed few of the long term complications of diabetes and had a rigid and self-disciplined approach to the management of her condition.

Richard (A1) a retired carpenter, had travelled extensively throughout the world. He lived with his wife, May, and was the father of two grown up sons. One son lived 30 miles away and the other over 100 miles away although both were supportive and visited often. Richard had been diagnosed with terminal lung cancer over two years before the assessment visit. At that time Richard had declined chemotherapy and he and the family were then told he had at most 6 months to live. Despite his growing physical discomfort and weakness he was cheerful and engaged with his treatment although more taciturn than his wife. He refused to use the word cancer referring to his tumour as *Fred*. May was now Richard's full time carer and rarely went out or left him alone. She had used great ingenuity and in the early days following his diagnosis kept very busy organising memorable outings such as a bi-plane flight and birthday parties for Richard.

Carol (A2) had lived and worked in the midlands where she was in an abusive marital relationship. She attributed the stroke she had suffered to the years of living in stress and fear. On leaving hospital she had moved with her daughter halfway across the country to live with her parents in a bungalow in a tiny rural village. Her father had suffered a stroke the year before Carol and was constantly comparing his progress with hers. She had almost no privacy within her parents' home and was dependent on them for all her needs. The tensions caused by bringing up a teenage daughter whilst living with her own parents and the frustrations of making a gradual recovery from her stroke were evident. Carol was also in extreme pain from the ulceration caused by a walking calliper and which required frequent dressing. She was patient and stoic but had little confidence in herself or hope for improvements in her circumstances.

Marjory (A3) lived alone but close to one of her daughters, she was married twice and had raised 7 children with her second husband now deceased. All but one of her children lived nearby. Marjory had 20 grand children and shortly-to-be 16 great grand children. Despite having chronic ulcers on both legs and lymphoedema her right leg was 23cms at the ankle and 56 cms at the knee, Marjory was moved from her home of 20 years and for the past 2 years she has lived in a one bedroom ground floor flat at the top of a steep hill. To enter or leave the flats a set of steep steps has to be negotiated and Marjory was therefore unable to go out walking or shopping. Whilst the nurse and I were with Marjory her daughter came in to cook her lunch. Marjory's bedroom was full of dressing packs, bandages and boxes containing prescription items and equipment needed for her dressings. She was patiently waiting to be re-housed, to have a rise and recline chair provided for her and to have a meeting with a dietician.

Bruce (A4) was in constant pain and unable to walk or climb stairs. He had returned home eight days before this assessment visit following seven months in a series of acute hospitals and a rehabilitation unit. His ground floor lounge has been turned into his bedroom with a hospital bed and commode. Bruce

lived in a house left to him by an aunt, with his wife and several dogs. His return home was fraught with tensions as his wife was finding it very hard to adapt to the level of his disability. Bruce was angry and his main topic of conversation was concerning his next move with regards to a series of complaints about the treatment he received in two of the acute hospitals in which he had stayed. He did not sleep well because of the constant pain and when he did fall asleep he was troubled by vivid, violent and frightening dreams. His constant conflicting statements regarding his relationship with his wife and his present situation gave a glimpse into his inner turmoil.

Carer participants

Eight of the carers who participated had given up their paid employment to care full time for their spouse or partner and two were recovering from cancer themselves. One patient was cared for by her parents and two patients had family members who came in at times to help them in the home but were not present for the assessments. One patient participant employed a carer to get him up in the morning and put him to bed at night.

To conclude in order to give an indication of the nature of the field in which this study has been carried out: Area A is a deprived rural area with high levels of unemployment. Area B is an affluent and thriving city and Area C is a prosperous suburban locality.

Examples of Information sheets used for this study.

Oxford REC B reference number: 07/Q1605/51

Information sheet: **Staff**

Title of Project: Exploring Nursing Assessment.

Name of Researchers:

Mrs Sue Beckwith.

You are being invited to take part in a research study which is grant funded and forms a part of my PhD studies. Before you decide whether to take part or not it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like further information.

What is the purpose of the study?

The main purpose of this research is to better understand the process of assessment and its relation to outcome both on the part of the nurse who is carrying out the assessment and the patient, their family or carer who are being assessed. Because the terms nursing assessment and patient needs assessment are described by words in everyday use it is presumed they are simple processes. However few studies or policy documents offer an operational definition and more understanding of these processes are required in order to classify and evaluate them.

Why have I been asked to take part?

You have been asked to take part as you have already expressed an interest in the study. We will be inviting other staff both in your practice and else where to take part.

One study area is set in a city practice and another in a rural area. 20 assessments will be observed involving 10-15 nurses.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you would be given this information sheet to keep and be asked to sign a consent form. Even if you do decide to take part you are free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, would not affect your employment or legal rights in any way.

What will happen to me if I take part?

If you decide to take part, I would like to observe and tape record an assessment that you are undertaking. Following the assessment the researcher would then like to ask you about the assessment process. This interview will be arranged at a time and place of your choice and will take about an hour. The recording, notes of the interview and observation of the event will be anonymised, transcribed and analysed in order to discover the

fundamental elements which make up nurses assessment of patients. This is not a judgemental process but one in which I will learn from observing your practice and the patients' responses.

I would also like you to ask the patient if they would mind me being there to observe the assessment and talk to them afterwards about how they found the assessment. (i.e. if you could get initial agreement, I can send them further information about the study and I will formalise the consent immediately before you do the assessment when we meet the patient, you would not have to do this).

What are the possible benefits of taking part?

You may not benefit directly from the study; however, we hope that what we find out from the research will be of benefit to others.

What are the possible disadvantages of taking part?

Some people may feel tired during or following an interview. You may have concerns regarding the amount of additional time caused by your involvement in the research. The recording and observation of the assessment will not add any additional time to this process. It is anticipated that each semi-structured interview will last no longer than 30 to 60 minutes. If you feel you do not want to answer some questions you can stop the interview at any time and refuse to answer any questions you do not wish to answer.

What if something goes wrong?

If you have a complaint about how you feel you have been treated during the course of this study, or how any aspect of it was carried out, then please contact: Dr Angela Dickinson who is supervising my research. (contact details are at the end of this sheet). If, during the interview, you tell the interviewer about an incident, involving for example, dangerous practice, the interview will be stopped and the researcher will explain the incident to your nurse manager (NMC Code of professional practice section 8).

Will my taking part in this study be kept confidential?

All information collected from you during the course of this research will be kept strictly confidential. The information you provide will be made anonymous by removing any personal details so that you cannot be identified from it. All data will be secured in a locked filing cabinet. Both written and recorded data storage and use will comply with the Data Protection Act (1998), and be kept for 10 years after the end of the study.

What will happen to the results of the research study?

The results of the research will be published in a report and nursing publications and presented at conferences. It is anticipated that the study will produce findings in 2008. A copy of the report or papers will be available and I will provide you with a copy if you would like one.

Who is organising and funding the research?

The main researcher organising the research project is Mrs Sue Beckwith (University of Hertfordshire). The Health Foundation is funding the research.

Who has reviewed the study?

The study has been reviewed by the Oxfordshire Research Ethics Committee B, your local PCT Research and Development Committee, the Consortium for Healthcare Research and the University of Hertfordshire Research Degrees Board.

If you would like further information about the study, then please contact:

**Mrs Sue Beckwith,
Centre for Research in Primary and Community Care (CRIPACC)
University of Hertfordshire
Hatfield Campus,
College Lane,
AL10 9AB
Telephone:
E mail: j.s.beckwith@herts.ac.uk**

Thank you for taking the time to read this, and for considering whether to take part.

You will be given a copy of this information sheet and a signed consent form to keep.

Research supervisor is : Dr Angela Dickinson
Senior Research Fellow
Centre for Research in Primary and Community Care
University of Hertfordshire
Hatfield Campus, College Lane, AL10 9AB
Tel: 01707 285 993
email: a.m.Dickinson@herts.ac.uk

Oxford REC B reference number: 07/Q1605/51

Information leaflet: Patient

Title of Project: Exploring Nursing Assessment.

Name of Researcher:

Mrs Sue Beckwith.

You are being invited to take part in a research study which is funded by a grant and forms part of a PhD. Before you decide whether to take part or not it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like further information.

What is the purpose of the study?

Little is known about the nature of nursing assessment. The main purpose of this research is to better understand how assessment is carried out and its relation to the ideas and expectations of those taking part. I will be looking at both the nurses who carry out the assessment and the patients who are being assessed.

Why have I been asked to take part?

You have been asked to take part in this study as you are about to undergo an assessment carried out by a nurse. The assessment process involves your nurse asking questions regarding your health and social care needs at the moment. The nurse will then complete some paperwork, noting your answers. This study is taking place in two places, one in a rural area and the other in a city. 20 patients and 10-20 nurses will be included.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you do decide to take part you would be free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, would not affect your healthcare or legal rights in any way.

What will happen to me if I take part?

You and the nurse assessing you will be observed asking and answering questions. I would like to tape record and take notes of this conversation. Following the assessment I would like to talk to

you about your impression of the assessment process. The recording will be transcribed along with all notes of the interview. Analysis of the interviews will be carried out in order to discover the elements which make up nurses assessment of patients. You will only be asked to take part on one occasion, and the interview after the assessment will take about half an hour. I will not be judging your answers to the questions the nurse asks you. I would also like to read your nursing notes to find out why the nurse was asked to see you.

What are the possible benefits of taking part?

You may not benefit directly from the study; however, I hope that what I find out from the research will be of benefit to others.

What are the possible disadvantages of taking part?

Some people may feel tired, or possibly upset, during or following an interview. You may also feel that you do not want to answer some questions. You can stop the interview at any time and refuse to answer any questions you do not wish to answer.

What if something goes wrong?

If you have a complaint about how you feel you have been treated during the course of this study, or how any aspect of it was carried out, then please contact: Dr Angela Dickinson who is supervising this research (contact details at the end of this sheet).

Will my taking part in this study be kept confidential?

All information collected from you during the course of this research will be kept strictly confidential. The information you provide will be made anonymous by removing any personal details so that you cannot be recognised from it. All data will be secured in a locked filing cabinet. Both written and recorded data storage and use will comply with the Data Protection Act (1998), and be kept for 10 years after the end of the study.

What will happen to the results of the research study?

The results of the research will be published in a thesis, nursing publications and presented at conferences. It is anticipated that the study will produce findings in 2008. A copy of any papers and findings from the study will be available and I will provide you with a copy if you would like one.

Who is organising and funding the research?

The main researcher organising the research project is Mrs Sue Beckwith (University of Hertfordshire). The **Health Foundation** is funding the research.

Who has reviewed the study?

The study has been reviewed by the Oxfordshire Research Ethics Committee B, your local Primary Care Trust Research Committee, the Consortium for Healthcare Research and the University of Hertfordshire Research Degrees Board. If you would like further information about the study, then please contact:

**Mrs Sue Beckwith,
Centre for Research in Primary and Community Care
(CRIPACC)
University of Hertfordshire
Hatfield Campus,
College Lane,
AL10 9AB
Telephone:
E mail: j.s.beckwith@herts.ac.uk**

Thank you for taking the time to read this, and for considering whether to take part.

You will be given a copy of this information sheet and a signed consent form to keep.

This research is supervised by : Dr Angela Dickinson, Senior Research Fellow,
Centre for Research in Primary and Community Care,
University of Hertfordshire,
Hatfield Campus, College Lane, AL10 9A
Tel: 01707 285 993
email: a.m.Dickinson@herts.ac.uk

Oxford REC B reference number: 07/Q1605/51

Information leaflet: Relative or carer

Title of Project: Exploring Nursing Assessment.

Name of Researcher: Mrs Sue Beckwith.

You are being invited to take part in a research study which is funded by a grant and forms part of a PhD. Before you decide whether to take part or not it is important for you to understand why the research is being done and what it would involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like further information.

What is the purpose of the study?

The main purpose of this research is to better understand the process of assessment and its relation to impact on the nurse who is carrying out the assessment and the patient, their family or carer, who are being assessed.

Why have I been asked to take part?

You have been asked to take part in this study as you are the relative or carer of someone who is about to undergo an assessment of their health needs carried out by a nurse at which you will be present.

This study is taking place in two centres one a rural area and the other a city. 20 patients and 15-20 nurses will be recruited to the study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you would be given this information sheet to keep and be asked to sign a consent form. If you do decide to take part you would still be free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, would not affect in any way the healthcare or legal rights of the person being assessed.

What will happen to me if I take part?

The assessment procedure will be observed, tape recorded and notes will be taken by the researcher. As you will be present it is important to ask your permission as you may pass a comment or

contribute in some way to the assessment. The recording will be transcribed and along with all notes of the interview and observation of the event will be anonymised so that you cannot be identified from any of the findings. Anything you say will be treated with the strictest confidence. Analysis of the transcription and the interviews will be carried out in order to discover the fundamental elements which make up nurses assessment of patients.

What are the possible benefits of taking part?

You may not benefit directly from the study however, we hope that what we find out from the research will be of benefit to others.

What are the possible disadvantages of taking part?

The person being assessed may feel tired, or possibly upset during or following the observation. However they can stop the interview at any time and refuse to answer any questions if they do not wish to answer.

What if something goes wrong?

If you have a complaint about how you feel you have been treated during the course of this study, or how any aspect of it was carried out, then please contact: Dr Angela Dickinson who is the person supervising this study, her contact details are at the end of this sheet.

Will my taking part in this study be kept confidential?

All information collected from you during the course of this research will be kept strictly confidential. The information you provide will be made anonymous by removing any personal details so that you cannot be recognised from it. All data will be secured in a locked filing cabinet. Both written and recorded data storage and use will comply with the Data Protection Act (1998), and be kept for 10 years after the end of the study.

What will happen to the results of the research study?

The results of the research will be published in a report and nursing publications and presented at conferences. It is anticipated that the study will produce findings in 2008. A copy of the report or papers will be available and I will let you know where and how copies can be obtained.

Who is organising and funding the research?

The main researcher organising the research project is Mrs Sue Beckwith (University of Hertfordshire). The Health Foundation is funding the research.

Who has reviewed the study?

The study has been reviewed by the Oxfordshire Research Ethics Committee B your local R and D committee, the Consortium for Healthcare Research and the University of Hertfordshire Research Degrees Board. If you would like further information about the study, then please contact:

Mrs Sue Beckwith,

Centre for Research in Primary and Community Care (CRIPACC)
University of Hertfordshire
Hatfield Campus,
College Lane,
Hatfield,
Hertfordshire.

AL10 9AB

Telephone: xx

E mail: j.s.beckwith@herts.ac.uk

Thank you for taking the time to read this, and for considering whether to take part. You will be given a copy of this information sheet and a signed consent form to keep.

This research is supervised by :

Dr Angela Dickinson,
Senior Research Fellow,
Centre for Research in Primary and Community Care,
University of Hertfordshire,
Hatfield Campus,
College Lane,
Hatfield,
Hertfordshire,
AL10 9A

Tel: 01707 285 993

email: a.m.Dickinson@herts.ac.uk

Oxford REC B reference number: 07/Q1605/51

CONSENT FORM: Patient: Non-participant observation, recording of assessment and interviews, use of anonymised quotes and access to the nursing notes.

Title of Project: **Exploring Nursing Assessment**

Name of Researcher:

Mrs Sue Beckwith

Please initial box

1. I confirm that I have read and understood the information sheet dated May 2007, version 5, for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical, or nursing care or legal rights being affected.

3. I understand that I will be observed while being assessed by a nurse then asked to talk about my experience of a nursing assessment.

4. I agree that the observation and interview can be tape-recorded

5. I agree that any words I may say during the observation and interview can be used, anonymously, in presentations of the research.

CONSENT FORM- Relative or carer. Non-participant observation, recording and transcribing of assessment and interviews

Title of Project: Exploring Nursing Assessment.

Name of Researcher Mrs. Sue Beckwith

Please initial box

7. I confirm that I have read and understood the information sheet dated May 2007 version (5) for the above study and have had the opportunity to ask questions.
8. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
9. I agree that the assessment at which I am present can be tape recorded.
10. I agree that any words I may say during the interview can be used anonymously, in the presentation of the research.
5. I have read and understand the arrangements for storage and handling of information given as described in the information sheet.
6. I agree to take part in the above study.

Name of relatives or carer	Date	Signature
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Researcher	Date	Signature
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Appendix 7

Transcription conventions used

cipher	meaning
[]	Text omitted
#	One speaker interrupts or talks over another
?	A raised inflection in the voice indicating a question
^	Marked raising and falling of the tone marked before the rise or fall
~	Indicates slurred inflection for effect as in yeeees
<u>stress</u>	Underlining indicates emphasis
TALK	Capital letters indicates a rise in volume
TALK	Capitalisation of emboldened letters indicates a raised voice
<u>TALK</u>	Indicates shouting
!	Indicates agitation or animated speech
◦talk◦	Indicates talking quietly an aside
hheh	Indicates aspirated laughter the more hhh the longer the laughter
gigg(h)le	(h) within a word indicates laughter within that word
HAHAHA	Indicates a belly laugh
<i>laughs</i>	Indicates a polite laugh
>speech<	Greater or lesser speed
.....	Indicates a pause of 2-3 seconds
.....(6).....	Indicates a pause of over (n) seconds
??????	Indicates speech indecipherable
... before text	indicates quotation taken from a longer passage of speech
(6.4)	indicates the number of minutes (6) and seconds (4) into the assessment

Example of Transcribed data – The first section of B2

[.....] or ** signifies identifying details such as Gp's name and local hospitals

Drs are the Gp and hospital consultant

D = son

N- nurse

P-patient

R-researcher

(6.4) indicates the number of minutes (6) and seconds (4) into the assessment

(4) signifies a pause of 4 seconds

Location:

Lounge of B2

French doors to garden



All laugh!!!

N Well Mark....

P Yes

N how have you been? I last saw you(3sec) a good month ago. maybe 6 weeks ago and er you were having all that tummy pain at the time weren't you?

P That's right um (2sec)...and also cos since I've seen you I've been up to the [name of hospital] twice and seen Dr [..]

N That's right

P And again I met up on... Maundy Thursday and had a follow up... and there's another appointment made for June

N Ah excellent oh that's good

P And

N We haven't had the letter for that appointment through yet of course with the bank holiday so I haven't heard how that went what

P Um before we go any further I have to tell you I actually went stone deaf about 3 weeks ago

N Oh

P And I couldn't hear anything

N Oh my goodness

P I couldn't hear the telephone I couldn't here the the door bell and that last time when you spoke to me on the telephone I had previously (2)..phoned your office and spoken to Jacqui and I knew what time you were going to phone me so I sat by the phone waiting for your phone call

N Oh bless you

All laugh

P And and last Thursday Maundy Thursday I went up the hearing department in the new wing of the JR and err they ...gave me another hearing test and they have given me 2 new hearing aids which is digital ones

N Ah

P.....(4) which is certainly much better I am able to hear a little bit better.. now but um

N Did they examine your ears?

P Err beg pardon

N Did they examine your ears to find out why you had suddenly gone more deaf or#

P #Yes they well actually I went down and saw Dr[...] you know when I went so deaf and I told him I was completely deaf I couldn't hear anything and he looked in my ears and said there was no sign of wax

N oh

P and there was no reason for it he said try new batteries in your hearing aids but of course that didn't make any difference and so I went up to the hearing department and.. I hadn't got an appointment and and the person I saw put a new tube connecting tube on

N MMmm

P and she said... is that any better and I said no it's it's just the same.... so she made an appointment for me there and then to see someone else and when I went up they looked in my ears both of them looked in my ears but there's no sign of wax and um the er person I saw a very nice girl on Maundy Thursday she gave me a proper hearing test where you press the bell

N Ah ha

P and in both ears and she... I mean it is it's marvellous what they can do today with those computers she then transferred it all to this computer and she showed me cos I took my papers up of previous tests and she showed me where the graph went and how my

N ahh

P hearing had deteriorated (3.23)

N Ohh how interesting

P And then she got 2 new hearing aids out and she connected themup to this computer so it they programmed them to exactly how the hearing test had come out

N wow really

P yes I said that's amazing because previously you used to do it manually and she said that's right with a screwdriver but she said now its spot on to what they have recorded on the ...

N That's fantastic so did they just feel your hearing had just deteriorated.. for whatever reason

P Well it it has it has come back slightly or its certainly um improved quite a bit since I've have had these new hearing aids um but they work differently from my old ones which I used to have 4 numbers on the hearing aid and I could turn it up from 1-4 but

this one she said is programmed exactly as we made it so really you shouldn't have to turn it up but you can adjust increase it um marginally and she said.... see how you get on give yourself time to get use to a new hearing aid and if necessary come back and see me and I can make it louder for you if it's necessary.

N That's wonderful

P So Yes so

N That's really good

P Its really good service I was very impressed

N I have had a few other patients go there and um and they have had these digital hearing aids and they are transformed-

P mm

N suddenly they can hear really well its

P Mm

N great isn't it

P Mm

N really good technology

Both laugh Oh so

P Well it was very inconvenient I I used to have to check my phone every night to find out who had been calling me and call them back ...and um.... I had I had booked in the car to be serviced and they were going to pick it and I was frightened to death I would not hear the chap and I didn't hear him ring the bell but I had the door open so I would see when he came (5.23) laughs

N Oh goodness

P Yes and then they phoned me up from the.. um garage to say it was all ready and he was explaining what he had done and I couldn't hear anything I said I can't hear you I said I will have to come in and face you and hear you straight across the desk but now I do hear the door bell

N Excellent and the phone you are hearing the phone

P Mm

N That's good

N So your are sort of back t where you were

P Mmm it's getting its there but I think it's just a question of getting use to it the sounds are much clearer on this one

N Oh right

P And I think it s just a question of readjusting to how I'm going to hear the sounds which are slightly different to what it used to be

N Well right well that's very interesting

P well that thts good

N mmm

P um

N so that's been a big thing you've been

P Yes

N sorting out and coping with isn't it

P Well I mean I was very concerned when I was so deaf cos I didn't really like to drive

N No

P I couldn't hear a horn you see or anything and ...your..your like in another world your not it somehow

N Yes

P It's awful. But that's in the past

N That's good

P Well and certainly since my first visit to the ..[name of hospital] um ...there was um ... a change of antibiotics wasn't there (6.53)

N there was

P and um also um.... Iwhen he asked me what ...what antibiotics I was on you know the first visit I said well I think it's aminophylline and he said it can't be amynoph. He said because that's not an antibiotic he said what made you say that

N *laughs*

P I said well I must have it in the past.

N *laughs* just popped into your mind

P *laughs* He said did it help you I said yes I think it did so he said well we'll put you back on that so I m on Amin. now

N and then you stopped it for a little while didn't you

P that's right

N after that

P Well I did I mean I went on A when I ..years ago... when I was hospitalised with asthma

N that's right I remember you saying yes

P and then I stopped it well and then Dr[...] tried me on it and I took some and I don't know why I stopped it ...um..probably I was fed up with taking so many tablets

N Maybe and I think this time after you had seen Dr[...]at the [name of hospital] ...um ...you started taking the A and then you had ...the tummy pain didn't you

P Yes yes

N and then you stopped it just for a while

P yes yes

N and that did settle eventually on its own

P mm

N and then you when I last phoned you you had restarted the A are you still on that now or

P Yes I am because um

N Right

P um I went down the last.... when I when I saw... saw Dr[..] um when I went so deaf I told him I was going to carry on with it and also the Atrovent new inhaler which I'm on ...so I've got another antibiotic I've got A and a new inhaler

N excellent

P and also a different antibiotic which I... I'm am on um so you know I went up on Maundy Thursday to see the Dr would you like the details of how I proceeded (*gets out a written list*)

N Please yes yes that would be lovely (9.05)

P because I was ...err so very deaf still as that was before I went to the

N ohhhh

P hearing department

N ahhhhh well that didn't help
P no well D came with me
N Oh great
P and I asked him if he would make some notes in case I
N Oh bless him that's a great idea
P so *both laugh*
N so they're the notes *both laugh*
P in case I missed anything
N Oh great *laughs*
P We were quite well organised
N You were
P um err when I got there the usual procedure um I went in and was weighed.... I didn't
...he didn't make a note of that as he was waiting outside and I can't remember
N He didn't say you have lost weight or anything
P No I don't think so they didn't make any comment about that and then the person at
reception who weighed me said err the Dr wants you to go and have another x ray I an x
ray um the first time up thee um so the test I had while I was there was an x ray a blood
test and then the O2 level in the blood....and I didn't see Dr [...] this time I saw his um
registrar (10.32)
M mm mm
P Dr [...] ...and um I blew through e the peak flow
N ah ha
P where it goes across the page what do you call that
N a spirometer
P Ah ha a spirometer yes
N Maybe
P The peak flow's the one where it measures the numbers
N yea just on the tube
P well spirometer the I blew on that and she was very pleased with that because it was an
improvement on the previous time
N thats wonderful
P yes
N that's really good
P Yes she had the old graph there to compare and um ...er..you know the drill you blow
and it goes all across the page and I thought when it got to the other end it um it stopped
but she said could you..carry on blowing and I said yes I could just for a short while I'm
sure ... so she said well don't worry cos it gets to the end cos it then comes back or
something
N ah alright
Both laugh
P so I had another go and and and ...she was very satisfied with it and she said that was
an improvement and then she, again, modern technology is marvellous, err she switched
on the computer screen and um reproduced my x ray results.. on the screen and also the
ones I'd had previously
N **WOW**

P and she was able to compare the two without having, well you always used to bring back the envelope and hold it up

N *laughs*

P *chuckles* to the light yea they were on the screen

N Fantastic

P She she said um there was a slight shadow on one of the lungs

N Right

P which though probably they might want me to go up and have a scan or something um anyway to be discussed um but she said um certainly your spirometer blowing has been much better and your x ray looks **better** than it did before just...

N still not quite

P she said um she didn't think there was any infection there um she asked me about my cough ...and um if I was coughing up any sputum and well I said well I've always had a cough I've always had a cough

N mmm

P now for years and years and years and I said I do cough up... occasionally but not as frequently I do when I have an infection

N it's a subtle change isn't it

P that's right

N that only **you** really would know the difference

P that's right I said that um er you kmnw I have been able to reduce very drastically the use of that em.... inhaler...

N ventolin?

P yes ventolin yes um I said I might.. use perhaps it once in ..during the day but some days (13.42) I don't

N That is better isn't it

P Yes

N Because you were needing it up and down the stairs weren't you at one point?

P Well that's right I ..I mean used to get to the top of the stairs and have to sit down and have a puff.

N and you're not doing that anymore?

P No no

N Oh that's great

P In fact this morning I mean it was .. it was nice it was quiet mild out in the garden and I

N excellent that's good (patient's first name]..that's really good

P um(5 secs) so any ..so any way she I asked her about what treatment to continue with and she said ..if I ..get an infection or the sputum is more frequent and it is coloured she has given me a little tube and a form all filled in and she wants a specimen

N oh great Ok

P she she said um I either drop it directly in up at the hospital or at your surgery and it will be sent up

N that's right

P so if I drop it up at the surgery I.. I've um looked things out for you

N Oh bless you..thank you so organised Mark

P well yes

N compared with other patients *laughs*

P so that's what she has given me

N oh right that's sounds good right that's all ready to go so all you do take it directly to the hospitals or to the surgery just fill in the date... and time on there that's all you need to do

P just date and time

N yes ...and I would put the date on this as well (*indicates tube*)

P Would you

N Yep just cos they can be funny in the lab and it would yes just to be safe

P Yes

N just to be safe

P Yep yea

N Oh that's that's that's a good ides

P Yep and she said that um if feel ill and I must start taking antibiotics and she wanted me to carry on with the ones which um they they suggested or Dr [...] suggested (*hands script to nurse*)

N co..mox.y..cillin ok (*records in notes*)

P Um So that is not recorded in my notes you see

N No we will have to change that don't we ..definitely

P well she she said um this had worked before we'd like you carry on

N yes

P and then if we have a specimen we can analyse that and find out if it is the right one to be using or whether you need some different ones

N Fine ..yep that sounds very sensible and what we'll do is as you say ad..adjust your notes so it says that's the one to take

P yep

N and to take the specimen in as well

P Yes and (*16.18*)

N what did she say about the er steroids during infection

P She didn't mention those

N so presumably carry on with the 40 then (*recording in nursing notes but looking up at patient as he speaks*)

P She never mentioned those um she said continue with the Activan um 4 times 2 puffs daily

N Mmm

P continue with the amynophylline

N MM

P...um and I I said to her I have now got 4 inhalers

N yes

P 3 I am using ..night and morning and the one reliever and I am also taking blood pressure, fencyide (?)

N mm mmyou've got a lot there haven't you

P yes um as I said amynophylline and all...course I take the um other one that put calcium in don't I

N You do ..yes you do

P What is that called?

N Calcichew

P thats right

N yes

P so I said it is it's such a lot I am like a walking chemist shop if I go anywhere and she said well ...we would like you to carry on for the time being um we will consider cutting down ...next time you come if everything is going all right

N Oh that's good

P Yes

N Yes I know that will please you won't it *Laughs*

P well I mean

N if she can (17.47)

P even if I sort of reduce .. err one..from 3 times a day from 4 times a day

N I suppose the other thing is um I don't know if you remember it might have been about a year ago but do you remember there are 2 of your inhalers that can combine into one.. and you get the same dose of both but just in one

P yes

N that might be something that we can suggest again

P Yes ...well you told me last time when I was saying how the time it took to take the all cos I

N yes

[The nurse and patient now move on to talk about the sensitive area of the patient's recent bereavement and some issues he has with the care his wife had received before her death.]

Extract from Researcher (R) and Nurse (N) s/s interview in nurse's car outside patient's house (55.12)

R was there anything there that you didn't expect or that was difficult?

N nothing that I didn't expect as such but the waiting of the amount of time spent on each separate thing obviously as a nurse you are going in with your agenda

R mmm

N and what I was trying to do was not to impose that on him so what I was taking from that was probably quite a small percentage in terms of what I was trying to judge against last time (55.54) and how well he is and what information he is taking in but for him it is more of a bereavement anniversary...

R mmm

N and that is why I try and keep it open really and err allow him to speak as he finds and that's why I say well how have you been since last time I saw you and he can pick out whether it is the clinic appointment or the bereavement anniversary or something else that is most important and that in itself gives you an idea of where he is at the moment from what he has chosen to talk about most or first you know what I mean....

R that was very much coming through..... (5) and would that be a typical amount of time you would spend with him?

N I think it would be with ** yes yes occasionally it has been shorter but generally I allow about an hour and it has been exactly an hour before when his wife first died very much virtually the whole would be spent talking about the death and during the death cos we'd be there and we could explain and go through it and then it was more about the

funeral and the sort of bereavement process rather than the facts about what had happened and then gradually very very slowly as time went on the focus got very slightly less about the bereavement and a little bit more each time about his health and it was just like a see-saw just very slowly tipping until until recently we're able you now to have the whole time talking about the ill health sort of things and his own rehabilitation from the bereavement in terms of the voluntary work and that sort of thing and he didn't talk very much about his wife a such but of course at anniversary time that become more again umm so I had thought to myself vaguely it was about 2 years ago um I said to you 2 years ago but I didn't realise it was the exact dateI think I covered hahaha that quite well

[..]

Extract from Researcher (R) and S/S interview with patient (P) immediately following s/s interview with nurse . Location patient's sitting room.

R. It seems a new kind of role she is taking

P yes.....

N have you found that useful?

P yes umm err... when... I was first told it was going to be operative um I was a bit dubious because....I was... all my life...I .. was used to seeing a Dr if I was not feeling well and I had great faith in the Drs I have seen and Dr 88 is exceedingly nice ummmm he you probably know he used to work apparently at the chest clinic in ** one time.... And he used to discuss with me about the antibiotics and he would look back in my notes and see which one seemed to have worked better than some..ummm still when I knew ** (the nurse) was taking over and was going to look after my welfare as it were um.... I had mixed feelings but I must admit that once she came to see me she was exceedingly good and I realised that it also was.....that was to my benefit because she could spend more time with me than the Dr could although I never felt Dr ** err... rushed things I mean he never whenever I have an appointment with him I am usually late seeing him because he has taken so much more time seeing patients than was anticipated I suppose he used to apologise and I used to say don't worry I don't mind at all because I knew that if he did it with them he would do it with **me** he and the time to delve into...he is not one of the Drs who gets up when he has finished and walks to the door to open the door to say goodbye (coughs)....but you see ** (nurse) has much more time to discuss things and going through things in greater depth she could also organise antibiotics for me and it meant I wasn't going down and sitting in the surgery amongst other people who were coughing and sneezing and I could pick something else.....

R good point

P and when it came to um...er last October I think it was err... we were going to start doing the flu' injections and I went down to book and they were already booked up and the only time they could see me was sort of late afternoon and the traffic gets horrendous at that time (laughs in the voice) and I didn't fancy it at all but I suddenly thought well (Nurse) ** comes to see me and oh he said I will just go and check and he said oh yes she's going to come up and see you and give you your injection ans so it was ...she combined it with a visit to see how I was anyway... and if she doesn't know the answers she finds them out for me she is so very good...

[]

Appendix 8

Article in press accepted for publication in *Worldviews on Evidence-Based Nursing* on 20.09.09.

What the papers say. Exploring understanding of the term nursing assessment: a mixed-method review of the literature.

Abstract:

Background:

Much skilled nursing practice is described by words that at face value appear low-tech and self explanatory. Despite being intrinsic to practice the term “nursing assessment” has few operational definitions. Evidence based practice and the quality agenda make it imperative this term is well understood.

Objectives:

To contribute to the evidence base and facilitate a greater understanding of assessment of patients as carried out by nurses through exploring the research question:

How is the term nursing assessment used in the current health care literature?

Design:

The review process, synthesised from the work of Greenhalgh, Clancy and Egger et al, identified and assessed the quality of articles, text books, the grey literature, policy documents and databases. Glaser’s Grounded Theory method was utilised to analyse the concept of “*assessment*” as exemplified within the included studies.

Methods:

The focus for this mixed-method review is the health-care literature between 1990 and 2005. Studies were identified, screened and assessed for methodological quality and data were extracted and recorded. Analysis of the included studies was facilitated using a Grounded Theory approach.

Possible tensions when using a mixed-method research design are acknowledged and briefly discussed.

Results

Of the 32,602 instances initially identified, 329 articles, policy documents and book extracts were closely read and after further screening 120 articles and 12 policy documents and book extracts were analysed. Seven overlapping categories were identified, with Judicial or Judgement making identified as the core category.

Conclusions.

Hierarchies of nursing practice, government policies and inter-professional agendas cause barriers to meaningful assessment. Informal and formal assessments and screening processes are often conflated resulting in confusion regarding the scope and nature of the process. Differences between the rhetoric of placing the patient at the heart of the assessment process and practice have been identified.

Key Words: Judicial, Grounded theory, Nursing Assessment, Mixed-method review

Introduction:

The purpose of this review is to better understand and contribute to the evidence base regarding the assessment of patients as carried out by nurses. Despite assertions that assessments are; intrinsic to all health care practice (Elstein et al 1978, Milner & O’Byrne 2002 and Houston & Cowley 2003), carried out daily in health care settings and “*a cornerstone of high quality care*” Challis (1999, p69), this review of the nursing literature revealed few operational definitions for the term. For example of six United Kingdom (UK) Government policy documents referring to assessment (Department of Health (DH) 2000, 2001a, 2001b, 2002a, 2002b, 2004) only two offer operational definitions (DH 2001a and 2002 a).

Etymologically in English “assess” was noted in the 1420 Rolls of Parliament. From the Medieval Latin *assessare* or to fix a tax on, via the Anglo-French *assesser*. It is a derivative of the frequentive Latin form *assidére* to sit and assist a judge or assessor, literally to “sit beside another”. Use of “assess” + ”ment” has been found in documents dating from 1548 (Chambers 2001). Interestingly these roots are echoed in this analysis of nursing assessment.

This paper describes the mixed-method review process undertaken to identify and evaluate examples of the term “assessment” in the health care literature (1990-2005) and the analysis of the review findings using Glaser’s (1978) general Grounded Theory (GT) approach.

Background

Internationally nursing faces challenges from both within and without (Dal & Hatipoğlu 1996, Donley 2005), as much skilled practice is described by words that seem self explanatory, appearing at face value, to be low-tech and therefore of little worth. For example Kane’s (1995) discussion of USA “Home Care” articulates the

complex consequences, for patients, caused by variations in interpretation of that seemingly well understood term. Similarly there is a lack of consensus regarding the meaning of assessment, resulting in blurring of the term and hampering attempts to measure or monitor the process. Yet nursing is rising to the challenge of incorporating evidence, founded on clarity of concepts and theories coupled with appropriate measurement techniques, into practice (Mulhall 1998, Rycroft-Malone et al 2002) Lord Darzi's report , *“High Quality of care for all “* (DH 2008) emphasises the need, *“to measure and understand exactly what we do”* p 48.

Before undertaking evaluative exercises it is necessary to better articulate the processes that comprise nursing assessment.

The late 20th century brought fundamental changes in health care delivery influenced by the World Health Organisation's (WHO, 1978) emphasis of good health resulting from good primary care delivery. This has prompted a shift in investment and practice from secondary to primary care. Jarvis (2001) describing USA practice notes, *“a revolution in health care delivery over the preceding two decades”* p 170. Similar situations are echoed across Europe (Council of Europe, 2000) with specific fundamental changes in the UK engendered by; the National Health Service and Community Care Act (DH 1990), Patients' Charter (DH 1991), Fund holding practices (DH 1990) and their abolition, the thrust towards partnership working outlined within the NSF for Older People (2001b) and introduced as the Single Assessment Process (DH 2002b). The WHO focus on global demands for equitable and effective primary health care strategies and delivery remain current (WHO 2008). Additionally the UK new medical contracts and alterations in the health professional workforce (DH 1996, 2000, 2003, Wanless 2002) have resulted in challenges to traditional professional boundaries (Nancarrow & Borthwick 2005). Nurses in

Switzerland, Germany, Thailand, Malaysia, Puerto Rico and the UK, (International Council of Nurses (ICN, 2004), noted extensions of their role in response to demographic and economic changes.

Implications for the process of nursing assessment have resulted as UK nurses now undertake formal and informal assessments, alone, jointly or as part of a team. The Single Assessment Process (SAP) (DH 2002a) was designed to curtail needless information duplication, collection and storage. The SAP requires that health professionals from different agencies assess for needs previously outside their role and share the information they collect. Intended to ensure a patient-centred approach to care delivery, by addressing dissonances resulting from competing agendas between the narratives of health professionals and patients (McKinley & Middleton 1999, Skelton et al 2002, Gillespie et al 2002). However the combination of poorly delineated boundaries between UK acute and primary healthcare sectors and social care (Nancarrow & Borthwick 2005). Coupled with their conflicting philosophical and implementation care delivery positions have led to the exposure of unresolved tensions within the SAP (Dickinson 2006).

Method

Foucault (1977) and Levine et al (1994) note alterations in the use of terminology at times of upheaval as particularly revealing as accepted understandings are thrown into flux. Therefore the period chosen for this review, 1990-2005, included the radical changes and challenges to nursing practice outlined above.

The identification of papers for review was facilitated by a seven-step process synthesised from the works of Clancy (2002), Egger et al (2005) and Greenhalgh et al (2005).

Step 1. *Formulate a research question to focus the study*

How is the term nursing assessment used in the current healthcare literature?

Step 2. *Eligibility criteria;*

Eligibility, quality criteria and data retrieval forms were based on information from <http://www.policyhub.gov.uk> and the criteria included qualitative or quantitative studies of assessments made throughout Scandinavia and western Europe;

- On health care premises
- In the patient's own home/ Care homes

Papers referring to assessment made by American, Australian, or Chinese nurses were excluded as Pang (2003) and Pang et al (2004) have shown the influence of role interpretation and practice bought about by cultural differences. Further the lack of universal healthcare in the USA impacts on the assessment experiences of nurses.

Step 3. *Location of studies:*

The 17 databases searched and the search terms used to identify journal publications between 1990 and 2005 are listed in table 1. A fingertip search of relevant policy documents, and nursing text books and conference publications since 1990 was also made.

Table 1: Data bases and search terms

Data bases searched 12.04.06 to 02.05.06	Search terms used	Numbers obtained after screening for duplicates
○ Web of science & Soc Services citation index	1. <i>Nurs* "and " assess*</i> <i>Assess *</i>	24,862
○ Allied and Complimentary medicine (AMED)	2. Patient "and " <i>nurs*</i> "and " <i>assess*</i>	731
○ ASSIA via illumine	3. <i>Nurs* "and " appraisal</i>	22

○ Age Concern	4. Nurs* “and” evaluation*	64
○ BIDS		
○ British Nursing Index (BNI)	5. Nurs* “and” judgement“	31
○ Cumulative Index for Nursing, Allied health literature (CINAHL)		
	6. Nurs* “and” review	
○ Database of Reviews effectiveness (DARE)	7. Nurs* “and” measure*	6,467
○ Diabetes UK		
		191
○ Economic evaluations,		
○ Expert patient programme		
○ Health Technology Assessment (HTA)		
○ HMIC		
○ Ingenta		
○ Kings fund data base		
○ LexisNexis European papers		
○ Medline		
○ National Research data base		
○ National Research register		
○ PROQUEST,		
○ PsycINFO		
○ Pub Med,		
○ RCN included in OVID		
○ Sigle		
○ Zetoc		
○ Grey literature searched.	Using the SIGLE and DISSABS data bases and Conference proceedings, abstracts and papers.	22
○ Key policy documents and text books	Text books identified from current HEI reading lists and	101

	Policy documents were finger tip searched .	
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Step 4. *Select studies*

All identified papers; nursing text books, the grey literature and policy documents published between 1990 and 2005 meeting the inclusion criteria were reviewed.

Examples using “assessment” with regard to nurse education, training, or referring to nurse’s or patient’s assessment of the work-place, colleagues or environment, were excluded during screening.

Step 5. *Assess study quality.*

Evaluation of the quality of each included study was undertaken and tabulated using the following criteria (Table 2).

Table 2. Adapted from Egger et al (2001)

Quality appraisal	
Methodological quality	<p>Noting for discussion whether:</p> <ul style="list-style-type: none"> ○ The aims and objectives of study are clearly stated. ○ A clear and answerable question was asked? ○ Clarity in exposition of a theoretical framework ○ Clear description and justification of the methods, settings and participants chosen ○ There is sufficient information to assess the data collection process. ○ There is rigour in documentation and process. ○ There is a clear ethical basis. ○ Possible sources of bias are acknowledged. ○ The researcher’s perspective is acknowledged. ○ Demonstration of analytical precision ○ Any deviant cases are included and discussed. ○ The conclusions are justified by the findings ○ Applicability and representativeness discussed

Step 6. *Extract data.*

32,602 records, including duplicates, were screened by title, abstract and finally full text. Papers were excluded at each stage leaving 329 articles, policy documents and book extracts that were closely read. A critical analysis of their research quality was

made and recorded on the data collection forms. Additional articles identified from reference lists which met the inclusion criteria were added to the study. Following further screening and a full text review; 120 articles and policy documents and 12 extracts from books (0.4% of the total number of hits, 40.1% of those read in full) were analysed.

Step 7. Analyse and present results

Each citation's methodological quality was tabulated and all excluded studies logged. An inductive Grounded Theory (GT) approach (Glaser 1978) , was chosen for this exploratory study as it avoids verification of a preconceived hypothesis that forces the data into the binary of accepted or unaccepted. Wittgenstein (1951) criticises inductive methods, as it is difficult to know when they are complete. However GT involves identification of instances at the conceptual level allowing for:

- Transferability between incompatible studies (Glaser 1978).
- Context determined concepts remaining contextually bound.
- Limitation of researcher bias as concepts rather than theories are identified and challenged within the process.
- Avoidance of the imposition and verification of a preconceived hypothesis.
- Confounding data included and explored.

This was seen as advantageous for the analysis of a portmanteau word like assessment. As comparisons are made at the conceptual level in GT, classification of the different types of study is unnecessary (Glaser 1978). Assessment examples covered the broadest possible spectrum. Each was read and categorised using the sensitising question of how assessment was portrayed within the study . Comparisons between the similarities and differences of the representation of assessment resulted in the

creation of initial codes. This process of open coding, identifying the represented concepts and generated memos which were continually challenged revised and re-written throughout theoretical sorting. For example the data exemplified assessments as based on predictions of how patients would respond to anticipated outcomes. At the axial coding stage the concept of prediction was differentiated from others, using comparison across memos. Prediction was then located within the category which comprised the methods nurses used to make decisions regarding assessment. Coding lists, diagrams and memos were then scrutinised and the central or core category Judicial was identified at this selective coding stage. Competing methods by which nurses make assessments were identified and categorised as follows.

Table 3 Competing and Core Category

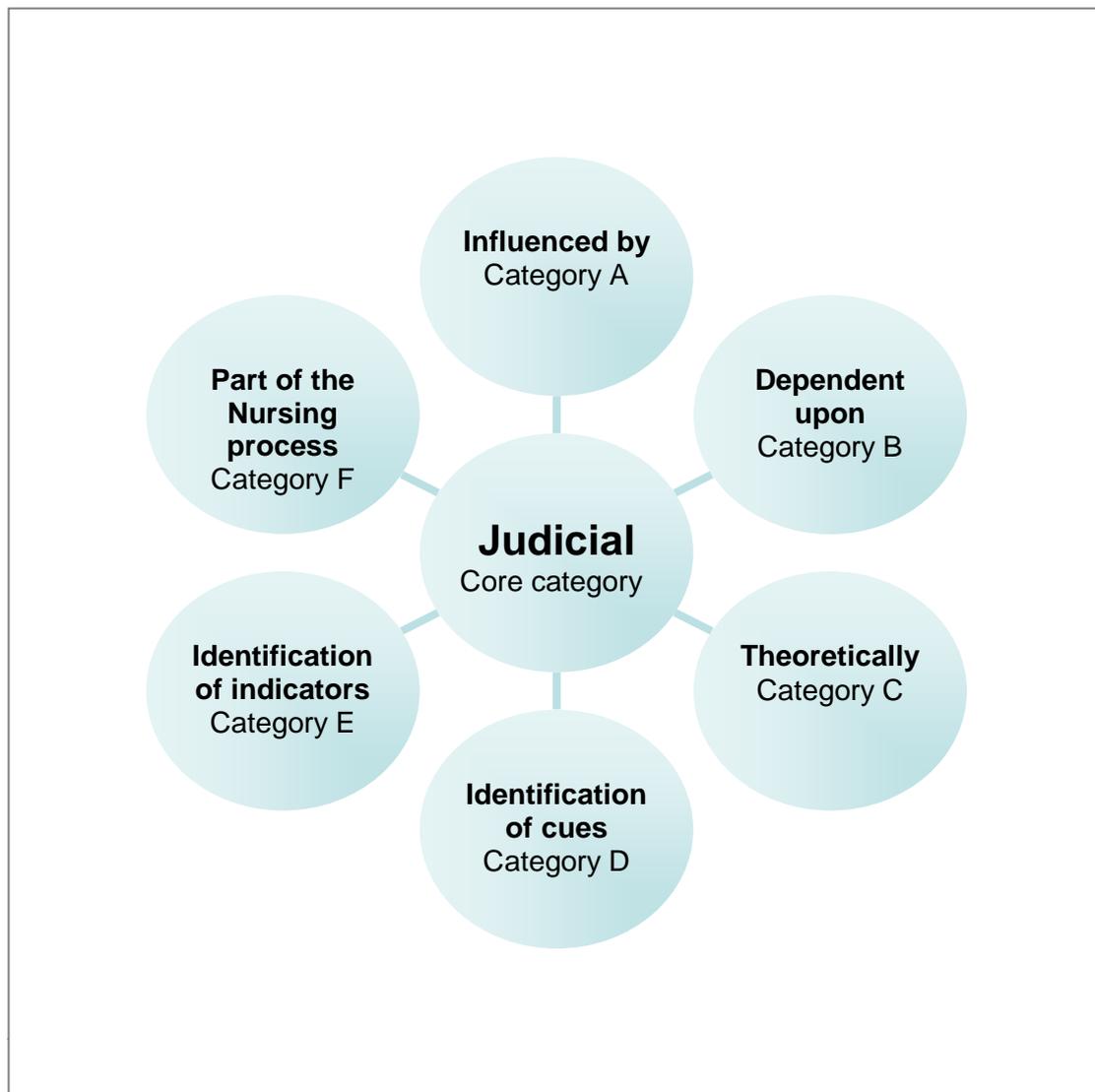
Category	Concept	examples of memos
Core	Judicial	<ul style="list-style-type: none"> • a process of evaluation • concerning knowing, • dependent on the nurses' ability • linked with formal processes such as diagnosis. • Often reliant on intuition or gut feeling
Competing	Influenced by	<ul style="list-style-type: none"> • process, participant • expectations, • perceptions, • culture, • first impressions, • face saving, • flattery, • arbitrary skill mix • prognosis
Competing	Dependent upon	<ul style="list-style-type: none"> • prestige, • status, • professional knowledge and skills, • experience, • intuition, • attention, • being there for the patient, • rapport,

		<ul style="list-style-type: none"> • empathy • power balance
Competing	Theoretically	<ul style="list-style-type: none"> • philosophical stance, • methodological process, • nurse experience • a descriptive process • non-evaluative
Competing	Reliant on cue identification	<p>Psychological cues:</p> <ul style="list-style-type: none"> • Loneliness, • well being, • fear, • anxiety, • depression, • physical distress, • tone of voice, • body language, • pain • spiritual distress <p>Social/ functional cues</p> <ul style="list-style-type: none"> • social relationships, • sexuality, • safety, • suitability of home environment, • ability to cope, • cognition, • hearing • sight, • oral hygiene, • sleep
Competing	Reliant on indicator identification	<p>clinical/ physical manifestations;</p> <ul style="list-style-type: none"> • changes in blood pressure, • pulse, • sleep patterns
Competing	Intrinsic to the nursing process	<ul style="list-style-type: none"> • holistic process • 1st stage decision making • followed by advising, • recommending, • negotiating, • asking questions.

Glaser (1978) acknowledges the emergence of competing categories but recommends researchers “*promote one core variable to the centre and demote others to sub-core variables*” p122, The core category/variable is identified as the one which best fits the narrative presented through coding of the data. Böhm (2004) notes that

“core category is characterised by it’s formal relationship with the other important categories” p274 (Fig 1.)

Figure 1. Diagrammatic representation of the conceptual categories.



Judicial activities based on sound professional knowledge emerged at the selective coding stage and were fundamental to all the other categories, for example:

- Experience and knowledge that “influence” the process of judgement making are core to nursing practice (categories A and F)
- “Cues and indicators” (categories D and E) that allow the patient’s condition and needs to be identified are reliant on judgement making

- Skills, professionalism required to make assessments are influenced by and predicated upon judgements (categories A and B).

Findings.

The Judicial was core to nineteen papers and represented in all categories identified and can be understood in terms of the mental processes which enable judgements to be made. .

1. Judgements - ways of knowing:

Harbison (1991) described two decision making approaches:

- the rationalist based on;
 - observation
 - analysis
 - logical response to data
- a phenomenological perspective where data is;
 - interpreted
 - contextualised within the arbiter's experience (Benner 1984).

Crow and Spicer (1995) and Schmidt and Boshurzen (1993) note the concept of “*illness scripts*”, causally linked categories that correspond to one particular illness.

Both papers suggest nurses remember an exemplar or prototype of any illness or condition and match the patient's cues and indicators, observed in practice, to this memory. Crow et al (1995a) refer to nurses forming, “*perceptual patterns which guide their internal search*” p 210.

These enable the recognition of disease. This implies a mechanistic approach of matching that does not allow for the diversity and complexity of manifestations of disease processes, illness, health, or lack of well-being that require observation as part

of an assessment. It may however be the process required for the interpretation of diagnostic cues and biomedical findings, such as blood results, x-rays and ECGs. Appleton and Cowley (2004) found that guidelines based on causative mechanistic assumptions of this kind are used only if found to have a value and are often actively resisted. Both they and Niven and Scott (2003) describe the use of “*professional judgement*”, to identify those for whom such guidelines are appropriate. Similarly Lake and John (2001) identify “*practice wisdom*” that underpins judgements. Latimer (1998) sees assessment as a cognitive process combining, information gathering, problem identification and diagnostic reasoning. This implies a metaphysical stance with patient’s needs “out in the ether” waiting for identification by the nurse.

Hamers et al (1994) and Crow et al (1995a) also link assessment with medical diagnosis suggesting assessment as a combination of surveillance, driven by the search for evidence to support a particular model of illness, that is synthesised with experiential knowledge. Sainfort and Booske (2000) describe this process as,

“*Constructing preferences and applying them*” p 51.

Diagnostic reasoning comprises a search for evidence to support the hypothesised medical diagnosis and is akin to the concept of “illness scripts” (Benner 1984, Schmidt et al 1990, and Crow and Spicer 1995). Crow et al (1995) note that diagnostic reasoning is an integral part of Elstein et al’s (1978) “Nursing Process”, concluding that assessment is based on diagnostic reasoning. However their examples of assessments have more in common with evaluation or appraisal of a patient, falling short of a medical diagnosis.

Crow and Spicer (1995) refer to “*domain- specific cognitive structures* “ p 414 that are similar to “illness scripts” and enable the information gathered to be categorised.

Sainfort and Booske (2000) note that in medicine these domains equate with the medical specialties and are experientially developed. This contrasts with Luker et al's (1998) suggestion that a nursing diagnosis, or assessment, is a synthesis of both scientific and analytical judgements.

Thommessen et al (1991) identify assessment as part of a screening tool. Green and Watson (2005) note that screening and assessment are often used interchangeably, as in *The Essence of Care* (DH 2001a). However, Green and Watson assert that nutritional assessment is a more complex process than nutritional screening suggesting these two processes are not in this instance synonymous. Bazian Ltd's (2005) systematic review of nurse's pre-operative assessments identified from one study of 60 children prior to orthopaedic surgery (Rushforth et al 2000), that nurses were "better" at history taking than senior house officers (SHOs). 'Better' indicating that nurses identified 94% of the detectable problems identified by a senior specialist registrar in anaesthetics. Comparison revealed SHO's detected 42% of these problems in the same cases.

Bazian Ltd's review included a study, undertaken by Stables et al (2004), who found more people reporting they were "very satisfied" when assessed by a nurse, than those assessed by a house officer. Differences in these findings highlight a disparity between medical and nursing assessments in these instances.

Luker et al (1998) and Lake and John (2001) note paucity of precise information available for nurses to evidence their judgements. Lake and John's (2001) work using Fuzzy Logic defines assessment as,

"An intuitive process in that the expert uses inexact or imprecise information to make judgements based on nursing knowledge and practice wisdom" p.10

Luker et al (1998) suggest nurses develop an implicit “*risk benefit analysis*” to overcome these information deficits. Conversely Crow et al (1995) conclude the accuracy of decision making depends on the quality of information gathered. Additionally Jordan (2002) notes that categorisation is required to facilitate clinical assessment which imposes,

“*artificial assumptions and boundaries*” p422

on the nurse patient interaction.

Nurses deliberately or unwittingly obscure the process of assessment because as McIntosh (1996) notes their thought processes cannot be directly observed. When asked District Nurses find these processes hard to articulate. Further Meerabeau (1992) notes, when questioned regarding their thinking, nurses often re-interpreted their activities to make them appear rational.

1. 2. Intuition.

Crow and Spicer (1995) see intuition as a nursing explanation of the cognitive skill of nursing assessment. Six other studies refer to the importance of empathetic feeling to intuitive decision making. Morse et al (1994) explore the practice of nurse assessment, including sensing or “*reading the patient*” in need, and list five metaphysical concepts to “*describe the process of sensing*”;

- intuition
- knowing
- countertransference
- embodiment,
- empathy. pg. 234

Both Morse et al (1994) and Meerabeau (1992) acknowledge that uncovering information regarding intuition by interviewing nurses is difficult. Paley (1996)

challenges Benner's (1984) assertions regarding "expert" decision making as the conscious "*highly intellectual analysis*" of the novice that is replaced by "*intuition*". Stating that Benner's notion of intuition is just something that experts do. Paley asks what do non-experts do when carrying out the same functions and in what ways do their action differ from intuition?

1.3 "Gut feeling"

Godin's (2004) research demonstrates the importance of "gut feeling" in risk assessment for Community Psychiatric nurses. Although he questions the exact nature of intuition and asks whether it can be discerned from; "*whim or prejudice*" p 353 Pyles and Stern (1983) define their term "*nursing gestalt*" as a matrix, linking knowledge, past experience with cue identification and "*gut feeling*". Describing this as noting if the patient's observable, but not necessarily clinical, condition falls significantly outside their usual pattern. Nurses interviewed based this feeling on their intuition, one noted that despite the stability of monitor readings;

"everything about the patient looks the same yet I just have the feeling something is going to happen." Pyles and Stern (1983 p 54).

1.4. Intuition a "subconscious" response.

Walker (2003) categorises aspects of assessment, which cannot be verbalised as events, as examples of intuition. Manias et al (2004) refer to this as happening at an "unconscious" level. In their study of twelve graduate nurses, each observed for two hours on a busy acute ward, they observed two instances of decisions attributed to intuition. Each occurrence was in connection with possible interpretations of a patient's behaviour. Intuition is included in Cader et al's (2005) Cognition Continuum theory of judgement making, referred to as, a rapid "unconscious" form of data processing. Eraut (1994) contends that professional deliberations consist of both

intuition and analysis. Benner and Tanner (1987) describe intuition as, “*understanding without rationale*” p.23.

While Rew (1986) asserts that intuition is, “*knowledge acquisition without a linear reasoning process*” p.37.

2. Predictive quality of assessment.

Benner (1984), Yates (1990), Molony and Mags (1999) and Kennedy (2002) note that assessments contain a predictive quality. For example when a patient’s condition is assessed to decide what help they will need, decisions are based on predictions of patient’s responses to the potential models of help available. Crow and Spicer’s (1995) study analysing nursing judgement showed these anticipated outcomes of interventions or “recovery” were a core deciding factor in how nurses view a patient’s, “*hold on life*” p. 419.

Yates refers to this predictive quality as “a likelihood judgement” of the patient’s future performance with the identified need resolved. This predictive aspect was noted in twenty-six studies that directly referred to intuitive assumptions.

3. Experience and expertise.

Thirteen studies listed expertise and experience as necessary assessment pre-requisites. Luker and Kennick (1995) and Kennedy (2002) refer to an experiential knowledge base that underpins assessment judgements made by nurses. However they do not differentiate between knowledge, science and experience. Crow and Spicer (1995), Hovi and Lauri (1999) and Richards et al (2004) note that expert assessments differ from novice assessments and Crow et al (1995) state that experts solve problems faster than novices. Schraeder and Fischer (1987) describe intuition as expert knowledge that is, “*acquired and refined with experience* “ p. 239

Marks et al's (1991) study of nurses' and doctor's subjective predictions of patient death noted that nurses were more accurate than doctors in these predictions and further that experts zeroed in on what was important. This they suggest was the cognitive response of "*seen it before recognise it*", however this seems to be the same mechanistic process that Sainfort and Booske (2000) described underpinning medical diagnosis. Therefore if doctors and nurses are both using the same cognitive process what might explain the nurses' greater accuracy in predicting death? Pyles and Stern (1983) noted the emphasis critical care nurses put on experience when developing "gut feelings" and intuition. They identify the nursing "Gestalt" as a process that the "neophyte nurse" learns from experienced nurses.

Clough (2002) tracked thirty-nine referrals for community care assessment and compared the different process and content when made by social care professionals and service users or carers. The results were found to be "*indistinguishable from assessment for a limited range of social care services*" p 2. Outcomes were discipline orientated and directed by service resources rather than identified needs. This type of assessment would fit into the pattern recognition noted by Marks. By implication Clough sees it as being less than ideal, concluding Social Services Departments were not translating assessment and care management into practice.

Lake and John (2001) note the, "*complexity of context and degree of acuity of nurse patient interaction*" p10. They identify aspects of "*holistic assessment*" whilst addressing a primary focus on, "*Physical/medical conditions or diagnosis*" p10. Further noting the ability of nurses to gather imprecise information that they translate into "*recognisable fragments of knowledge*" p10.

Lake and John note the specific use of types of language used by nurses for assessment and handover. Their example, "stable", used as a descriptor is not

measurable in the same way as “tallness” and yet it has a precision when used in this context.

Nine additional studies referred to familiarity with the patient and or their prognosis or having nursed others with the condition as concepts that enable decision making.

The importance of the context of care is highlighted by Sbiah’s (1998) research where first impressions of the patient played an important part in judgement making in triage for Accident and Emergency treatment.

4. Diagnosis- a combination of inductive and deductive reasoning.

The literature (Elstein et al 1988, Latimer 1998) indicates that both inductive and deductive reasoning were required to make a diagnosis. They identified four stages in hypothetic-deductive reasoning, firstly cue recognition, which they described as collecting information regarding the patient’s signs and symptoms. This was followed by hypothesis generation and cue interpretation where possible matches between the hypothesis and the assessed signs and symptoms were made. This process culminated in hypothesis evaluation.

Discussion

Mixed-method approach.

This study borrows from the systematic review process, a quantitative research method, to locate, retrieve, select and screen examples from the literature that are then analysed using the qualitative approach of Grounded Theory.

Much has been written regarding the integration of qualitative and quantitative studies within the same review (Thomas et al 2004, Harden and Thomas 2005, Dixon-Woods et al 2005) or the “phase method,” (Barton and Lazarsfeld 1952), where qualitative studies are used for hypothesis generation then verified by quantitative procedures.

Creswell's (1998) discussion of the combination of paradigmatically different research methods in the same study describes a shift from a qualitative versus quantitative debate to consideration of the research process as a continuum between these two poles. Hammersley (1992) argues the "*process of inquiry is the same whatever method is used*" p 182

The searching, identification, screening, and quality assessment processes of this study provided rigour and replicability (Egger et al 2001). However Egger et al's systematic review analysis is predicated on the assumption, inappropriate for an exploratory study, that studies are outcome orientated. Compromises regarding the quality assessment of studies were needed as not all published studies, with stringent word limits, explicitly state all components of quality (Table 2) and omission need not indicate absence in the original research.

Limitations

Ideally more than one reviewer is used in order to reduce personal subjectivity and bias. However bias may be partially ameliorated when using GT as it requires the researcher to challenge all the memos generated as every converse case is considered.

Implication of findings

We have found that assessment has a multiplicity of meanings and nuances. The question remaining is how better to understand the term and create a matrix of these meanings that will have relevance to practice?

Studies have shown that when assessing, nurse's judgements are "influenced by" (category A) a patient's prognosis (Hamers et al 1994, Lake and John 2001) and the severity of their condition (Crow and Spicer 1995, Dowding et al 2005). Kratz (1978), Hamers et al (1994), Crow and Spicer (1995) and Thompson et al (2005) suggest that

nurses focus on alleviating the needs of critically or terminally ill patients. However, patients with chronic or stable conditions receive a less needs focused assessment.

Analysis of the literature has identified the following features across the various assessment types. Assessment is:

- a dynamic process (category F),
- requires nurses to “attend” to patients (category B) ,
- requires the establishment of rapport and trust (category B),
- has consequences for a patient’s future (category G),
- gathers information (category F),
- is undertaken by nurses who have received post qualification training (category B) ,
- involves expertise and domain specific knowledge (category G),
- influenced by:
 - ethical considerations-(e.g. nursing professional code of conduct) (category C),
 - Government policies (category A),
 - resource allocation (category A),
 - culture and agenda of the employing organisation, the assessor and those assessed (category B)
 - is influenced by nurse’s and patient’s own life experiences (category B) .

The literature suggests assessment combines processes of induction, deduction and analytical reasoning, linked with intuition and practical, theoretical and experiential knowledge. Screening and assessment are often incorrectly conflated as screening requires only cue recognition and inductive reasoning using the binary of, is it A, or

not A. In contrast the following factors were used by nurses as part of the judicial process of assessment;

- cue recognition (categories D and G),
- observation classification and prioritisation (categories F and G),
- predictive estimation of probable outcomes (category G),
- intuition (category B).

Additionally Lake and Scott (2001) note assessment involves clarification of imprecise and obscure information although they do not identify processes used.

Implications for practice

Department of Health (1992a) policies in England have led to changes in composition and skill-mix of community and acute nursing teams for policy, demographic and managerial reasons. These changes have resulted in the intimate caring practice previously carried out by UK registered nurses, being devolved to unregistered staff. The literature suggests rapport and trust are established while sensitively carrying out such intimate tasks (Twigg 2000, Niven and Scott 2003, Appleton and Cowley 2004) and that rapport and trust between nurse and patient are essential for effective assessment (Dickinson et al 2006, Maher and Hemmings 2005).

Many papers note differences in the quality of expert and novice assessments with newly qualified nurses learning from the experiences of their established colleagues (Pyles and Stern 1983, Crow and Spicer 1995, Hovi and Lauri 1999, Richards et al 2004, Darzi 2008). Changes in skill mix and the devolution of core practice to unregistered colleagues militate against both optimal assessment conditions and the preceptor-ship needed for expertise to develop.

Nurse Managers need to consider the importance of mentorship and the retention of experienced nurses which this implies. Additionally that although the intimate aspects

of care delivery appear to be low tech and suitable for untrained staff they are the interactions which facilitate the establishment of trust and rapport (Kennedy 2002) between nurses and patients (category B).

Resource allocation further constrains assessment with practitioners reluctant either to discuss or record unmet needs with service users for fear of legal ramifications (Bryans and McIntosh 1996, Ellis 2000, Kennedy 2002, Niven and Scot 2003, Appleton and Cowley 2004). Assessment must reflect the identification of genuine need and not consist of a process of distributing available resources.

Additionally, financial and staffing constraints have led to limitations being imposed on the number, length and frequency of home visits to patients by staff. These restrictions constrain the dynamic process of assessment that may require frequent reviews and contacts (Crow et al 1995, Appleton and Cowley 2004) and can impose target led limitations on assessment practice.

Kennedy 's (2002) study records a community nurse's observation;

“once you start chatting with them they start to give you information you need without even asking”.p.716

This begs two questions, firstly, why are these patients not self-assessing? Secondly how aware are patients that the information they give when “*chatting*” may be used in ways they may not anticipate or desire?

Griffiths et al (2005) noted the absence of research into or working definitions of Self-assessment, indicating three core elements

- self-reporting,
- self-completion,
- self as potential beneficiary.

Kennedy's (2002) study of nursing practice provides evidence of gate keeping, paternalism and clandestine judging of patients, factors that limit self-assessment opportunities.

Whilst evaluating congruency between nurse's and patient's assessments Nikolaichuk et al (1999) conclude that nurses are able to assess as accurately as patients.

Conversely therefore patients can assess as accurately as nurses. Self-assessment would seem a more desirable practice than imposing opinions constructed by others and reflecting their experiential, cultural, and institutional agendas. Further consideration is required as to the effect on both patient and nurse of co-assessment and the cultural agendas that health care professionals from different backgrounds bring to this task.

Nursing theory, policy and practice guidelines indicate the centrality of translating patient's decisions into care delivery. However representation of the unique quality of individual experiences and symptoms appear diluted in assessment practice. Sbah's (1998) study of Accident and Emergency nurse's assessments, found if a mismatch between the patient's narrative and the nurse's assessment was apparent the patient's motives were questioned.

Conclusion

The literature relevant to the analysis of assessment has been identified and evaluated using a mixed-method process in answer to the question,

"How is the term nursing assessment used in the current healthcare literature?"

Overall this study has demonstrated the complexity of ideas, practices and presumptions that are encapsulated in the everyday term assessment. The themes

identified by the analysis (Figure 1) indicate that “judicial/decision making” is at the core of nursing assessment.

Areas for further research include the exploration of the conflation of “formal” and “informal” assessments and screening that has led to confusion regarding the scope and sophistication of the process under review.

This review raises the need for further exploration of efficacy of the current delegation of intimate care to unregistered staff and the effect this may have on trust and rapport building, so vital for meaningful assessment.

Discrepancies between rhetoric and practice regarding assessment have been recognised. These may be addressed by repositioning the patient as central to the process by focusing on their embodiment of the experience of illness rather than its medical or nursing construct. Patient self-assessment should be considered wherever possible.

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