Speech and Language Therapist and Nurse Information Sharing:

An Ethnographic Study on Stroke Units

Rachel Barnard

Submitted to City, University of London for the Degree of Doctor of Philosophy in Language and Communication Science

Division of Language and Communication Science

School of Health Sciences

City, University of London

January 2020

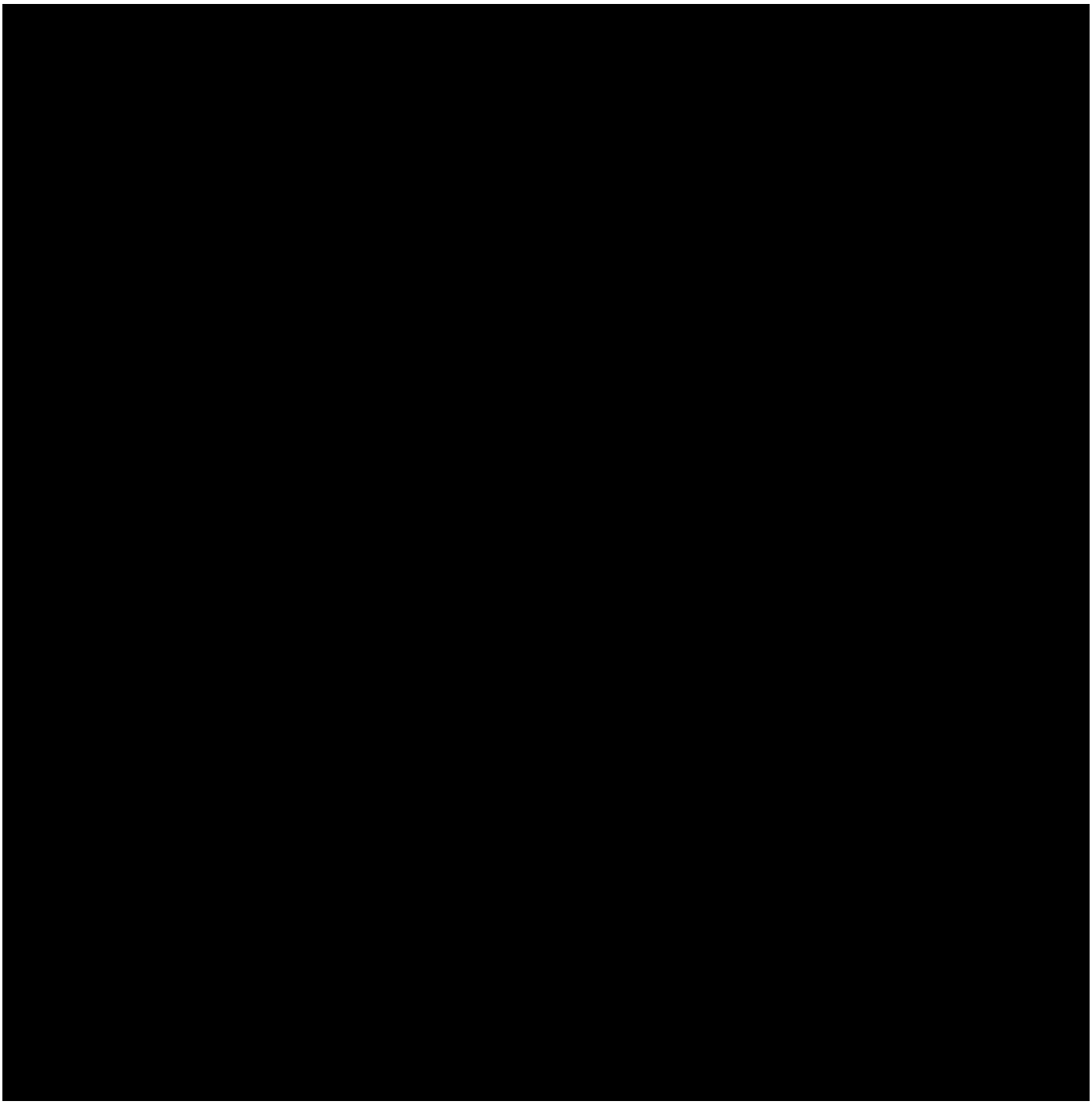
CONTENTS

Tables and Figures

Abbreviations

CPT	Communication Partner Training
HCP	Healthcare Professional
GCS	Glasgow Coma Scale
NA	Nursing Assistant
NBM	Nil by Mouth
NGT	Nasogastric Tube
SLT	Speech and Language Therapist
SOB	Short of Breath
VX	Voice

Acknowledgements



Declaration

The author grants powers of discretion for the university librarian to allow the thesis to be copied in whole or in part without further reference to the author. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Abstract

Patients with communication and swallowing needs during their hospital admissions on stroke units depend on speech and language therapy (SLT) and nursing staff for their care, yet very little is known about how they interact to accomplish that care. This study is the first to direct focused and sustained attention to how these two disciplines share information to meet their common clinical interests in patients with communication and swallowing difficulties.

This ethnographic study was based on three stroke units in one inner city area of the UK. The study explored how the two disciplines engaged with each other as they went about their work on the wards in order to understand what influenced how they interacted, what they talked about, and professional alliances. Qualitative data were collected during 357 hours of fieldwork and included 43 interviews with speech and language therapy and nursing staff and the patient records of 19 patients. Data was primarily interpreted through the lens of symbolic interactionism, with additional support from bioethics, high reliability principles, professional socialisation and humanising care. As part of this study, a systematic review and meta-ethnography was completed and this generated a new conceptualisation that the contingencies of need, capacity, opportunity and quality of relationships underpin communication between therapists and nurses. This conceptualisation was applied to the SLT-nurse relationship through the ethnographic study.

The temporal-spatial context was found to create the conditions through which swallowing information was privileged over communication information, with little interdependence between SLT and nursing roles with patients with stroke-associated communication difficulties. Structured routes for sharing information on the units were less useful to nurses than SLTs, and relationships between SLTs and nurses were hard to build. Despite swallowing having a higher profile on stroke units, the temporal-spatial context introduced ambiguity to swallowing recommendations creating dilemmas for nurses associated with the intermittent presence of SLTs.

Improved sharing by SLTs and nurses of information they hold about how best to meet patients' needs has the potential to benefit patient care.

1. Introduction

What is this life, if full of care
We have no time to stand and stare.

No time to stand beneath the boughs
And stare as long as sheep or cows

No time to see, when woods we pass
Where squirrels hide their nuts in grass….

W.H. Davies, 1911

This study was an opportunity to *stand and stare*… and hear, and ask questions, and join in, through the eyes of a speech and language therapist turned researcher. This is the first study that has directed focused and sustained attention to how speech and language therapy (SLT) and nursing staff interact. Very little is known about how these two disciplines share information with each other. The study was inspired by conviction that greater understanding of how SLTs and nurses share information has potential to improve how they work together to meet the communication and swallowing needs of patients on stroke units. This chapter begins with an introduction to stroke unit care, followed by an outline of the communication and swallowing difficulties associated with stroke. SLT and nursing roles with communication and swallowing are then introduced and the existing prominence of swallowing over communication in stroke unit care is discussed. This leads into a summary of the aims and objectives of the study and the research questions. The methodological and theoretical approach is then introduced. Finally a conceptual framework for the study is introduced and an overview of the chapters is provided to guide the reader through the thesis.

1.1 Stroke Unit Care

There is strong evidence that organised care is associated with a number of important outcomes for patients admitted to stroke units (Stroke Unit Trialists' Collaboration-SUTC, 2013). A systematic review of clinical trials revealed an association between care coordinated through specialist healthcare professionals (HCPs) on stroke units and reduced mortality, dependency and institutional care one year after stroke (SUTC, 2013). During the ten years between 2007 and 2017 stroke declined from being the second to the third most common cause of death in the UK (Institute for Health Metrics and Evaluation, 2017), yet it remains a common cause of a wide range of long term disabilities (Stroke Association, 2018). The importance of organised stroke unit care is

reflected in UK quality standards directed towards ensuring people are admitted as early as possible onto specialist stroke units (NICE, 2019). There is a hierarchy of inpatient stroke care: stroke ward, mixed rehabilitation ward, mobile stroke team and general medical ward (SUTC, 2013). Stroke wards are further classified by intensity and usual length of admission: hyper-acute stroke units treat patients in the first few days of acute stroke and if further treatment is required patients may be transferred to another unit, usually within a week. Patients admitted to mixed rehabilitation wards are treated by professionals who may also care for patients with non-stroke conditions on the same ward (SUTC, 2013). One of the wards in this study would be classified as a mixed rehabilitation ward, however patients were allocated to stroke bays. Therapists and doctors worked exclusively with stroke patients, whilst nurses were intermittently allocated to stroke bays. It was referred to as a stroke unit by the hospital.

Stroke unit care is expensive. In 2009 the cost was calculated as £164 per bed day compared to £114.80 for general medical wards (Saka, McGuire & Wolfe, 2009). These costs can be expected to have increased, and more recent figures calculate that new cases of stroke cost the NHS £1.6 billion per year (Stroke Association, 2017). The provision of care through organised teams means that a large proportion of expenditure relates to staff costs. Specialist HCPs working across the whole stroke care pathway are guided to provide evidence based care through the National Clinical Guideline for Stroke (Rudd, Bowen, Young & James, 2016). However, the guideline dedicates minimal attention to the processes through which clinicians are expected to work together. The only specific reference to information sharing across professions in the guideline is that it is recommended that once a week there is a meeting by a 'co-ordinated multidisciplinary team' (Rudd et al., 2016:17). Thus more knowledge is needed for *how* professionals organise their work to accomplish stroke unit care. This study aims to generate new knowledge for how specific clinical aspects of care (communication and swallowing) are organised through the information sharing work of SLTs and nurses. It is hoped that this knowledge will enhance patient care by informing effective collaboration between the disciplines.

1.2 Stroke-Associated Communication and Swallowing Difficulties

The communication difficulties associated with stroke include disorders of language (aphasia), neuromuscular control for speech (dysarthria), planning and execution of speech (apraxia of speech) and the impact of neurologically acquired disruption to thinking or social skills on communication (cognitive communication difficulties). The Stroke Association estimates that one third of stroke survivors have stroke-associated

aphasia (Stroke Association, 2018). Only one study was identified that included incidence statistics for both aphasia and dysarthria within a cohort of acute stroke admissions. This study reported that out of 936 patients, 24.67% were diagnosed with aphasia and 57.69% with dysarthria (Vidovic, Sinanovic, Sabaskik, Haticic & Brkic, 2011). When pre-existing communication difficulties are also taken into account, the number of patients on a stroke unit with some level of communication need is likely to be much higher. An Australian study identified that 88% of the 65 patients admitted to two acute stroke units had one or more impairments of hearing, visual, speech, language or cognitive-communication, often in combination (O'Halloran, Worrall and Hickson, 2009). This means that nursing staff will routinely interact with patients who experience minor or major difficulties with getting across what they want to say, and/or understanding the spoken and written word.

The incidence of dysphagia after stroke has been variably reported at between 40 and 78% (Martino et al., 2005). The correct figure is likely to be at the lower end of this range; a very large prospective cohort study of 63,650 patients indicated that 39% of patients admitted with acute stroke were referred to SLT for comprehensive dysphagia assessment following an unsuccessful swallow screen (Bray et al., 2017). Despite being at the lower end of the incidence range, these figures represent a very large number of stroke patients and indicate that patients with swallowing difficulties will be routinely encountered by clinicians working in acute stroke unit care. Swallowing difficulties affect patients' ability to safely eat, drink or take medication and thus have a significant impact on nurses' roles in providing care.

1.3 Disciplinary Difference in Scope of Practice

Across all inpatient settings, SLT and nursing staff each have responsibilities with respect to patients with communication and swallowing difficulties, but there are key differences in their scope of practice. SLTs hold expertise in assessing and managing communication and swallowing as defined areas of specialist skill and knowledge (Royal College of Speech and Language Therapists - RCSLT, 2019a). In contrast, nurses and nursing assistants are responsible for managing patients both with and without communication and swallowing difficulties. The proficiencies outlined in professional standards for registered nurses that relate to communication and swallowing are set within broader frames of care for the whole person (Nursing and Midwifery Council - NMC, 2018). They reflect nurses' obligations to all patients in their care. The specific needs of vulnerable groups are visible in the expectation that registered nurses 'adjust and apply the principles and processes for making

reasonable adjustments' (NMC, 2018:14). However, this is in the context of also ensuring that *all* patients receive person-centred, compassionate care, and accessible information to facilitate involvement in care decisions (NMC, 2018). Nursing assistants in the UK are guided by a code of conduct (Skills for Care & Skills for Health, 2013). The code of conduct stresses the importance of safe and compassionate care and also emphasises the need to work within levels of competence and alert others when they have concerns (Skills for Care & Skills for Health, 2013).

The way that the professional bodies for SLT and nursing frame communication with patients has significance for this research. For SLTs, communication is a specialist area that is assessed and managed, and is thus classified by diagnostic categories or by types of treatment, such as various forms of therapy or ways of supporting patients' communication (RCSLT, 2019a). For registered nurses, standards of proficiency for communicating with patients are described using the language of compassionate care, person-centred care and strength based care, applied across all patients (NMC, 2018). Compassionate care is not a term that is much seen in SLT. It has been defined as encompassing the following:

> 'Dignity and comfort: taking time and patience to listen, explain and communicate; demonstrating empathy, kindness and warmth; care centred around an individual person's needs, involving people in the decisions about their healthcare, care and support' (Skills for Care & Skills for Health, 2013:11).

When the RCSLT discusses SLT roles in terms of taking time to listen, explain and involve people with communication disorders, this bears a relationship with the definition above (RCSLT, 2019a). However words like dignity, comfort, kindness and warmth are not visible in the web pages of the RCSLT (RCSLT, 2019a). Thus whilst the representative bodies for SLTs and nurses have a common interest in patients' communication, they do not necessarily view it through the same lens.

With respect to dysphagia, professional standards across SLT and nursing emphasise the importance of ensuring patient safety, and this creates a common interest in swallowing. The Health Care Professions Council (HCPC) standards of proficiency indicate that SLTs usually take lead responsibility for assessing, treating and educating others about dysphagia (HCPC, 2014). Registered nurses are expected to ensure that they safely meet the hydration and nutritional needs of patients, identify and act on risk, and make referrals as needed (NMC, 2018). Common interest in swallowing is reflected in a national SLT-led project to update an interprofessional framework for

dysphagia (RCSLT, 2019b). The aim is to foster a whole team approach to screening, assessing and supporting swallowing, through dysphagia competencies across six levels. The first level develops awareness, levels two and three involve implementing plans prepared by others, and levels four to six are intended for registered professionals, and include proficiencies of gradually increasing complexity, from screening, to comprehensive, complex assessment and management (RCSLT, 2019b). However, although there is potential for nursing staff to extend practice by developing competencies in swallowing, there remains a fundamental difference in the focus of attention of the two disciplines. SLTs hold specialist interest in specific areas of clinical need and nurses are focused on the whole person, and all patients in their care, not just those with swallowing and communication difficulties.

1.4 Roles of SLTs and Nurses in Stroke Unit Care

This section considers the roles of SLTs and nurses in stroke unit care as represented in stroke care guidelines and audit. Assessment and management of both communication and swallowing are represented in the guidelines, however audited activity is limited to identification of swallowing.

According to the National Clinical Guideline for Stroke, the work of SLTs with respect to patients with communication disorders includes timely diagnostic assessment, offering patients information and education, provision of therapy and opportunities for communication practice, consideration for assistive technology and communication aids, and provision of education to other team members to 'optimise engagement in rehabilitation, and promote autonomy and social participation' (Rudd et al., 2016:66). The guideline does not specify a role for stroke nurses with patients with communication disorders. Nurses are implicated with respect to *receiving* information and education in order to act as effective communication partners, as well as being guided to increase therapy intensity by incorporating therapeutic approaches into nursing tasks (Rudd et al., 2016). Nurses are thus not strongly positioned as agents in the management of stroke-associated communication difficulty.

Neither SLTs nor registered nurses are specifically named as responsible for swallowing in the National Clinical Guideline for Stroke. However, both disciplines are implicated in audited targets for identification and assessment of dysphagia. In the UK it is usually registered nurses that conduct dysphagia screening for newly admitted stroke patients (Smithard, 2016), with SLTs responsible for comprehensive assessment and ongoing management following screening. Dysphagia screening

usually refers to a brief bedside assessment designed to reliably detect the presence of dysphagia through the use of a validated protocol (Hines, Kynoch & Munday, 2016). Comprehensive assessment includes various procedures such as cranial nerve examination, trials of different consistencies of food and fluids or therapeutic techniques (McFarlane, Miles, Atwal & Parmar, 2014). Comprehensive assessment might also encompass instrumental techniques that can indicate silent aspiration, which is when food or fluid passes into the lungs without triggering a reflexive cough. The most commonly used instrumental techniques are fibreoptic endoscopic evaluation of swallowing (FEES) of the pharyngeal and laryngeal structures, and radiographic examination of the swallow, using videofluoroscopy (McFarlane et al., 2014).

Audited targets for dysphagia identification and assessment reinforce the importance these clinical activities are afforded in stroke unit care. The targets include timely completion of dysphagia assessment; swallow screening within four hours of arrival at hospital, and specialist assessment within 72 hours (Rudd et al., 2016). Outcomes are audited quarterly in England and Wales through the Sentinel Stroke National Audit Programme (SSNAP). Reports are published online, providing a benchmark against which NHS Trusts can consider their capacity to optimise patient safety through early identification of dysphagia (SSNAP, 2019). Figures from a single year revealed that 88% of stroke patients were screened and 39% received comprehensive dysphagia assessment (Bray et al., 2017). Safe eating and drinking is thus a clinical interest that SLTs and nurses have in common, potentially affording a reason for the two disciplines to share information (McFarlane et al., 2014).

The emphasis on swallowing in stroke unit care has brought benefits for identification of risks associated with choking, pneumonia, malnutrition and dehydration (Rudd et al., 2016). However, there is scant research that increases understanding for how SLTs and nurses work together to accomplish their roles in identifying dysphagia. Research is focused on validation and reliability of screening tools (e.g. Edmiaston, Tabor Connor, Loehr, & Nassief, 2010; Weinhardt et al., 2008), and the relationship between screening and incidence of stroke-associated pneumonia (Bray et al., 2017; Hines et al., 2016). Beyond the assessment stage, research of relevance to both disciplines is restricted to a small number of studies focused on adherence to safe eating and drinking recommendations (McCullough, Estes, McCullough, Gary & Rainey, 2007; Rosenvinge & Starke, 2005; Ross, Mudge, Young & Banks, 2011). Thus little is known about how the disciplines work together to manage the swallowing needs of patients.

The focus of audit attention on identification and assessment of swallowing may have the effect of heightening accountability for one activity to the detriment other non-audited activities (Taylor, Jones & McKevitt, 2018). With respect to stroke-associated communication needs, the previous version of the National Clinical Guideline for Stroke included a four-hour target for identification of patients' 'capacity to understand and follow instructions' and 'communicate their needs and wishes' (Intercollegiate Stroke Working Party, 2012:55). The target implied an active role for nurses (and doctors) because of their presence over the 24-hour day. The latest version does not include this target, thus SLTs are the only profession named with respect to assessment and management of patients with communication disorders (Rudd et al., 2016).

All clinicians are expected communicate in ways that communicatively vulnerable patients can understand, and the requirement that NHS organisations provide accessible information is now supported by a legal standard (NHS England, 2017). The pre-registration training of SLTs equips them with specialist skills that can be used to support other healthcare professionals to meet communication need (RCSLT, 2018). However SLT capacity for attending to patients' communication needs in acute settings is restricted by emphasis on dysphagia (e.g. Rose, Ferguson, Power, Togher & Worrall, 2014). Nurses also have constraints on their capacity to balance the additional time needed for communication with meeting patients' physical care needs (e.g. Loft et al., 2017a). Thus both disciplines operate within constraints that have consequences for patients, for whom the experience of newly acquired communication disability is extremely challenging. Studies with people with stroke-associated communication difficulties report a wide range of negative feelings associated with their experiences of communicating with healthcare providers in hospital, such as frustration, loss, uncertainty, confusion, strangeness, insecurity, exclusion, and fear (Clancy, Povey & Rodham, 2018; Gordon, Ellis-Hill & Ashburn, 2008: Johansson, Carlsson & Sonnander, 2012; Loft et al., 2017b).

1.5 Prioritising Swallowing over Communication in Acute Care

For a number of years, researchers in the UK and Australia have been reporting concerns about the dominance of dysphagia and the decline in SLT attention to the communication needs of patients in acute settings (Code & Petheram, 2011; Enderby & Petheram, 2002; Foster, Worrall, Rose & O'Halloran, 2013; Foster, O'Halloran, Rose & Worrall, 2016a; Rose et al., 2014). Dysphagia was found to comprise the primary caseload for 89% of the SLTs (n=188) involved in a survey conducted in Australia (Rose, et al., 2014). Lesser attention to meeting the communication needs of patients

in stroke unit care impacts on the capacity of patients to communicate their physical and emotional health care needs (O'Halloran, Worrall & Hickson, 2011).

The prominence of dysphagia appears to arise out of a myriad of factors. When questioned as participants in a phenomenological study, SLTs working in acute care (n=14) frequently suggested time pressures and the privileging of patient safety as key to their decisions to prioritise swallowing, however this was underpinned by their conception of the SLT role in the context of a medical model of care (Foster, Worrall, Rose & O'Halloran, 2015; Foster et al., 2016a). Competence with dysphagia carried a level of esteem; SLTs were confident in their dysphagia knowledge, and they perceived this to be an area of expertise that doctors had particular respect for (Foster et al., 2015, 2016a). Nevertheless, the SLTs experienced dissonance in their professional conceptions of self when working in the acute setting. This was because they held values for the importance of addressing patients' communication needs that they did not feel able to adequately address (Foster et al., 2015, 2016a). Perpetuation of clinical attention to swallowing over communication thus appears to be underpinned by complex factors. It is hoped that this study will create new understanding for these factors through exploration of the information sharing practices of SLTs and nurses.

1.6 Research Aims, Objectives and Questions

Research Aim: To explore how SLTs and nurses share information about the communication and swallowing needs of their patients on stroke units.

Objectives

1. To synthesise evidence from existing qualitative studies about therapist-nurse communication in inpatient hospital settings, using meta-ethnography.
2. To identify through review of the literature where the clinical care interests of SLTs and nurses overlap in stroke unit care.
3. To conduct fieldwork on three stroke units (hyper-acute and acute) to understand how information sharing happens within the usual work routines of SLTs and nurses, across different time periods and in different spaces on the units, and through verbal and written information sharing routes.
4. To conduct interviews with SLT and nursing staff to understand perceptions of roles and interdependencies with respect to caring for patients with difficulties communicating and swallowing.

Overarching Research Question: What are the influences on SLT-nurse information sharing about the communication and swallowing needs of their patients on stroke units?

Secondary Research Questions

1. How are different information sharing routes used to share information about communication and swallowing?
2. How does information sharing happen across different spaces on the ward and different periods in time?
3. How do SLTs and nurses perceive their roles and interdependence in management of communication and swallowing?
4. What raises the salience of communication sufficiently for it to be shared?

1.7 Theoretical Framework and Methodology

The research aim called for a theoretical framework and a methodology that could capture and explore the complexity of interaction between two professional groups within a wider context. This resulted in the adoption of symbolic interactionism as the primary theoretical framework and ethnography as the methodology for this study. Ethnographic methodology and methods are discussed in depth in later chapters, however for the purposes of this introduction the following definition provides a comprehensive overview of key features. Ethnography can be defined as:

> 'Iterative-inductive research (that evolves in design through the study), drawing on a family of methods, involving direct and sustained contact with human agents, within the context of their daily lives (and cultures), watching what happens, listening to what is said, asking questions, and producing a richly written account that respects the irreducibility of human experience, that acknowledges the role of theory, as well as the researcher's own role and that views humans as part object/part subject' (O'Reilly, 2005: 3).

Symbolic interactionism is a theoretical perspective on social life based on the premise that society is created through interaction (Charon, 2010). Symbolic interactionism originated with the philosophical ideas of George Herbert Mead, posthumously captured in print by his students (Mead, 1934). However it is Herbert Blumer who is credited with developing Mead's ideas into an explicit approach to exploring social life (Blumer, 1969). Blumer laid out the premises upon which symbolic interactionism is based:

> ‘Human beings act towards things on the basis of the meaning the things have for them (…), the meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows (…), these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters’ (Blumer, 1969:2).

The word ‘things’ does not just mean objects; things might be people, ideas or activities. A central idea within symbolic interactionism is that people define the situations they are in. What this means is that people attend selectively to the ‘things’ in their environment in accordance with their perspectives on them, and it is the ways people define and act towards things that give them meaning (Charon, 2010). The *symbolic* in symbolic interactionism refers to ways in which people communicate, and might include language, gestures, non-verbal indicators and so on (Blumer, 1969). The above premises can be illustrated in an example related to the approaches SLTs make towards nurses for the purpose of sharing information on the wards. The nurse may define an approaching SLT in a host of different ways, for example they may define the approach as welcome if they have been waiting to get an update, or as unwelcome if they are busy with something else. This definition will be influenced by previous interactions with SLTs in general, or this particular SLT.

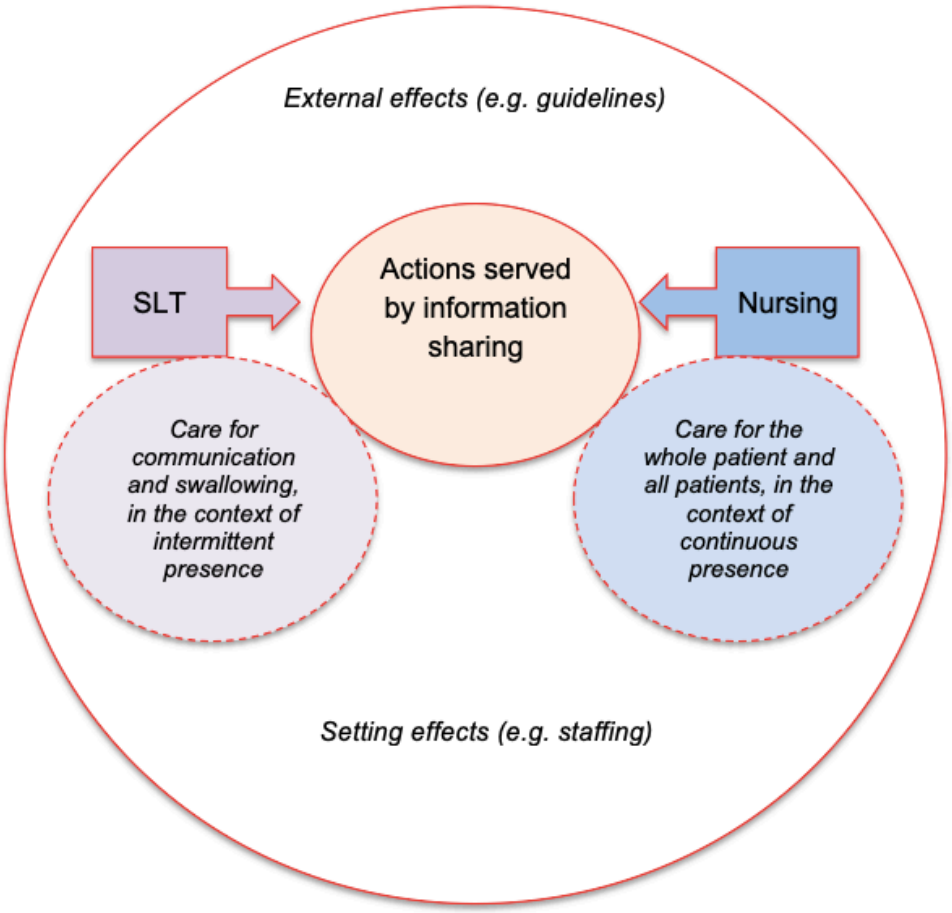
Symbolic interactionism can be seen to contrast with more deterministic ways of looking at social life, because each interaction can bring a new definition. Actors are continuously interpreting and re-interpreting their world, and shared culture is created in interaction (Blumer, 1969). The aspects of social interactionism that are of most relevance to this study relate to the concepts that relate to thought, perspective taking and the line of action, which will be explained through developing the example offered above. Mead argued that how people act towards others originates in how they act on the self, that is they act on the basis of imagining what the other might be thinking (Mead, 1934). The SLT in the scenario above engages in self-talk as she or he imagines the nurse’s perspective and interprets the situation according to her or his own and the nurses’ goals. The decision by the SLT on how to act (such as how much information to share having gained the nurse’s attention) may be influenced by *thoughts* about the nurse’s interest in, and readiness to hear the information. The continuous goal directed actions (lines of action) of each party impact on interaction (Blumer, 1969). Charon describes this as a *stream* of action, in which the flow of goal directed action and thought is disrupted when interaction occurs; deciding to set goals aside is influenced by how the person being interrupted defines the situation (Charon,

2010). In summary, symbolic interactionism involves interaction both with oneself (through thinking what the other person thinks) and with other people. These interactions are what give meaning to things and are considered to have more influence on society or culture than social forces, individual pre-dispositions or attitudes (Charon, 2010). The importance of *action* in symbolic interactionism is represented in a conceptual framework created for this study on the basis of the literature reviews.

1.8 Conceptual Framework

A conceptual framework (Figure 1) was developed on the basis of reviews of the literature (chapters 2 and 3). The framework gives centre place to the actions served by information sharing. SLT and nursing staff are the *actors* of interest to this study. Members of each discipline enter into interaction underpinned by particular parameters for care. SLTs have specific interest in communication and swallowing, which they attend to during specific hours, and nurses care for the whole person on a continuous basis. Both disciplines operate within a wider context that includes factors related to the setting, such as staffing levels and external factors such as guidelines and audit.

Figure 1.1: Conceptual Framework



1.9 Thesis Structure

Chapter 2: This is the first of two literature review chapters. It reports on a systematic review and meta-ethnography conducted as part of this study and now published (Barnard, Jones & Cruice, 2018), to explore the processes of information sharing between therapists and nurses in interprofessional inpatient hospital teams. The outcome of the meta-ethnography was a line of argument that four contingencies underpin communication. The chapter concludes with a discussion of the relevance of the findings to the specific interface between SLTs and nurses.

Chapter 3: This second literature review chapter explores the overlap between SLT and nursing interest in swallowing and communication to understand the content of information that SLTs and nurses might be expected to share in inpatient hospital care in general, and in stroke unit care in particular.

Chapter 4: Methodology: This chapter discusses the key characteristics of ethnography and the reason this methodology was selected. Standards for enhancing rigour in ethnography are discussed, with particular consideration for the relational and ethical issues associated with practitioner research in a hospital setting.

Chapter 5: Methods: This chapter describes data collection methods. Fieldwork included participant observation and viewing patient records. Formal semi-structured interviews were carried out with SLT and nursing participants.

Chapter 6: Setting and Participants: This chapter provides descriptive information about the characteristics of the wards and the participants.

Chapter 7-10: Findings: The research questions are addressed within four findings chapters. Chapters 7 and 8 develop conceptual understanding of the temporal-spatial context for interaction between SLT and nursing staff. Chapter 7 explores the informal route. Structured (or formal) channels are considered in Chapter 8. The next two chapters give specific consideration for how the temporal-spatial context impacts on roles and interdependencies with swallowing and communication. Chapter 9 extends exploration of the privileged position of swallowing, including in-depth analysis of how swallowing is managed as a patient safety concern. Chapter 10 explores the under-use of information sharing routes between SLT and nursing staff for information about patients' communication needs.

Chapter 11: Discussion: This chapter uses existing literature and theoretical and philosophical frameworks to synthesise the findings into a coherent interpretative description of the influences on information sharing between SLTs and nurses.

Chapter 12: Conclusion: This final chapter condenses the key messages from the study, considers the strengths and limitations, highlights the significance of the research and makes recommendations for research, clinical practice and education.

1.10.Writing Style

It is conventional in ethnography to write in the first person to position the author as co-creator of knowledge (Clifford, 1986). This thesis uses the first person in the Methods, Setting, Findings and Conclusion chapters. Remaining chapters are written in the third person except when referring to researcher experience.

Introduction to the Literature Review Chapters

Identifying literature to frame this study presented challenges, because although the swallowing and communication difficulties experienced by patients have been much researched, such studies have paid minimal interpretative attention to the interface between SLT and nursing roles in meeting these needs. Little is known about how SLTs and nurses interact to navigate common clinical interests in communication and swallowing on hospital wards in general, and stroke units in particular. The professional boundaries between the disciplines are particularly unclear for work with patients with communication difficulties. The limited amount of research directed towards understanding how swallowing and communication work is enacted made it necessary to critically review a wider literature than that pertaining to stroke unit care. First of all, understanding was needed for the issues surrounding information sharing as a *process*. For the first review (chapter two), SLTs were considered, along with occupational therapists and physiotherapists, as sharing a therapist/nurse boundary with nurses within interprofessional teams across a range of hospital inpatient settings. Secondly, attention was directed to the boundary between SLT and nurse clinical interest in communication and swallowing. The second review (chapter three) again included literature from inpatient settings beyond stroke care, for the purpose of increasing understanding of the *content* of information that might be of interest across both disciplines, whilst also applying more focused attention to stroke-associated communication and swallowing difficulties.

Chapter two is a report of a systematic review and meta-ethnography that addressed the following question: What are the influences on communication between therapists and nurses in inpatient interprofessional teams? (Barnard et al., 2018). The systematic review and meta-ethnography is included in the thesis as it appeared in its published format, with only minor formatting adjustments. Chapter Three adopts a systemised approach (as described by Grant & Booth, 2009) to review a diffuse literature that addresses the following question: Where do the care interests of SLTs and nurses overlap in acute stroke care? The two chapters combined create a framework for this research to develop new understanding for both the process and content of information sharing between SLTs and nurses working on stroke units.

2. Information-sharing between Therapists and Nurses

2.1 Introduction

This chapter reports on the results of a systematic review and meta-ethnography about communication between therapists and nurses working in inpatient interprofessional teams. The synthesis makes an original contribution to knowledge through introducing a line of argument that effective therapist-nurse communication is contingent upon need for information, capacity, opportunity and the quality of relationships. The research also makes a methodological contribution through the introduction of a matrix to support researchers to weigh the evidence when making judgments about the quality of studies considered for inclusion in meta-ethnography.

The project supervisors had no prior experience of conducting meta-ethnography and the process was entirely led by the doctoral candidate. For the purpose of rigour, project supervisors were involved in processes that required more than one researcher. The doctoral candidate researched what was needed for each phase of the meta-ethnography, transferred this knowledge to the other researchers, and directed them in carrying out specific activities to enhance rigour.

The systematic review and meta-ethnography is presented below almost exactly as it appeared in the published paper (section 2.2). The only changes are slight formatting adjustments to headings and tables, made for the purpose of keeping the formatting of the thesis consistent. The numbering for figures and tables has been adjusted to enable them to be incorporated within the table of contents for the thesis. The referencing style required by the journal was maintained, and the reference list has been left in situ to ease cross-referencing against included studies. An additional section that was not part of the publication has been added (section 2.3) to extend discussion of the line of argument presented in the published paper to the specific interest of this thesis for the SLT-nurse interface in inpatient stroke care.

2.2 Systematic Review and Meta-ethnography

Barnard, R., Jones, J., Cruice, M. (2018). Communication between therapists and nurses working in inpatient interprofessional teams: Systematic review and meta-ethnography. *Disability and Rehabilitation, 4*(18), 1-11.

****Beginning of Paper as Published****

Purpose: The aim of the synthesis was to develop new understanding about the influences on communication in interprofessional teams from therapist and nurse perspectives. Methods: Six electronic databases were searched, combined with citation tracking and hand searching, yielding 3994 papers. Three researchers were involved in screening and quality appraisal, resulting in 18 papers for synthesis, using the process of meta-ethnography. Concepts were identified, compared and translated under five category headings. Two researchers mapped interpretative summaries and a line of argument was created. Results: The line of argument is that four inter-related contingences underpin effective communication between therapists and nurses. Effective communication depends on there being a genuine need to give and receive information for patient care, the capacity to attend to, hold, and use information, and opportunities to share space to enable communication to occur. The fourth contingency is good quality relationships and this is the glue that holds the contingencies together. Conclusion: This synthesis has provided an opportunity to illuminate how therapists and nurses accomplish interprofessional work through communication. The contingencies of need, capacity, opportunity and quality of relationships create a new structure for understanding what underpins communication between these two groups.

Keywords: communication; relationships; interprofessional; therapist; nursing

Implications for Rehabilitation

- Need, capacity and opportunity should be understood as contingencies that underpin effective communication about patients, strongly centred on the fourth contingency, quality of relationships between professionals.
- Therapists and nurses should examine what information they genuinely need from each other to effectively conduct integrated care, from the perspective of both giving and receiving information.
- Consideration should be given to whether a culture of reciprocity might expand the capacity of professionals to attend to, hold and use the information they share about patients.

- Therapists and nurses should examine how the way they share space on the ward creates or limits their opportunities to communicate about patients and develop relationships.

Background

There is strong support amongst professionals for the importance and value of interprofessional teamwork [1,2]. The term interprofessional was preferred over others such as multidisciplinary or interdisciplinary. This follows a definition which classifies interprofessional teams as those that share a team identity and work in both integrated and independent ways, in order to solve problems and deliver services [3]. It is recognised that the teams reviewed in the literature did not necessarily operate at this level of integration, however it is the lens through which teams are discussed in this synthesis. There is evidence that organising specialist health care in an integrated way is associated with improved outcomes, in certain conditions. This includes, for example reduced morbidity and increased independence in stroke care [4], and improved activity and participation for people with Multiple Sclerosis [5]. There are difficulties in isolating the interpersonal aspects of team working that underpin achievement of outcomes, hence structural components of teamwork, such as team composition and ward rounds tend to be prominent when evaluating teams, for example in the quarterly audits for the Sentinel Stroke National Audit Plan in the UK [6]. Models of collaboration recognise that the components of teamwork are interpersonal in nature, and this is reflected in discussion of concepts such as interdependence [7,8], information sharing [8,9], and role understanding [10]. However communication is difficult to unpack, as one discrete component of teamwork, and this may be why the particular role of communication tends to be *implicit* in such models. A study by Suter [11] identified communication (together with role appreciation) as a core competency for effective collaboration, based on interviews with 60 health care providers, suggesting that communication warrants stronger recognition as a concept in its own right. Appreciating communication as more than a taken for granted process through which teamwork happens [12] requires understanding of the *actions* that communication accomplishes [13]. Acts of communication between professionals serve the primary purpose of facilitating coordinated patient care, accomplished through shared understanding of the problem at hand [13]. When communication is viewed in terms of the actions it accomplishes (for example generating shared interprofessional understanding for how to help a patient get out of bed safely), it is easier to see how factors such as role appreciation can be understood as potentially influencing whether and how communication is enacted

Increased professionalization in the past three decades has brought expectations that nurses and non-medical professionals collaborate to plan treatment and make decisions for the benefit of patient care [14]. However, the extent to which meaningful professional collaboration is actually accomplished is highly variable across settings [2]. Different professionals see clinical issues through the lens of their distinct knowledge and ethical frameworks [15], and this creates the potential for uncertainty and emotional dissonance when they are required to integrate the clinical perspectives of other professionals [16]. Much has been written from nursing perspectives that reveals a critical view of how nurses experience interprofessional practice. A systematic review of nursing practice in stroke rehabilitation synthesised some of this literature, which indicated: divisions between nurses and therapists, difficulties for nurses in engaging in team processes such as meetings and training, and lack of appreciation by therapists for nurses' contribution to rehabilitation [17]. Thus there are communication issues that relate specifically to the interface between therapists and nurses, and focused attention in this area has the potential to inform practice between these disciplines. The therapists referred to in this article are those that are the key therapy providers in most UK inpatient hospital settings: physiotherapists, occupational therapists and speech and language therapists. Although therapists have been included as participants in interprofessional research [e.g. 18-20], there have been few studies of the therapist-nurse interface written from a therapist perspective. The limited body of research that has been identified is based on small sample sizes; in these studies nurses are framed as 'other'. Carpenter [21] contrasts perceptions by physiotherapists of successful negotiation of role overlap with occupational therapists, to a more conflictual intersection with nurses, and suggests that nurses operate through different philosophical approaches to care. Other therapist-authored research has focused on nurses' role in executing therapists' advice. The eight speech-language pathologists interviewed by Smith-Tamaray et al. [22] experienced dissatisfaction with nurses (and doctors) follow-through on recommendations for safe swallowing. Physiotherapists interviewed as part of a participatory action research study [23] revealed a level of distrust for nurses' capacity to incorporate training for therapeutic positioning and mobilisation. Overall, the literature reveals challenges in interprofessional working from both therapist and nurse perspectives. This synthesis aims to understand more about how communication is implicated in the discordance that exists at the boundary of therapist and nursing work, with a view to giving greater representation to therapist perspective than has previously been evident in the literature. This research is focused on inpatient care in order to increase transferability of the findings to similar settings where nurses provide continuous care and therapists

provide more intermittent contributions to that care. The synthesis was conducted as part of the process of conducting doctoral research on information sharing between speech and language therapists and nurses in acute stroke care.

Methods

Study Design

Synthesis of qualitative research is a means of widening the potential of qualitative work to influence health care practice [24]. It addresses the how and why questions that meta-analyses of quantitative studies are less well suited to [25]. Meta-ethnography is a particular type of synthesis that was introduced by Noblit and Hare [26], and involves seven distinct phases: Getting started, deciding what's relevant, reading the studies, determining how studies are related, translating the studies, synthesizing translations, and expressing the synthesis. The method followed for the first six stages is described below, and this article is one means of expressing the synthesis. Meta-ethnography was selected as the most appropriate method of synthesis for this study because the explicit aim is to develop conceptual understanding beyond individual qualitative studies [25,27]. A methodology that is interpretative rather than aggregative [26] was necessary in order to gain deeper understanding of how interprofessional work is actually accomplished in healthcare through communication. The concepts identified in each study are the primary data for the synthesis, thus meta-ethnography relies on studies that report conceptual rather than purely descriptive findings [28]. Concepts are examined in relation to others within and across studies in a process of translation, similar to the method of constant comparison [27,29]. Some researchers express concern that synthesizing findings creates unacceptable extension of individual units of meaning beyond their particular contexts [27]. Meta-ethnography recognises these concerns and demands attention to the context of the original studies during the process of synthesis [25].

Phase one: Getting started

The initial research question was 'to explore communication between allied health professionals (AHPs) and nurses working in inpatient settings within interprofessional teams'. Scope was kept wide to increase the potential for studies from disparate clinical settings to extend the concepts for consideration [24]. At the start it was not known which AHPs were the subject of research attention in relation to their interface with nurses, hence a broad definition of AHP was applied to include professions that are similarly positioned as separate from nurses or doctors in teams. Following the

initial screening process the AHPs were narrowed to include the therapists most commonly located as treating members of interprofessional teams in UK inpatient hospital settings (physiotherapists, occupational therapists and speech and language therapists). The question was reframed as 'what are the influences on communication between therapists and nurses in inpatient interprofessional teams'; this allowed the studies that *implicated* communication through discussion of collaboration and role perception to be incorporated.

Phase two: Deciding what is relevant to the initial interest - inclusion decisions

Although systematic search techniques are not always relevant to meta-ethnography [30], it was considered necessary in this study because communication is often poorly articulated as a concept in interprofessional research. Search terms were identified through discussion with a subject librarian and the research team (table 2.1). The research was led by the first author, supported by active involvement of PhD supervisors (second and third authors) in various processes designed to enhance rigour. Six databases were searched on 06/05/15 for papers published in the English language (repeated three times, most recently on 26/02/18): Cinahl, Medline, Embase, AMED, Psychinfo and SocINDEX. No date limits were applied to retain openness to relevant historical information. Citation searching and hand searching supplemented the electronic search.

Table 2.1. Search terms used in EBSCOhost

Interprofessional (abstract or title)	interprofessional or inter-professional or multidisciplinary or multi-disciplinary or interdisciplinary or inter-disciplinary or transdisciplinary or trans-disciplinary or team or teamwork* or team work*
Communication (abstract or title)	communicat* or collaborat* or joint work* or cooperat* or co-operat* or negotiat* or partner* or coordinat* or co-ordinat*
Therapists (all text)	speech W2 therap* or speech W2 patholog* or physiotherap* or physical therap* or occupational therap* or dietician or nutritionist or dietetic* or pharmacist or social work* or psycholog* or neuropsycholog* or neuro-psycholog* or allied health
Nursing (all text)	nurs*
Inpatient (all text)	hospital or ward or unit or inpatient
Qualitative (all text)	qualitative or interview* or ethnograph* or focus group or observation*

Criteria for inclusion were that the paper reported qualitative findings about the interface between practicing AHPs and nurses in inpatient settings, even if this was not the key focus of the research paper. Research was sought from within practice rather than pre-registration education to reflect the experience of qualified professionals. The following exclusion criteria were applied: (1) No attention to the interface between AHPs and nurses, (2) Quantitative research, (3) Emphasis on pre-registration interprofessional education, (4) Not primary research (also excluded within this category were non-peer reviewed studies, systematic reviews and theses). The first author screened all retrieved papers by title and abstract. Papers were included at this stage even where there was slight uncertainty, in order to mitigate the risk of a single researcher excluding important work too early. The first and second authors then independently conducted a full text review of the first half of the included papers and classified papers as 'include', 'exclude' and 'potentially include'. The third author independently reviewed discrepancies and the 'potentially includes' and inclusion decisions were made through discussion. The first author then independently completed full text review of the second half of the papers. All the papers that remained at the end of this process were discussed with the third author, resulting in further exclusions against the criteria. One additional paper from repeat searching on 25.02.16 was added and put through to the quality appraisal stage.

Phase three: Reading the studies and assessing quality

The final set of included papers were subject to a two-stage process of quality appraisal involving the three authors. The use of appraisal tools in evaluating the quality of qualitative research for inclusion in meta-ethnography has been much debated in relation to the status given to meaning [31], researcher disagreement about quality indicators [28], and the impact of editorial restrictions on the ability to demonstrate rigour [30]. For this study, a first stage of quality appraisal was carried out on papers that met the inclusion criteria, using the Critical Appraisal Checklist for Qualitative Research [32]. The purpose was not to eliminate studies, but to closely read and summarise the studies in terms of (1) Strengths and limitations against the CASP criteria (2) Study setting (3) Participants and (4) Methods.

CASP review of studies did not yield information that was helpful in determining quality for meta-ethnography, and a second stage of quality appraisal directed towards weighing the evidence was considered necessary [33]. Seminal research in this area indicates that consideration for conceptual clarity and interpretative rigour (also referred to as trustworthiness) is key to judging quality for this kind of synthesis [28].

The concepts contained within each study were listed and each paper was given a 'weight of evidence' score. This was accomplished through creation of a matrix, based on the ideas presented in a discussion paper by Toye et al. [28]. The purpose of this second stage was to exclude studies judged to be *insufficiently rich* in trusted concepts to be translated into one another [28,30]. The first author rated the papers as having *high, medium* or *low* weight of evidence by reviewing each paper against the questions on the axes of the matrix: (1) Is there at least one clear translatable concept that addresses the research question? (2) Do you trust the interpretations? (table 2.2).

Table 2.2 Weight of evidence decision matrix

Trust for interpretations?	Clear translatable concept that addresses the question?	
	Concepts unclear or not translatable Trust the data LOW weight of evidence *One paper*	Clear, translatable concepts Trust the data HIGH weight of evidence *Three papers*
	Concepts unclear or not translatable Question trust LOW weight of evidence *Nine papers*	Clear translatable concepts Question trust MEDIUM weight of evidence *Fifteen papers*

A questionable rating for trustworthiness was not necessarily a judgment of the overall methodological quality of the study (and as such differs greatly from the CASP approach); rather it reflected trust in the concepts relevant to the research question that were intended for translation (i.e. specific to the task at hand). Being confident to trust the concepts was considered particularly salient because communication between therapists and nurses was often not the primary focus of the studies. It was also important that at a minimum, included studies could demonstrate *adequate* concept-data links for the relevant concepts [28]. The second and third authors independently rated a proportion (17) of the papers placed in the high, medium and low categories by the first author, and final agreement was arrived at through discussion. For example one paper [21] reported interesting discussion suggesting conflict at the boundary between physiotherapy and nursing, however following discussion it was agreed that the concept (in relation to communication) was not sufficiently developed. The links between the concept and the data presented in the paper were not strong enough for the paper to be translated into the other papers in the synthesis. Weight of evidence was thus judged to be low. All papers rated as low weight of evidence were excluded.

Phase four: Determining how the studies are related

Completion of phase four was eased by the systematic identification of concepts for translation during phase three by all members of the research team. The first author identified relationships between the concepts and organised into categories. The research team agreed to commence the translation process with five working categories, as detailed in the results section. Similar to previous studies [25,34], the categories were conceived as an organizing, rather than a thematic framework and formed the basis for the translation process.

Phase five: Translating the studies

Reciprocal translation is the process used for translating concepts that are broadly similar, and was the approach used for this study. The intention was to progress to a line of argument synthesis if following reciprocal translation it seemed that an overarching picture of the whole could be constructed [26]. NVIVO 11 [35] was used to help organize the data and papers were coded against the categories agreed in phase four in chronological order, by year of publication, starting with the earliest study. The findings of each paper were revisited in full each time a new category was coded, in this way the concepts were considered within their original context, and then compared with those that followed through the process of translation. This resulted in an interpretative summary of five categories, also known as third order constructs [34].

Phase six: Synthesising translations

The first and second author independently reviewed the interpretative summaries and mapped relationships between concepts before coming together to compare interpretations. Through discussion it became apparent that a line of argument could be articulated that developed understanding of the picture as a whole. Potential contradictory evidence in each of the papers was systematically explored to test the line of argument and through discussion it was agreed that the line of argument remained strong.

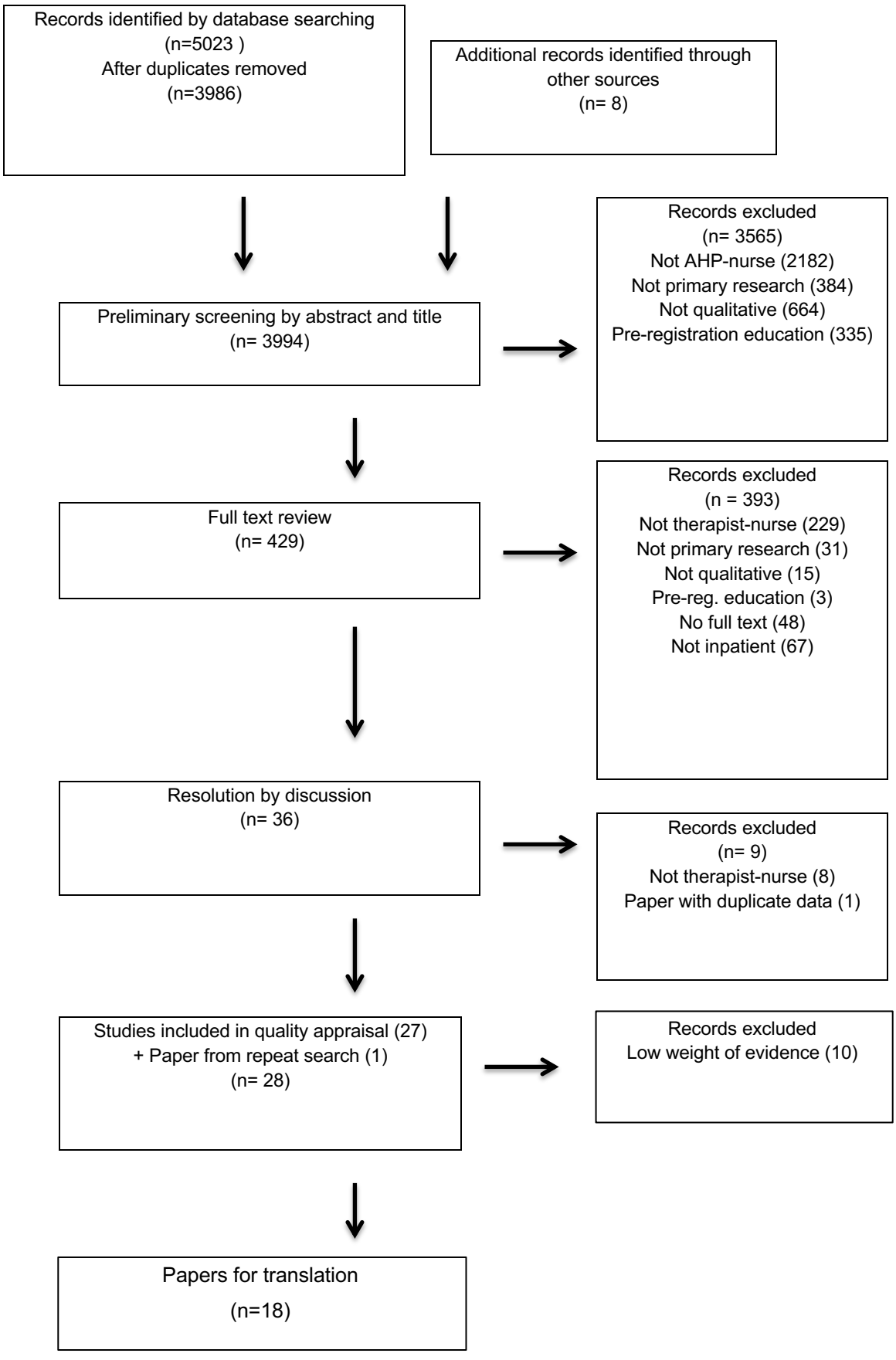
Results

Included studies

The search strategy is detailed in figure 2.1. The initial search yielded 3986 papers; citation searching and known papers increased the total to 3994. Following screening by title and/or abstract 429 papers remained. The first and second author independently completed full text review on half of these papers before coming back together for discussion. Initial researcher agreement over papers to include was low; this was because communication was often not explicitly explored in the studies. For example many papers discussed roles or the tensions that arose around boundary work without extending into discussion about how professionals communicated to negotiate the boundaries. Disagreements about inclusion were resolved through independent review by the third author and discussion. Exclusion criteria were tightened for full text review by the first author of the second half of the papers: (1) Insufficient conceptual analysis or participant quotes in relation to communication (or

collaboration or the relationship) between therapists and nurses, (2) therapists and nurses not identifiably distinct from each other, (3) inpatient data not distinctly reported from community data, and (4) Full text not available through databases subscribed to by the university or the British Library. Uncertainties were resolved through discussion with the research team. The tighter criteria meant that some of the papers from the first half of the full text review may have been excluded if re-reviewed, however they were subject to repeat scrutiny in the quality appraisal process. At the end of this process, the 36 papers that remained were discussed with the third author, resulting in further exclusions against the criteria, leaving 27 papers for quality appraisal. This number was increased to 28 following repeat searching on 25.02.16.

Figure 2.1. Flow diagram of studies included in the review



Quality appraisal

Consistent with the experience of other researchers, as reported in France et al. [30], the time consuming process of quality appraisal against a checklist added little to the judgments needed to determine whether the papers were sufficiently rich in concepts to be translated into one another. The 28 studies were rated against the weight of evidence matrix and each paper was given a score. Following this process 18 papers were weighted as high (3) or medium (15) and went through to phase four to be translated; with 10 papers with low weight of evidence excluded. Papers rated as high weight of evidence are identified through an asterisk* in the tables.

Description of included studies

Summary information of included studies is shown in table 2.3. The studies were published across 18 years, from 1996 to 2014. They were conducted in the UK (11), Canada (4), Australia (2) and USA (1). Study settings included: Six rehabilitation wards, three stroke wards, seven acute/general medical wards, one acute mental health ward, and one spinal cord injury unit. Study designs included six interview studies, two observation studies, and ten studies that combined interview and observation, of which three were ethnographies.

Table 2.3. Main criteria of included studies

Paper	Setting	Data collection	Study aim
Waters 1996 [47]	Two rehabilitation wards. UK.	Interviews. Nurses (28), student nurses (6), auxiliaries (9), doctors (5), PT (3), OT (3), SW (2).	Explore staff perceptions of rehabilitation work, with particular emphasis on the role of the nurse.
Dowswell 1999 [23]	Elderly care rehabilitation ward. UK.	Participatory action research, interviews. Nurses (13) and PT (unspecified number).	Describe the development process and content of a training programme.
Pound 2000 [48]	Three wards across two hospitals. UK.	Observation (146 hours). Participants not listed.	Explore the less tangible aspects of the process of care missed using quantitative or survey techniques.
Dalley 2001 [46]	Two rehabilitation wards. UK.	Interviews. Nurses (8)	Explore how rehabilitation nurses perceive physiotherapists as rehabilitation team members.
*Long 2002 [44]	Six NHS Trusts (community and hospital). UK.	Ethnographic case studies, observation (330 hours), interviews and expert workshops. Case studies (49), staff (88) and carers (21).	Explore the contribution of the nurse in the multidisciplinary team.
Atwal 2002 [43]	Acute hospital. UK.	Interviews and non-participant observation. Nursing staff (19).	Explore nurses' perceptions of discharge planning, to identify interactions in multi-disciplinary team meetings and impact on discharge planning.

Pellatt 2005 [45]	Spinal cord injury unit. UK.	Ethnographic interviews. Nurses (14), doctors (5), OT (30), PT (5).	Identify perceptions of interprofessional roles and relationships within the rehabilitation team.
Pryor 2008 [37]	Five inpatient rehabilitation units. Australia.	Observation and interviews. Nurses (53 – of these 44 interviewed).	Generate a deeper understanding of contextual factors influencing nursing's contribution to inpatient rehabilitation units.
Miller 2008 [42]	Three general medical hospitals. Canada.	Interviews and observation (secondary analysis). Nurses (13), AHP (13), doctors (3), administrator (1).	Identify emotion work considerations for nurses working with an interprofessional context in hospital setting and how it facilitates or impedes nursing interprofessional care.
Seneviratne 2009 [20]	One stroke unit. Canada.	Ethnography: Observation (9 months) and interviews. RN (10), LPN (2), PCA (1), NP (1), PT (3), doctor (3). Of these 9 interviewed (unspecified profession).	Uncover nurses' perceptions of the contexts of caring for acute stroke survivors.
Burton 2009 [18]	Two acute stroke units. Canada.	Interviews. Nursing staff (12), SLT (1), OT (2), PT (3), SW (1), doctor (1).	Identify organizational factors that support delivery of high quality nursing care in stroke units.
Clarke 2010 [1]	Two stroke units. UK.	Ethnography: Participant observation (220 hours) and interviews. Registered Nurses (7), Assistants (7), OT (3), SLT (1), PT (3), dietician (2), ward clerk (1), ward manager (2), doctor (4), SW (4).	Understand and explain how teamwork was achieved and maintained in two stroke rehabilitation units.
Smith-Tamaray 2010 [22]	Non-metropolitan healthcare settings. Australia.	Interviews. SLP (8)	Develop an understanding of how SLPs work as part of a multidisciplinary team within the non-metropolitan setting.
Lewin 2011 [40]	Two medical wards. UK.	Interviews (individual and group) and observation (90 hours). Doctors/nursing/PT/pharmacists/SW/care coordinators (49).	Explore how professions 'present' themselves when working on wards, and how they use front and backstage spaces.
*Deacon 2013 [41]	Acute mental health ward. UK.	Observation (two years). RNs (18), NAs (16)	Explore the occupational activities of mental health nurses in an acute inpatient mental health ward.
Miller 2013 [19]	Two inpatient neurorehabilitaton units. Canada.	Non-participant observation and interviews. Nursing (11), OT (5), PT (5), SLP (6), SW (3), Recreational therapy (1), RN leader (4).	Examine neurorehabilitation nurses' intra- and inter- professional negotiative practices.
Apesoa-Varano 2013 [38]	Teaching hospital, different wards. USA.	Interviews and participant observation. Nurses (30), OT/PT/SLT (20), SW (20), Respiratory therapists (21) and doctors	Explore boundary work and the accomplishment of work among various groups claiming professional status at the bedside in the hospital.

Tyson 2014 [39]	Eight hospital based rehabilitation teams. UK.	Non-participant observation (12 meetings) and interviews. Nurses (4), PT (4), OT (4), SLT (2), psychologist (1), SW (1), stroke coordinator (1), stroke ward manager (1).	Explore how teams operate in day-to-day practice.

* Papers rated as high 'weight of evidence'

Key to abbreviations: PT: Physiotherapist, OT: Occupational therapist, SW: Social worker, AHP: Allied health professional, RN: Registered nurse, LPN: Licenced practical nurse, PCA: Patient care attendant, NP: Nurse practitioner, NA: Nursing assistant, SLT: Speech and language therapist, SLP: Speech language pathologist.

Synthesis

Five categories were identified: Formal information sharing practices, informal information sharing practices, conceptions of interdependence, perceptions of role value and team geography. The categories reflect the third order interpretation by the research team of the second order constructs identified by the authors of the papers [34]. Participant quotes were not included as primary data (as Toye et al. [36]). The contribution made by each paper to the categories was tabulated for transparency (table 2.4). Of note, three papers included concepts that contributed to all five categories (20,22,37), and two of the papers contributed to only one of the categories (38,39).

Table 2.4. Contribution of concepts from individual papers to categories

Papers	Formal information sharing practices	Informal information sharing practices	Conceptions of inter-dependence	Perceptions of role value	Team geography
Waters [47]			x	x	x
Dowswell [23]		x	x	x	
Pound [48]		x	x		
Dalley [46]		x	x	x	
*Long [44]			x	x	
Atwal [43]	x	x			
Pellatt [45]			x	x	
Pryor [37]	x	x	x	x	x
Miller [42]	x	x	x	x	
Seneviratne [20]	x	x	x	x	x
Burton [18]	x	x	x		
*Clarke [1]		x	x	x	x
Smith-Tamaray [22]	x	x	x	x	x
Lewin [40]		x	x		x
*Deacon [41]	x				x
Miller [19]	x	x	x	x	
Apesoa-Varano [38]			x		
Tyson [39]	x				

* Papers rated as high 'weight of evidence'.

Formal information sharing practices

Formal information sharing practices discussed in the reviewed papers included meetings (team meetings, case conferences and ward rounds), use of medical records, and nursing handover. Team meetings are considered important to interprofessional practice (18,20,22,37,39,40), particularly for professionals who are infrequent visitors to a ward (22,41). However meetings vary in format, leadership, team climate and effectiveness (39) and their function can be ritualistic, with informal means better suited to meet professionals' information needs (40). Nurses' capacity to engage in meetings is impacted by their positioning; they frequently represent the work of their nursing colleagues, or enter and leave the meeting in succession in contrast to therapists who usually report on their own patients (37,39,41,42). Attending meetings can be difficult for nurses due to their continuous multiple caseload and time constraints (20,37,40) and they report feelings of discomfort and intimidation, and difficulties asserting counter views in this context (42,43). They also experience professional conflict with regard to *what* to present at the meeting, responding to non-verbal indicators (19,42) that information pertaining to emotional aspects of care is perceived as less clinically relevant than the contributions made by other professionals (19,41). Condensing reporting restricts their opportunity to demonstrate the expertise that is evident in nurse-to-nurse handover, for example the skills used to persuade a distressed patient to provide a urine sample (41). The consequences of nurses' disadvantaged position in meetings include abstention or withholding information (19,20,37,39,42,) and reduced opportunity to engage or develop relationships with other professionals in this context (41,42,43). Therapists who cover multiple wards or settings are also often absent from meetings, reducing their participation in both formal and informal opportunities for decision-making (22). When verbal communication is not possible, therapists use their entries in the medical record as a substitute (22,37,44), despite acknowledging that they may not be read (22). However written communication is a poor substitute for verbal information because messages are less clear (36,44) or inaccessible at the time of need (22,37,45). Nursing handover is a formal means of information sharing that has relevance to interprofessional practice due to nurse shift working patterns and the potential for misinformation or 'chinese whispers' (43).

Informal Information Sharing Practices

Much of the work of interprofessional practice takes place outside of formal processes for information sharing, such as when professionals 'seize moments' to give or receive information as they pass in the corridor or at the nursing station (1,40,42). Therapists

value information nurses derive from the bedside (1,42,44), and nurses are perceived as 'holders' of pieces of information, expected to act as intermediaries between patients, families and other professionals (42,43,44). In order for informal information sharing to arise, therapists and nurses need to occupy shared space (1,22,37,40), and each party needs to have the physical and emotional capacity to hear or give information at the opportune moment (1,22,37,40,43,46). Conflicting demands such as physical care and medication rounds impact on nurses' capacity for information sharing (37,43) and their ability to use information is limited where understanding of therapists' terminology is not shared (37,44,46). Interpersonal relationships and rapport influence the quality of communication (1,19,22,37,40,43,45), and the manner in which information is exchanged can create tension (19,37,40,43). Interprofessional communication is more effective when organizational level attention is paid to shared working and training (1,18).

Conceptions of interdependence

The interface between the work of nurses and therapists is discussed through reference to the role of nurses in integrating or 'carrying on' rehabilitation activities introduced by therapists (18,19,23,37,44-48). Therapist roles are boundaried by their particular specialisms and by their working hours, in contrast to nurses' continuous availability to patients (1,23,38,47). Because therapists are temporally boundaried, they depend on nurses' support for patients to be ready in time for therapy and for encouraging patients to do tasks in the manner they recommend (20,44,46). Nurses attempting to meet therapists' expectations can experience conflicts of time, ethics of care, and professional autonomy (18,44-46); for example, watching patients struggle to perform tasks in a therapeutic manner can be experienced as uncaring (44). Tensions also arise out of unsatisfied expectations by nurses that therapists should reciprocate by sharing in 'nursing' tasks, such as toileting, when patients are in session with them (1,44). Therapists do sometimes help nurses with such tasks, however they have more agency to resist than nurses, justified through their specialist, temporally boundaried role (1,38).

Perceptions of role value

In studies in rehabilitation contexts, therapists were located as 'experts', positioning nurses as recipients of recommendations (19,22,23,38,46-48). Although nurses resist the framing of therapists as the only experts (19,37,47), the unboundaried nature of nurses' work creates challenges in asserting their own areas of specialty (23,41,46,47). The experience of being under-valued can lead nurses to hold back from full

engagement (20,42); there is potential to expand their role when therapists aren't present (19), but making autonomous decisions to do things differently to that which has been advised invites criticism (19,37,48). Because therapists are positioned as the 'experts' in rehabilitation their sense of professional purpose is vulnerable if nurses don't recognize their role (22,45). However therapist researchers tend to suggest training or ways of demonstrating professional competence in response to nurses not doing as therapists advise (22,23), which may indicate some resilience to therapists' expert identity. There is recognition for the nurses' roles as intermediaries, referrers and creators of a supportive rehabilitation environment, but these tend not to be identified by either nurses or therapist as expert roles (19,22,37,44,46,47). The expert-generalist dichotomy is a source of tension and relates to a pervasive perception by nurses that therapists undervalue their professional contribution (19,37,45-47), and do not fully appreciate their additional obligations towards medical management (20,37). Therapists appear to value nurses' contribution in a constrained way, as a precursor to their specialist work (20,44,45,47).

Team geography

Nurses' ward presence is continuous (18,19,23,37,41,44), even during meetings they remain available to the ward (41). This gives them a certain ownership of the ward space (19) and can create cohesive ties amongst nurses (41). In contrast therapists are often based away from the ward and their work with patients is temporally boundaried (22,37). Being on the ward increases opportunities for sharing of information between therapists and nurses (1,22,37,47), either through *ad hoc* conversations in liminal spaces such as corridors, or in formal meetings (40). Whether or not professionals will seek each other out when sharing space however relates to dispositions towards interprofessional working, which appear to be individual dependent (22,37) and require appreciation of interdependence (1). For therapists who are infrequent visitors to the ward, lack of presence makes it harder to establish the trust needed for nurses to value and incorporate the advice they offer (22).

Line of argument

The line of argument is that effective therapist - nurse communication is contingent upon need for information, capacity, opportunity and the quality of relationships. The contingencies are conceptualised in figure 2.2 as four inter-related domains, with quality of relationships occupying a central position. The process through which a line of argument has been developed is commonly under-reported in meta-ethnography [30], hence the inclusion of table 2.5 to illustrate points of substantiation from each

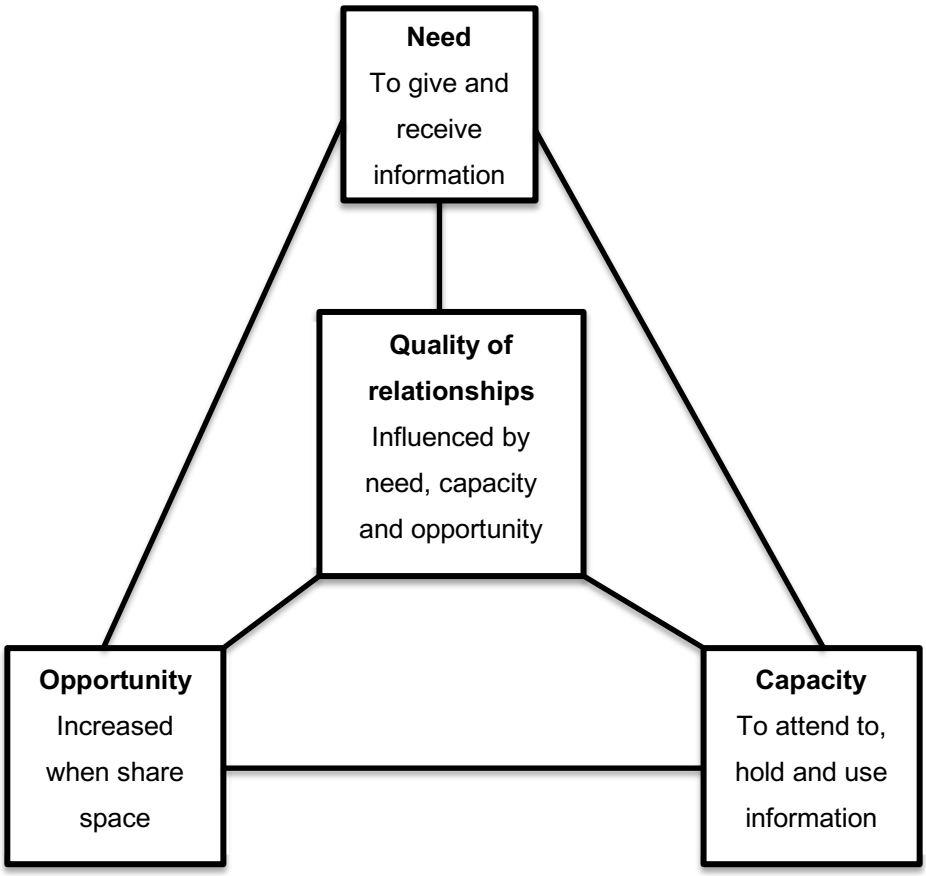
paper that contributed to the line of argument, wherein each cross signifies one interpretation from the paper that supports the contingency.

Table 2.5. Papers with interpretations contributing to the line of argument

Paper	Quality of relationships	Need for information	Capacity	Opportunity	Total
Waters [47]	xxx	x	xx	x	7
Dowswell [23]	xx		xx		4
Pound [48]	x	x			2
Dalley [46]	xx	xx	xxxx		8
*Long [44]	x	xxx	xxxx		8
Atwal [43]	xx	x	xx		5
Pellatt [45]	xxx	xx	xx		7
Pryor [37]	xxxx	xxxx	xxxxxx	xx	16
Miller [42]	xx	xx	x	x	6
Seneviratne [20]	xx	xxx			5
Burton [18]	x	xxx	x		5
*Clarke [1]	xxx	xxx	xxx	xxx	12
Smith-Tamaray [22]	xxxx	xxx	xx	xxx	12
Lewin [40]	x	x	x	xxx	6
*Deacon [41]	xx	x	x		4
Miller 2013	xxxxxx	xx	x		9
Apesoa-Varano [38]	xx		xx		4
Tyson [39]	x	xx	x		4

* Papers rated as high ‘weight of evidence’

Figure 2.2. Contingencies for therapist-nurse communication



The quality of relationships: Need, capacity and opportunity are all related to the quality of relationships. The reviewed studies commonly referenced the importance of personal relationships but most directed limited interpretative attention towards why they matter. The central position of quality of relationships in the diagram illustrates the key role of this contingency; it influences, and is influenced by, the other three contingencies.

Need: Communication is more likely if parties see a need to give or receive information. Although the need to *give* information is central to the therapist role, nurses' need to *receive* the information that therapists offer is related to how they conceive their rehabilitation role and immediate need. For example information that is related to safe execution of physical care, such as the number of staff needed to transfer the patient to a chair, has a clear relationship to the job at hand, whereas more nuanced information from therapists may have a less evident fit with safe and

expedient execution of nursing tasks. Viewed through the lens of need, the literature provides little clarity with regard to what information nurses need to give and what therapists need to receive. This is important because when it is unclear whether and how tasks are interdependent it is difficult to see a purpose for interprofessional working [8]. Without need there is little clinical motivation for professionals to seek each other out, and reduced opportunities to develop good quality working relationships.

Capacity: Communication relies on having the capacity to attend to, hold, and use information in informal and formal interactions and in written information. Capacity is particularly influenced by the pressures of time, but also by shared understanding of terminology, the problem at hand and rationales for doing things in specified ways. To a limited extent therapists and nurses have potential to expand capacity, through reprioritization of other demands. However when time is pressured or when professionals feel undervalued, the decision to adjust priorities to meet the agenda of another professional, or attend team meetings, is likely to be influenced by perceptions of need for the information, the quality of relationships and the prevailing culture with respect to reciprocity, or give and take.

Opportunity: Opportunities to communicate are increased when therapists and nurses share space on the ward, in meetings and in training. Opportunity is more likely to result in engagement if there is a need to communicate or where there is a personal relationship, and when capacity is not overly constrained by other demands. The opportunity to share written information is dependent on timely access to documentation.

Discussion

This synthesis has afforded a valuable opportunity to bring interpretative attention to the process of communication as it is operationalized at the boundaries between therapist and nurse professional practice. It is remarkable how little has changed over the eighteen years covered by the reviewed studies, hence the importance of this new lens for making visible the work accomplished by communication and the contingencies that underpin effective communication. The contingencies of need, capacity, opportunity and the quality of relationships reflect both the transactional and interactional purposes of communication [13,49]. That is, purposes and processes of knowledge sharing need to be considered within a relational context, hence the central positioning of quality of relationships amongst the contingencies.

The relational context tends to be reflected in the structures of teamwork, such as scheduled interprofessional meetings [18], or with respect to the opportunities created by the built environment for therapists and nurses to interact on the wards [1,2]. However much of what creates the relational context is less tangible, and this may be why relationships tend to be lightly conceptualized in the literature. By considering quality of relationships at the intersections of the contingencies of need, capacity and opportunity, this synthesis has made it possible to bring substance to some of the more abstract aspects of relational context, for example, at times of reduced capacity a personal decision by a therapist or nurse for whether or not to attend a team meeting is likely to be related to perceptions of genuine need to give and receive information, as well as perceptions of the relational environment, that is the respect and attention afforded to the information to be shared.

The transactional reason professionals share knowledge is to 'get the job done', and for therapists the job is not complete until their imparted recommendations are enacted [50]. Nurses tend to integrate recommendations into tasks on a 'time permitting' basis [17], unless dismissing a request would place the patient at risk [38]. Therapists are thus dependent on nurses, and this implies a relational imperative for them to create the conditions by which nurses are disposed to carry out what they advise. They need to demonstrate how their recommendations improve patient care, to encourage nurses to accommodate the request within their other demands. For the nurse at the bedside, the information needs for getting the job done tend to relate to what is needed for the current patients on the current shift. This creates a point of difference with the therapists (and more senior or specialist nurses) who retain responsibility for the same patient over their stay on a ward [21,50]; therapists convey information that is expected to travel across different nurses over several shifts [23]. This temporal distinction may underpin some of the tensions that have been reported in expectations of other. It also creates a challenge to relationship building, as each new encounter around patient management may be with a new nurse.

Information sharing in most UK NHS hospitals occurs in a context of staffing shortages for both nurses and therapists [51]. Nurses' role at the centre of patient care places particularly high demands on their information load due to frequent interruptions of their work by multiple professionals [52]. There are thus limits to the extent to which therapists can negotiate with nurses to stretch capacity to meet their specialist agenda. Therapists also operate under capacity constraints, for example lists of patients awaiting assessment and treatment [1], less visible demands such as discharge

planning [53], and covering multiple sites [22]. However there is perhaps scope for therapists to go some way towards helping nurses, particularly when patients have 'nursing needs' within a therapy session that therapists have the skills to address [38], and such acts of mutuality have potential to benefit the therapist nurse relationships [54].

The most positive study in the review indicated that a discursive culture was facilitated by the combination of organization-level commitment to joint working and learning, and therapists spending time on the wards [1]. Education and training are commonly suggested as ways of bringing therapist and nurse agendas into closer alignment, however preparing and attending training is impacted by capacity constraints, with nurses in particular reporting difficulties in leaving the ward to participate in training [55]. Training cannot therefore be expected to improve team communication without also considering the context of team functioning as a whole [22]. West and Lyubovnikova [8] distinguish between what they call 'pseudo-like groups' and 'real teams'; one of the characteristics of 'real' teams is that they apply regular reflexive attention to how they are performing. Reflexive review by teams of how they are communicating has the potential to help professionals better understand where they need to direct their attention if they want to improve interprofessional performance. Different teams require different levels of intensity of collaboration in relation to client complexity [56]. Hence the contingencies can be considered in specific ways in relation to the particular goals of particular teams. It is suggested that framing discussion around the contingencies of need, capacity, opportunity and quality of relationships creates more possibilities for change than the negative attention to aspects such as role value reported in much of the interprofessional literature.

Limitations

This study has responded to the call for more transparency in reporting in meta-ethnography [30]; quality appraisal decisions were made using a new weight of evidence matrix, and the contribution of interpretations to the synthesis were clearly reported. However a great deal of time was expended in this direction, and the benefits of weighting evidence are not clear. Three studies were rated as having high weight of evidence, yet one of these [41] contributed very few interpretations (table 5), although this study's unique location in a mental health setting with therapists as 'visitors' did provide a valuable difference in perspective. Distinguishing papers according to how 'key' they are to the research question may have more merit as a criterion [36],

however it was the process of the synthesis that highlighted which papers were key, thus making this alternative approach challenging to implement. The value of weighting of the papers for evidence was more clear cut in supporting identification of those papers that did not have sufficient conceptual clarity to be entered into the translation process.

A further limitation is that physiotherapists, occupational therapists and speech and language therapists were treated as a group in this study. Whilst the identified therapies share an orientation towards information giving, they operate under different ethical frameworks and professional hierarchies. Further research would be expected to reveal professional differences in the impact of the contingencies on communication. This could be extended to other professional interfaces, such as with medics or social workers. It would also be of interest to research the contingencies in other settings, such as primary care or nursing homes. A final limitation relates to membership of the research team, of which two are speech and language therapists by profession, and this is likely to have influenced interpretations. The third researcher is a health geographer who has worked in nursing as a researcher and educator for 20 years. Although she is not a trained nurse, her experience enabled her to provide challenge to therapist-centric viewpoints. Physiotherapist or occupational therapist researchers may have reached different interpretations.

Conclusion

This synthesis has generated new understanding of the specific role of communication in the interprofessional work of therapists and nurses, and the contingencies that underpin it. Effective communication between therapists and nurses depends on there being a genuine need to give and receive information for patient care, the capacity to attend to, hold, and use information, and opportunities to share space to enable communication to occur. Good quality relationships are the glue that holds these contingencies together. Conceptualising communication in this way creates a new structure that has the potential to support disciplinary engagement in creative thinking about how to improve collaboration for optimal patient care.

Declaration of interest

The authors report no conflicts of interest.

References

[1] Clarke DJ. Achieving teamwork in stroke units: The contribution of opportunistic dialogue. J Interprof Care. 2010;24(3):285-297.

[2] Nugus P, Greenfield D, Travaglia, J et al. How and where clinicians exercise power: Interprofessional relations in health care. Soc Sci Med. 2010;71(5):898-909.

[3] Reeves S, Lewin, S, Espin, S. Interprofessional teamwork for health and social care. Online: Blackwell; 2010.

[4] Stroke Unit Trialists' Collaboration. Organised inpatient (stroke unit) care for stroke. Cochrane Database Syst Rev. 2013;9:CD000197.

[5] Khan F, Turner-Stokes L, Ng L, Kilpatrick T. Multidisciplinary rehabilitation for adults with multiple sclerosis. Cochrane Database Syst Rev. 2007;2:CD006036.

[6] Strokeaudit.org [internet]. UK. [cited 2018 Jun 14]. Available from: https://www.strokeaudit.org/results/Organisational/National-Organisational.aspx

[7] D'Amour D, Ferrada-Videla M, San Martin Rodriguez L et al. The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. J Interprof Care. 2005;19(S1):116-131.

[8] West MA, Lyubovnikova J. Illusions of team working in health care. J Health Organ Manag. 2013;27(1):134-142.

[9] Petri L. Concept analysis of interdisciplinary collaboration. Nurs Forum. 2010;45(2):73-82.

[10] Croker A, Higgs J, Trede F. What do we mean by ‘collaboration’ and when is a ‘team’ not a ‘team’? Qual Res. 2009;9(1):28-42.

[11] Suter E, Arndt J, Arthur N et al. Role understanding and effective communication as core competencies for collaborative practice. J Interprof Care. 2009;23(1):41-51.

[12] Dixon-Woods M. Why is patient safety so hard? A selective review of ethnographic studies. J Health Serv Res Policy. 2010;15(1 suppl):11-16.

[13] Manojlovich M, Squires JE, Davies B et al. Hiding in plain sight: Communication theory in implementation science. Implement Sci. 2015;10(1): 58.

[14] Colyer HM. The construction and development of health professions: Where will it end? J Adv Nurs. 2004;48(4):406-412.

[15] Engel J, Prentice D. The ethics of interprofessional collaboration. Nurs Ethics. 2013;20(4):426-435.

[16] McCallin A, Bamford A. Interdisciplinary teamwork: Is the influence of emotional intelligence fully appreciated? J Nurs Manag. 2007;15(4):386-391.

[17] Clarke DJ. Nursing practice in stroke rehabilitation: Systematic review and meta-ethnography. J Clin Nurs. 2014;23(9):1201-1226.

[18] Burton CR, Fisher A, Green TL. The organisational context of nursing care in stroke units: A case study approach. Int J Nurs Stud. 2009;46(1):85-94.

[19] Miller K, Kontos PC. The intraprofessional and interprofessional relations of neurorehabilitation nurses: A negotiated order perspective. J Adv Nurs. 2013;69(8):1797-1807.

[20] Seneviratne CC, Mather CM, Then KL. Understanding nursing on an acute stroke unit: Perceptions of space, time and interprofessional practice. J Adv Nurs. 2009;65(9):1872-1881.

[21] Carpenter C. Dilemmas of practice as experienced by physical therapists in rehabilitation settings. Physiother Can. 2005;57(1):63-76.

[22] Smith-Tamaray M, Wilson L, McAllister L. Factors affecting dysphagia management and compliance with recommendations in non-metropolitan healthcare settings. Int J Speech Lang Pathol. 2011;13(3):268-279.

[23] Dowswell G, Forster A, Young J et al. The development of a collaborative stroke training programme for nurses. J Clin Nurs. 1999;8(6):743-752.

[24] Britten N, Campbell R, Pope C et al. Using meta ethnography to synthesise qualitative research: A worked example. J Health Serv Res Policy. 2002;7(4):209-215.

[25] Atkins S, Lewin S, Smith H et al. Conducting a meta-ethnography of qualitative literature: Lessons learnt. BMC Med Res Methodol. 2008;8(1):21.

[26] Noblit GW, Hare RD. Meta-ethnography: Synthesizing qualitative studies. Newbury Park (UK): Sage; 1988.

[27] Campbell R, Pound P, Pope C et al. Evaluating meta-ethnography: A synthesis of qualitative research on lay experiences of diabetes and diabetes care. Soc Sci Med. 2003;56(4):671-684.

[28] Toye F, Seers K, Allcock N et al. 'Trying to pin down jelly' - exploring intuitive processes in quality assessment for meta-ethnography. BMC Med Res Methodol. 2013;13(1):46.

[29] Glaser BG, Strauss AL. The discovery of grounded theory: Strategies for qualitative research. Chicago (IL): Aldine; 1967.

[30] France EF, Ring N, Thomas R et al. A methodological systematic review of what's wrong with meta-ethnography reporting. BMC Med Res Methodol. 2014;14:119.

[31] Walsh D, Downe S. Appraising the quality of qualitative research. Midwifery. 2006;22;108-119.

[32] Casp-uk.net [Internet]. UK. [cited 2018 Jun 14]. Available from: https://casp-uk.net/referencing/

[33] Bridges J, Nicholson C, Maben J et al. Capacity for care: meta-ethnography of acute care nurses experiences of the nurse-patient relationship. JAN. 2013:69(4):760-772.

[34] Malpass A, Shaw A, Sharp D et al. "Medication career" or "moral career"? the two sides of managing antidepressants: A meta-ethnography of patients' experience of antidepressants. Soc Sci Med. 2009;68(1):154-68.

[35] NVIVO 11. QSR International Pty Ltd; 2015.

[36] Toye F, Seers K, Allcock N et al. A synthesis of qualitative research exploring the barriers to staying in work with chronic musculoskeletal pain. Disabil Rehabil. 2016;38(6):566-572.

[37] Pryor J. A nursing perspective on the relationship between nursing and allied health in inpatient rehabilitation. Disabil Rehabil. 2008;30(4):314-322.

[38] Apesoa-Varano E. Interprofessional conflict and repair: A study of boundary work in the hospital. Sociol Perspect. 2013;56(3):327-349.

[39] Tyson SF, Burton L, McGovern A. Multi-disciplinary team meetings in stroke rehabilitation: An observation study and conceptual framework. Clin Rehabil. 2014;28(12):1237-1247.

[40] Lewin S, Reeves S. Enacting 'team' and 'teamwork': Using Goffman's theory of impression management to illuminate interprofessional practice on hospital wards. Soc Sci Med. 2011;72(10):1595-1602.

[41] Deacon M, Cleary M. The reality of teamwork in an acute mental health ward. Perspect Psychiatr Care. 2013;49(1):50-57.

[42] Miller K, Reeves S, Zwarenstein M et al. Nursing emotion work and interprofessional collaboration in general internal medicine wards: A qualitative study. J Adv Nurs. 2008;64(4):332-343.

[43] Atwal A. Nurses' perceptions of discharge planning in acute health care: A case study in one British teaching hospital. J Adv Nurs. 2002;39(5):450-458.

[44] Long AF Kneafsey R, Ryan J et al. The role of the nurse within the multi-professional rehabilitation team. J Adv Nurs. 2002;37(1);70-78.

[45] Pellatt GC. Perceptions of interprofessional roles within the spinal cord injury rehabilitation team. Int J Ther Rehabil. 2005;12(4):143-150.

[46] Dalley J, Sim J. Nurses' perceptions of physiotherapists as rehabilitation team members. Clin Rehabil. 2001;15(4):380-389.

[47] Waters KR, Luker KA. Staff perspectives on the role of the nurse in rehabilitation wards for elderly people. J Clin Nurs. 1996;5(2):105-114.

[48] Pound P, Ebrahim S. Rhetoric and reality in stroke patient care. Soc Sci Med. 2000;51(10):1437-1446.

[49] Brown G, Yule G. Discourse analysis. Cambridge (UK): Cambridge University Press; 1983.

[50] Cott C. Structure and meaning in multidisciplinary teamwork. Sociol Health Illn. 1998;20(6):848-873.

[51] The NHS workforce in numbers [Internet]. (2018). Nuffield Trust. [cited 2018 Jun 14]. Available from: https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers

[52] Hall LM, Ferguson-Pare M, Peter E et al. Going blank: Factors contributing to interruptions to nurses' work and related outcomes. J Nurs Manag. 2010;18(8):1040-1047.

[53] Taylor E, McKevitt C, Jones F. Factors shaping the delivery of acute inpatient stroke therapy: A narrative synthesis. J Rehabil Med. 2015;47(2):107-119.

[54] Kraft M, Blomberg K, Hedman A et al. The health care professionals' perspectives of collaboration in rehabilitation: An interview study. Int J Older People Nurs. 2014;9(3):20916.

[55] Clarke DJ, Holt J. Understanding nursing practice in stroke units: A Q-methodological study. Disabil Rehabil. 2014:1-11.

[56] Careau E, Brière N, Houle N et al. (2015). Interprofessional collaboration: Development of a tool to enhance knowledge translation. Disabil & Rehabil. 2015;37(4):372-378.

*** *End of Published Paper* ***

2.3 The Contingencies and the SLT-Nurse Professional Boundary

The line of argument developed through the meta-ethnography was that effective therapist-nurse communication is contingent upon need for information, capacity, opportunity and the quality of relationships. This section provides a bridge with the next chapter by indicating where existing literature supports application of the contingencies to the clinical interests that SLTs and nurses have in common, and indicates gaps in knowledge that this thesis is intended to fill.

Need for Information: The meta-ethnography indicated that therapist-nurse communication is needed for the purpose of task completion, that more nuanced information is a less immediate need, and that whilst therapists have a clear sense of needing to give information, there is less clarity about what information therapists need to *receive* from nurses (Barnard et al., 2018). Chapter three reviews literature directed towards improving care for patients with communication and swallowing difficulties. This literature mainly considers the associated information sharing need in terms of training. For example, SLT need to give communication information focuses almost entirely on educating nurses so they can support patients when communicating with them (Horton & Pound, 2018). No corresponding need was identified from nurses to share their disciplinary knowledge about patients' communication needs with other professions. This thesis seeks to address a gap in knowledge of the routes through which SLTs and nurses currently share information, and the extent to which information is viewed as a need for managing communication and swallowing.

Capacity: The meta-ethnography showed that the capacity to hear, hold and use information was related to time, but also to perceptions of need for information, relationships and reciprocity (Barnard et al., 2018). Previous research has mostly considered capacity for interprofessional exchange from the perspective of nurses. However, reduced nurse capacity presents a challenge for therapists when they want to share information that may not be perceived as imperative for the immediate execution of nursing tasks (Barnard et al., 2018). Existing research does not provide insight into how SLTs orient to nurses' capacity constraints, thus little is known about how SLTs manage their information sharing needs in the context of nurses' orientation to the here and now. New knowledge is needed to understand how nurses' capacity constraints may impact on SLTs' own capacity to navigate routine sharing of information about communication and swallowing. Chapter three explores consideration for nurses' roles with communication across *all* patients, rather than just those with difficulties. This offers a route towards informing how SLTs position their

particular interest in the communication support needs of patients with communication disabilities in the context of constraints on nurses' capacity to communicate optimally with patients in general (e.g. Chan, Jones & Wong, 2012). The chapter also considers nurses' capacity to attend training and apply learning in the context of competing demands, such as meeting physical care needs and managing multiple patients (Clarke & Holt, 2015; Horton & Pound, 2018).

Opportunity and **Quality of Relationship:** The meta-ethnography indicated that sharing ward space increased opportunities for therapists and nurses to communicate, but that take-up of these opportunities related to need, capacity and quality of relationships (Barnard et al., 2018). There is very little existing literature that sheds light on these contingencies in relation to SLT and nurse information sharing. However, it is evident in the National Clinical Guideline for Stroke that SLTs in the UK are expected to be integral members of acute stroke teams (Rudd et al., 2016). This implies that SLTs have potential opportunities to communicate with nurses through ward presence. Nurse participants in the research studies included in the meta-ethnography tended to talk of all allied health therapists as a single entity (e.g. Pryor, 2008), thus it is unclear how they conceive of their particular relationship with SLTs. There is a gap in knowledge for how SLTs occupy and use the ward as an information sharing space, and the impact of this on their relationships with nurses. Chapter three reviews literature that is suggestive of an underlying level of discord between SLTs and nurses in relation to adherence to swallowing recommendations (e.g. Smith-Tamaray, Wilson & McAllister, 2011).

In summary, consideration for how the contingencies apply to SLTs as distinct from therapists has indicated a number of gaps in knowledge that this thesis aims to address. To recap, new knowledge is needed to understand the routes SLTs and nurses use to share information, the extent to which information is viewed as a need, the impact of nurses' capacity constraints on SLTs' capacity to share information, SLT engagement with the ward as an information sharing space, and the impact of the information sharing context on SLT-nurse relationships. This study considers the contingencies in relation the SLT-nurse dyad and the context of stroke unit care.

3. Clinical Interests in Common: Literature Review

3.1 Introduction

This inquiry lies at the intersection of two areas of research: interprofessional practice in inpatient teams (process), and management of stroke-associated communication and swallowing difficulties (content). This chapter adds further substance to the discussion about process covered in the previous chapter, by drawing attention to *what* SLTs and nurses may have clinical cause to talk to each other about. SLTs and nurses working in stroke unit care both have responsibilities for patients with communication and swallowing difficulties; for SLTs, this is their primary role. However, although there is a great deal of research exploring management of stroke-associated communication and swallowing difficulties in stroke care, such as that which is summarised in reviews of treatment for aphasia (Brady, Kelly, Godwin, Enderby & Campbell, 2016) and dysphagia (Foley, Teasell, Salter, Kruger & Martino, 2008), very little in this research considers communication and swallowing from an explicitly dual SLT and nurse perspective. The focus of the current review on the overlapping interests of the two disciplines required an inclusive approach, informed by broad literature from a range of inpatient settings.

3.2 Search Strategy

Literature for this chapter was first searched and identified using a systemised review approach in July 2016, in preparation for PhD upgrade examination. It was subsequently updated (December 2018) as explained below. A systemised approach involves elements from systematic review processes, but does not reach the same standards for comprehensiveness, transparency and rigour, usually for pragmatic reasons (Grant & Booth, 2009). This was the approach adopted for this review for two reasons. Firstly, a more fluid, iterative approach seemed more useful for making use of literature that is very diffuse, and serves the context of inquiry for this chapter. Secondly it was a pragmatic decision based on time and resource limitations in the context of the overall doctoral study (and in the context of already having published a systematic review and meta-ethnography). The approach is acknowledged as less methodologically rigorous than that reported in the previous chapter. Nonetheless, systematic processes included establishing inclusion criteria, listing the database search terms, and explaining the search strategy adopted. Limited research in the exact area of interest meant it was necessary to expand out to related areas, and this

introduced challenges in determining the boundaries of what to include. The approach taken had similarities to a scoping review, where broad literature is explored in order to identify gaps and map concepts (Peters et al., 2015). However, the aim was to provide an integrated overview of literature in relation to a specific question rather than provide a map of existing literature, thus broad literature was searched in order to increase sensitivity to concepts that were expected to have relevance to the review question: Where do the care interests of SLTs and nurses overlap in stroke unit care?

The following inclusion criteria were applied, with no date limits:

1. Literature written in English.
2. Primary research, literature reviews (systematic and not systematic), discussion papers and service reviews or audits. Opinion pieces and theses were not included.
3. Literature reporting on communication and swallowing in ways that might illuminate the roles or perspectives of SLTs or nurses, and have resonance with acute stroke care.
4. Literature from within any hospital inpatient setting that might have relevance to information sharing in the acute stroke care context.

The latter two criteria relied on judgments from clinical and research experience. Decisions for where to draw boundaries thus required self-governance to resist being overly influenced by presuppositions, particularly as a single researcher (doctoral candidate) made the inclusion decisions. This was addressed by remaining open to what nurses might find relevant, as well as the more familiar SLT interest. Included in the third criterion, for example, was research from nursing reporting on the experience of communicating with patients with limited English proficiency. Although such patients might not have communication disability, the research had the potential to illuminate how nurses navigated a communication barrier, and this was judged to be of potential interest to the SLT perspective. An example of the fourth criterion was papers from within intensive care settings reporting on the experiences of nurses in communicating with ventilated patients who were unable to speak. Three different searches were carried out in the MEDLINE database:

1. [MeSH terms: nurses OR nurse-patient relations] AND [MeSH terms: speech-language pathologists OR speech therapy OR aphasia OR dysarthria OR communicative disorders OR speech disorders OR deglutition disorders OR swallowing therapy'] AND [All text: inpatient OR hospital OR ward OR unit].

2. [Abstract and title variants of speech and language therapy] AND [abstract and title: environment or access] AND [All text: inpatient OR hospital OR ward OR unit].
3. [Abstract and title variants of speech and language therapy] AND [MeSH terms: deglutition disorders or swallowing therapy] AND [All text: inpatient OR hospital OR ward OR unit AND [Abstract and title: teaching OR training OR education].

The initial MEDLINE search raised 502 papers, which were screened by title and abstract against the inclusion criteria. Relevant papers were read in full and hand searched for additional references, using citations and the Scopus database. Further searching was carried out to explore relevant areas in more depth, for example a focused search was conducted to find papers relating to adherence to recommendations in stroke care. Thus identification of literature increased exponentially through the various search strategies. It became unwieldy to continue to audit the search numerically and it was not possible to produce a PRISMA diagram (Moher et al., 2009). The search was repeated on 4th December 2018, and supplemented by further hand searching. The original search was re-run in MEDLINE, and expanded to a second database (CINAHL) to increase coverage. These two databases were selected because they were the main databases where the meta-ethnography literature was indexed.

3.3 Included Literature

In total 67 journal articles were reviewed by full text (see summary table: Appendix 1), of which 43 were about communication and 24 about swallowing. Articles included primary research (45), reviews (10), discussion papers (8), audits (2), service developments (1), and combined audit and service development (1). The disciplines of the primary author were identified on the basis of information provided by the first author to the journal or inferred from the department of the first author. Primary authors were identified as SLT (33), nursing (28), and other health care professional (6). Nationality of origin included: UK (17), Australia (20), USA (13), Canada (4), Ireland (3), New Zealand (2), Denmark (3), Hong Kong (1), Botswana (1), Spain (1), Israel (1), Sweden (1). The vast majority of the papers retrieved reflected SLT or nurse disciplinary interest in communication or swallowing, rather than attending to the interface with the other discipline or the information sharing aspect.

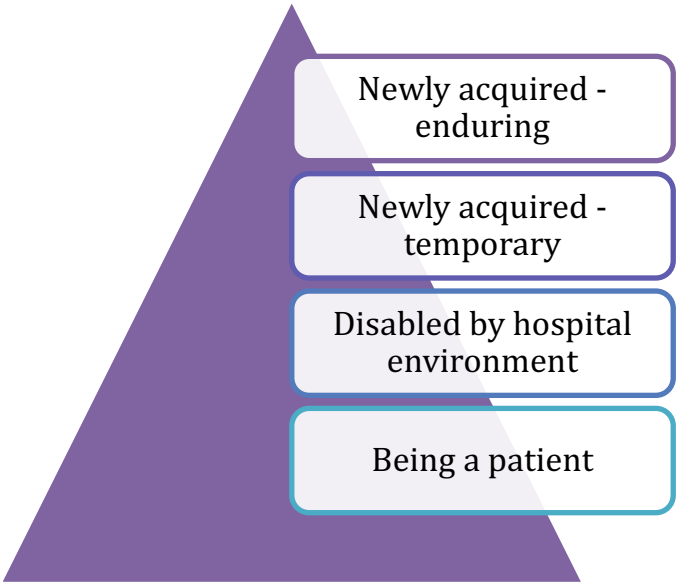
3.4 Introduction to the Communication Literature

The search strategy described above (section 3.2) generated parallel bodies of literature about communication in inpatient hospital care from SLT and nurse perspectives. The 43 communication papers covered the following topics:

- General nurse-patient communication (8): Nurse authored (8).
- Non-stroke communication difficulty (11): Nurse authored (9), SLT authored (2).
- Stroke-associated communication difficulty (20): Nurse authored (6), SLT authored (13), of which 7 were on the topic of communication partner training.
- Mixed stroke and non-stroke communication difficulty (4): SLT authored (4).

During the process of reviewing literature written from disciplinary perspectives, it became apparent that determining *where* SLT and nurse interest in communication difficulty overlapped was complicated by differences in meanings carried by each discipline about patients' communication needs. As discussed in the introductory chapter (section 1.7), it is suggested that people act towards things on the basis of the meanings they ascribe to them (Blumer, 1969). For SLTs, the communication needs of patients have meaning for them in relation to deployment of specialist skills with patients that might appear on their caseload. This varies by client group. In intensive care units this mostly means expressive difficulties associated with respiratory tract intubation (e.g. Magnus & Turkington, 2006), with patients with pre-existing communication impairments, this mostly means the disabling effect of being inhibited in use of communication aids they depend on in their home setting (e.g. Balandin, Hemsley, Sigafoos & Green, 2007), and in stroke care, this mostly means patients with newly acquired aphasia and dysarthria (e.g. Hersh, Godecke, Armstrong, Ciccone & Bernhardt, 2016). For nurses, the communication needs of patients have a much wider meaning, relating to the relational needs of *all* patients, as well as specific communication barriers or restrictions that might impact on their ability to perform nursing tasks or provide compassionate care (e.g. Bridges et al., 2013; Chan et al., 2012). Patients' communication needs in hospital can thus be conceptualised as layered (Figure 3.1). At the base are communication needs associated with relying on others for care in a strange environment. Above are needs that are created or exacerbated by the environment, such as speaking a different language, hearing difficulties, or lack of access to usual devices such as communication aids. The top two layers relate to newly acquired impairments that may be temporary, as with intubation, or enduring, as with stroke-associated communication impairments.

Figure 3.1: Layers of Patients' Communication Need in Hospital



This review of the communication literature commences by exploring the scope of the literature from disciplinary perspectives, followed by discussion of the limiting effect of the hospital as a communication environment. Nurses' capacity for communication with patients is then explored. Finally, the need to share information about stroke-associated communication difficulties across the disciplines is discussed.

3.4.1 Disciplinary Interest in Communication

SLT-authored research that appeared to overlap with nurses' interests included investigations of the communication support needs of patients with communication disabilities in hospital, and training interventions directed at helping HCPs better meet these needs. SLT-authored research into communication support needs explored stroke-associated communication difficulty (e.g. O'Halloran et al., 2011), inability to speak as a consequence of intubation in intensive care (Magnus & Turkington, 2006; O'Halloran, Worrall & Hickson, 2008), lifelong complex communication and intellectual disabilities (Hemsley, Balandin & Worrall, 2011; Lewis, Gaffney & Wilson, 2016;), and combined pre-existing and newly acquired difficulties (e.g. O'Halloran et al., 2011; O'Halloran, Shan Lee, Rose & Liamputtong al., 2014; Hemsley & Balandin, 2014). Research that more explicitly addressed The SLT-nurse interface included several studies exploring the outcomes of communication partner training initiatives for training HCPs on stroke wards (e.g. Horton, Lane & Shiggins, 2016), one study testing the scientific properties of a screening tool for nurses to identify patients with difficulties communicating (O'Halloran, Coyle & Lamont, 2017), and one study that included

discussion of informal information sharing in relation to SLTs informing nurses of communication needs identified through assessment (Foster et al., 2016a).

The scope of nurse-authored research was very wide. Research explored nurses' experiences of providing nursing care for patients with communication difficulties associated with hearing impairment (Funk, Garcia & Mullen, 2018), limited proficiency in English (Ali & Watson, 2017), respiratory tract intubation (e.g. Dithole, Sibanda, Moleki. & Thupayagale-Tshweneagae, 2016), and stroke-associated communication disability (e.g. Gordon et al., 2008). Nurse-authored research also explored communication between nurses and patients who did not necessarily have specific communication difficulties, from perspectives of relational care (e.g. Bridges, Flatley & Meyer, 2010). Two SLT-authored papers from stroke care also adopted a relational perspective: one reported research exploring relational engagement (Bright, Kayes, Worrall & McPherson, 2018), and the second was a discussion paper about humanising care (Pound & Jensen, 2018). The language of relational and compassionate care was more associated with nurse-authored than SLT-authored research.

There were differences with respect to the focus of research interest by each discipline. This mirrors fundamental differences in SLT and nursing scope of practice in relation to the communication needs of patients. SLTs are responsible for patients with conditions that fall within their specialist roles, whereas nurses have responsibility for all patients allocated to them. Additionally, SLTs meet their responsibilities in 'sessions', whilst nurses provide continuous care (Barnard et al., 2018), thus communication is relevant to *all* nursing work. Need for information sharing across the disciplines may only become apparent at the top two layers of the pyramid (Figure 3.1), where communication has disciplinary meaning to SLTs. Even when people with pre-existing communication impairments enter hospital they might not register as relevant to SLT interest when their communication difficulties are not associated with the reason for their acute admission (O'Halloran et al., 2017). Conceptualising communication as layered is helpful for visualising how an acquired communication impairment sits on top of communication difficulties common to most patients that arise out of the experience of relying on others for care (Malone, 2003), and difficulties that may arise when there are additional barriers such as not speaking English (Ali & Watson, 2017) or having pre-existing hearing difficulties (Funk et al., 2018).

Although disciplinary overlap with SLT was not evident in the general nurse-patient communication literature that forms the bottom layer of the pyramid, it provided a foundation for appreciating how issues such as time to communicate (Chan et al., 2012) and forming compassionate, caring relationships (Bridges et al., 2010; Bridges et al., 2013) are relevant as the underlying basis for all communication needs.

Different disciplinary meanings ascribed to patient communication needs may be one reason why there is very little attention in the literature directed towards cross-disciplinary sharing of information about communication. The exception is SLT training of nurses, which will be discussed in section 3.4.5.

3.4.2 The Hospital as a Communication Environment

Research from both SLT and nursing has identified barriers that affect communication between patients and HCPs in hospital. A review of 44 studies indicated that people with different communication conditions in hospital appear to experience similar physical, information and emotional barriers, ranging from access to resources such as communication aids to inadequate skills and knowledge of HCPs for supporting communication (O'Halloran et al., 2008). Interview participants in a study involving former patients (15 people with complex communication and learning difficulties), carers (15) and nurses (15) reported that communication difficulties affected provision of five basic needs: pain, hunger and thirst, comfort, hygiene and nausea, with information and emotional needs also affected, but infrequently addressed (Hemsley et al., 2011). When asked about their roles in rehabilitation, the nursing staff (14) interviewed in a study based on a stroke ward emphasised provision of basic care rather than informational or emotional support for adjustment to newly acquired disabilities (Loft et al., 2017a), whereas reports from patients (10) indicated that what patients needed (and found lacking) from nursing staff was person to person contact and opportunities to share their concerns (Loft et al., 2017b). The largest number of studies in the review by O'Halloran and colleagues came from the critical care setting and the majority were nurse authored which indicates this as a particular area of nurse interest in communication difficulty (O'Halloran et al., 2008). Critical care nurses may look less towards SLTs for help with meeting communication needs because, as indicated in the Guidelines for Provision of Intensive Care Services, SLT presence in these settings is variable in the UK (Materson & Baudouin, 2016).

Communication disturbance for patients in critical care may be temporary and isolated to speech. The emotional difficulties associated with temporary loss of speech are

similar to those associated with more enduring communication difficulties. A systematic review investigating communication challenges between nurses and intubated patients revealed feelings of anxiety, worry and fear by patients when nurses were inattentive or absent (Dithole et al., 2016), with moderate to high levels of psycho-emotional distress associated with inability to speak (Khalaila et al., 2011). Such challenges are likely to be exacerbated when receptive language or cognitive abilities are also impaired, and where patients face the prospect of living with communication disability (Clancy et al., 2018; Gordon et al., 2008; Hersh et al., 2016; Pound & Jensen, 2018). Acquired, enduring difficulties have thus been represented in Figure 3.1 as the highest layer of communication need.

Since publication of the Accessible Information Standard (NHS England, 2017), NHS organisations are legally required to provide accessible information to meet information and support needs relating to disability, impairment or sensory loss. The Standard 'directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting' these needs, and includes specific guidelines for implementation (NHS England, 2017:10). *Identifying* (communication) disability is a role that crosses both disciplines. This role is recognised in recent research developing a nurse-completed screening tool intended for early identification and to facilitate information sharing with SLT following referral (O'Halloran et al., 2017). Literature reviews considered for this review that related to accessibility of the ward for people with communication difficulties indicate that changes in practice would be needed to fulfil the Standard's aim for organisations to *meet* information and support needs. Changes in practice recommended by the literature included: training for HCPs about different communication disabilities and overcoming communication barriers (O'Halloran et al., 2008); training for nurses to assess and adapt communication for the benefit of patients that are unable to speak due to intubation (Dithole et al., 2016), and pre-registration training and continuing professional development to prepare nurses for communication with people with intellectual disabilities (Lewis et al., 2016). In addition, research was recommended to enact and evaluate strategies known to improve the experience of communication in the hospital environment (Hemsley & Balandin, 2014), and to establish whether providing training for healthcare professionals to act as communication partners is effective in acute settings (Simmons-Mackie, Raymer & Cherney, 2016).

Common to many communicatively vulnerable populations in hospital is a tendency to become more passive or withdraw, rather than engage in distressing communication

encounters (Funk et al., 2018; Magnus & Turkington, 2006; Pound & Jensen, 2018; Thompson & McKeever, 2014), and withdrawal is likely to impact on satisfaction with, and outcomes of care. It has been suggested that effects such as these can be countered by directing attention to the relational 'atmosphere' as a means of improving engagement (Bright et al., 2018:982). A systematic review and meta-synthesis of the acute care experiences of older adults indicates that the communication environment is essentially a relational environment, with components that include attention to personal connection, identity and involvement in decision making (Bridges et al., 2010). Even in the absence of communication disability patients commonly experience reliance on strangers in the unfamiliar setting of the hospital as an uncomfortable loss of control (Malone, 2003). It is therefore unsurprising that specific barriers to communication can exacerbate such feelings. Patients act in ways that are responsive to the relational environment, for example older people with hearing impairments (n=8) reported that they responded to verbal and non-verbal cues from staff to decide whether or not they would disclose their impairment (Funk et al., 2018). Observations with staff (5 SLTs, 7 nurses, and 16 other stroke clinicians), and patients with aphasia (3) during their usual care indicated that feeling known and heard were considered important influences on patient engagement (Bright et al., 2018). Engagement was accomplished through supported, two way person-to-person communication (Bright et al., 2018). The relational environment thus requires reciprocity (Bridges et al., 2010), and when patients have no expectation that difficulties will be accommodated they may disconnect from participating in their care (Funk et al., 2018).

Being a patient in hospital is challenging to all patients, not just those with disorders of communication (O'Halloran et al., 2014), thus the responsibility for creating more inclusive environments for communication extends beyond SLT interest in specific populations (O'Halloran et al., 2014). Nurses have more sustained contact with patients than other disciplines and thus play a heightened role in patients' experience of the relational environment. Research collaboration across disciplines has been suggested as a means of widening attention to the hospital as a communication environment for all patients (O'Halloran et al., 2008). The new legal requirement as stated in the Standard (NHS England, 2017) may provide an impetus for such collaborations in the future. The nature of nursing work brings substantial challenges to nurses' capacity to communicate optimally with patients (with and without communication difficulties) however, and these are considered in the next section.

3.4.3 Nurse Capacity for Communication

This section explores research studies that inform the complex interplay between time, task performance, care provision and emotion, in addition to the relationship between these factors and the capacity of nurses to communicate optimally with patients. Nurses frequently cite lack of time as a barrier to achieving high standards of communication, despite a stated desire to get to know their patients (Bridges et al., 2013; Chan et al., 2012; McCabe, 2004; Radtke et al., 2012). A particularly rich exploration of time and its relationship with care and communication was achieved in a study involving three repeated narrative interviews across a year, with five nurses (Chan et al., 2012). Participants in this study reported complex reasons for prioritising task completion over talking with patients. For example, collegial relationships made nurses unwilling to leave unfinished work for their colleagues on the next shift to complete. The reflections of one nurse: 'they will be upset because you have spent time on triviality' (Chan et al., 2012:2023), illustrates the impact of nurses' accountability to the next shift, and suggests that when it came to handover, nursing work in communication with patients was not viewed as equivalent to the work of completing tasks.

The pressure of time is a very real influence on nursing work, particularly in the context of significant NHS staff shortages (Nuffield Trust, 2018; Royal College of Nursing, 2017). However perceptions of time can be subjective, and patients have been found to respond well to clinicians who create the *impression* of time through their manner, even when actual time is scarce (Thorne, Hislop, Stajduhar & Oglov, 2009). Provided that task focus is balanced with human connection, patients have been found to be quite accepting of time constraints on nurses (McCabe, 2004). Patients (8) admitted to a teaching hospital in Ireland were interviewed in a phenomenological study, and most reported that small acts of attention, empathy, humour and engagement made communication feel more person-centred, even when completed within the context of the busyness of task completion (McCabe, 2004). Performing nursing tasks *and* attending to personhood are thus not necessarily mutually exclusive, and physical proximity can be used as a route to other kinds of proximity, including being there and advocating for the patient, understanding them and hearing their story (Malone, 2003).

Nurses do often use the opportunity of task performance to spend time creating a therapeutic relationship (Chan et al., 2012). However when nurses have restricted time within which to complete multiple tasks they are more likely to perform them in habituated ways, impacting on their capacity for personal connection (Chan et al.,

2012). Observational studies included in this review indicate that the additional demands of barriers to communication exacerbate these effects. Gordon and colleagues used conversation analysis to explore interaction between nurses and patients with aphasia (4) and dysarthria (1) and concluded that nurses were often focused on the task at hand, exercised control over topic, and limited patients' response options to those that fit with their agenda (Gordon et al., 2008). Another in-depth study compared video-recorded interactions between nursing staff and three patients (two with aphasia and one without) and found that interactions with all three patients were mostly centred on physical care (Hersh et al., 2016). However interactions with patients with aphasia were particularly constrained, and rarely went beyond responses to closed questions, or involved attempts by nurses to support more expansive participation (Hersh et al., 2016). A study involving observer-rated video recordings of nurses (10) in interaction with non-speaking patients (30) in critical care indicated that interaction was mostly focused on care tasks, and nurses rarely used strategies to support communication (Happ et al., 2011). The direct impact of lack of communication success on provision of care was revealed in relation to pain, which was rated as being unsuccessfully communicated 37.7% of the time (Happ et al., 2011).

Although nurses face very real constraints on time, other factors also influence how they engage with patients. It has been suggested that when interaction is uncomfortable, nurses are inclined to assume a sense of control by focusing more on execution of care tasks than the person before them. Adopting a controlling role may be a response to feeling inadequately knowledgeable or skilled in supporting communication (Gordon et al., 2008; Hersh et al., 2016; Radtke et al., 2012). Because communication is reciprocal, barriers that impact on provision of relational care are distressing to nurses as well as patients (Bridges et al., 2013). Patients have reported that forming relationships with staff is a way in which they attempt to exercise control in hospital (Williams, Dawson & Kristjanson, 2008). However, language impairments disrupt these usual ways of connecting and shift responsibility for the interaction to the HCP. A narrative review of nurses' experiences of caring for people with intellectual disabilities indicated that they did not feel prepared for communication with this group, threatening their confidence and leading them to experience feelings of vulnerability and awkwardness (Lewis et al., 2016). Nurses can lose confidence for working with patients with stroke-associated communication needs if unsuccessful encounters cause them to perceive themselves as lacking in competence. This can create a cycle where they fear further attempts at communication (Horton et al., 2016; Jones, O'Neill,

Waterman & Webb, 1997; Pound & Jensen, 2018). One of the nurses interviewed in a study based on a stroke rehabilitation ward, reported that unsuccessful attempts at communication could lead them to pass the patient to another colleague perceived as more competent in communication (Jones et al., 1997). However, when a question about avoidance was asked through a survey instrument on an acute stroke ward, nursing staff did not agree that they avoided communication with patients with aphasia (Jensen et al., 2015). This suggests that avoidance may occur at different levels that are difficult to discern through a survey instrument. For example communication may occur for the purposes of meeting the five basic needs discussed earlier (Hemsley et al., 2011), but be avoided for humanising purposes (Loft et al., 2017b; Radtke et al., 2012). It is therefore likely that if nurses question their competence in communicating with patients with difficulties, the way they act will be complex and varied. It is important to be aware that a tendency to focus on task is not just true of nurses; all stroke-care practitioners have been found to control the content and conduct of talk, with some more skilled than others at doing this in ways that also nurture the therapeutic relationship (Bright et al., 2018).

3.4.4 Bridging the Disciplines

SLT researchers have begun to broaden consideration of communication beyond introduction of SLT-led strategies for supporting communication, into relational or humanising aspects of care (Bright et al., 2018; Pound & Jensen, 2018). This helps conceptualise supporting communication as an *approach to care* that has potential to bridge SLT and nursing interest in meeting communication need. Understanding that reciprocity in communication relies not only on language (Jones et al., 1997), but also on other means of establishing connection, opens up an under-exploited space for SLTs and nurses to view communication as an area where both disciplines have specific expertise. Nursing expertise is illustrated in the findings of a qualitative observational study that revealed the use of a range of communication skills by nurses who were judged by their peers to be skilled at communicating with patients with aphasia (Sundin & Jannson, 2003). The five nurses in the study were video recorded whilst completing morning care tasks with three patients, and what was striking was how incidental spoken language was to the encounters. Successful communication was characterized by attentiveness, interest and respect, communicated through mirroring of body language and tone, use of touch, and comfortable silences (Sundin & Jannson, 2003). This highlights the importance of attending to personhood, and this is also evident in other research that emphasises that qualities such as kindness, respect or connection are critical to meeting patients emotional and existential needs (Bridges

et al., 2010; Bright et al., 2018; Loft et al., 2017b).

Relational skills are critical to patients' experience of care, however supplementary skills are needed for HCPs to effectively support patients with communication difficulties to be active agents in their own care (Nystrom, 2009). Experience alone does not appear to be sufficient to equip professionals for effective communication in the context of disability (Horton et al., 2016; O'Halloran et al., 2011). O'Halloran and colleagues observed interactions between 43 patients and their healthcare teams (unspecified numbers of doctors, nurses, AHPs and others) on two stroke units (O'Halloran et al., 2011). The authors presented several examples where communication attempts were impeded by limitations in knowledge or awareness of the communication disability, insufficient skills for supporting communication, and the attitudes of professionals towards respectful care (O'Halloran et al., 2011). Communication difficulties can make nursing tasks more difficult, for example locating pain (Fry, Arendts & Chenoweth, 2017), knowing when patients need the toilet (Clancy et al., 2018; Hemsley, Werninck & Worrall, 2013), or involving patients in decisions (Hemsley & Balandin, 2014). Thus in addition to relational skills, specific strategies are also needed to help patients process incoming information and successfully get their messages across (Heard, O'Halloran & McKinley, 2017). The next section explores how SLTs have addressed patients' need for others to use strategies to support them to communicate in hospital.

3.4.5 Information Sharing as a Need

The reviewed literature that referenced SLT-nurse information sharing was almost exclusively directed towards SLT-led training for HCPs. Attention to training is compatible with professional obligations for *sharing* and *flagging* information about the information and support needs of patients, as stated in the Accessible Information Standard (NHS England, 2017). Two of the reviewed studies also included minor references to factors associated with documentation of communication information through the patient record (Clancy et al., 2018; Juve-Udina et al., 2014), which relate to the requirement in the Standard that information and support needs are *recorded* (NHS England, 2017). References to information sharing through documentation in the reviewed studies were peripheral to the key findings; they included a quote from a nurse indicating lack of understanding of language used by SLT in the patient record (Clancy et al., 2018) and a retrospective chart review, which reported on brevity of entries in the patient record about psychosocial needs (Juve-Udina et al., 2014). Another study included perspective from interviews with SLTs (14) in which one

participant reported that written signage at the bedside was provided for swallowing but not communication (Foster et al., 2016a). Overall however, the reviewed research added little to understanding for the role of documentation as a route for sharing information about patients' communication across professional groups. The main need for information sharing was reflected in reports of SLT-led training, with no corresponding literature identified reporting a need from nursing to share the knowledge that nurses hold about patients' communication needs with other professionals.

The primary training intervention reported was communication partner training (CPT). CPT is based on the premise that the communication partner can reveal the competence of a person with aphasia by adapting how they communicate (Kagan, 1995). CPT refers to assorted training initiatives defined as 'a form of environmental intervention in which people around the person with aphasia learn to use strategies and communication resources to aid the individual with aphasia' (Simmons-Mackie et al., 2016:2202). A recent narrative synthesis of CPT interventions revealed consistency in their purpose for increasing awareness and knowledge, and identification and practice of strategies, but much variability in how CPT is reported and executed (Cruice, Blom Johansson, Isaksen & Horton, 2018). Within healthcare settings CPT is most commonly delivered by SLTs, to groups of professionals in teaching interventions that can involve several hours of education (Cruice et al., 2018). The time commitment for training may be one reason why the proportion of nurses involved in CPT interventions is quite variable. In one study, 6 of the 37 HCP participants were nurses (Simmons-Mackie, O'Neill, Huijbregts, McEwen & Willems., 2007), whilst in another 18 of the 28 HCPs were nurses or nursing assistants (Horton et al., 2016). Even an abridged version of the training involving an hour of face to face teaching and e-learning presented challenges for nurse attendance (Heard et al., 2017).

The challenges involved in CPT interventions are particularly evident in acute settings where priorities are weighed towards meeting the needs of severely ill patients during short admissions, in a rapidly changing clinical setting (Jensen et al., 2015; Simmons-Mackie et al., 2007). Lack of time has been considered to be a significant barrier to transfer of learning from CPT by HCPs (Horton et al., 2016; Jensen, et al., 2015), with another barrier potentially related to contradictions between what is learnt in the 'classroom', and in-the-moment realities of care-giving (Horton & Pound, 2018). All seven nursing participants in one study based on an acute stroke ward in Denmark reported difficulties in transferring the learning into practice; the words of one nurse

were particularly revealing when she suggested that her 'dream scenario' was having twenty minutes to explain the plan for her care that day (Jensen et al., 2015:70).

The nature of the tasks nurses need to perform may in themselves be a barrier to using taught techniques to support communication, a point that resonates with how the nurses (59) in a study of language barriers discussed their experiences of using foreign language translators (Ali & Watson, 2017). Participants considered translators helpful for explaining specific information, but of less value for more routine interactions, especially in the context of other factors such as patients being in pain or anxious (Ali & Watson, 2017). Also relevant to this discussion are the challenges reported by critical care nurses (6) in incorporating taught communication techniques into nursing routines (Radtke et al., 2012). It was the nurses who received ongoing support from SLT that felt most able to implement what they had learned (Radtke et al., 2012).

Despite research interest in CPT, it has had limited uptake as an intervention of choice by SLTs (Heard et al., 2017; Simmons-Mackie et al., 2016), and findings from systematic review indicate that outcomes are less positive in acute than chronic stages of care (Simmons-Mackie et al., 2016). Several of the studies included in this review concluded with recommendations for training as a means of improving patients' experience of communication in hospital. There was almost no equivalent emphasis on routine ways through which SLTs and nurses might share information during their everyday work on the wards. The only reference to the informal route was through an interview study with SLTs (14) in which SLTs reported the importance of conveying assessment-derived advice to nurses, however discussion did not extend to how enactment of this advice was supported (Foster et al., 2016a). More knowledge is needed to understand how SLTs meet the expectation that they provide education and support the competence of other professionals, as outlined in stroke care guidelines (Rudd et al., 2016).

3.4.6 Summary

The reviewed literature indicated that SLTs and nurses have common interests in the communication needs of patients, but that there is limited overlap in execution of these interests in their clinical work. Further research is needed to understand how SLTs and nurses conceptualise their work with communication as a basis for understanding *whether* and *where* cross-disciplinary interests lie, and whether increased information exchange between the disciplines could benefit patients' experience of communication in hospital. Research is also needed to better understand how time and capacity

impact on giving and receiving information about communication by both disciplines, in the context of competing priorities and the fast-paced context of acute care.

3.5 Introduction to the Swallowing Literature

The search strategy for the swallowing literature (section 3.2) generated literature with more obvious areas of overlap in clinical interest than the communication literature. As a consequence, there was not the same need to draw on the full range of settings and the included literature relates to dysphagia (swallowing difficulties) of neurogenic origin. The 24 included papers covered topics relating to dysphagia identification (11) and management (13). SLTs and nurses were represented equally in authorship of identification papers (five each, and one doctor-authored). The majority of the management papers were SLT authored (9), with the remainder authored by dietician (2), doctor (1) and OT (1). The balance of included papers indicates that nurse interest in dysphagia relates to their roles in swallow screening.

3.5.1 Identifying Dysphagia

The literature focused on identifying dysphagia directed almost no attention to processes of interaction associated with SLT and nursing roles. Much of this literature related to validation and reliability of screening tools (e.g. Edmiaston, Tabor Connor, Loehr, & Nassief, 2010; Weinhardt et al., 2008), and the relationship between screening and incidence of stroke-associated pneumonia (Bray, Smith, Cloud & Enderby et al., 2017; Hines, Kynoch & Munday, 2016). The existence of processes through which information sharing occurred was implied rather than explicit. For example there were indications that SLTs provided training for nurses to conduct screening (Warner, Suiter, Nystom, Poskus & Leder, 2013), but no discussion of how this training was delivered or received. Two papers indicated that referral to SLT for comprehensive assessment was the step subsequent to failed screens (Bray et al., 2017; Hines et al., 2016) but there was no discussion of SLT-nurse interactions that might take place in between screening and comprehensive assessment.

Nursing interventions in identifying dysphagia were the subject of a systematic review, which reported on 15 studies published between 2000 and 2011 (Hines et al., 2016). The review findings were inconclusive about the impact of nurse-initiated screening on the amount of time patients went without oral intake and time waiting for SLT assessment following failed review, with a recommendation for further research in these areas (Hines et al., 2016). The amount of time patients spend nil by mouth has potential operational implications for nurses that were not drawn out in the literature.

Research involving audit data from all patients admitted to stroke units in England and Wales across a year, found that 88% had a dysphagia screen, and 39% had a comprehensive assessment (Bray et al., 2017). The median time from admission to screening was 2.9 hours, and from admission to comprehensive assessment it was 22.9 hours. The figure of most interest to this inquiry is the large interquartile range for comprehensive assessment, which was 6.2 to 49.4 hours. This indicates that many patients spent long periods of time waiting for comprehensive assessment, with this delay found to impact on the incidence of stroke-associated pneumonia (Bray et al., 2017).

The review did not generate any literature that examined the impact of time waiting for comprehensive assessment on nurses. It is not known how nurses act in this period to manage the absence of an oral route for giving food, drink and medication, and to ensure their patients are assessed by SLT. A case note audit of 53 patients discharged from an acute stroke unit in Australia, over a six month period, found that 29 patients charted as being nil by mouth were given medications orally whilst waiting for SLT assessment (Kenny, Barr & Laver, 2016). This mostly happened in the emergency department, but on 14% of occasions, it occurred on the stroke unit (Kenny et al., 2016). This is contrary to stroke guidelines that patients do not take anything orally whilst waiting for comprehensive assessment following screening (Rudd et al., 2016).

The swallow screening literature rarely touched on the experiential dimension relating to nurse involvement in identifying dysphagia. One study that evaluated accuracy of a screening tool incorporated focus groups to gain nurse perspectives (Cichero, Heaton & Bassett, 2009). The authors suggest that the tool helped nurses gain confidence in making referrals, however focus group findings were reported as supplementary information rather than empirical data, limiting the value of this indication (Cichero et al., 2009). From an SLT perspective, an audit report was identified that provided some indication of how SLTs act on the basis of information about failed swallow screens. This audit of 19 stroke units in Australia, involving 718 patients, reported that SLTs reassessed 68% of the patients that had passed the nurse-initiated screen, with almost all of these patients (97%) confirmed as safe to swallow (Drury, Levi, McInnes, et al., 2014). The report does not enquire as to what motivated the SLTs on these stroke units to act in a way that appeared to duplicate the work of the nurses.

The only literature identified that directly challenged the work at the interface between SLT and nursing in assessing dysphagia was a discussion paper (Miller & Krawczyk,

2001). This paper was written 18 years ago, at a time when screening tools for dysphagia had been in the process of development in the UK for around a decade. This SLT-authored paper took an unusual systems view, for example reflecting on perceived differences in nursing and SLT professional culture, and viewing screening within the context of nutrition and mealtime management priorities held by other team members (Miller & Krawczyk, 2001). However empirical research is needed to understand how SLTs and nurses operate at this disciplinary boundary for the purposes of identifying dysphagia, with particular attention to how nurses act whilst waiting for SLTs to assess or review, and the interactions that occur in this space.

3.5.2 Dysphagia Management

When SLTs assess a patient as having some dysfunction in their swallowing ability they usually make recommendations to reduce the risk of food or liquid being taken into the lungs (aspiration) or blocking the airway (choking). Recommendations might include modifications to how food and drink are delivered such as slower pace, or smaller spoon, attention to positioning, and modifying the textures of food and fluids, such as by adding thickening agents to drinks to slow the transit of fluids, or recommending more manageable textures of food (Rosenvinge & Starke, 2005). SLTs may also make recommendations for oral care, to reduce the risks to patients from aspiration of oral pathogens (Yoon & Steele, 2012). The literature now explored relates to execution of SLT-initiated dysphagia recommendations. Factors that impact on nurses' role in ensuring that patients follow such advice is discussed, with particular consideration for issues surrounding non-adherence to recommendations.

SLT-Initiated Swallowing Recommendations

Recommendation for the addition of thickening agents to fluids is extremely common following SLT assessments. Almost half of the SLTs (n=145) surveyed in a study across a range of settings in the USA (68.3% worked in acute or sub-acute care) indicated that SLTs prescribed thickened fluids to 25-75% of their patients (Garcia, Chambers & Molander, 2005). This widespread practice is based on clinical experience, and instrumental evidence from videofluoroscopy that thickened fluids slow the passage of the bolus, allowing more time for airway closure (Steele et al., 2015). However evidence that thickening drinks is effective for preventing pneumonia is not strong, and moreover, modifying fluids in this way carries potential for harm due to the impact on hydration, nutrition, medication absorption and quality of life (O'Keefe, 2018). Nevertheless, if thickened fluids are recommended by SLTs, nurses are expected to follow the guidelines, on the understanding that the SLT has weighed the risks and

benefits as part of comprehensive assessment (Atkinson & O'Kane, 2018). Direct care-giving nurses usually play a key role in ensuring that swallowing recommendations are followed during hospital admissions, because they are the professionals in most frequent contact with patients (Dondorf, Fabus & Ghassemi, 2015). Two papers indicated a level of burden associated with this role. A survey designed by SLTs to investigate acute nurses' perceptions of compliance with swallowing recommendations in the US indicated that nurses considered that they complied quite well with advice (McCullough, Estes, McCullough, Gary & Rainey, 2007). However, almost all (95%) reported that patients were supported to eat under time constraints, and 42% reported frustration in relation to patients with feeding and swallowing difficulties. Qualitative analysis of freeform written comments in this study revealed a range of reasons for the reported frustration, the most frequent was time spent supporting feeding, with other factors relating to staffing, catering, and reluctance by patients (McCullough et al., 2007). The suggestion that reduced staffing impacts on nursing roles at mealtimes is reinforced by an Australian study that used focus group methodology to seek staff perspectives of barriers to supporting patients with difficulties eating in hospital (Ross et al., 2011). The study involved three focus groups, with 22 participants (nurses, dieticians, SLTs and others). All participants agreed that mealtime activities were particularly constraining for nursing staff, due to difficulties balancing support for eating and drinking with other priorities, such as medication rounds (Ross et al., 2011). These two papers indicate that time is an issue for nursing role, however they are small studies. The survey relied on self-report by 77 registered nurses (McCullough et al., 2007), and the focus groups included nine nurses and two SLTs, who were allocated to separate focus groups (Ross et al., 2011).

A further factor that may impact on nurses' role in ensuring recommendations are followed, relates to patient dislike of dietary modifications. No research was identified that explored this from the perspective of inpatient hospital staff, however from a patient perspective, palatability can impact on willingness to consume food and fluids that have been modified. In a study comparing the nutritional intake of patients on texture modified diets (n=30) with those on normal diets (n=25) on care of the elderly wards in the UK, only four of the patients on texture modified diets finished their meals, and none met their nutritional needs (Wright, Cotter, Hickson & Frost, 2005). All bar one of 14 stroke survivors asked to reflect on their experiences of having thickened fluids in hospital, reported negatively on the experience, often in extreme terms (McCurtin et al., 2018). Acute stroke patients with dysphagia have been found to have limited awareness of their condition (Parker et al., 2004), and this, compounded by

dislike for modified consistencies, may further impact on nurses' role in ensuring advice is adhered to on stroke wards.

As part of dysphagia management, SLTs offer recommendations about oral hygiene, and in this way overlap with a routine nursing role. An investigation into perceptions of oral care practice by nurses (n=6), SLTs (n=6), and dental hygienists (n=4) found disciplinary differences in perspectives of why oral hygiene was important (Yoon & Steel, 2012). SLTs and nurses were both concerned to reduce pain and discomfort. However whilst SLTs were primarily concerned with limiting the risk of developing aspiration pneumonia, nurses fore-fronted social and self-esteem dimensions of care and emphasised the importance to patients of having fresh breath (Yoon & Steel, 2012). Focus groups were discipline specific so there was no opportunity for cross-disciplinary exploration of these perspectives, and the work setting of participants was not specified, limiting transferability. However the findings do give some indication that SLTs and nurses may hold different ethical drivers for determining what doing good for a patient means to them (Engel & Prentice, 2013), and this could potentially impact on the nature of interactions between them.

Issues of Adherence

When patients did not follow swallowing recommendations, it was referred to as non-compliance or non-adherence in the literature, and nurses were positioned as responsible for ensuring recommendations were adhered to (Rosenvinge & Starke, 2005). There was a level of authority implicit in the SLT advice-giving role that was revealed in participant quotes reported in research, for example one SLT described how the nurse 'went behind my back' when not doing as recommended (Smith-Tamaray et al., 2011:274). In another study (in which SLTs had worked closely with nurses whilst introducing a new fibre-endoscopic swallowing screening service), one of the nurses reflected in interview that prior to this intervention 'we just got told thickened fluids and we did it' (Green, McFarlane, Bax & Miles, 2014:77). The prevalence of non-adherence to swallowing recommendations in stroke care has not been clearly established. A recent systematic review sought to identify research based on objective measures of adherence; only three of the twelve papers included in the review related to adherence to dietary modifications, with the majority (eight studies) reporting on adherence to swallow exercise regimes within a head and neck population (Krekeler, Broadfoot, Johnson, Connor & Rogus-Pulia, 2018). In the three studies reporting on adherence to dietary modifications, non-adherence ranged from 21-43.5% (Krekeler et al., 2018), however only one of these studies was based entirely on inpatients, and

included stroke patients, and this was a small-scale study with eight participants (Leiter & Windsor, 1996). Thus it is not possible to say how much of an issue non-adherence to dysphagia recommendations actually is in stroke units.

A study that may better reflect adherence to the recommendations included within SLT swallowing advice is a report of an intervention on a stroke unit. This study audited adherence to recommendations across two periods (five days each), before and after a ward based intervention aimed at improving adherence (Rosenvinge & Starke, 2005). The intervention involved both SLT-led teaching and systems change. This included: the creation of specialist link nurse responsibilities; making pre-thickened drinks uniformly available, and senior level monitoring and support. Adherence was audited against a checklist, which included consistencies, amounts, strategies, level of supervision and general safe swallowing advice such as posture and alertness. Following the intervention, the only area where improvement did not reach significance was adherence to swallowing strategies, such as sitting fully upright. Adherence to dietary modifications (e.g. puree diet) and remaining nil by mouth was rated as similarly high both pre and post intervention (Rosenvinge & Starke, 2005). Systems level thinking was also evident in a report of a service improvement aimed at involving patients in adherence decisions (Kaizer, Spiridigliozzi & Hunt, 2012). Senior level interest in dysphagia was evident through an interdisciplinary dysphagia management committee. A decision tool was introduced to increase patient involvement, but also to relieve the moral and ethical dilemmas staff experienced when encouraging reluctant patients to follow recommendations. The tool provided a means for staff to explore reasons for non-adherence with patients, to consider whether risk was ‘assumed’ or ‘real’, and use team discussion to plan the way ahead (Kaizer et al., 2012). Staff perceptions were not empirically investigated in this study, however the authors drew on practice experience to suggest that staff feel anxiety and guilt when they find themselves acting in ways that are discordant with their personal and professional values.

3.5.3 Summary

The literature reviewed about identification and management of dysphagia indicates that research is needed to understand how SLTs and nurses navigate their common clinical interests in swallowing. Specifically: how SLTs and nurses navigate information exchange to manage swallowing on hospital wards; how nurses act whilst waiting for SLTs to assess or review; how nurses execute dysphagia recommendations in the context of limitations, such as time, ethics of care, and need to maintain nutrition,

hydration and medication, and how SLTs and nurses perceive roles and interdependence in relation to swallowing.

Gaps: Literature Review Chapters and Research Questions

The primary research question asks what the influences are on SLT-nurse information sharing about the communication and swallowing needs of their patients on stroke units. The meta-ethnography reported in chapter two provided increased understanding for the influences on communication between therapists and nurses, which can now be extended to consider SLTs and nurses in particular in the stroke unit setting. The literature reviewed in chapter three indicated that knowledge is needed for how SLTs and nurses navigate their common clinical interests in communication and swallowing. The following table maps the gaps in the literature identified in the summaries in each chapter against the secondary research questions.

Table 3.1: Gaps in Literature Mapped to Research Questions

Gaps Identified	Research questions
Little is known about how SLTs and nurses engage with each other through the various communication routes on stroke units, for the purposes of sharing information about communication and swallowing.	How are different information sharing routes used to share information about communication and swallowing?
Specific knowledge gaps for how SLTs and nurses engage with the ward as a space for information sharing included: • How SLTs and nurses navigate information exchange to manage swallowing. • How nurses execute swallowing recommendations in the context of other demands. • How nurses act whilst waiting for SLTs to assess or review swallowing. • The impact of nurses' capacity constraints on SLTs' capacity to share information. • The impact of the information-sharing context on SLT-nurse relationships.	How does information sharing happen across different spaces on the ward and different periods in time?

There is limited knowledge about what SLTs and nurses consider *needed* information for meeting patients' swallowing or communication needs. For communication in particular, knowledge is needed for how both disciplines conceptualise their roles and view the impact of time and capacity on the need to give and receive information, in the context of competing priorities and the fast-paced context of acute care. There is currently little in the literature, other than that reporting CPT, that explicitly frames SLT and nurse interest in communication as a cross disciplinary concern.	How do SLTs and nurses perceive their roles and interdependence in management of communication and swallowing?

The knowledge gaps listed above were identified by exploring literature from a range of inpatient settings that did not have information sharing between SLTs and nurses as its primary focus. Thus there is a need for research that is specifically directed towards understanding how SLTs and nurses share information for the purpose of managing communication and swallowing on stroke units. The limited research in this area indicated that the methodology and methods selected would need to generate foundational knowledge. The chapter that follows will explain why ethnography was considered appropriate for this exploration.

4. Methodology

4.1 Introduction

This chapter provides background to the methodology adopted in this study. A brief history of ethnography has been included in order to locate the current study within the context of the rich and diverse history of the methodology. The key characteristics of ethnographic inquiry are discussed with particular reference to clinicians conducting this type of research in a hospital setting. This is followed by a rationale for why ethnography was selected over other potential methodologies to answer the questions posed by the study. The chapter concludes with a discussion of the status afforded to knowledge in studies of this kind and approaches used to enhance rigour.

4.2 The Historical Context of Ethnographic Research

Ethnography has its origins in fieldwork carried out by anthropologists from the turn of the twentieth century, where researchers lived amongst people in 'exotic' settings far from home. These studies were initially carried out from privileged positions. An example is the research into aboriginal marriage practices conducted by the British social anthropologist Radcliffe-Brown. His research (along with other studies around this time) has been critiqued for treating the people involved in research as specimens, brought onto the 'colonial veranda' for questioning (Burgess, 1984). It was Malinowski's field research in Papua New Guinea in the 1920s and 30s that is credited with shifting the paradigm towards participant observation, in which the researcher aims to gain first-hand experience of a culture by participating in the same activities as the people of that culture (Burgess, 1984).

The claims made by these early studies for authority in their representations of 'otherness' have subsequently been subject to challenge, especially when viewed through the lens of post colonialism (Clifford, 1983). From the 1920s, sociologists from the influential Chicago School adopted the core principles of observation and participation from social anthropology, in order to study urban societies closer to home (Burgess, 1984). This group of researchers developed the theoretical framework of symbolic interactionism used in the current study (see section 1.7). The Chicago School researchers shared the anthropologists' outsider interest in the 'strange', and commitment to long periods of time in the field. However, a key point of difference was that their interests tended to be directed more towards understanding particular aspects of social life (for example gang membership), than a culture as a whole (Burgess, 1984).

Over the past fifty years, ethnographies have been carried out in a very wide variety of settings. Of particular relevance to the current study is the adoption of ethnography in applied settings by researchers who are not outsiders to the field of study, for example by teachers in schools and clinicians in hospitals. This creates particular challenges in adopting the stranger's perspective and the ethnographic distance required to notice taken for granted activity by participants (Fine & Hallett, 2014). In the current study, the practitioner-researcher can be equated with a 'fish trying to discover the water that surrounds them' (de Jong, Kamsteeg, Ybema, 2013:169). Balancing familiarity with the necessary distance to see 'strangeness' is an intellectual challenge that needs to be managed in ethnographic inquiry (Hammersley and Atkinson, 2007).

Different types of ethnography have developed over time, including new approaches that diverge from its original descriptive or explanatory aims. An example is critical ethnography, which is directed towards social change by revealing imbalances of power (Hammersley and Atkinson, 2007). A critical approach has not been adopted for this study because not enough is currently known about information sharing between SLTs and nurses to assume that power differentials are at play. The aim of the current study was to produce a descriptive account that would be 'thick' and interpretative in order to increase the ecological validity of the research for practitioners (Bloor, 2001). Geertz contends that good ethnography *is* thick description, by which he is referring to the way in which the ethnographer interprets a culture and renders it alive and coherent through writing (Geertz, 1973). The way in which an ethnographic account is written is revealing of authorial claims to representation of truth. It has been argued that such truths are 'inherently partial-committed and incomplete', however this is not taken as being incompatible with rigour (Clifford, 1986:7). Acceptance of this position implies beliefs about the nature of knowledge and reality that will be discussed in section 4.5.

4.3 Ethnographies in Hospital Settings

Methodological and theoretical features of medical ethnographies are not necessarily distinct from ethnographies conducted in other settings (Bloor, 2001). However, particular issues are associated with participant observation when ethnographers are also practitioners. Since the seminal 'Boys in White', in which researchers from the Chicago School reported their research about medical student socialisation (Becker, Geer, Hughes & Strauss, 1961), ethnographers have explored the social context of the hospital whilst also participating in the activities of the studied setting. In recent years, ethnography has increasingly been used to investigate how healthcare professionals

navigate shared agendas for patient care. For example, to understand how patient safety is put into practice (Dixon-Woods, 2010), or to identify barriers to interprofessional communication (e.g. Fernando et al., 2016). Such research is usually described as involving participant observation, which is widely accepted as a central feature of ethnography and often taken to be synonymous with it (Delamont, 2004).

Spending long periods of time becoming familiar with the life world of participants is well established as a means of capturing the routine and out of the ordinary events on which ethnography is based (Goffman, 1989). However the centrality of participant observation to ethnography is not universally accepted. Bourdieu (1990) questioned the extent to which genuine participation is actually possible in any setting because the researcher has such a different agenda to the participants; the researcher explores their lives, whilst those being explored *live* their lives, and will continue to do so after the researcher has moved on (Bourdieu, 1990). Gold's much referenced taxonomy of researcher roles included the roles of complete observer, observer as participant, participant as observer and complete participant (Gold, 1958), however practitioner ethnographers find it hard to place themselves at a single point on this spectrum. For example, even where clinicians create distance by not participating in clinical tasks, they observe through a clinical lens and others position them by their profession (Jacoby, 2017). The effect of this on the current study is explored further in section 5.7 when ethical considerations are discussed.

There has been epistemological debate about the extent to which direct observation can really render participant voice as known, and ontological discussion relating to the constructed nature of data from naturally occurring settings (Hammersley, 2018). The term *proper* ethnography has been used to distinguish studies judged to be sufficiently immersive (Delamont, 2004), implying a contrasting *improper* ethnography. However, there is no single criterion for what qualifies a time period as being sufficiently long (Hammersley, 2018). Wind (2008) draws on her experience as both anthropologist and nurse to discuss how researching her own profession led her to question whether she was doing her ward-based ethnographic study of trauma patients 'wrong'. She argues for acknowledgment of the particular constraints on immersion and participation on hospital wards, and suggests 'negotiated interactive observation' as a more accurate description of what is possible where the roles available to the non-practicing clinician as researcher are limited. The ethnographer's role is to understand what is going on by observing in an interactive way, and this involves ongoing negotiation of who, what and how to observe (Wind, 2008).

On the whole, practitioner researchers view familiarity with the setting positively because it helps them navigate a complex environment and facilitates field relationships (e.g., Clarke, 2010). However the benefits of familiarity need to be balanced with the need to approximate the stranger perspective that is important in ethnographic work (Burns, Fenwick, Schmeid & Sheehan 2012; Simmons, 2007; Thomsen, 2011). Familiarity increases the risk that researchers will over-extend interpretations into claims that their accounts are authentic representations of reality (Bloor, 2001). Such temptations to conflate *being there* with *discovery* can be mediated to some extent by accepting that 'social reality is accomplished rather than experienced' (Ryen, 2011:423). This is discussed further in section 4.5 below.

The ethnographies that were reviewed as part of the meta-ethnography (chapter 2) did not typically involve comparable levels of immersion to the studies reported at the start of this chapter. Although the studies often covered similar periods of calendar time (one to two years) they were characterised by episodic contact over that time period. Typical of this is the research about nurse experience on stroke teams reported by Clarke (2010), in which 220 hours of fieldwork were spread over 18 months. This reflects a point of difference for ethnography in applied settings (Fetterman, 1998). Ethnographers can compensate for shorter periods of time *living amongst* the researched groups by active attempts to sample diverse participants and field observations (Hammersley & Atkinson, 2007). The sampling approach in the current study is detailed in section 5.5. Entering and leaving the field rather than being totally immersed in it also carries advantages, chief of which is that it affords the researcher the opportunity to step between the emic (insider) perspective of the lived world of the participants, and the necessary etic (outsider) perspective needed for sense making (Fetterman, 1998). Movement between the etic and the emic in the current study is discussed in relation to the importance of time out of the field to the iterative analytic process (section 5.6) and navigation across insider and outsider positions (5.2.3).

4.4 Rationale for Use of Ethnography in this Particular Study

Ethnography was selected to address the questions of this study for reasons relating to both methodology and method. As a methodology, the emphasis on immersive participation in ethnography was anticipated to facilitate depth of understanding of SLT-nurse information sharing practice. From the outset, the challenges for the researcher in researching both the well known and the less familiar were evident (discussed in section 5.7). It was important to use a methodology that allowed space for full consideration of issues relating to familiarity, distance and authenticity. From a

methods perspective, the association of ethnography with combined methods of data collection offered an opportunity to explore interprofessional practice in a more comprehensive way than much of the previous research in this area.

The research topic could have been explored in alternative ways. Previous studies have commonly used single methods, such as interviews or focus groups to understand how participants perceive structures, such as meetings, that support communication, and their perspectives of why communication is important in teams (Morris & Matthews, 2014; Rowlands & Callen, 2013). However elicited perspectives of participants are not sufficient to illuminate how communication plays out in practice, as respondents tend to frame their accounts to align with their perceptions of the researchers' interests (Rapley, 2004). Respondents may be ethically disposed towards supporting the dominant paradigm in healthcare that good practice is underpinned by teamwork, as reflected in clinical guidelines such as the National Clinical Guideline for Stroke (Rudd et al., 2016). Reliance on interview as a single method also excludes the possibility of interrogating both critical (e.g., Smith-Tamaray et al., 2011) and uncritical (e.g., Barreca & Wilkins, 2008) participant accounts of interprofessional practice through reference to observed practice. Combining the methods of observation and interview facilitates exploration of meaning through different lenses and can result in a more dynamic picture (Rapley, 2004). For example, Baxter and Brumfitt (2008) conducted in-depth case studies across three stroke care settings, and by combining observations of practice with interview they strengthened their argument for the persistence of clear demarcations between professional roles. It was thus considered important to use combined methods of data collection in this study.

The strongest methodological contender for better understanding of information exchange was detailed micro-level inquiry, using discourse analysis or conversation analysis. This would have resulted in deep understanding about how language was used to create constructions of interprofessional work. For example, discourse analysis of focus group data revealed how the use of the words 'we' and 'they' by therapists indicated how they positioned themselves as a team within the wider team (Kvarnstrom & Cedersund, 2006). One of the assumptions of this study was that the manner in which SLTs spoke to nurses would be of central importance, and the initial intention *was* to subject some sequences of interaction to conversation analysis. In practice, the ethical requirements attached to audio recording (consent required from SLT, nurse and patient) meant that dialogue was collected through field notes rather than recordings. However this did not detract from the analysis as it became evident through

the course of the research that the key conceptual finding was the influencing effect of the temporal-spatial context on the privileging of swallowing information, in other words *what* was talked about in very brief time-slots. Field notes provided sufficient detail about *how* SLTs and nurses did this to support the finding.

No previous ethnographies have been identified that focus on the interface between SLTs and nurses, hence ethnographic inquiry was expected to lead to new ways of interpreting taken for granted ways of doing things (Rock, 2001). Although SLTs have participated in ethnographies that explored the behaviour of professionals in interprofessional teams (Clarke, 2010; Lewin & Reeves, 2011; Long, Kneafsey, Ryan, & Berry 2002; Miller & Kontos, 2013; Seneviratne et al. 2009), these studies provided limited opportunity to apply learning to SLTs because SLTs were treated as a group with other therapists. Overall, ethnography was considered a strong methodology for seeking novel insights into the taken for granted ways in which SLTs and nurses share information during their work on stroke units.

4.5 The Status of Knowledge

The three subsections that follow explain the beliefs about knowledge that underpinned this study, principles for rigour, and the use of reflexivity in ethnographic research. The methods chapter includes full detail for how approaches for increasing rigour were specifically applied in this study.

4.5.1 Epistemological and Ontological Considerations

The truth claims made by this study are based on social constructionist beliefs about the creation of knowledge and the nature of reality. Social constructionism embraces the socio-historically located position of the researcher as part of the process of knowledge creation. Social constructionist thinking contrasts with positivist perspectives about the existence of a stable, reality that can be discovered (Crotty, 1988), and has been defined as follows:

> 'All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context' (Crotty, 1998).

Adopting a social constructionist epistemology allowed the ward environment to be explored, whilst at the same time accepting that it could not be represented in its

entirety. It is argued that social constructionists hold their understandings 'lightly and tentatively and far less dogmatically, seeing them as historically and culturally effected interpretations rather than eternal truths of some kind' (Crotty, 1998: 64). The outcome of the study was not expected to be discovery of an authentic reality of communication between SLTs and nurses on stroke units, because hospital wards are in constant flux. Actors change frequently due to shift work (Pryor, 2008) and staff turnover (Nuffield Trust, 2018). Communication is a highly varied phenomenon, from brief moments in the corridor (Clarke, 2010) to formal exchanges in a meeting (Deacon & Cleary, 2013). Communication and relationships in this context are thus constructed and re-constructed minute-by-minute, at the same time as which the researcher constructs and re-constructs the sense being made of it all. This research, in common with much healthcare research was conducted for the purpose of generating empirically derived knowledge for clinical practice (Thorne, 2016). Whilst it is acknowledged that researchers need to be tentative when making truth claims, knowledge derived within social constructionist epistemology is not so relative that meaning cannot be claimed (Crotty, 1998). Rigorous processes of analysis and transparency in reflexive practice are used to increase trust in the findings (Hammersley & Atkinson, 2007). Data gathered through fieldwork and interviews were transformed into new knowledge through rigorous processes that will now be discussed.

4.5.2 Rigour in Ethnography

Rigour in qualitative work is commonly described using the criteria of credibility, transferability, confirmability and dependability, terms introduced to distinguish the particular requirements for determining quality in qualitative work (Korstjens & Moser, 2018; Lincoln & Guba, 1985). These factors apply to ethnographic research to varying degrees. Credibility relates to the believability of the findings (Lincoln & Guba, 1985). Credibility is enhanced through sustained contact with the lives of participants, triangulation of different types of data, negative case analysis and attention to the role of the researcher in knowledge creation (Hammersley & Atkinson, 2007). Transferability is the extent that new knowledge can be transferred to other settings (Lincoln & Guba, 1985). Transferability can be increased in ethnography by including sufficient description to allow readers to judge the applicability of findings to their own circumstances (Bloor, 2001) and by including multiple field sites (Hall, 2003). Confirmability is the extent to which findings reflect participant experience rather than researcher presuppositions (Lincoln & Guba, 1985). From a social constructionist perspective, confirmability is less significant as a quality marker in ethnography than credibility. This is because it is assumed that researcher presuppositions cannot be

completely eliminated. Processes of reflexivity can *heighten awareness* of presuppositions and different sources of data add layers of meaning rather than *confirm* findings (Hammersley & Atkinson, 2007). Dependability relates to explication of processes through which interpretations have been made, to such a degree that someone external to the research could audit them and make a judgment as to the dependability of the findings (Lincoln & Guba, 1985). Ethnographic accounts within social anthropology commonly include quite minimal explanation of processes leading to the findings, claiming credibility from sustained exposure to the setting (Hammersley & Atkinson, 2007). In the current study, processes have been explained to increase trust that the knowledge claims are empirically derived, however this is within the understanding that knowledge is co-constructed and thus not singular in meaning. It has been argued that over-reliance on such determinants of quality can actually undermine quality by failing to fully acknowledge that the paradigm through which knowledge is derived is 'multiple and constructed', and that interpretation involves an element of art as well as science (Sandelowski, 1993:3). Nevertheless, there is general acceptance of the overarching need to demonstrate that findings are trustworthy (Lincoln & Guba, 1995), and the approaches used to demonstrate trust in the findings of this study are explained in the next chapter. This chapter concludes with discussion of the central place of reflexivity in ethnography and an overview of the position of the researcher in this study.

4.5.3 Reflexivity

Reflexive practices involve attending to, and making transparent, the ways in which researcher subjectivities, methodological decisions and presence in the field impact on data (Hammersley & Atkinson, 2007). Bloor describes ethnography as involving 'obsessive concern' for the relationship between the observer and the observed (Bloor, 2001:179). Concerns for reflexivity developed out of concerns that the pursuit of objectivity in earlier ethnographic studies neglected to acknowledge the inter-subjectivity inherent in this kind of research (Clifford, 1983). Bourdieu argues that researchers need to apply their research instruments to themselves (Bourdieu, 1990). However the aim is for *epistemic* reflexivity that strengthens knowledge claims, rather than undermines them (Wacquant, 2008). This contrasts with accounts that make use of researcher experience as a means for suggesting authenticity on the basis of 'being there' (Clifford, 1983).

Practitioner-ethnographers conduct reflexive work towards different purposes in accordance with their beliefs about objectivity. For example, reflexive practice for

Jacoby (2016), a nurse-ethnographer, led her to examine how her subjectivities (nurse, white, female) structured her interpretations during her research with black, mostly male, trauma patients. She does not treat her subjectivities as an impediment, but recognizes that her interpretations are co-constructed and utilizes her insights as a means of adding to knowledge. Other researchers use language that suggests they have adopted reflexivity as a means to increase objectivity, for example a nurse-ethnographer in another interprofessional study talks of 'control for potential biases' (Seneviratne et al., 2009:1875). These examples reflect a lack of agreement as to how much of the researcher self to incorporate into reflexive accounts and to what purpose. For the current study, the key principle guiding the writing of reflexive work was its capacity to illuminate new knowledge and increase transparency about how meaning was derived (Allen, 2004). Acknowledgement of the need for honest reporting of the 'messiness' of research (Dean, 2017) was balanced with respect for the centrality of the data, rather than the researcher (Coffey, 1999). In this way, readers can examine the processes through which interpretations have emerged and judge trustworthiness of the account (Hammersley and Atkinson, 2007).

The nature of this inquiry into the practices of two disciplines required particular vigilance to maintain an egalitarian perspective and avoid privileging understandings from one group over the other (Bloor, 2001). The following identity memo has been included to make transparent the potential impact of this researcher's socio-historical positioning and professional identity on ways of seeing and reporting.

4.5.5 Identity Memo

The inspiration for this study originates in my earliest experiences as a junior SLT. I have strong memories of awkwardly trying to get the attention of the nurses on acute wards, usually to help me sit a patient up for an assessment or to provide feedback on the outcome. I quite quickly learnt that it was information about swallowing that held attention, in conversations on the ward and when talking in meetings. From the beginning, nurses seemed more culturally distant from me than the other therapists. As I became more experienced I shifted from seeing my role as telling the nurses what I had found towards something more dialogic, yet although I no longer felt uncomfortable, my conversations with nurses were rarely as satisfying as the continuous, easy knowledge sharing that occurred with therapists.

I had previously worked in both Trusts in this study, but on different wards, with patients at the sub-acute stage of the care pathway. I had been a colleague of two of

the SLTs, but did not know any of the nurses. I was thus professionally an insider to the SLTs and an outsider to the nurses. My position in the research settings was a changeable one, with frequent movements across an insider-outsider spectrum. I was familiar with ward environments, rituals of teamwork and the language of healthcare, however my new identity as a researcher based in a university positioned me as an outsider to the organisational purpose of the wards (Burns et al. 2012). As a white female, I am in many ways a typical exemplar of my profession, although I am much older than most of the SLTs I encountered. The nurses were more diverse than the SLTs in terms of gender, ethnicity and age. Hence whilst I shared a professional, gender and ethnic identity with the SLTs, there were times when my age brought me into closer alignment with the life world of the nurses.

In addition to my own particular biography, the presuppositions I carried from pre and post registration education and clinical experience were that information about communication is as important to patient care as information about swallowing, that interprofessional working is a satisfying way of working and benefits patients, and that SLTs have more collegial relationships with therapists than nurses. Care has been taken through the use of reflexive processes to subject these presuppositions and my own socio-historical way of seeing and being to rigorous questioning. For example I was aware that I needed to work harder to know the nurses and this meant spending more time in nursing spaces in the early stages of fieldwork, despite feeling more at ease with the familiarity of the SLTs. Processes used to retain a questioning attitude for the duration of the study were accomplished through my reflexive diary, rigour in analysis, sharing findings with participants, and discussion with others, including supervisors and my PhD community.

5. Methods

5.1 Introduction

The methods used to answer the research questions are those that are commonly associated with ethnographic methodology; they include observation and shadowing, informal questioning, semi-structured interview, collection of documents, and reflexive diary keeping. Data of relevance to all the research questions were generated through field notes and semi-structured interviews carried out during fieldwork on three acute stroke units across two inner city NHS trusts in the UK, between September 2015 and July 2017. Field notes included participant observation and shadowing, and written notes copied from SLT and nurse entries in the patient record. A reflexive diary was kept from conception of the study until the end of fieldwork. All data sources were used to address the research questions, but with variations in weighting. For example question three was concerned with participant perspectives and thus relied most heavily on interview, but was also informed by field notes. The questions are repeated here for ease of reference:

Overarching question: What are the influences on SLT-nurse information sharing about the communication and swallowing needs of their patients on stroke units?

1. How are different information sharing routes used to share information about communication and swallowing?
2. How does information sharing happen across different spaces on the ward and different periods in time?
3. How do SLTs and nurses perceive their roles and interdependence in management of communication and swallowing?
4. What raises the salience of communication sufficiently for it to be shared?

Data collection and analysis were informed by social constructionist epistemology (see section 4.5.1), and the focus of inquiry was under constant revision during the iterative processes of fieldwork and interview, preliminary analysis and reflection in between each of the fieldwork sites, through to final analysis and writing. The process felt very similar to Rock's conceptualisation of a constructing a jigsaw, in which 'each new piece alters the picture and the emerging whole alters and directs the search for each succeeding piece' (Rock, 2001:35).

5.2 Participant Observation

The terms participant observation and fieldwork are often used interchangeably in ethnographic reporting (Delamont, 2004). In this account participant observation is used as an over-arching term reflecting both the immersive process and fieldwork activities. Fieldwork refers to the activities of collecting data (observation, interview, documents), as well as keeping a reflexive diary.

5.2.1 Fieldwork Process

Observations were made from the places in which SLTs and nurses routinely came together, including nursing stations, corridors, meeting rooms, therapy offices, and staff rooms. It was not possible to capture all of the interactions that took place during periods of observation because for ethical reasons I avoided entering the bed space of the patients. However, when it did not feel intrusive to do so, I asked SLTs or nurses to tell me what had been discussed. The main activities observed included discussions between SLTs and nurses about patients before and after SLT sessions with patients, interprofessional meetings and nursing handover, as well as ad-hoc interactions in various ward spaces, such when the SLT was writing notes. Field notes were used to record observations on the ward, information from the patient record and informal questioning of SLTs and nurses to clarify observed practices in the moment. Field note entries included a combination of captured dialogue and broader observations, including descriptions of behaviours, diagrams (for example of where people sat in meetings), copied down information posted on the walls, informal questioning of participants, and anything else that seemed relevant to understanding the context within which information exchange occurred.

Field notes were taken in accordance with the situation. For example when other people were writing, such as during handovers or meetings, I wrote quite openly. At other times, I made brief notes and left the ward to write more extended notes. I was frequently disturbed whilst taking notes from the patient record because clinicians often needed to access the paper records (or the computers for the ward with electronic records). Capturing dialogue outside of structured information sharing routes required very fast reaction times. As soon as I sensed that an exchange between a SLT and a nurse was about to happen I would approach, seek a nod of assent and then write down what was being said. I often couldn't write fast enough to keep up and was therefore careful to make a distinction in my field notes between verbatim and summarized content from these exchanges. I typed up and expanded on notes each evening without fail and organised my reflexive thoughts under headings, including

'themes and thoughts', 'methodological issues', and 'field relationships' (Quirk, 2006). A field note extract is included in Appendix 2.

There were times when it felt like there was nothing much to observe, and on such occasions I refocused my attention, guided by a prompt I had noted in the back of my field diary, to consider aspects such as space, actors, activities, objects, acts, events, time, goals, or feelings (Spradley, 1980). For example, on one occasion whilst waiting for the SLT to finish with a patient I directed focused attention to what the nurse was doing. In my field notes I described how she entered and left the bed space where the SLT was working to open breakfast containers and check the monitor, her standing position in relation to the seated position of the SLT, and the gently apologetic way in which the two professions accommodated each other. The meaning of sketches such as these was often not apparent at the time, but the descriptions made them easy to recall, and when added to by new information they could become analytically important. In this case as part of understanding the subtle ways in which SLTs and nurses navigated through their own agendas in shared space (nurse: give breakfast, SLT: complete session), whilst orientating towards an accommodating relationship.

5.2.2 Shadowing SLTs and Directed Observation of Nurses

At the outset of the study, the intention had been to shadow both SLTs and nurses, and I initially conducted the SLT and nurse shadows in a similar way. I approached those who had given written consent and asked if I could shadow them for some time during that day. I was eager not to be a burden, and made it clear that they didn't need to give me a running commentary of what they were doing. As I shadowed, I periodically checked they were still happy to have me along to ensure I didn't over extend their tolerance for my presence. Shadowing SLTs was an important way of gathering detail of their interaction with nurses because their work with patients routinely involved them in dialogue before or after sessions, and they frequently engaged in unplanned exchanges, for example whilst getting a food item from the kitchen to try with a patient. The benefits for shadowing the nurses were less clear. Even a long shadow with one nurse might not involve any dialogue with an SLT, and in the absence of this, the purpose of the shadow was unclear, making it uncomfortable for both of us, bringing me unnecessarily close to the patients' bed space. After the first nurse shadow, through supervisory discussion, I clarified the purpose of these shadows as being a means of gaining temporal understanding of the demands on nurse attention and the tasks they undertake, essentially this was about better understanding the context SLTs step into when they engage with nurses. From that

point on, instead of asking to shadow the nurses, I asked if I could spend an agreed amount of time (usually around an hour) directing my observations towards them as they worked, positioning myself at the nursing station or just outside of the bay.

5.2.3 Participant Observation and Finding a Role

The level of immersion achieved in the current study is comparable (somewhat higher) to other ward based ethnographies of interprofessional practice in terms of time in the field (e.g. Clarke, 2010; Liu, Manias & Gerdtz 2014; Seneviratne et al., 2009). My professional insider position eased the immersive process with the SLTs, who generally accepted me as one of their own, within the limits afforded by my non-clinical role. Although I had worked with nurses before, I was an outsider to them professionally. I hoped that by spending time in communion with them, in their space and on their terms, I would better understand their perspectives and ways of being. However, as will be discussed, developing their trust took time and impacted on research processes.

Consistent with other practitioner-ethnographers, my early field note entries reveal a pre-occupation with trying to find a role for myself on each of the wards (Burns et al., 2012; Wind, 2008). It felt extremely uncomfortable to observe whilst others worked. However, my attempts to feel more involved by helping one profession made me feel distanced from the other. I considered supporting patients at mealtimes as an activity that both SLTs and nurses engage in, however when SLTs support patients to eat and drink they are also assessing and I was reluctant to put myself in a position where I might need to invoke my professional role and enter into discussions with nursing staff about optimal ways of maintaining patient safety. I ultimately settled on the position of an acceptable marginal member (Hammersley & Atkinson, 2007), and engaged in a similar way to that described by Wind (2008) as negotiated interactive observation. I made myself useful whenever I possibly could, such as by answering the phone or fetching things. I participated by sharing in general social chat and emotional concerns, such as when the SLT caseload was particularly high or when the nurses were exhausted by increased patient acuity, but essentially I remained a friendly face, positioned at the edge of both SLT and nursing clinical worlds. Sometimes I felt at ease and part of the team but there were also times when I needed to renegotiate relationships and explain my purpose, for example when arriving on the ward at evening handover long after therapists had gone home.

5.3 Interviews

SLT and nurse perspectives on information sharing were sought through informal questioning as a means of extending interpretations of observations (Hammersley & Atkinson, 2007), and more formally through audio-recorded semi-structured interviews that took place in meeting rooms or cafes. Semi-structured interviews were aimed at deepening observational insights and providing a forum for SLTs and nurses to elaborate on their perceptions of the working relationship. Formal interviews commenced a few weeks into each period of fieldwork to allow emerging insights to shape the line of questioning. For example I noted that nurses often did not add their experiential knowledge of patients' communication abilities when the team engaged in discussion at MDMs and I was able to use the interview to probe further. A topic guide was also developed on the basis of the literature review and the research questions (Appendix 3). This was used as a loose frame to support navigation around pre-considered topics, following the interviewee's line of thinking. Topics included perceptions of common care interests, roles and relationships, and issues surrounding training. Consistent with the social constructionist perspective that interview-derived accounts are co-constructed (Rapley, 2004), both the question and the response were transcribed verbatim and were coded together during analysis. Following each interview I listened to the recording in full before transcribing, increasing my familiarity with and closeness to the data.

A key difference between SLT and nurse interviewees was how each discipline oriented to me as inside or outside of their professional experience. The interview situation itself carried particular meanings; sitting at a table and speaking one on one in private space was very different to the day-to-day work of most of the nurses but quite familiar to SLT ways of working. This may have created a heightened expectation by the nurses that something of gravitas was expected in relation to the topics raised (Rapley, 2004). A key challenge in interviewing the SLTs was retaining curiosity about things for which we could be expected to have shared understanding. For example it is taken for granted amongst SLTs that nurses are generally more open to hearing swallowing information than communication information. I was thus particularly careful to ask this question in such a way that allowed new information to be shared. For the nurse interviews, I was aware that they reacted to me as a SLT, and I continually questioned how this might have impacted on the co-created meanings. For example the process of being asked about their roles with patients with communication difficulties triggered some of the nurses to question *during the interview* whether they should pay more attention to the communication difficulties of these patients. For one

nurse this heightened awareness was manifest in nursing handover a few days after the interview, during which she spoke more about patients' communication difficulties than was usual, and then concluded her handover by saying 'and that concludes my research [*sic*: handover]', at which everyone laughed and looked towards me. This was a stark illustration of how others reacted to me as a researcher, illuminating both strengths and limitations in ethnographic inquiry. Discussion of communication awakened more attention to the communication needs of patients and the transfer of this awakening into handover offered insight into nurses' beliefs about the 'right' way to do things that could be explored further in subsequent interviews. Conversely however, it was important to appreciate that reactivity also placed limits on claims for 'truth'.

5.3.1 Procedural Differences in Arranging Interviews

The process of arranging interviews with SLTs and nurses revealed marked differences in their ability to schedule an interview into their day. This mirrored findings of this research with respect to the temporal-spatial context of stroke unit care. All the SLT interviews took place during working hours and arranging an interview was a fairly straightforward scheduling task. However five of the nurses were interviewed on their days off due to difficulties taking time away from the ward. As a consequence most of the interviews with SLTs were of longer duration than interviews with nurses. SLT interviews ranged in length from 32 to 55 minutes with a mean of 48 minutes. Nurse interviews ranged from 21 to 55 minutes, with a mean of 36 minutes.

At about six weeks into field work on each ward I would begin to feel concerned that I was not managing to arrange interviews with the nurses. However, once the first nurse agreed to an interview, there was something of a snowball effect, and subsequent interviews were arranged with much more ease, often facilitated by nurses who had already been interviewed. The nurses clearly needed to become familiar with, and develop some trust in me, and I needed to demonstrate that I was comfortable with short notice rearrangement or interruption. When nurses signalled their availability it was often a 'now or never' scenario affording little time for preparation.

5.4 Documentary Information

Collection of documentary information formed part of the field data and was collected for the purpose of understanding the place of writing as a means of communication between SLTs and nurses. Writing in, or reading, the patient record was a routine activity for SLTs and nurses, hence notes taken from the patient record were the main documents collected. Notes from the patient record and from signs SLTs wrote to place

above patients' beds were used to explore differences in how communication and swallowing information were reported. Information copied down from the patient record included SLT and nurse entries that related to swallowing and communication. This included content that was loosely related, for example nursing entries such as 'nil concerns voiced', as well as information I considered potentially of interest to either profession, such as reference to a visit from a family member.

Data pertaining to the patient record was not only collected for content, but also to understand the context in which it was created and used (Jacobsson, 2016). Contextual information related to how, when and where SLTs and nurses engaged with the patient record, and perceptions from interview of the purposes and readership of the record. Exploration of the context in which entries were made and read provided additional information about the impact of the temporal-spatial context. For example there was less opportunistic conversation during note writing in the ward that had electronic records in comparison with the two wards using paper records. Other documents encountered during fieldwork provided additional sources of contextual information, such as handover sheets, goal-setting schedules, information posted on notice boards about training events, and notices about patient care priorities.

5.5 Sampling

Diversity was accomplished by conducting fieldwork across different time periods, activities and routines. Decisions for when to conduct periods of fieldwork were taken with consideration for the different work schedules of SLTs and nursing staff. Each group was contracted to work 37.5 hours a week, however this was spread over five days for SLTs (with rotational Saturday morning cover on one of the wards), and for the nurses over three long days or nights. Although the focus of inquiry was on exchanges of information between SLTs and nurses, it was important to experience the nursing day more broadly for the purposes of: (a) capturing information of SLT relevance that passed between nurses, (b) increasing understanding of how nurses managed SLT relevant issues in the absence of SLTs, and (c) increasing appreciation for how professionals occupied ward space in and outside of therapy hours. Being present outside of times that SLTs were on the wards also contributed to development of nurses' acceptance and trust in me as a researcher.

The majority of fieldwork was conducted during times when both professions were scheduled to work, however over the course of the study, fieldwork periods covered 0715 to 2030, seven days a week. I often commenced fieldwork at morning handover

in order to begin the day with the nursing staff. Handover was the key time when the nurses were together as a group and not involved in direct patient care, hence as well as enabling me to capture information about how nurses shared information amongst themselves about swallowing, communication and general management, it was an important space for building relationships and trust with the nurses. The length of the fieldwork episodes varied according to activities I was seeking to sample. The majority were three to four hours in duration, and this was usually enough time to capture a sample of activities on the ward, including meetings and moments of interaction. The shortest period was one hour, for the purpose of attending a night shift handover and the longest was 12.5 hours in order to experience a full nursing shift.

Sampling with regard to which nurses to observe was largely opportunistic and heavily dependent on the presence of nurses on a particular shift who had consented to participate in the study. Observation and shadowing of the SLTs was far more straightforward because the SLTs allocated to the wards consented at the start of the study. The nurses entered the study in a less timely way which meant that I was only able to capture conversations between SLTs and nurses when the nurse she was speaking to had given consent to participate.

Sampling for SLTs was exhaustive, reflecting the fact that they were far fewer in number than nursing staff. All the SLTs assigned to, or providing occasional cover, to the wards were observed, and all bar one of these were interviewed. Nurses were purposefully sampled to participate in interviews, with the aim of achieving diversity with respect to years of experience and gender.

The patient records viewed represented something between a purposive and a convenience sample. The aim was to include a range of severities of communication and swallowing difficulties and this was accomplished. However, as will be discussed later, sampling was influenced by the presence of patients on the ward considered able to consent.

5.6 Method of Analysis

Three main sources of data have been analysed in this study: field notes, semi-structured interviews, and documents. The account that follows explains the interactive process between researcher and data that evolved throughout the study (Lofland, Snow, Anderson & Lofland et al., 2006): during fieldwork within each ward; when

conducting preliminary analysis in between fieldwork episodes; when sharing preliminary findings with participants, and after fieldwork was completed.

There is no singular approach to analysing ethnographic data (Fetterman, 1998). Hammersley and Atkinson (2007) conceptualise ethnographic data as 'materials to think with', strongly rejecting step-by-step approaches to data analysis. They do however provide broad guidance. They suggest following a number of stages including repeated reading, some means of sorting the data, noting patterns and contradictions and developing sensitising concepts, categories and potentially typologies, with an ultimate aim of achieving thick description (Hammersley and Atkinson, 2007), that is, explanation that is sufficiently thorough to enable meaning to be read from the description (Geertz, 1973). Hammersley and Atkinson (2007) also emphasise the iterative way in which the focus of interest is developed in ethnographic inquiry. Foreshadowed problems are gradually transformed into more specific understanding of what is *really* going on in the researched setting. Their approach to analysis was attractive in that it demonstrates respect for creativity in the inductive process and the authors have credibility as a frequently cited source in ethnography. However as a novice researcher I *did* feel the need for some step-by-step guidance at the start. For this reason, I used the process of domain analysis (Spradley, 1980) for preliminary analysis of data during and following fieldwork on the first ward. Domains are categories of meaning that include activities and talk that are related to each other, for example by being a 'kind of' or 'reason for doing' X or Y. Domains were identified through repeated reading of the field notes to generate handwritten lists of observed behaviours under a number of domains. However, the interview data did not feel congruent with these domains and was therefore organised differently, into broad category codes using NVIVO 11. Hence at the end of a five-month period of preliminary analysis prior to starting on the second ward, the observation and interview data had been subject to different analytic processes.

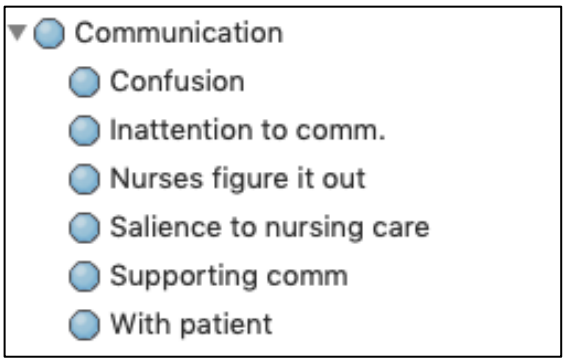
The process of domain analysis was helpful in focusing my inquiry in the second ward. For example, the domain 'result of interruptions' included 'note writing takes longer' and I entered the second ward attuned to look for further evidence of this domain. However I needed a method of analysis that would more coherently bring together the field and interview data. During the second period of preliminary analysis (seven months) between the second and third ward, I returned to the overarching guidance from Hammersley and Atkinson (2007) and began to use their broadly defined process of identifying and contrasting patterns and categories as described above. The field note data was coded within the same coding frame as the interview data. The codes

remained quite broad but were continuously revised with the addition of each new piece of data in a process of constant comparison. At this point I asked one of my supervisors to independently code three pages of field notes and three interviews. Coding decisions were were discussed and compared and informed development of coding categories on entering the next site. The outcome of this second stage of preliminary analysis was a refined focus for starting fieldwork in the final ward. Fieldwork and interviews in the third ward were directed towards seeking evidence confirming and disconfirming preliminary findings from the first two wards, as well as specific attention to a new research question relating to the circumstances that raise the salience of communication information to a level sufficient for it to be shared.

Preliminary analysis of findings was presented to SLTs and nurses from the researched wards between fieldwork on ward two and three, and after ward three. The initial intention had been to use a workshop format to present to SLTs and nurses together. However, the nurses had limited capacity to come together in this way and thus feedback was presented in disciplinary groups. The SLTs were able to allocate much more time than the nurses to the feedback sessions resulting in greater depth of discussion, and mirroring the temporal-spatial differences reported in the findings. The aim of the feedback sessions was to hear perspectives on the resonance of preliminary findings for the purpose of further questioning the data, rather than to confirm their 'truth' (Sandelowski, 1993). The response by the SLTs and nurses in attendance indicated that the developing focus of inquiry had resonance, and their feedback contributed to the on going analytic process. For example whilst the nurses in ward three confirmed that communication was of lower priority than swallowing information, they also expressed that in previous years SLTs had been more active in promoting communication, such as by providing specific tools for patients. This provided some context and resulted in deeper inquiry into the cyclical nature of inattention to communication information.

At the end of the data collection period, a final intense period of data analysis commenced. The field notes and interview data from ward three were coded within the existing coding frame. This involved revision of categories as data was compared and resulted in a stable set of categories. Figure 5.1 illustrates that nodes in NVIVO functioned both as simple collecting places, such as all references to 'confusion', and for holding more analytic concepts such as 'inattention to comm.' (communication), which included evidence of lack of attention by either discipline towards information about communication.

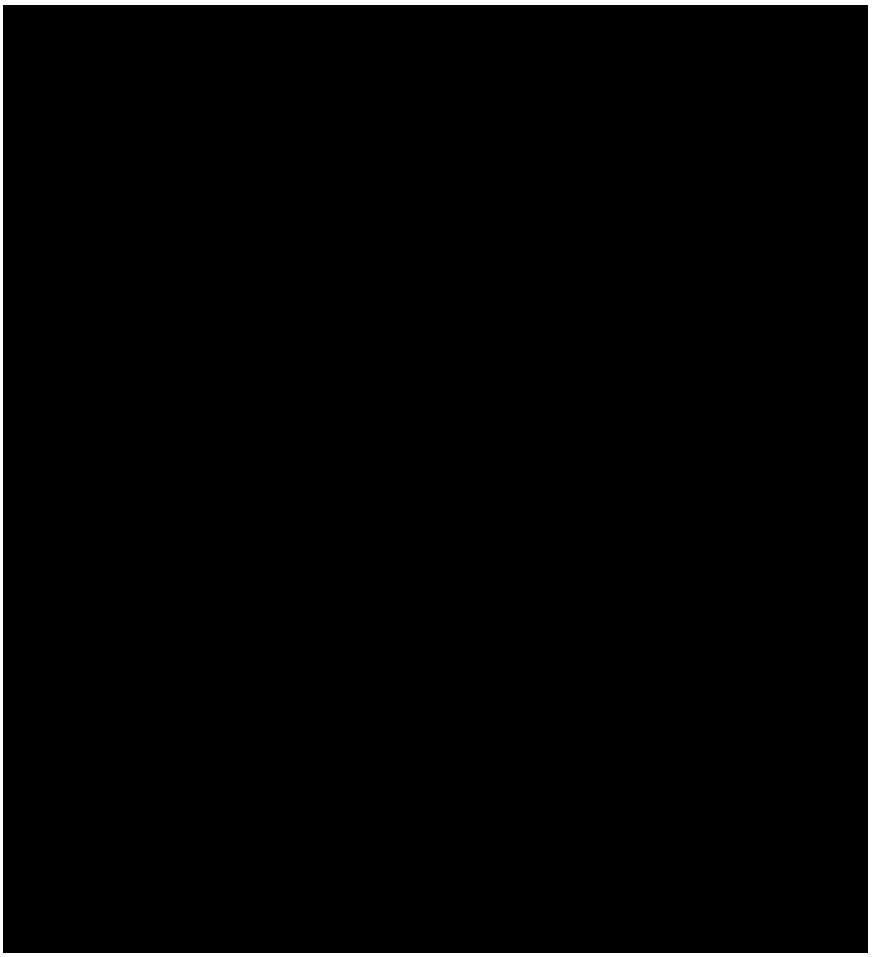
Figure 5.1: Example of a Coding Frame



The dialogue contained within the field notes was coded in two ways: (1) the meaning contained within the dialogue was coded within the category nodes, and (2) where different sources of dialogue related to the same patient, they were sequenced using the case node function in NVIVO. This included short sequences such as dialogue relating to information from handover and a team meeting, and longer ones including informal SLT-nurse interaction. These sequences of dialogue were used to illustrate interpretations. Contextual data relating to use of documents was coded with the category nodes. Notes taken from the patient record were considered as field note data but were not typed to retain the essence of how they appeared on the page. They were manually coded for the primary purpose of highlighting disciplinary orientation to recording of swallowing and communication information and to indicate entries that appeared to serve more of a communicative than an archival function.

Once the data were coded into categories, analysis switched to a paper-based process in which patterns and relationships were creatively explored. This suspension of formal coding was intended to reduce the risk of becoming too attached to particular ways of summarising the data and thus reaching interpretations too soon (Thorne, 2016). Thorne recognises the particular issues faced by clinicians researching within their own professions and suggests systematic questioning of how disciplinary knowledge might influence researcher interpretations of data. Guided by her advice, I worked the data differently each time I returned to it, with the aim of viewing it in alternative ways, questioning why I was seeing things in certain ways and whether a nurse might see different meanings (Thorne, 2016). This was a very practical and creative exercise that involved mapping concepts, exploring new patterns and actively seeking negative cases. The following extract from my analytic notebook is illustrative of the process of exploring patterns in the data.

Figure 5.2: Extract from Analytic Notebook



The appeal of confirmatory findings was actively resisted through careful analysis of contradictory data. I was guided by Thorne's advice against 'misinterpreting frequency' (Thorne, 2016: 156). She argues that few instances of a phenomenon do not necessarily mean the data is not important. However such data needs to be *worked* before it can be accommodated within findings, and this involves critical questioning by the researcher of what they are seeing and may not be seeing in the data (Thorne, 2016:160). I searched for negative cases and examined whether they supported findings, demanded re-evaluation of findings, or were idiosyncratic outliers (Rapley, 2011). The final stage of analysis occurred during the writing process and is explained in 'Introduction to the Findings', preceding chapter 7.

5.7 Ethical Considerations

Ethical approval from NRES Committee North West Preston was received on 30th March 2015. REC reference: 15/NW/0271: IRAS project ID: 166663 (Appendix 4). The process of completing documentation for ethics committees and Trust Research and

Development departments highlighted how different ethnographic research was from the kind of research the procedures were set up to accommodate (Murphy & Dingwall, 2007). An ethnographic inquiry is expected to undergo change in focus as it develops, making it less straightforward to fully anticipate the consent and risk issues at the start. I found the process confusing, but was keen to meet the requirements of the committee in order to make a timely start on the fieldwork. Morse and Savage (2002) argue that more understanding is needed from ethics committees that ethical considerations are ongoing in this kind of research. They give an example of how in their efforts to pre-empt the committee's concerns, they created a repeat verbal consent process that had a negative effect on research relationships (Morse & Savage, 2002). It can be difficult at the start of ethnographic research in hospitals to clearly define who the participants are (Murphy & Dingwall, 2007). The large numbers of people coming and going on a ward can mean that seeking consent from everyone would actually be disruptive (Goodwin, 2006). Patients and visitors were alerted to my research presence by a single page information sheet. I repeatedly introduced myself to members of the wider interprofessional team as I encountered them and explained that my research interest was in the nurses and the SLTs. However, this was only ever partially successful due to the numbers involved and their concern with getting on with clinical tasks and I was just one face amongst many on the ward. I dressed in a blue polo top and black trousers in order to blend in with other HCPs and it became evident that others made their own interpretations of my role. For example whilst introducing myself, a couple of clinicians told me that they had taken my standing and watching behaviour as an indication that I was an infection control nurse.

The ethical issues that were encountered in this research relate to the immersive nature of participant observation. Personal integrity and an orientation towards ethical behaviour as a registered healthcare professional acted as a stronger guide through these issues than institutional ethics. One positive effect of the difficulties I experienced in finding an immersive role was that my researcher position remained quite visible, and I did not encounter some of the difficulties reported by other researchers, such as changed relationships as a consequence of regretted disclosures (Burns et al., 2012). Participants can forget why you are there, however they sometimes demonstrated in light hearted ways that they were alert to my researcher role, for example on one occasion when a therapist was bemoaning an interaction that had taken place, she looked to me and said 'don't minute that'. However, there were occasions where my researcher role was more blurred, for example over lunch in the staff room. I was guided by my own moral compass and appreciation that 'knowledge production comes

with moral responsibility towards research participants' (Ryen, 2011:432). However, this was not always an easy line to tread and I was mindful that my purpose for being in the setting was research.

Fieldwork over an extended time frame depends on good relationships, and maintaining these requires trust and ethical decision-making in the moment (Murphy & Dingwall, 2007). For example when asking to shadow members of staff who had previously given consent, I was sensitive to how they replied, if their agreement was tentative, I would check their assent. This illustrates the on going negotiations involved in consent and a willingness to sacrifice data due to the imperative to preserve relationships and retain access to the field. Murphy and Dingwall describe this as 'self-denying ordinance' (2007:2230). The relationships I developed with nurses created an unexpected ethical dilemma in relation to observation of sub-optimal practice. As I began to see things more as they did I became less certain about what sub-optimal really meant. For example patients had signs above their bed signalling the amount of supervision required for mealtimes, however there were often more patients needing supervision or assistance than there were nursing staff. Patients advised to have full supervision might periodically have distant supervision as the nurse attended to another patient. As a clinician I was aware that nurses don't or can't always follow recommendations to the letter but I was now face to face with it as a pragmatic reality. Even though I did not consider the situations to be dangerous, had I been there as a practicing SLT I might have felt compelled to say something.

Protection of identity is a particular concern in ethnographic research because the research involves spending long periods of time with relatively small numbers of people. This was less marked for the nurses than the SLTs because they were greater in number. Reporting has attempted to give enough information about the settings and the staff for readers to make sense of the findings, balanced with the need to protect identity. Nevertheless, it has been argued that despite concerted efforts by researchers to conceal identity there will inevitably be some clues that point to a narrow range of settings, in addition, it is important to be aware that protection of identity has potential epistemological implications (Goodwin, 2006). For example, in the meta-ethnography reported in chapter two (Barnard et al., 2018) one of the studies did not attribute quotes by profession in order to protect individual professionals from potential identification. The cost was that the voice of each profession was represented as a homogenised 'team' voice, constricting the interpretative potential of the research and the potential for the findings to be extended by other researchers (Burton, Fisher & Green, 2009).

During fieldwork I was present in spaces where patient information was routinely shared, requiring protection for confidentiality. I wrote my notes quite openly in these spaces and no one asked to see what I was writing down. I thus needed to adopt strict self-governance and was careful not to write down any identifying information and to only note information relevant to my inquiry. Self-governance was also required when seeking consent from patients. The process as set out in the ethics application was that the SLT or nurse would advise if patients were able to consent, however even when given permission to approach patients, I made my own judgments. For example talking through the forms with one patient caused me to question whether she did in fact understand, and led me to discontinue the process despite being very keen to see what was written in this patient's notes. It is easy to see how, in the pursuit of recruitment, consent can be taken that is not really informed, even where it follows the process laid out in the ethical application.

A particular ethical concern with this research related to my shifting insider-outsider positioning with the two professions. For example nurses and SLTs would tell me things in the confidential space of the interview, which I would want to explore through interviews with other participants and fieldwork, and I needed to do this in a generic way that could not be attributed to a particular person. These issues and others during fieldwork observations brought attention to how the writing of the study would represent the setting and the participants, and this may be where the most risk to participants lies (Murphy & Dingwall, 2007). Beyond protecting identity the researcher has a responsibility to protect the spirit in which information has been shared, whilst at the same time as meeting the need to share new knowledge. The pursuit of balancing my goals as a researcher with my commitments to ethical practice (institutionally, clinically and personally) was aided by conscientious completion of my reflexive diary, discussion in supervisory meetings, and with critical friends from my PhD community.

6. Settings and Participants

6.1 Introduction

The purpose of this chapter is to describe the wards and the research participants included in the study. The chapter begins with discussion of the pre-fieldwork considerations involved in site selection, followed by information about the three included wards. Key characteristics of staff and patients are summarised and recruitment issues discussed.

6.2 Site Selection

The research was conducted in three wards across two NHS Trusts (for R&D purposes each Trust was a separate site). The study commenced as an exploration of interprofessional practice at different points in the inpatient care pathway for patients with neurological conditions, in a single NHS Trust. The first site had provision for three points of care across two hospitals: hyper-acute stroke, acute stroke rehabilitation and sub-acute neurorehabilitation. The study experienced an early set back when the neurorehabilitation ward withdrew their interest in participating. Unsettling as this was, it created an opportunity to redirect the inquiry in light of preliminary analysis of findings on completion of the first episode of fieldwork. It was evident that the integrity of the study could be improved by gathering data from an additional acute stroke rehabilitation unit in a different Trust, narrowing the focus to stroke, and increasing the potential for transferability of the findings. The decision was taken to identify a stroke unit in a second NHS Trust that offered some contrast to the first two units. The first unit would be classified as 'mixed rehabilitation' because it was embedded within two neighbouring general neurology wards (SUTC, 2013), and the second was a dedicated hyper-acute stroke unit at a different hospital in the same Trust. Hence a contrast could be afforded by seeking a dedicated stroke unit in a new Trust. An important benefit of the addition of a further NHS Trust was the increased capacity to protect participant anonymity, particularly SLT participants because of their fewer numbers.

The decision of which Trusts to approach was a pragmatic one. Securing access to healthcare settings requires the support of gatekeepers and I took advantage of my insider status to capitalise on personal connections arising out of previous employment at both Trusts. Negotiation of access drew early attention to issues of researcher position in conducting ethnographic research within a familiar environment. Although many aspects were familiar to me (the SLT profession, the three hospitals, stroke

care), I had not worked in an acute setting for several years, and was more distant from the nursing profession. My reading of the literature had attuned me to the challenges associated with balancing familiarity and analytic distance (Burns et al., 2012; Thomsen, 2011). However, I had not anticipated the speed and frequency with which I would move between these two states as a consequence of researching my own and another profession. When introducing the study I worried that nurses would read hidden motives into my research (Blix & Wettergren, 2014). In the event, the only suspicion that was voiced during pre-entry negotiations came from concerns within my own profession that the study might reveal flaws in SLT communication skills. This appeared to relate to issues of role vulnerability, due to SLT positioning as 'experts' in communication, and fear of identification due to SLTs being small in number. The experience was a cautionary reminder not to make assumptions about the beliefs of the two groups, and issues relating to familiarity and distance featured heavily in my reflexive notes throughout the research. The experience also led me to give careful consideration to protecting anonymity when writing up the findings (Goodwin, 2006).

6.3 Characteristics of Research Settings

Wards have been given fictional names: Shelley (Trust one), Keats (Trust one) and Brooke (Trust two). The teams referred to themselves as 'the MDT' (multidisciplinary team). The core professionals expected to be present at MDT meetings included nursing representatives, treating therapists or therapist representatives in cases of absence, consultants and doctors. The term 'therapist' is used to refer to SLTs, physiotherapists and occupational therapists. Other people were also variably present in meetings; this included neuropsychologists, social workers, dieticians, discharge coordinators, nurse specialists, students, SSNAP administrators and researchers. The periods of fieldwork on each ward are summarised in table 6.1. Allocation of staffing and stroke beds is summarised in table 6.2. Staffing numbers represent establishment figures provided by nursing and SLT service managers.

Table 6.1: Fieldwork Summary

Name of ward	Type of ward	Duration of fieldwork	Fieldwork hours
Shelley (A and B)	Mixed rehabilitation/stroke rehabilitation unit (acute)*	16 weeks** Sep 2015 to Dec 2015	124.5
Keats	Hyper-acute stroke unit	12 weeks Jun to Oct 2016	110
Brooke	Stroke rehabilitation unit (acute)	12 weeks May to Jul 2017	122.5

*The therapists and doctors worked exclusively with stroke patients, whilst nurses covered the whole of a single ward (A or B), intermittently allocated to stroke bays.
**The longer duration on Shelley reflected need to split observations across two wards and build relationships with two different nursing teams.

Table 6.2: Allocation of Staffing and Stroke Beds

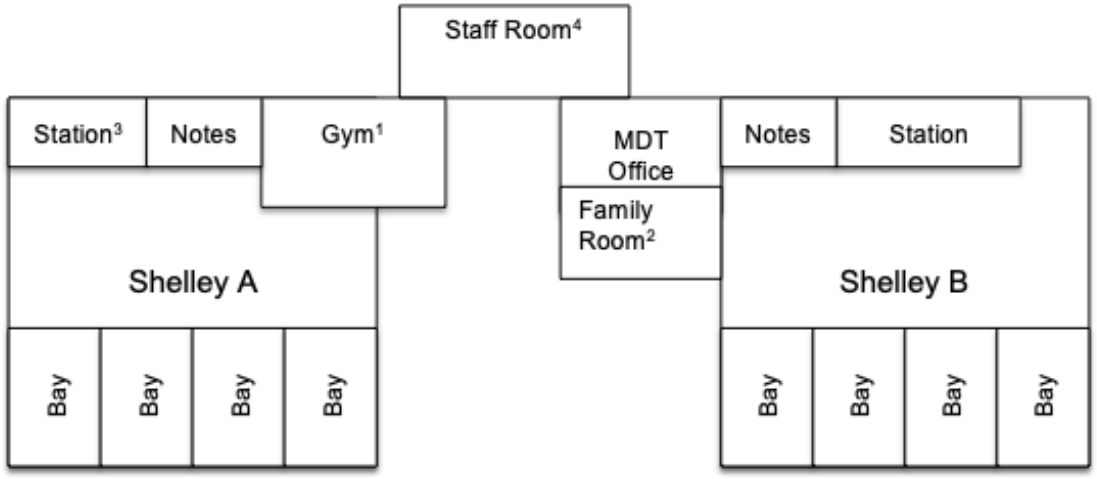
	Shelley	Keats	Brooke
Allocated beds	17 (across A+B)	18	24
Nurses	54 (A+B)	40	15
Nursing Assistants (NA)	18 (A+B)	6	11
SLTs	2 (1.4 WTE)	2 (1.2 WTE)	3 (2.5 WTE)
SLT Assistants (SLTA)			1 (0.5 WTE)

6.3.1 Characteristics of the Wards

Schematic diagrams are presented below to illustrate positioning of therapy offices, staff rooms, nursing stations and meeting spaces across the three wards. This is followed by a summary of ward characteristics. For reasons of simplicity and focus, the diagrams are not to scale, and do not include side rooms, clean and dirty utilities, drugs rooms, and offices or spaces dedicated to other professionals, unless these were also used as spaces for meetings. Rooms that were used for other purposes of relevance to this study are labelled as such. The SLTs on Keats were permanently located on the ward, whereas those on Brooke and Shelley shared neighbouring office space with other therapists. On Brooke, the office was occupied by therapy staff alone, and on Shelley, other allied health professionals and junior doctors shared the space.

Shelley Ward

Figure 6.1: Layout of Shelley Ward



[1] Used for MDT meeting

[2] Used for handover on B

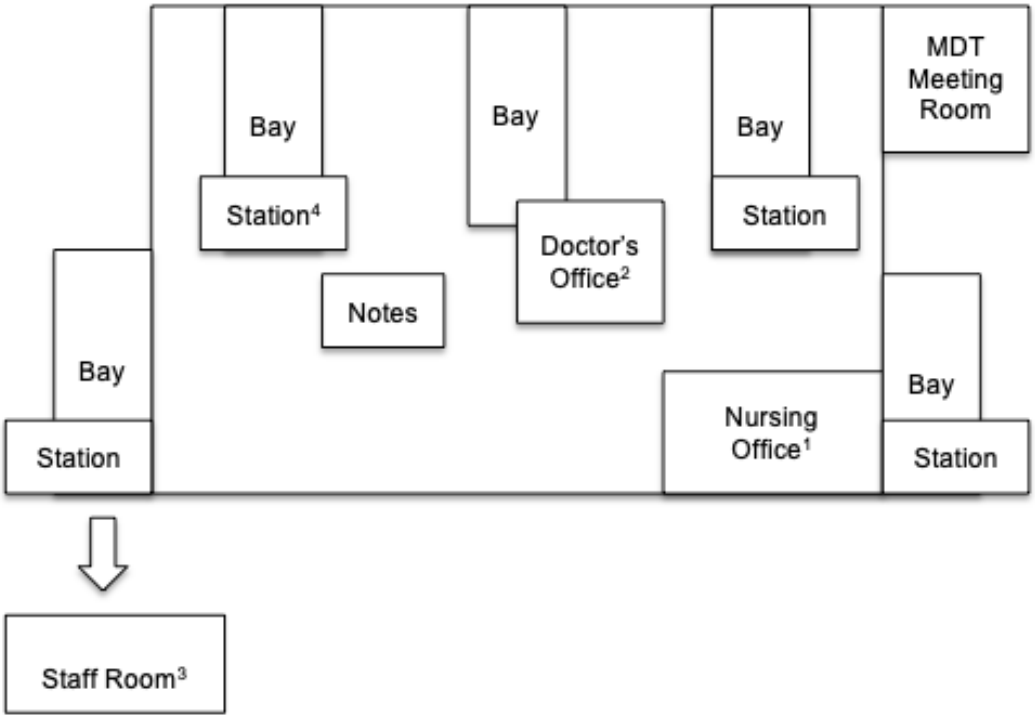
[3] Used for handover on A

[4] Used by all

Ward Characteristics: Shelley was a stroke unit made up of two gender specific wards, A and B, separated by a corridor. Patients were admitted to the wards following early admission to the hyper-acute stroke unit (Keats). Shelley comprised a dedicated stroke team that included therapists and doctors that worked exclusively with the stroke patients across the two wards. Nurses were allocated to work on either A or B ward and worked with stroke patients as well as medical neurology patients, thus the majority of the nurses did not identify themselves as stroke nurses. Although there were 17 dedicated stroke beds across the two wards, the actual number of patients admitted with stroke and managed by the stroke team was often higher in number.

Keats Ward

Figure 6.2: Layout of Keats Ward



[1] Used for nursing handover and also by MDT to make hot drinks

[2] Used by MDT for afternoon meeting

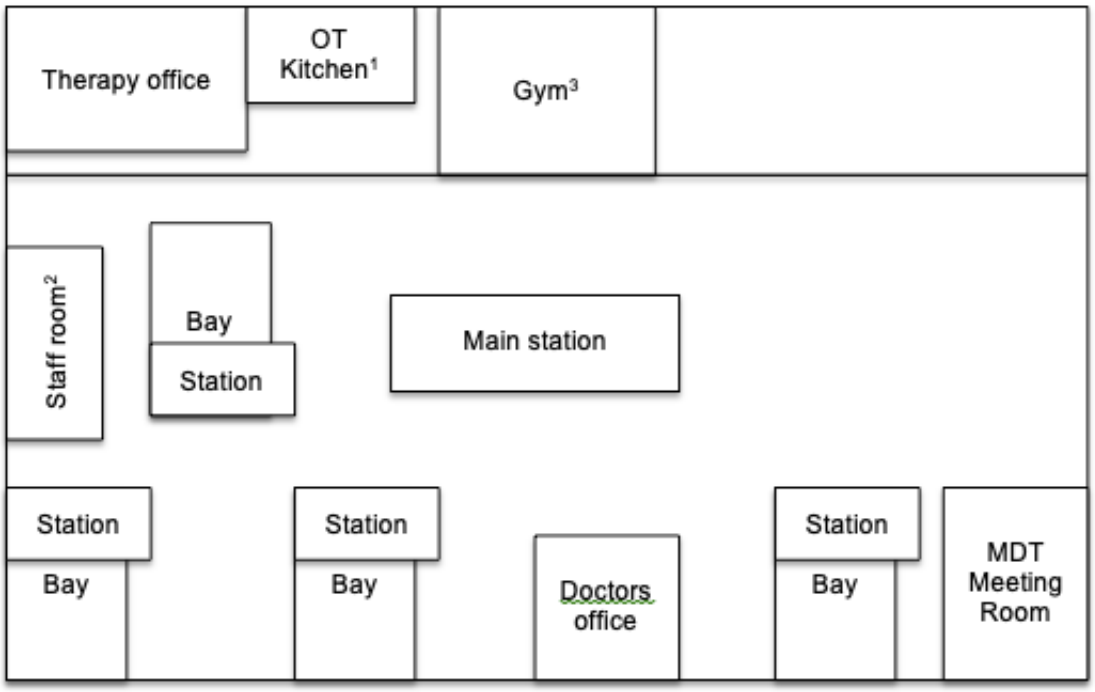
[3] Used by nurses and therapists but shared with neighbouring ward

[4] Therapists' home base

Ward Characteristics: Keats was a hyper-acute stroke unit (HASU) located in a different hospital in the same Trust as Shelley. This ward included nursing roles not present on the other two wards; (1) some of the nurses were trained to deliver thrombolysis treatment (a clot busting treatment administered in the first few hours of stroke presentation), (2) one nurse on each shift was allocated to repatriation; this nurse was not usually responsible for a bay of patients on that shift, but was dedicated to liaison for onward referral to other hospitals or wards, with the aim of expediting discharge, and (3) several of the nurses were trained by SLTs to screen newly admitted patients for swallowing difficulties. In addition to the 18 beds on the unit, stroke patients awaiting a bed on HASU ('outliers') were included in the caseload.

Brooke Ward

Figure 6.3: Layout of Brooke Ward



[1] Used as a lunch space by therapists

[2] Used only by nursing staff

[3] Used as a meeting space by therapists

Ward Characteristics: Brooke was a stroke unit in a different Trust. Patients were admitted from hyper-acute wards outside of the Trust, to 24 dedicated stroke beds. Medical records were electronic. A Saturday service was provided by the SLTs on this ward, with one SLT and SLT Assistant (SLTA) working a four-hour shift on a rotational basis.

6.3.2 Structured Routines

Structured routines that were common to SLTs and nurses across all wards were team meetings and writing in the patient record. Other routines included regularly scheduled interprofessional training (mostly attended by therapists), nursing handover and goal setting (a therapist activity).

Meetings: The most substantive meeting was referred to by participants as 'the MDM' or the 'MDT' on all wards, and was distinguished from shorter 'whiteboard' meetings, which were quick fire meetings based around the full list of patients (listed on a

whiteboard) intended for raising immediately pertinent issues. The rooms used for team meetings were not large enough to easily accommodate those in attendance. On Shelley, the treatment gym was used for the MDM, but it was too small for the purpose and conditions were very cramped meaning that people were often out of the line of sight of each other. On Keats, the MDM was held in a dedicated meeting room, however it was awkwardly laid out. There was an immovable row of about ten chairs attached together on one side, and on the other side there were three or four movable chairs around two sides of a small table. The consultant and the nurses usually occupied the movable chairs, other professionals sat on the immovable chairs in a row, and doctors stood up at the notes trolley. Parties could get adequate sight of each other by leaning out of their seats but the arrangement was not ideal, and two separate Consultants were heard to joke that it felt like they were doing an interview. Brooke had a dedicated meeting room with a central table that was just large enough for all the parties to sit around for the MDM. This space was too small for the whiteboard meeting and some sat at the table, whilst others sat on chairs around the edge or stood.

The minimum of weekly meetings for stroke teams recommended in the National Clinical Guideline for Stroke (Rudd et al., 2016) was met on Shelley, and exceeded on the other two wards:

Table 6.3: Meeting schedule

	Shelley	Keats	Brooke
MDM	Weekly	Daily (weekdays)	Once a week
Whiteboard	N/A	Daily (weekdays)	Four weekdays

On Shelley the weekly MDM took place after a ward round at 10am. On Keats, a seated MDM was held after a ward round every weekday morning at 10am with a briefer whiteboard meeting at 4pm held in standing position in the doctors office. Brooke had meetings on each weekday, four of which were brief whiteboard meetings, and one of which was what was considered the MDM proper, in which all the patients on the ward were discussed in depth. The MDM on Brooke was actually two meetings as therapists were divided into two teams; hence each team attended an MDM either in the morning or the afternoon, whilst the doctors and a senior nurse attended both.

The SLT allocated full time to the ward attended all meetings. SLTs that were allocated to the wards part time had more variable attendance. The ease with which nurses were able to balance attendance at meetings with other demands varied across the three

wards. On Keats and Brooke, the attending nurse was usually a senior nurse with lighter direct care-giving responsibilities, and on Keats, the nurse responsible for repatriation on that shift also attended. Attendance was more challenging for nurses on Shelley than other wards, because nurse representatives were usually direct care-giving nurses who happened to be allocated a bay where the stroke patients were sited, essentially these nurses held intermittent membership of the stroke team on the shifts in which they nursed stroke patients. The MDM in Shelley was split in two parts; a nurse representative from one ward presented their patients and left the meeting, to be replaced by a nurse representative from the other ward. The nurse representatives from Keats and Brooke stayed for the duration of the meeting.

Nursing Handover: Handover on the three wards occurred at the beginning and the end of each shift. On each ward there was a ward handover to the full incoming nursing team about all the patients, based around a handover sheet. On Shelley and Keats, the outgoing senior nurse, or nurse in charge usually prepared the handover sheet and delivered the ward handover. On Brooke, the outgoing nurses from each bay completed the handover sheet for their own patients and handed them over by entering and leaving the meeting in succession. There was a second stage of more detailed handover on Shelley and Keats on the ward, whereby the outgoing nurse from each bay handed over to the incoming nursing team allocated to that bay. Other than on Shelley A, where nurses stood at the nursing station, the full ward handover took place in a separate room. This created an uninterrupted space for the full nursing shift to come together away from the demands of patients.

Nurse-Therapist Handover: On Shelley, one of the therapists would start the day by asking a senior nurse or the individual bay nurses if there was anything of relevance to therapies from the nursing handover. The therapist would pass on the information gained during a brief timetabling meeting with the other therapists, prior to going out onto the wards. Brooke had previously used a similar system, but the team had found the repeated handing over of information time consuming and inefficient, and it had been changed to the whiteboard meeting, which was attended by one nurse and the rest of the team. On Keats, there was no formal sharing of information from nursing handover with therapists, however therapists commenced the day with a brief meeting amongst themselves based around the nursing handover sheet.

Other Structured Routes for Information Sharing: SLTs and nurses both completed entries in the patient record, which was paper based on Shelley and Keats and electronic on Brooke. Shelley and Brooke had weekly scheduled teaching sessions of one-hour duration. These sessions were intended as learning opportunities for the full team but were mostly delivered and attended by therapists. SLTs on Shelley and Brooke participated in scheduled goal-setting meetings with other therapists at least twice each week. Nurses did not attend these meetings.

6.4 Participants

Participants recruited included qualified SLTs, one SLTA, registered nurses, nursing assistants and patients. Members of the wider interprofessional team were not participants; they were formally made aware of the study by the lead consultant at multidisciplinary team meetings. Posters were displayed in profession-specific spaces to introduce the study and the researcher to the wider professional group. SLTs and nurses were also frequently in communication with other professionals who weren't part of the study and throughout the fieldwork I introduced myself to other professionals as I encountered them and directed them to the posters. Other professionals presented an ethical dilemma as it was sometimes necessary to reflect the other side of an interaction in order to make sense of what SLTs or nurses were responding to when writing field notes. This was discussed with the supervisory team and the agreed approach was to advise other professionals that SLTs and nursing staff were the focus of the inquiry and seek verbal consent to make brief anonymous notes of their side of the interaction when needed for context. When other professionals are referred to in the findings they are referred to by broad categories such as therapist or doctor rather than physiotherapist or consultant for example, unless essential to meaning. The combined use of field notes and interviews made it possible to overcome some of the limitations associated with not having other professionals as part of the study. For example, therapists were sometimes seen asking SLTs to do joint sessions with them with patients they found hard to communicate with, which nurses were not observed doing, and the interview provided an opportunity to explore this SLT-therapist activity further.

6.5 Recruitment of SLTs and Nurses

Prior to commencement of the study I delivered formal presentations at interprofessional team meetings in both Trusts. SLT team leaders provided an additional opportunity to present to the acute SLT team during SLT meetings, and most SLTs consented to participate within the first few days of fieldwork. It was more difficult

to provide pre-entry information to the nursing staff as few direct caregiving nurses attended the formal presentations. I arranged further discussion with nurse leaders, and their preferred approach was that they introduce the study to their teams by email. Recruitment of nursing staff occurred once the study had commenced and involved regular introductions in the time-pressured environment of nursing handover, followed up with informal approaches to talk them through information sheets (Appendix 5). The process of seeking consent from nursing staff usually took several weeks, affected by shift working patterns and frequent interruption due to the immediacy of nurses' work with patients.

6.5.1 SLTs Included in the Study

All 15 SLTs allocated to, and providing occasional cover to the three stroke wards participated, in addition to one SLTA. Interviews were conducted with 14 SLTs and the SLTA. One SLT was observed but left the Trust before an interview could be arranged. Biographical information has been provided in composite across the three Trusts because revealing the bandings could potentially identify sites, giving clues to the identities of participants.

- All SLT participants were female
- NHS Pay Bands: 8b (n=1); 7 (n=8); 6 (n=4); 5 (n=2); 2 (n=1)
- Years of experience*: Range 1.5 years to 27 years, Mean = 7.7 years
  *Data collected for interviewed SLT staff only.

6.5.2 Nursing Staff Included in the Study

A total of 57 members of nursing staff participated; 50 nurses and 7 nursing assistants (NAs). Of these 28 (24 nurses and 4 NAs) were interviewed, and an additional 29 (26 nurses and 3 NAs) were observed but not interviewed. One nurse and one NA declined to participate. Every effort was made to create a purposive sample of nursing staff, to include diversity in gender, grade and experience working on the ward. All covered both day and night shifts. I was careful to reduce distortion by approaching nursing staff that appeared more reticent, as well as those that were open and welcoming towards me. However issues with obtaining consent meant that convenience also played a role in sampling decisions. Because my interest was in exchanges between SLTs and nursing, there was an imperative to have sufficient nursing staff consented into the study to be able to listen in on the conversations between them. The higher numbers of participants from nursing makes it possible to include a breakdown of information about nursing participants by ward, without compromising identities.

Table 6.4: Summary of Nursing Participants

	Band 2-3	Band 5	Band 6	Band 7	Total
Shelley (20)					
Interviewed and observed	1	6	2	1	10
Observed only	1	6	2	1	10
Female (10) Male (10)					
Keats (19)					
Interviewed and observed	2	4	2	1	9
Observed only	1	8	3	0	12
Female (17) Male (5)					
Brooke (16)					
Interviewed and observed	1	6	1	1	9
Observed only	1	5	1	0	7
Female (14) Male (2)					

Information relating to years of experience was only captured for interview participants:
Shelley: Range 4m to 15 years, mean = 5.2 years
Keats: Range 1 to 22 years, mean = 7.2 years
Brooke: Range 1 year to 40 years, mean = 13.4 years

The most notable differences between the SLT and nursing participants relate to gender and their position on the pay scale. All the SLTs were female compared to 31 (72%) of the nursing staff. The majority of the nursing participants (61%) were employed at band 5, in contrast to SLT participants, of whom only a third were employed at band 5, and over half were employed at band 7 or above. Level of experience was markedly higher for the nursing staff on Brooke ward.

6.6 Recruitment of Patients

Patients were alerted to the study through provision of a single page overview of the project, including the researcher's photograph (Appendix 6). Patients with swallowing or communication difficulties, considered by their SLT or nurse to be able to consent, were invited to participate and talked through an information sheet (Appendix 7). No further input from patients was required beyond the consent process itself. Consent was required for me to view SLT and nurse entries in the patient record. The initial intention was that dialogue between SLTs and nurses be audio-recorded and this required consent from the patient they were discussing. However this aspect of the project was abandoned due to the requirement for consent from all three parties, SLT,

nurse and patient. Changes to the process of shadowing removed the need to enter patients' space and thus the dialogue between SLTs and nurses took place outside of the context of patient care. I used my professional SLT experience to support patients with communication difficulties to understand the consent process, and to discontinue the process if I was not confident the patient had understood.

6.6.1 Patients Included in the Study

The intention was to purposively sample patients for access to their records, with the aim of including records from patients with a range of severities of communication and swallowing difficulties. I had aimed to recruit 25 patients to the study, based on the number recruited for a previous ethnographic study of interprofessional documentation (Liu et al., 2014). Nineteen patients were recruited, reflecting the difficulties in recruiting patients in acute settings. A large number of the patients were too unwell to be approached for consent, or were judged by their SLT as unable to participate due to reduced cognitive or language skills. A particular difficulty on Keats was the short admission times of the patients, thus the included patients were closer to a convenience sample. The following extract illustrates some of the difficulties experienced in recruiting patients with acute care needs:

> There are three potentially consentable patients on the ward today and the SLT introduces me to all of them. One of them is quite sleepy and his daughter suggests now not a good time so I leave them with an information sheet, she also makes a point about the amount of people approaching for research on the ward and I feel it is best to give them some space. Another patient gets whisked off for a scan as I approach, when he returns he has physio and then lunch. So by the time he is free he is fast asleep. The last one is able to consent.
> [Keats: FN080716].

The included patients had a range of severities of difficulties with both communication and swallowing. Of the 19 patients, 18 had communication difficulties and 14 had swallowing difficulties. Six were recruited from Shelley, eight from Keats and five from Brooke. There were nine women and ten men. Information regarding severity is provided below, based on initial SLT entries about communication and swallowing in the patient record.

Table 6.5: Severity of Communication and Swallowing Difficulties

	Communication	Swallowing
Mild	7	3
Mild to Moderate	1	0
Moderate	6	3
Moderate to Severe	3	3
Severe	1	5

6.7 Summary of Methodology and Methods

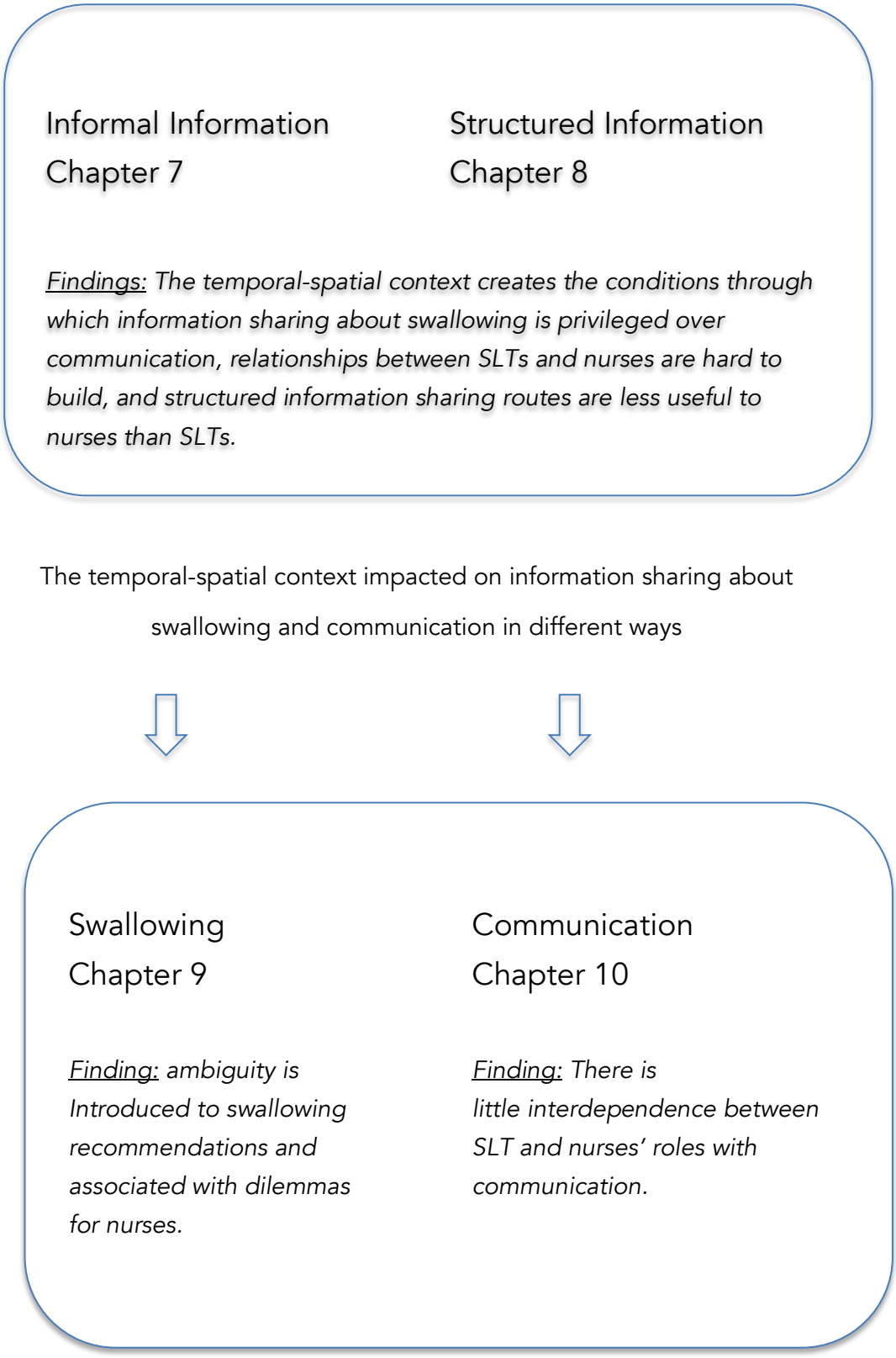
Previous chapters demonstrated why ethnography was well suited to understanding the influences on SLT and nurse information sharing about the communication and swallowing needs of their patients on stroke units. The complexities associated with ethnography were discussed in relation to researcher position, ethical considerations, and the evolving task of analysing large volumes of data from multiple sources and settings. The current chapter described the research settings, the participants and the data collection methods. To summarise, the research explored three acute stroke units across two NHS trusts and involved 40 weeks of participant observation and 43 interviews. Participants included 15 SLTs, one SLTA, 50 nurses, 7 NAs and 19 patients. Multiple sources of data were interrogated; they included observation, shadowing, informal questioning, semi-structured interview, and documents. The chapters made reference to the relationship between some of the challenges encountered in conducting the study (such as recruiting nurses) and the temporal-spatial context as represented in the findings of the study. These findings are now presented in the four chapters that follow.

Introduction to Findings Chapters

The analytic process (section 5.6) resulted in an over-arching conceptual theme, and a framework for organising its constituent patterns and parts (Hammersley & Atkinson, 2007). The over-arching theme was that the temporal-spatial context of interaction on stroke units impacts on how SLTs and nurses share information in stroke unit care. The constituent parts were the influences of informal and structured routes for information sharing on interaction, and differences in interaction according to whether information was about communication or about swallowing. Thus the constituent parts remained close to how the inquiry was framed by the reviews of the literature, and the organisation of the four chapters follows this structure.

The expression of this ethnography through writing formed the final stage in the interpretative process. It was during the writing process that deeper conceptual understanding of what was going on in the studied settings developed, consistent with expectations in ethnographic inquiry that there is an element of craft to ethnographic writing, with analysis and writing being integrated activities (Hammersley & Atkinson 2007). This resulted in five conceptual themes under the umbrella of the overarching theme. The temporal spatial context was found to create the conditions through which (1) information sharing about swallowing difficulties is privileged over communication difficulties, (2) relationships between SLTs and nurses are hard to build, (3) structured information sharing routes are less useful to nurses than SLTs, (4) ambiguity is introduced to swallowing recommendations that is associated with dilemmas for nurses, and (5) there is little interdependence between SLT and nurse roles with communication. Figure 7.1 below summarises the structure for the findings chapters. Findings have been mapped onto the chapters where they are most visible, however the fluidity of the inquiry means that they are also represented within other chapters.

Figure 7.1: Overview of Findings Chapters



The research questions were addressed within the narrative, to retain a sense of flow and representation of the social world of SLTs and nurses. However, an overview of findings as they relate to the questions is provided in chapter summaries. The over-arching research question is addressed throughout the findings. To recap:

> What are the influences on SLT-nurse information sharing about the communication and swallowing needs of their patients on stroke units?

The first two secondary questions are primarily addressed in chapters 7 and 8. The chapters explore the environmental context of the stroke unit, including how it shaped disciplinary and shared perspectives surrounding information sharing, and privileged swallowing over communication information:

- How are different information sharing routes used to share information about communication and swallowing?
- How does information sharing happen across different spaces on the ward and different periods in time?

Chapters 9 and 10 build on these findings and address the final research questions by examining how swallowing information was positioned in relation to risk and uncertainty, the conditions that led to information about communication being attended to, and SLT and nurse perspectives on their roles and interdependence:

- How do SLTs and nurses perceive their roles and interdependence in management of communication and swallowing?
- What raises the salience of communication sufficiently for information about it to be shared?

Each chapter draws on data from field notes and interviews. The interpretative process was iterative, thus although there are differences in the representation of field and interview data across the chapters, these data sources influenced each other in interpretation of meaning. Data from patient records formed part of field note data, it was sometimes part of this iterative process but also stood alone to illustrate written communication as a distinct aspect of information sharing.

A Note about Disciplinary Perspective

As discussed earlier (section 4.2), ethnographic accounts can only ever partially represent the field of study (Clifford, 1986), and the disciplinary perspectives of practitioner researchers further increase partiality (Thorne, 2016). Researcher presuppositions and the reflexive processes employed to challenge them were discussed in section 4.5. An equitable approach was sought in analysis and representation of both SLT and nursing perspective. Nevertheless the study was intended as an applied piece of research conducted for the primary purpose of informing SLT practice, a standpoint that is visible in the findings. Data that disconfirmed conceptual themes was actively sought in order to remain open to new perspectives, this was discussed earlier as analysis of negative cases (section 5.6). In the selection of illustrative extracts, the aim was to achieve a degree of equity by representing the perspectives of both disciplines, and a range of participants. However the voices of some participants are represented more than others because extracts were primarily selected on the basis of their capacity to encapsulate the interpretation they represented (Thorne, 2016). The aim was that extracts should represent triangulated data, be representative of multiple field observations, or the perspectives of more than one participant. When extracts are used that represent exceptional or uncommon findings this is indicated in the text.

Information about Referents

Illustrative extracts from interviews are labelled with participant number, S for SLT and N for nurse. Field notes (FN) are labelled with the date the field note relates to. Patient records are labelled with participant number and the ward.

(…) Indicates information that has been removed for the purposes of succinctly illustrating the interpretation.

[…] Indicates missing dialogue, not captured when taking field notes.

7. Informal Communication

7.1 Introduction

This chapter explores the contribution of informal means of interaction to engagement between SLTs and nurses. This is considered through conceptual description of the impact of the built environment on interaction, and of how interaction represents interruption to the flow of work. Interaction could occur at any point where SLTs and nurses came into contact, and the nature and extent of this contact was influenced by how they engaged with each other in spaces on and off the ward. The purposes served by informal communication included SLTs asking for and giving information before and after sessions, nurses seeking reviews and updates, and more abstract purposes relating to camaraderie. These exchanges were sometimes sought out intentionally, but they also occurred opportunistically in the moment. For example, a SLT bumping into a nurse in the kitchen could lead to a request from a nurse for a patient's swallow to be reviewed, or common systems failures such as outages of the computer network, could lead to light hearted shared expressions of exasperation. The concepts of space and time are central to the findings presented in this chapter. Space is key to consideration for the built environment; the quantity and quality of interactions that occurred between SLTs and nurses were influenced by the layout of the wards, and how spaces on and off the ward were occupied. Time was key for the concept of interaction as interruption. On almost all occasions when SLTs and nurses initiated communication the other was involved in some kind of activity at that time and thus interactions were influenced by the circumstances in which they happened.

7.2 Engaging with the Built Environment

The built environment influenced the extent to which opportunities for informal interaction between SLTs and nurses arose. Therapists were located either on the ward or very close by in neighbouring spaces (section 6.3.1). In spite of how the built environment was organised, divisions between therapists and nurses were evident in the ways therapist specific spaces and staff rooms were occupied. Factors that impacted on divisions in space will be discussed and considered in relation to their impact on working relationships.

7.2.1 Divisions in Space

The amount of time SLTs spent on the wards was influenced by the nature of therapist-specific spaces. Occupation of space revealed an element of segregation across each of the wards. SLTs on all wards affiliated more with other therapists than with nurses. Therapists on Keats were permanently located on the ward and they congregated at one of the nursing stations. During therapists' working hours, the Keats' nursing station was oriented to as therapists' space by all, reverting to nurse-owned space when therapists left for the day. Prior to arrival of the therapists in the morning, the nurses fully occupied this area; they spread out their files across the desk, used the fixed computers, sat on the chairs, and talked with colleagues here. However, as the therapists began their day, they gradually took over the space, and by 9am the nurses tended to have vacated or shifted to the edges of the nursing station, and mostly used computers fixed onto mobile units rather than those behind the desk. When the Keats' SLTs were not with patients, they used this nursing station as their space for completing administrative tasks such as onward referrals, report writing and preparing resources. SLT use of the space was very similar to how the SLTs in Shelley and Brooke occupied their offices. Although the SLTs were located on the ward they created a distinct therapists' zone within it with other therapists. SLTs worked closely with therapists and there was often much discussion amongst therapists in this space. SLT and therapist aims were quite closely aligned; they agreed rehabilitation goals and shared an orientation to both future needs (such as discharge planning) as well as the immediate needs of patients. SLTs viewed their exchanges with therapists as critical to execution of SLT activities in a way that differed to how they viewed interactions with nurses, which had less of a problem-solving quality. The following extract illustrates a commonly held view by SLTs that rehabilitation and discharge planning were less associated with nurses than therapists:

> It's our role, our job to decide when patients are functionally safe to go home, so I think I allow myself more time to trouble shoot that with the therapists than with the nurses, because I appreciate that that's part of their job as well [S10]

The feeling of segregated space was most evident on Brooke, where the therapy office was located beside other therapist-specific spaces (physiotherapy gym and occupational therapy kitchen). Nurses tended to approach therapist office space quite tentatively, usually only entering the office to deal with immediately pertinent issues, such as asking for a patient's swallow to be urgently reviewed or clarifying information about a patient due for imminent discharge. Nurses' orientation to therapist space as

outside of nursing domain became quite apparent one morning on Brooke, when the room usually used for nursing handover was unavailable:

> There is someone deep cleaning a bed in the handover room, this causes a bit of consternation as they suggest possibilities. One nurse suggests using the drugs room, which has been used in the past but is very small, I hear one person suggest using the gym but it takes a while for the nurses to take that on, someone suggests the kitchen but it's too small and nowhere to sit. Eventually they plump for the gym, someone worries about confidentiality but I can't really see why, I get the feeling it's to do with it being a therapy space [FN090617]

Shared space in the built environment did not necessarily result in relationship building. Both Shelley and Keats had shared staff rooms and therapists ate their lunch there; the therapists all had lunch at the same time and formed a discernable group, creating a division that was particularly evident on Shelley. A note from my reflexive diary illustrates how my attempts to navigate between the two disciplines brought this separation into uncomfortable focus:

> The staff room has two circular tables that comfortably fit 4-5 people. One of the tables had about 10 AHPs sitting round it chatting very animatedly. The other table had 2 nurses sitting at it, not speaking. I had planned to spend some time in the staff room but I felt so uncertain where to sit that I left [FN021015]

Having a shared space for eating lunch at least created an *opportunity* for socialisation, regardless of whether this was taken up, and more interaction between therapists and nurses was noticed in the Keats staff room, which had a single, more circular seating area. Brooke did not have a shared staff room. Members of both disciplines on Brooke recalled organised team lunches in the distant past, but such attempts to increase socialisation had been difficult to sustain. Shared lunches occurred quite frequently amongst the therapists on Brooke. On one occasion [FN270717] when a lunch was taking place to mark a therapist leaving, a nurse entered the gym to seek out a therapist. Tables had been put together and covered in a tablecloth, they were laden with food, and a large group of therapists were chatting and laughing around the table. The therapist dealt with the nurse’s query and then invited her to tell the other nurses to come and have some food. Although this invitation was delivered in a warm manner, it came across as an afterthought, and none of the nurses came to join them. On Keats, greater proximity increased opportunities for socialisation, hence when a shared

lunch was arranged for a nurse who was leaving, the SLT entered the room and joined without hesitation. Thus, although the Keats' SLTs mostly allied to the therapists in space, being positioned on the ward meant they were more immediately part of social activities involving nurses.

7.2.2 Relationships

Irrespective of the amount of time SLTs spent in shared space with nurses, their relationships were of a different quality to those with therapists. SLTs and nurses were polite and friendly towards each other, but interactions rarely matched the more relaxed, discursive relationships SLTs had with therapists. The following extracts illustrate how SLTs and nurses viewed their interactions with the other to be centred on issues that needed resolving:

> We tend to see the doctors and the nurses purely to communicate about a patient so it's always reasonably formal [S4]

> You don't build any relationship with each other (…) unless there's a problem that we need to discuss [N4]

When questioned, the SLTs appeared to be more troubled by this divide than the nurses, perhaps reflecting nurses' greater numbers and their reliance on each other as a peer group in responding to patient need. One of the nurses reflected awareness for, but lack of issue with, these divisions:

> I don't think there's any animosity there, I don't know why, there's just some kind of divide [N2]

The Saturday service on Brooke provided an opportunity to explore the interactional impact on SLTs of this disciplinary division. The SLTs experienced their Saturday shifts as calmer than those in the week and found their interactions with nurses more satisfying. They usually started at 10am and spent most of their four-hour shift on the ward, in direct contact with patients. The shift was covered on a rotational basis by one SLT and an SLTA, and there were fewer therapists and no meetings. The only administrative burden was documenting in the electronic patient record. One SLT reported that she was more likely to use ward-based than office computers for this task on Saturdays. Thus on Saturdays SLTs often occupied the ward space in a similar way to the nurses, potentially creating a closer affiliation as peers and easing their

information sharing approaches. The impact of this different energy on Saturdays on relationships is illustrated in the following extract:

> You haven't got other things going on, you just go and you do your therapy and you leave (…) you can spend more time to hand over information, generally you just have a bit of chit chat… there isn't always an opportunity for that and I think that's important to build relationships (…) everyone just seems a bit happier and calmer on a Saturday [S15]

When asked to contrast Saturday working to weekday working, one member of SLT staff reflected that she had mentioned her sense that Saturdays felt calmer to one of the nurses, who had replied that it was because 'you lot aren't here'. This was related in a jokey way to illustrate that the exchange was light hearted, but is revealing of a different experience for nurses when they have fewer people vying for their time, and reflects that for most of the time, the ward was the nurses' domain, with therapists present for a much shorter proportion of the 24-hour, seven-day week.

In summary, the built environment could create or limit opportunities for interaction. SLTs came and went from the ward, whereas the ward was a continuous nursing domain, appropriated periodically by others in the interprofessional team. The factors that influenced whether and how interaction occurred between SLTs and nurses were complex and related to divisions between the disciplines that maintained some distance between them.

7.3 Interaction as Interruption

Every approach from an SLT or nurse to the other could be considered as temporarily disrupting their flow of work. SLTs tended to seek out nurses before or after their sessions with patients, and because nurses were often involved in some kind of direct nursing task when they wanted to speak to them, their interactions usually involved some kind of interruption. The idea that interaction occurs whilst each party is occupied in their own stream of action (Charon, 2010) was discussed in the introduction (section 1.7). The concept of interaction as interruption is illustrated in the following extract, which emphasises how for nurses, one act follows another in a continuous stream, with no clear break for interaction to occur without disrupting the flow.

> They may come (…) and I'm busy with someone else, because we're always busy, we don't stop, we don't have the beginning and the end, there is always something to do continuously [N26]

The impact of interruption on interaction is now explored through consideration for how SLTs wait for the right moment to interrupt nursing flow, and discussion of the capacity of each discipline to hear and hold different kinds of information.

7.3.1 Waiting for a Window

SLTs spent a lot of time looking for the allocated nurse or waiting for nurses to step out from behind the curtains. Interactions were marked by a sense of immediacy, as SLTs seized on the window of opportunity when nurses were between tasks. When the allocated nurse was not available, the SLT sometimes tried to find another nurse. However this could be uncomfortable. It often involved being directed through a number of nurses, and ultimately not finding anyone with knowledge of the patient. The SLT in the following extract from Shelley had just completed an assessment and returned to place a sign with swallowing recommendations above the bed. She was covering absence of the usual SLT and keen to get back to her own wards, however the patient asked her a question that required her to seek out a nurse.

> She puts the notice above the patient's bed and the patient asks her a question she can't answer about his cannula, she says she will pass on his query to a nurse, however the nurse is behind the curtains so she is unable to. She hangs about a bit behind the curtains but doesn't want to disturb the nurse and says 'he's going to hate me'. I ask her why and she says she is aware that 'the nurses get bothered all day by different people giving them little bits of information' [FN051015]

In another example one of the SLTs on Brooke [FN200517] responded to a request from a patient for the toilet by seeking out a nurse, and eventually found her in the drugs room. She passed on the message, to which the nurse said 'later' in quite a curt tone. The nurse was preparing medication for a patient, suggesting a need to prioritise completing this task before helping another patient. Being on the ward thus made SLTs potentially available to the demands of other patients in the bay and could create a challenge on an interactional level when the request required them to seek out and hold the attention of a nurse.

Despite SLT intention to talk to a nurse prior to or after seeing patients, it was not always possible. When interactions did occur SLTs showed awareness that the nurse had other priorities and had little time to give by keeping communication very brief, purposeful and fast paced.

> I find often it's less of a sort of a long dialogue, more of a 'this is what, I appreciate you're really busy, you've got twenty thousand other things to do so this is what you need to know from my assessment' (…) I try and think (…) what do they need to know from me, and that tends to be a bit briefer [S8]

The above extract illustrates SLT internal dialogue based on her perception of what information the nurse needs, and has the capacity, to take on. This had a direct impact on what was shared, with swallowing information being considered to fit better with nurse capacity. Nurses accepted interruptions as part of the job, particularly when the information was considered important for safe execution of nursing care, and they generally considered the SLTs to be respectful in the manner in which they approached them. However they did not always have the capacity to hold information in that moment, either because they were in the middle of doing something else or they didn't have the headspace.

Two observed interactions illustrate interruptions by SLTs that had implications for nurse capacity to hold and use information. The approaches by the SLTs were very polite however they remained focused on goal execution. On Shelley [FN141215], the SLT had been waiting for a while to speak to a nurse who appeared, but then headed towards the dirty utility holding a pile of soiled towels. On her return the SLT politely apologised for the disturbance, and the nurse asked her to wait a minute while she cleaned fluids up from the floor, the SLT apologised again for interrupting and indicated that she would wait. Nevertheless the nurse commenced the discussion from her position cleaning up on the floor. On Brooke [FN100617], a SLT was seeking out the nurse in charge to discuss concerns raised by a patient who was upset about how one of the nurses had responded to him overnight. At that moment the nurse in charge was deep in discussion with a bay nurse, so the SLT stood around tentatively for a while before approaching and politely asking if she had a minute to talk. The way the nurse responded ('my head is exploding') made it clear that she really didn't have the time or mental capacity for the conversation because the ward was short on nursing staff, however the discussion took place anyway.

Informal interactions with nurses, particularly about swallowing, were integral to the SLT role on the stroke unit. SLTs needed to have these interactions to limit risks to patients, despite being aware that they interrupted the nurses' stream of action and increased their load. The need to pass on information was particularly pressing for SLTs from other wards providing absence cover. Their need to close the episode of care could mean sharing information at sub-optimal times, as this extract following a swallowing assessment illustrates:

> I kind of want to get that done, tell them and then go (…) it does feel overloading (…) I know I forget little bits of information so I'm sure they would as well [S2]

One of the SLTs on Brooke described periods of waiting and searching as 'bumbling around', implying a weakening effect on professional identity. SLTs sometimes pre-empted requests from patients by returning to the office, using it as a refuge from being drawn into unrelated activity, an option not available to nurses who had to find other ways to manage the demands placed on them. SLT decisions to wait on the ward for nurses or patients to be free were thus complex. They related to interactional challenges associated with disturbing the flow of nursing work.

7.3.2 Capacity to Hear and Hold Information: Nurses

The nurses commonly attempted to retain information from informal interactions by writing on their handover sheets, which by the end of the day were covered in scribbled notes. However, the information they wrote down was usually in the form of key words and there was a high chance of forgetting anything nuanced. This extract illustrates the challenge for nurses of holding onto the information that was shared with them:

> So many times the speech and language therapist, they've spoken to me about it and then 10 minutes later I've completely forgotten what they've said [N11]

It was usually the case that there was *no* good time to have a conversation. SLTs were often to be seen hovering near a nurse engaged in activity, waiting for them to look up and give their attention. This was sometimes quite uncomfortable to watch. There was an occasion on Keats that caused me to consider the impact of nurse capacity on what I initially observed as disregard for the approaching SLT. The SLT was behind the curtains with a patient and her interaction with him was clearly audible from where the nurse was positioned at a mobile computer in the bay.

> I can hear from behind the curtains that the SLT is recommending puree and thick (thickened fluids) and that the patient needs to take his time. When she is finished with the patient she approaches the nurse, she stands in front of her and tries to read her name badge but it is angled away. The nurse doesn't look up until she has been standing there for a few seconds. This is noticeable because as soon as the SLT steps out from behind the curtains the physiotherapist looks towards her for an update and the SLT tells her that he is safe to start eating [FN150916]

The nurse eventually looked up, and the SLT advised on safe consistencies for the patient, adding in a light hearted manner 'you probably heard me from behind the curtains'. The nurse laughed and said 'slow down, slow down', repeating what she had heard her say to the patient. The nurse's collegial response indicated that she was actually receptive to the interaction, despite taking longer than felt comfortable to look up. Nurse inattention to the approaching SLT may thus have been a strategy for managing capacity, an attempt to complete the current task before taking on new information. This scenario also suggests that the SLT was hindered in her attempt to disrupt the stream of action by not knowing the nurse's name. Shift working patterns meant that the SLTs encountered different nurses on different days; hence, even though the names of the nurses' allocated to particular patients were written on a whiteboard, SLTs often found it difficult to match names to faces, complicating the task of locating nurses. Interactions thus often felt more profession-to-profession than personal, particularly when SLTs were new or infrequent visitors to the ward. In contrast the SLT allocated to the ward knew the therapists by name. They worked with them daily, usually around the same patients, and in general had more collegial working relationships.

7.3.3 Capacity to Hear and Hold Information: SLTs

When it was nurses that were asking things of SLTs, the interaction felt less like an interruption to the stream of action than when SLTs approached nurses. As SLTs moved around the ward, nurses would sometimes stop them and ask for a particular patient to be reviewed or seek an update (almost always in relation to swallowing rather than communication). Interactions initiated by nurses tended to relate directly to SLTs' primary role and were thus potentially easier to accommodate within the SLTs' current stream of action. When asked in interview to recall a particularly satisfying encounter with a nurse, one SLT related a time when a nurse had asked her *three times* in one day to review a patient. Although this represented unscheduled demand

on the SLTs time, she viewed the encounters positively because they improved her ability to tailor treatment to the patient, and she enjoyed having a shared agenda with the nurse:

> Obviously you haven't timetabled it in and you're busy you know, that's exactly what you want isn't it, you know if you've recommended something and it's not working you need to know so you can figure out what else to do and how to work around it [S13]

Thus SLT tolerance, and even welcoming of interruptions from nurses whilst on the ward or writing notes may be because the interruptions were relevant to their immediate goals. In contrast, when SLTs interrupted nurses, the information related to just one of nurses' many roles with patients. Unless the nurse was engaged in that role at that time, or had been waiting on information from SLT, attending to the information created a more marked disruption to their stream of action.

SLTs were commonly interrupted whilst writing notes at the nursing station. The nursing station/notes trolley was a hub on all the wards, but particularly on Shelley. During therapists' working hours, it was often a hive of activity, with different groups of professionals in interaction with one another. SLTs were commonly to be found here, writing notes and sharing informal discussions about patients. Interruptions occurred frequently during the act of note writing. For example, one of the SLTs on Shelley [FN180915] was observed to spend half an hour writing two sets of patient notes. During this time she experienced eleven interruptions from other professionals, including nurses, dietician, physiotherapist, OT, pharmacist and doctor. The SLT considered these discursive exchanges essential to managing patients and her only frustration was that these encounters were not audited as patient contact. In contrast, the therapists on Brooke usually wrote their notes in the office and were less seen to congregate around the nursing station. Thus an unintended consequence of electronic records was the loss of a space for informal interaction with nurses.

7.3.4 Aligning in Space and Time

SLTs were sometimes observed to engage with nurses in a way that suggested closer alignment with the nurses' immediate agenda than indicated earlier (section 7.3.2). These occasions occurred as SLTs and nurses moved around each other within a bay, and were characterised by interactions that appeared more relaxed and collegial. On Keats for example [FN280616], the nurse had been waiting for the outcome of the SLT

assessment before giving medication to a patient, hence when the SLT gave her recommendation for thickened fluids she immediately went to get a pot of syrup fluids so she could complete the task. As the SLT gave the recommendation, she quite casually stated that the patient was better when sitting up. I noticed this because it was more usual for SLTs to use more directive language when giving recommendations. There was something about SLTs and nurses going about their work in the same space and time, either with the same patient or moving about the bay together, that created the conditions for interactions that could be more collegial than instructional. Such synchronicity was particularly evident in relation to medication. This is illustrated by a further example, in which the SLT was with a patient who had indicated during informal assessment that she was waiting for painkillers:

> The nurse returns with the tablets and the SLT and the nurse sort of work together now, the nurse retains responsibility for giving the painkiller but the SLT heralds her as a 'nurse angel' in quite a fun way that feels collaborative between the three of them. The nurse stays until the patient has taken the tablets [FN210916]

The agendas of SLTs and nurses were also brought into closer alignment when discharge was imminent. Nurses became very busy on the day of discharge because they needed to arrange medication and transport, as well as complete discharge paperwork. On these occasions nurses sought out therapists more than usual, and this involved SLTs when they were the key worker for the patient or there were specific issues in relation to swallowing. For example, on Shelley [FN231115], one of the nurses made a rare visit to the therapy office to discuss her concerns about a patient about to embark on a very long journey with only pots of thickened fluids for sustenance. These encounters were notable because the urgency in the nurse's need for information caused them to seek therapists out in ways less commonly seen at other times.

7.4 Chapter Summary

This chapter makes a new contribution to knowledge for how temporal-spatial factors influence how SLTs and nurses share information. The majority of their day-to-day interactions occurred through the informal route. Opportunities were facilitated by but not determined by geography that encouraged them to share space: office space, staff rooms and ward-based patient records. Time was an important influence on interaction. The conceptualisation of interaction as interruption enhanced

understanding for how approaches by SLTs disrupted the flow of nursing work, how SLTs navigated their need to execute their own goals, and the impact of nurse capacity on SLT perceptions of what information nurses would be receptive to. The findings offered a novel way to consider circumstances in which interactions appeared less like interruptions, signalling this as an area for further exploration if closer alignment is desired. Space and time were seen to be more facilitative of supporting SLT-therapist than SLT-nurse relationships. Interactions were polite but formal and time-restricted, and shift working made it harder to get to know nurses by name.

Temporal-spatial considerations were also implicated in the structural routes for information sharing that will be considered in the next chapter. However they manifested quite differently. Meetings and training ostensibly brought SLTs and nurses into the same space and time. Patient records gave written information permanence in time. Nursing handover was a time-bound space that punctuated shifts, and was an important route through which information of relevance to SLT was channelled across shifts.

8. Structured Routes for Information Sharing

8.1 Introduction

This chapter considers how SLTs and nurses engaged through the structured channels for information sharing available on the wards and suggests what this might indicate about their communicative purpose. The most visible routes for information sharing amongst professionals were regular team meetings and the patient record. Other structured routines also served interprofessional purposes, these included nursing handover and in-service training. Although nursing handover was a nurse-to-nurse activity, it operated as a link in a chain of information that had been derived through interaction with other professionals.

8.2 Interprofessional Team Meetings

Routinely scheduled meetings (MDMs) were the most visible demonstrations of interprofessional practice on the wards. The overall aim of the MDMs was to keep patients progressing towards a point of discharge, however information shared through MDMs was not necessarily new for those in attendance due to the role played by informal means of information sharing. The consultants were less involved in informal routes for information sharing and the majority of interactions in the MDMs radiated through them. There were similarities in the scope of information SLTs and nurses each contributed to MDMs on all the wards. SLTs gave information arising out of assessment and management of communication and swallowing, and contributed to discussion about rehabilitation potential and discharge options. Nurses gave information from clinical observations, including scores and specialist nursing information, for example about skin integrity. Nurses also contributed to discharge management, and provided holistic perspective on patient management and change. With respect to the clinical interests they had in common with SLTs, nurses were more likely to contribute to discussions about swallowing than communication. Although there were differences across the wards in the content and style of MDMs, the manner of communication was usually polite and respectful and overt conflict was rarely observed. The following sections explore the ergonomics of the meeting spaces, the extent to which discharge was the focus of meetings, differences in SLT and nurse attendance at meetings, and the nature of the contributions made.

8.2.1 Ergonomic Features of Meeting Spaces

Rooms used for meetings varied in their suitability for the purpose (section 6.3.2) and capacity to demonstrate engagement in meetings was influenced by how the meeting spaces were arranged. There were unspoken conventions regarding where to sit, as illustrated in the following field note extract from Shelley:

> The nurse sits in a row with the other therapists, a senior nurse sits a little bit back, so not in SLT line of sight. When I sit down there are two empty seats beside me, a therapist comes in late, looks at the empty seats and goes over to sit at the end of the plinth in the corner, After the meeting I asked him why he did this and he said that he didn't know if any other doctors were coming and they usually sit there. I wonder how people get inducted into this as I was quite happily sitting in what could be considered to be a doctor's slot [FN131015]

Communication that occurred directly between SLTs and nurses was often non-verbal, through eye contact or sharing nods and shakes of the head, however the capacity to do this was influenced by the ergonomics of the meeting space. When SLTs and nurses were out of line of sight of each other, it reduced opportunities to see from facial expressions how information was received. Space was often cramped, and although tight quarters were not ideal, they did lend a sense of intimacy. On Shelley in particular, although people often had to climb over each other and squeeze in very closely to make room, close proximity created a space that was often quite convivial. People were frequently shuffling to accommodate a new entrant to the meeting and light exchanges occurred whilst waiting for the meeting to start. However, as nurses were usually the last to arrive, or transitioned in and out of the meeting, they often missed out on this more social time.

8.2.2 Focus on Discharge

Meetings on all the wards involved discussions about discharge, but the extent to which this purpose dominated the meeting varied according to the usual length of patient admissions on the wards. On Keats the meetings were the key mechanism for facilitating speedy decisions about whether patients should go home or be repatriated to another hospital, thus information presented to the meeting was more diagnostic and prognostic than rehabilitation focused. On Shelley and Brooke discharge planning was often complex, and discussions about rehabilitation progress and medical management were also prominent.

A novel finding from this study is that when discharge was imminent, the agendas of nurses and therapists were in closer alignment and nurses contributed actively to discharge discussions. Senior nurses on Keats were very involved in discharge planning because the ward's explicit purpose was to move patients elsewhere within days of admission, either home or to another setting. This brought nurses' agendas into close alignment with the day-to-day roles in discharge planning of SLTs and other therapists. This alignment was also evident on Shelley and Brooke, but usually only when the patient was due to be discharged in the coming day/s. In these circumstances the nurses freely offered information to meetings, for example relating to medication and transport and occasionally were seen to contribute more substantial information that placed the discharge in doubt. For example on one occasion on Brooke [FN140617] when discharge was imminent, the nurse contributed her judgment that due to the patient's continuous PEG feeding regime, supervision was needed at night. The late addition of this new information was met with some irritation from the therapist coordinating the care plan. However, despite the timing issue, the nurse later related in interview her satisfaction at having had this uncommon opportunity to share specialist knowledge. When discharge was further into the future the nurses played a less active role in the frequent, often quite circular, discussions about onward plans for patients with highly complex medical, rehabilitative and social needs.

Discharge processes could create an underlying level of conflict because the demands of continuous nursing care took priority over the administrative aspects of discharge. A particularly dominant role by senior therapists in the processes of discharge planning was evident on Brooke. There was a lot of paperwork associated with discharge, and the senior therapists on this ward used the meetings to chase others to complete the sections they were responsible for. During interview a senior SLT demonstrated awareness that form completion was an unwelcome task that placed a demand on whichever nurse happened to be in the meeting. She described it as 'kind of a volunteer system, like who wants to do this really terrible job' [S11]. Repeatedly reminding nurses about discharge paperwork made her feel like she was 'hounding people over and over' creating discomfort in relationships. During fieldwork one of the nurses expressed to me her view that other disciplines failed to appreciate the difficulties presented by shift working, and tasks requiring nurses to be away from the patients. Shift working exacerbated disciplinary differences in perspective. Accountability for filling out discharge related forms could move to the nurse on the next shift unless discharge was imminent.

8.2.3 The Disadvantaged Position of Nurses in Meetings

The ease with which nurses were able to balance attendance at meetings with other demands varied across the three wards (section 6.3.2) and related particularly to their direct care giving responsibilities on that shift. The attending nurses on Shelley experienced particular difficulties, because the nurse due to attend the meeting was usually responsible for a full bay of patients. This meant that they needed to complete their usual morning activities of washing patients and medication rounds whilst also preparing for the meeting. This involved collecting various scores relating to patients, and nurses worried that insufficient preparation would lead them to provide incorrect information to the meeting. The following extract illustrates the burden associated with getting everything done in time:

> The meeting is timed around 10 o' clock, now when you come (…) some patients have not been washed, you have to prepare them, get them ready for breakfast, give medications (…) next thing you realise is time is gone [N5].

When the nurse says 'now when you come' he is referring to HCPs coming onto the ward to call a nurse to attend the meeting. Nurses usually kept working on tasks until the last moment. It was common to hear someone in the meeting say words to the effect of *do we have a nurse?* when everyone else was seated, at which point someone would go onto the ward and ask a nurse to attend. This contrasted with most attendees who appeared to have more capacity to attend the meeting at the allotted time and wait for others to arrive.

Succinct presentation of information was preferred on all wards. The amount of information shared varied according to patient complexity, individual inclination, and the time available. Keats nurses contributed more than the nurses on other wards due to the importance to the team of information relating to repatriation and thrombolysis. Any professional could at any time be the focus of a direct question. This required constant readiness to demonstrate competence by providing a fulsome, clinically reasoned response. Because nurses commonly had little personal experience of nursing the patients they represented, their capacity to show certainty and expertise was restricted. Nurses needed to draw on information acquired by other nurses, in the patient record or through nursing handover. For example, after an MDM on Shelley [FN061015] one of the nurses told me that his inability to answer a question from a therapist about a bowel regime had impacted on his sense of being knowledgeable and able to fully participate. Nurses on Shelley restricted their input to the meeting by using

a standard format for presenting and offered information that was mostly numeric, such as scores for weight and dependency. There was only space on the A4 preparation sheet for a single line of qualitative comment. Keeping to the prepared sheet resulted in somewhat ritualistic input, and the nurses had mixed feelings about the way this narrowed their role. The word *trespass* used by the nurse below indicates that keeping to the structure prevented them from straying into therapists' territory and was considered safer.

> With the therapists you also have a sense of it's their speciality and they've got a little circle around it so you don't trespass too much [N4]

The prepared format for contributing to the meeting had the benefit of minimising the amount of time nurses needed to be present, allowing them to get back to their patients. However, the restrictions of the format caused them to omit more expansive explanations. Nurses had no real way of anticipating what would be considered relevant and thus information was often shared with little conviction. For example, information about how well a patient slept was sometimes ignored, and sometimes picked up by others as relevant to some other piece of rehabilitation information. In contrast, unless the SLT was covering absence, they usually knew the patients and could more readily demonstrate competence by sharing profession-specific knowledge derived through assessment and treatment.

With respect to the clinical interests they had in common with SLTs, nurses were far more likely to extend information about swallowing than about communication. Swallow related information that nurses added to the meeting was often already known, such as stating SLT-recommended food and fluid consistencies. However, they also contributed to problem solving, such as in relation to enteral feeding decisions when patients repeatedly removed nasogastric tubes. Contributions from nurses to discussions about rehabilitation based on their bedside experience were notable for their infrequency, and this was particularly the case for information about communication. On occasions where SLT information about patients' communication abilities resulted in team discussion, it was far more usual for other therapists than nurses to contribute their experience of how patients were communicating. Nurses appeared less likely than therapists to consider their day-to-day experience of patients' communication as knowledge that would be of value to team discussion.

Following attendance at a MDM, nurses on all wards attempted to feed new information to their nursing colleagues, however capacity to do this effectively was limited by time and availability of the relevant nurse. Key points from the meetings were recorded in the patient record by doctors or therapists, and on Brooke, the attending nurse entered information of relevance to nurses in a separate file. The onus was on individual nurses to read what had been discussed about their patients. However scope for more nuanced information to be conveyed was limited by succinct recording of key points. Consequently nurses had fewer opportunities than other professionals to receive comprehensive information about the needs of their patients.

In summary, the primary purpose of meetings on all wards was to facilitate the team to work towards the aim of safely discharging patients. The extent to which rehabilitation discussion was a visible part of that aim differed across wards. SLT role was consistently aligned with the discharge agenda, whereas nurses had more to contribute when discharge was imminent. The ways in which SLTs and nurses engaged in meetings were influenced by the ergonomics of the meeting space and capacity to participate. Overall, meetings were characterised by an unequal floor. Nurses were disadvantaged by limited first-hand knowledge of patients and had less opportunity than other HCPs to develop relationships through this route. Across both disciplines meetings played a lesser role than informal routes for sharing clinical information.

8.3 Written Information

With respect to the interests SLTs and nurses had in common, both professions wrote down information for the purposes of recording communication and swallowing information in the patient record. SLTs used writing as a tool for calling nurses to act on advice through the patient record and via an A4 sign they put above the patient's bed. They consistently placed recommendations for swallowing at the bedside, but only sometimes for communication. Both disciplines used the patient record with and without intent to communicate, although it was always symbolic. That is to say the entries always had meaning, because those writing were aware that should a clinical incident subject the record to managerial review, their entries would be under scrutiny. The purpose of writing sometimes appeared to be to create an archive of assessments or interventions with no specific audience in mind. At other times the language used in the entries indicated they were written with specific intent to back up or replace verbal messages, and in this way compensate for difficulties associated with capacity to give and receive information through informal routes. This section considers the extent to which the patient record and the bedside sign were considered useful as an

information-sharing route and explores the under-representation of communication information in written routes.

There were disciplinary differences in how SLTs and nurses viewed each other's entries, in terms of their usefulness to execution of patient care. SLTs tended to write quite detailed, lengthy entries immediately after each patient encounter, whereas nurses' entries were usually shorter, unless it was the first entry for a newly admitted patient. Nurses used information they had gathered throughout the day, and recorded as jottings on their handover sheets, as a source for writing entries near the end of their shift. In this way their entries created a chain of information derived from various sources and transferred to the next nursing shift. SLTs commonly followed the structure of SOAP reporting, in which information is presented under the headings of Subjective, Objective, Assessment and Plan. Some nurses used the extended SOAPIER format (+ Implementation, Evaluation and Revision), whilst others used the ABCDE approach, which stands for Airway, Breathing, Circulation, Disability and Exposure. Sometimes SLTs and nurses wrote freestyle entries without headings.

The nurses consistently reported in interview that accessing the patient record at times of need was difficult. They preferred to receive information verbally, backed up by documentation. They reported that they accessed the notes during the shift when they had specific queries or concerns or to compensate for deficiencies in verbal routes. This included incomplete handover from other nurses, not receiving updates following SLT sessions, or feedback about patients from meetings. Senior and in-charge nurses tended to access the patient record more often, particularly if dealing with reported incidents. Nurses reported that unless there was a specific issue, it was when they were writing their own notes and preparing to handover at the end of the shift that they might read SLT entries.

Swallowing entries by SLTs almost always included both assessment and advisory information. Although SLTs wrote comprehensive entries about communication, this information was less consistently written as a call for others to take some kind of action. Entries about communication that included both assessment *and* advice were infrequent. A breakdown of information recorded by qualified SLTs for each patient is provided in Appendix 8. Out of a total of 61 entries about communication, 13 (21%) included advice that appeared to be intended to inform other HCPs about how to support patients' communication. Out of 71 entries about swallowing, 67 (94%) included advice for managing swallowing.

Recommendations were written in instructional forms of language to communicate that action was required. The following is a typical example of the recommendations concluding a SLT entry in the patient record, with clear direction for managing risk. This extract relates to oral trials, which are very small quantities offered under strict conditions, with the patient remaining nil by mouth outside of these trials.

> *Increase oral trials to: - up to 10 teaspoons of either syrup fluids or yoghurt textures hourly (when alert) NGT to continue to provide majority of requirements including medication. Stop oral trials if concerned re aspiration including temperature spikes and/or chest* 🡻. [Shelley: P5]

Information of this kind was usually headed 'recommendations' or 'plan'. SLTs reported during interview that it was only this section that they expected nurses to find useful. This formed the basis for a bedside sign on A4 paper that they consistently placed above patients' beds with swallowing recommendations. SLTs used writing as way of managing the need for information to travel across shifts and as compensation for reduced nurse capacity to attend to verbal messages. Thus when information was considered important, especially relating to risk, SLTs supplemented verbal handover by writing information in several places:

> We rely a lot on the written modality to communicate, so we'll stick a sign above someone's bed or we'll write in the nursing handover or we'll write in the medical notes (…) you rely on the permanence of writing to have it above the bed and you feel better cause you've got it there [S4]

Nurses' entries were usually written at the end of a long shift, which was a sub-optimal time for writing comprehensive notes. During interview, one of the nurses [N3] expressed dissatisfaction with the capacity of her notes to adequately reflect patient complexity due to lack of time. Nevertheless, she acknowledged the clinical value of recording nursing experience for shared management of swallowing. She gave an example of a scenario where recording detail about a patient's tolerance of oral trials supported decisions about removal of NG feeding. Nurses' entries were generally brief and often repetitive. This made them less useful to SLT work with communication and swallowing. SLTs relied much more on asking nurses for progress updates than on what was written in the notes and both disciplines preferred to exchange swallowing information verbally, with written information as an important back up.

> I think people, nurses in auto pilot, and we probably do it as well, but write 'eating and drinking well', because we're just used to saying the same thing, and then underneath actually might write patient's like 'coughing when drinking water' and it's like there's two things being said here, so often I don't, I kind of ignore the 'eating and drinking well' bit, and if I've got concerns I'll just go and ask 'just checking everything's been going alright this weekend' [S15]

SLTs found the entries written by nurses on Keats to be more meaningful than those on other wards they had experience of because qualitative information was more likely to be included, as illustrated below:

> The other wards all they say is risk of aspiration, risk of pressure sore, risk of this, risk of that, I'm like well that's not a helpful thing at all, whereas here they write much better. I think the newer nurses are still in a bit of habit of just doing a fairly standard spiel and like a minimum documentation standards, but I think the better nurses will be the one's who'll do that, but then add a bit of anecdotal information, a bit of more substance to what the patient actually looked like on the day [S6]

The distinction with Keats may relate to nurses' greater ownership of swallowing arising out of their swallow screening roles. Keats nurses were also attuned to record markers of change following thrombolysis treatment. This combination of factors may have given more meaning to areas of clinical interest to SLT and an impetus to record this information. For example *'patient much more verbal this evening than she was during the day'* [Keats, P6]. Conversely nurses who had previously been involved in swallow screening (Brooke) reported dissatisfaction regarding loss of ownership of this role as a consequence of their ward having ceased accepting patients in the first 72 hours.

The key written information nurses relied on from SLT was the bedside sign. Nurses trusted the sign and many viewed it as their primary and most accessible means of communication with SLTs. However the importance to them of this signage related to swallowing rather than communication information, as the following field note extract taken during a quiet time on Keats illustrates:

> I took the opportunity to ask the nurse about the written information above the bed, she said she uses the swallowing information and when I asked about the

> communication information she said she hadn't seen it much. I said that [patient name] has communication advice and she went over to the bed and came back and acknowledged it was there. I asked her why she doesn't pay much attention to this advice and she said that she goes to the patient and talks to them and that she knows to keep to yes and no. It seems that she basically just works it out for herself [FN010716].

Written information about swallowing served a function that both disciplines considered important for ensuring that patients were safely nourished, hydrated and medicated. SLTs used multiple verbal and written routes to communicate messages about swallow safety, particularly when risks were heightened. Nurses frequently mentioned swallowing or eating and drinking in the patient record. Entries appeared to act in both communicative and somewhat ritualistic ways (such as, 'eating and drinking well', or repetitive use of 'risk of aspiration'). Included information related to enteral feeding, details of modified diet, tolerance of SLT recommendations, positioning, quantities taken, swallow screening (Keats), need for SLT review, and clinical concerns, such as a cough that might or might not relate to the swallow function.

Mentions of communication in the nursing notes were usually assessment related. For example stating scores or language from the Glasgow Coma Scale (GCS), such as 'incomprehensible sounds'. Specific terms were also sometimes recorded, for example 'aphasia', 'word finding difficulty', 'orientated', or 'confused'. Entries often alluded quite loosely to communication, such as *'nil complaint of pain voiced or noted'*. [Brooke, P15]. Such entries implied a verbal exchange but it was difficult to judge whether they were written with intent to share information about the patients' ability to communicate or were more ritualistic in function. It was also unclear whether entries such as 'call bell within reach' acted as indirect indicators of communication need. Entries written with clear communicative intent were not frequently seen. There were occasional references to the impact of communication difficulty on emotion, such as '*gets frustrated at times due to dysphasia'* [Shelley, P2]. Only one patient record was viewed that revealed intent from a nurse to share a communication support *strategy*:

> *Pt voices concerns successfully through writing (…) unable to speak words clearly… impaired verbal communication (…) to communicate needs through alternative ways (…) established rapport, introduced self to patient, patiently waits for patient to*

finish what he wants to say, provided pen and paper to assist patient in communicating his needs. [Shelley: P4]

Although this example was an exceptional case, it created an opportunity to examine what it was that made communication salient to nursing care on this occasion. The entry related to a patient who was very persistent in attempts to communicate and for whom the strategy of writing was a significant help. Entering information from nurse experience in the record thus appeared to serve the function of sharing information that was immediately and unambiguously useful. The combined factors of patient persistence and the usefulness of the strategy appeared to increase the status of information about communication. This will be discussed further in the final findings chapter (chapter 10).

In summary, the most prominent information written in the patient record and bedside signs related to patients' swallowing rather than communication needs. For the purposes of the immediate management of patients, both SLTs and nurses expressed a preference for verbal information. The bedside sign for swallowing was the exception, and this was of critical importance to nurses as their most accessible source of information.

8.4 Nursing handover

Nursing handover was an intra-professional activity conducted for the purpose of facilitating safe and effective care across nursing shifts. Information was conveyed that was considered to be of immediate utility for the upcoming shift. However handover also served as a conduit for information originating from, or feeding forward into, interactions with other professionals. This section discusses how handover was organised across the three wards and explores how information of interest to SLT travelled through handover.

8.4.1 The Process of Handover

Handover created an uninterrupted space for the full nursing shift to come together away from the demands of patients. This represented a period of relative calm. For the nurses on the morning shift handover was followed by two to three hours of physically demanding work as they helped patients have breakfast and get washed and ready for the day. The processes of handover differed across the wards (section 6.3.2). The need to cover a lot of information in a defined time period meant that information was usually quite concrete and brief. On Shelley and Keats, nurses commenced their work

with patients as soon as information had been handed over, whereas on Brooke the senior nurse leading the handover often took a few minutes at the end for ward management issues, such as actions needed following investigations of clinical incidents. This space was also sometimes used for brief periods of informal education, for example the SLTs had used this space to offer 10-15 minute teaching sessions about swallowing and oral care, jointly leading the oral care teaching with the ward manager.

SLTs learned of information from nursing handover in different ways. None of the structured routes for hearing information from nursing handover were considered to be very effective because therapists and nurses did not have a shared view of what information was needed. The whiteboard meeting on Brooke exemplified this lack of clarity. The meeting had been introduced to increase efficiency by providing a nurse to therapist handover of information of relevance to the day ahead, but its purpose had become distorted to such an extent that none of those interviewed found it useful. SLTs fed into the upcoming evening handover indirectly through their encounters throughout the day. Information verbally conveyed by SLTs was more likely to be carried across shifts through handover if it was unambiguous and related to risk.

8.4.2 Handover Information of Relevance to SLT

Information from nurses that travelled from handover to SLTs primarily related to concerns over execution of swallowing recommendations or the need for newly admitted patients to be assessed. The need for SLT input was particularly pressing after weekends or when difficulties siting nasogastric (NG) tubes meant that nurses were unable to give nutrition, hydration or medication. Information from SLTs that appeared in handovers primarily related to recommendations for safe swallowing.

Information about patients' communication abilities was sometimes evident in nursing handover, however it was not usually intended as a call from nurses for the SLT to take action. Exceptions related to referral for newly admitted patients and when change in communication was seen as a flag for change in medical status. Nurses might also raise communication as a need with colleagues when it impacted on tasks such as giving medication or slowed them down on the shift. A notable example occurred during handover on Shelley, when the nurse's lament that she had spent fifteen minutes trying to understand what the patient was trying to say about his home was treated as exceptional, and received a sympathetic response ('that's very hard') from the receiving nurse [FN211115]. Unlike information about swallowing however,

concerns shared about communication were more oriented to as issues for the nursing team than for sharing with SLTs.

In summary, handover was an important means for nurses to share information about tangible information of relevance to the coming shift. Information in handover of relevance to SLT mostly related to their common interest in swallowing rather than communication. When communication information *was* exchanged it was less likely to be treated as of interest to SLT than swallowing information.

8.5 In-service Training

In-service training had a purpose that was more instructional than interactive and thus served a different function to the information sharing routes discussed thus far. However it was a space that was intended to bring together all professionals working on the stroke units to share professional knowledge. Shelley and Brooke scheduled weekly slots for whole team teaching. In practice it was mostly therapists who took up these learning opportunities. Nurses and doctors rarely attended the teaching, and SLTs and nurses were only able to recall one occasion when a nurse had presented. Nurses experienced difficulties leaving the ward to attend training. This is illustrated by the explanation given by this senior nurse for what she might say to a therapist asking her for nurses to be released:

> I'm sorry but safety's first, I can't send anyone, 'just one person', no because at that time somebody might be on break, two people are on break, otherwise we'll be on breaks at 6 o clock in the afternoon [N4]

This suggests that these training opportunities were not strongly valued and were oriented to as somewhat outside of nursing. The therapists on Brooke sometimes offered to cover bays to enable nurses to attend. However even with this offer nurses were reluctant to leave their care giving roles, citing difficulty with breaks or need to finish tasks as reasons. Thus when nursing staff did attend, they were more likely to be nursing assistants or students, reducing the potential of this forum as a space for SLTs and registered nurses to develop working relationships through shared learning.

Outside of these scheduled teaching sessions, SLTs on all wards also provided specific education to nurses about swallowing. No education was offered to nurses about communication. Periodic teaching sessions on Shelley and Brooke covered foundation level information, usually based around the rationales for altering food and

fluid consistencies and practical support for thickening fluids. SLTs were aware of the time restrictions on nurses and felt that brief ward-based teaching sessions would be more useful. This had been used to good effect on Brooke (section 8.4.1). The SLTs on Keats had introduced a competency based swallow screening training for nurses, involving a self-learning package and skills assessment by SLT and experienced nurses. The nurses were keen to receive this training and it created an opportunity for closer SLT and nurse working, with several encounters between SLTs and nurses observed to make reference to these competencies.

The SLTs interviewed reported that, during their time in post, the teaching on all three wards had been exclusively in the areas of swallowing or oral care. They considered nurses to be more interested and engaged with these topics, having experienced less positive engagement with education about communication when delivered to nurses elsewhere. However when interviewed nurses often expressed that they would welcome some education in different kinds of communication difficulty and ways of supporting communication to fill gaps in their knowledge.

In summary, scheduled in-service interprofessional training opportunities were little used by nurses. SLT training to nurses was entirely focused on swallowing, and this appeared to be related to SLT perceptions of nurses' interest in communication based on prior experience. This indicates that more creative approaches may be needed if education about communication is to be given in a way that nurses consider valuable.

8.6 Summary

This chapter reported on the various structured information sharing routes used by SLTs and nurses and reinforces the findings of the previous chapter that the informal route was the main way in which SLTs and nurses shared information for the purposes of immediate patient care. Meetings were less useful than informal routes for sharing clinical information. Therapists had more capacity to participate in rehabilitation discussion in meetings than nurses and the focus on discharge planning was less relevant to nurses, unless discharge was happening imminently. Patient safety information communicated through the patient record was important as a backup to verbal information. SLTs consistently offered recommendations for swallowing, and infrequently for communication. It was difficult for nurses to make full use of documented information due to the demands of patient care. The written information they found most useful for their immediate needs were the signs summarising swallowing advice that SLTs placed above the beds. Scheduled interprofessional

training sessions were oriented to as therapists' forums. Handover was primarily an intra-professional activity, however it played a role in channelling information of interest to SLTs that does not appear to have been previously researched.

Space and time impacted on how SLTs and nurses used all routes for sharing information. The previous chapter demonstrated that opportunities for informal interaction were reduced by the ways in which SLTs and nurses were separated in space, and that interactions generally represented some interruption to the flow of the other. In structured routes SLTs were advantaged over nurses in their engagement with the three structures that ostensibly served as spaces for information to be shared between professionals. Meetings privileged those presenting their own patients, and able to stay for the duration, the patient record privileged those with time to read and write, and in-service training privileged those with time to attend. Nursing handover privileged transfer of clear, tangible information. Because SLTs shared capacity to attend meetings and training with therapists, these structures were more facilitative of developing relationships with therapists than with direct care giving nurses. Time was a significant factor that had a particular impact on nurses' capacity for information sharing, however both professions experienced limitations in time to be expansive in interaction and this favoured information that could be conveyed succinctly.

As with information shared informally, the information most closely aligned with nursing needs related to swallowing due to its relevance to safe execution of patient care in the immediate term. Nurses were primarily accountable for work done on the current shift in contrast with SLTs, who shared with therapists an additional accountability for the full trajectory of the patient admission. Swallowing information was considered more concrete than communication information, it related to risk and SLTs ensured it was conveyed through different communication routes. It can be surmised that the context for sharing both informal and structured information supported the privileging of information about swallowing over information about communication and the two chapters that follow explore this in greater depth.

9. Privileging of Swallowing Information

The previous findings chapters provided new understanding for the context in which information about communication and swallowing was communicated by SLTs and nurses on the wards. It was suggested that the temporal-spatial context privileged exchange of swallowing information, raising its profile as information that needed to be shared in contrast to information about communication. The vast majority of the interactions between SLTs and nurses related to managing the risks associated with swallowing. SLT and nurse care interests were most closely aligned in the assessment and execution of patient safety advice through all information sharing routes. The purpose of this chapter is to apply interpretative attention to interdependence between SLTs and nurses in execution of their roles in swallowing, whilst also extending the findings from the previous two chapters. In particular this chapter adds to conceptual understanding of the temporal-spatial context in relation to adherence to swallowing recommendations.

Further support is provided for the assertion that swallowing information had a high profile on the wards and was better suited to the fast pace of interaction on stroke units than communication information. The particular impact of temporality on execution of swallowing recommendations is then explored. Support is provided for an argument that SLT initiated swallowing recommendations became more ambiguous over time, creating dilemmas for nurses. This is followed by analysis of factors that gave swallowing information its profile as an information-sharing need, and how the need for information to travel across time introduced ambiguity and created uncertainty for nurse decision-making. Disciplinary differences in meanings ascribed to harm avoidance are then explored. The chapter concludes with analysis of the difficulties nurses experienced in following SLT recommendations, and the consequences for clinical incident reporting and the SLT-nurse relationship.

9.1 Swallowing Information has High Profile

Swallowing information had a high profile for nurses because it related to patient safety, and had immediate utility for nursing tasks relating to mealtimes, hydration and medication. Safety was also a priority concern for SLTs and they valued vigilance from nurses in following their recommendations. SLTs and nurses shared understanding that the role of nursing staff in swallowing included implementing SLT recommendations, liaising with family, monitoring how patients were managing, seeking out SLT when they had concerns, and, on Keats, swallow screening. The

information-sharing environment supported fast exchanges of information and the information that was most useful to nurses was that which was available in the immediate through informal routes. This included verbal updates and bedside signs from SLTs, and the brief notes nurses added to their handover sheets after speaking to SLTs. SLTs viewed information about swallowing as less ambiguous than information about communication and they tended to hand it over using clear, instructional language:

> I think swallowing stuff is much more practical, easy to follow, it's either you do this, you do that, you don't do this, you don't do that, and if you see this, then you come and get us basically, whereas communication is so much more subjective and doesn't always work (…) there's not like a rule book so much, whereas I think the swallowing, even though it is really like variable and there's a lot more going on, it does feel a bit more like a rule book [S12]

Implicit within this extract is the view that swallowing information is straightforward and objective, and unlike communication information, if you follow the rules it *works*. Nurses' viewed swallowing advice in terms that were similarly concrete. They valued clear advice and timely reviews from SLTs to enable them to safely maintain the nutritional and hydration needs of patients, and administer medication. They wanted their concerns to be heard and to receive succinct information that they could use for the immediate purpose of providing safe care for their patients. Nurses generally indicated that they were satisfied to receive information about swallowing that was quite instructional in nature:

> We want them to ask us if we've got any concerns, and we want quite straightforward advice (…) even having specialised in stroke (…) I'm not concerned at all being taught how to like suck eggs or anything, I'm quite happy for someone to continually advise me the same stuff over and over again [N11]

SLTs and nurses on all wards were well aligned in their interest in sharing information about swallowing. Both nurses and SLTs brought information to MDMs about swallowing, particularly when decisions needed to be made about enteral feeding. Relevant information about eating and drinking or enteral feeding was routinely included in nursing handovers, often including information about the consistencies patients should be taking, and signalling when SLT review was needed. Nurses were often seen approaching SLTs when they appeared on the wards to ask them to assess

new patients or review patients who weren't tolerating what had been recommended, and SLTs almost always ensured they handed information over after seeing patients. Alignment was particularly strong on Keats due to the nurses' swallow-screening role. The screening training and competency assessments brought SLTs into close contact with nurses, and having skills in screening gave these nurses a notable sense of ownership of swallowing. This was evident in handover, where they would say if swallow screens had been passed or failed, and often gave additional qualitative information, such as why a fail decision had been made.

A common situation that led nurses to make a concerted effort to seek out SLT assessment or review was when patients repeatedly pulled out NG tubes, because this directly impacted on their ability to meet patients' needs. Nurses often experienced trepidation around siting tubes when they expected patients to pull them out. Their need for SLT was particularly pressing when nurses didn't have a route to give medication, or when patients were active agents in demanding food or drink.

Difficult conversations around denying patients food and water fell mostly on nursing staff. The burden in executing swallowing advice is illustrated through an occasion on Keats [FN131016] when a patient assessed by SLT as unsafe for oral intake was very persistent in asking nurses to let him drink. The outgoing nurse at morning handover explained to the oncoming nurse that the patient was desperate to drink and constantly asking for water. The patients' cries for water had been emotionally challenging for the night shift, and they anticipated that he was likely to pull out an NG if they had to site one. This made seeking out the SLT to review the swallow a high priority. During the MDM, the nurse in charge urged the SLT to prioritise him. The SLT had assessed the patient the day before, and attempted to manage expectations in the meeting by saying 'he was asking for it yesterday and he choked […] and he was still asking for it'. However she agreed to see him at the next available opportunity, which was two hours later. The nurse in charge said that she thought he would 'pass', thus communicating her desire for a positive outcome, and the SLT reiterated that he would be seen straight after lunch, as she had an appointment to go to after the meeting. A different SLT started her shift on Keats after lunch and prioritised seeing the patient first when she came to the ward, arriving in the bay at the promised time. The nurse was pleased to see her approach and repeated the patient's urgent appeals for water. The SLT oriented to this palpable need for resolution, as she placed her hand on the nurse's shoulder and said: 'we may not be able to give the answer he's looking for but I'll do my best'. After the session three nurses came to hear the outcome, which from the

facial expression of the SLT, they could see had not gone well. The SLT explained why he wasn't safe to eat, but recommended ten teaspoons of water, acknowledging that she would have to start him with something 'to maintain sanity'. She was aware that ten teaspoons would not satisfy the patient, and that her recommendation of NG feeding could be problematic. The nurses were very attentive throughout, but their faces showed concern; they talked about the difficulties in siting NG for this restless patient, and in having to keep telling him he was not able to drink. They had hoped for a different outcome. The nurse in charge quipped in a jokey way 'that's not good enough' and the SLT responded in the same tone 'it's the best I can do'. Although the exchanges were good-natured, the desire for an outcome that would make the nurses' job easier was clear.

This scenario demonstrates that proximity to patients gave nurses a very different role to SLTs. The nurse was permanently located in the bay and had to repeatedly say no to emotional appeals from the patient. In comparison, the SLT conducted a time-bound assessment and by virtue of specialist knowledge was able to leave the nurses with advice that she herself did not have to bear the consequences of. There was no indication that the nurses resented the SLT for the advice she gave. The outgoing nurse who gave handover information at the start was well aware of the patients' difficulties, having conducted the screen herself the previous day. However, although both disciplines were aligned in treating this patient as a priority, the nature of their interactions reflected the temporal-spatial differences between them. The following section considers the impact of ambiguity in exacerbating these differences.

9.2 Ambiguity Across Time

Although swallowing information was considered to be clear and concrete at the time it was shared by the SLT, the information always needed to pass through more than one nurse. This introduced the possibility of information becoming less clear across shifts. Problems could be created for nurses when swallowing presented as either better or worse than at the time of the SLT assessment. These situations required nurses to make decisions at the time of need that either they or the SLT did not consider they had the authority to make. This section explores how these ambiguities were navigated and their impact on SLT and nurse communication.

9.2.1 Miscommunication Across Shifts

Quite minor miscommunications could have consequences on patient care, create unnecessary work, and impact on the SLT nurse relationship. This is illustrated through

an episode on Shelley [FN300915], when there was some confusion regarding what had been recommended for a patient who had been assessed by a SLT on the previous ward. The patient had been transferred overnight and the outgoing senior nurse at the ward handover explained that she had been started on a puree diet. The senior nurse advised that SLT needed to see her 'to put a card on the wall'. At the bay handover, the oncoming nurse repeated what she had understood from the ward handover, which was that she needed to be seen by SLT, however the outgoing nurse was unable to clarify as she had started the shift halfway through the night. The oncoming nurse had misunderstood the handover information. The senior nurse had not asked that SLT review, but that they provide a sign for the bedside. The nurse placed the patient nil by mouth and informed the catering assistant not to give breakfast. When a therapist came to seek handover from the nurses for the therapists, the nurse urged that she needed SLT, adding: 'she's on modified diet […] but we don't know that', which is revealing of a lack of trust in the information received at handover (puree diet). The nurse hadn't checked the patient record, as there was little time at this early part of the day to look in the notes. When the therapist passed on the request for SLT review, the SLT was mildly irritated because her SLT colleague had told her that the patient was on a soft diet. However she adjusted her priorities and went to see the patient first. As soon as the SLT appeared on the ward, the nurse approached her and explained that she had been advised that the patient had been previously assessed for a modified diet but was uncertain what. The SLT communicated the inappropriateness of the urgency by saying: 'she's practically on a normal diet'. When we spoke about this later in the morning, the SLT expressed to me her frustration that when patients were transferred, nurses tended to ask for a review rather than try and find the information in the patient record themselves. A trivial miscommunication thus had consequences. For the nurse, her uncertainty led her to place the patient nil by mouth unnecessarily and spend time over the busy morning period seeking SLT review. For the SLT it led her to deprioritise other patients, and had a subtly undermining effect on her trust in this nurse's judgment.

9.2.2 Managing Uncertainty in the Moment of Need

When nurses' experience of patients' swallowing was out of sync with what had been recommended, and SLTs were not available, nurses needed to make decisions in that moment. However, their options were limited because ultimate authority for swallowing rested with the SLTs. SLT advice usually included some direction for what to do if patients didn't cope with what had been recommended. This was usually to stop oral intake until the patient could be re-assessed. SLTs did not usually offer advice for what

to do if patients coped better than expected. Nurses needed to assess risk with each meal or drink. The following is an extract copied from a patient record showing an example of how a SLT recommendation might be written in the notes:

Rec: full supervision with all E&D

- *puree diet*
- *syrup thick fluids*
- *liquid crushable meds*
- *fully upright and alert*
- *prompt pt to swallow each mouthful before taking next + not talk whilst E+D*
- *if any coughing/wet VX/SOB, STOP + place NBM* [Keats:P11]

The instructions in this extract include clear information about consistencies of food and drink, advice for taking medication, specific advice about how to position and supervise and signs that should prompt nursing staff to discontinue. However, over weekends or public holidays, it could be days before the SLT returned to the ward, creating dilemmas of practice for nurses. One of the nurses explained that when faced with a patient who was not coping well with recommendations over the weekend, she would confer with her nursing colleagues, and if the risk was clear, seek a medical review. However, if she was ambivalent about the risk she might make her own judgment and this extract illustrates that when there was a pressing need to give medication the nurse would consider giving the medication with a thicker consistency than recommended, whilst acknowledging that this was not best practice:

> Policy says that we should keep them nil by mouth if we're worried about their swallow (…) but if this is a Saturday morning we don't really want them nil by mouth for the whole time, so (…) in practice I've found that we've given medication to them in the easiest possible way, so we've given it to them with thickened fluids, and we've crushed the medication if we're at all worried about it, but the minimum amount that's possible, so it's also minimising the risk to the patient, and they'd be on IV fluids or whatever until they were actually able to be assessed [N10].

This dilemma was also occasionally observed in nursing handover, for example on Brooke [FN180517], one of the nurses was explaining that the NG tube had come out

for a patient who was not for oral intake other than oral trials of three teaspoons of yoghurt. She suggested giving medication with the yoghurt. When the nurse quoted above (N10) was asked what she would hand over to the next shift, she suggested that she would explain her lack of confidence in the SLT recommendation, and share how she had given the medication. Ultimately however, she would allow the oncoming nurse to make her own judgment about whether to give the medication with a thicker consistency or keep the patient nil by mouth. Thus she did not consider her judgment to be authoritative, and uncertainty in managing the patient might travel through each nurse until the SLT was back and able to reassess. The reference in the extract to what 'policy says' reveals an ethical dilemma for nurses surrounding doing their best for the patient. Even on Keats, where many of the nurses had competencies in swallow screening, they were only trained to screen and were discouraged from re-screening if patients failed the first time. Nurses were very aware of the risks associated with swallow, but risk was operationalized in relation to the care need presented in the situation before them.

There was an occasion on Shelley [FN241115] that illustrated the difference between SLT and nurse perspective of agency in making decisions when nurses judged patients to be at lesser risk than advised following SLT assessment. The scenario was narrated to me by the SLT on the ward, and I had the opportunity to explore both SLT and nurse perspective of this incident during interviews with them both a short time later. On Friday the SLT had recommended oral trials of only five teaspoons at each meal, due to a fatigue effect on the swallow. However when seeking an update on Monday, the nurse advised the SLT that the patient had been eating over half of her meal. The SLT was thrown by this and explained to me that she gently gave the nurse a rationale for why her actions had created potential for harm. Although the SLT found the encounter awkward, she felt compelled to raise it as a clinical incident. The senior nurse that had been responsible for investigating the incident explained to me that the nurses had been placed in an uncomfortable position by the patient, who was asking to eat more of the meal. There appeared to be disciplinary differences in judgment of swallow risk. The nurses had made a judgment that the patient could tolerate greater quantities because she wasn't coughing and didn't appear to be tired. The cough was the most prominent indicator SLT and nursing staff used to signal potential harm from swallowing. However, coughing is an ambiguous sign; aspiration can be silent, or a cough can be unrelated to swallowing. When the relationship between the cough and the swallow was uncertain this could result in management difficulties for nurses. In this case the judgment was made in the context of the alertness of the patient and no

cough being triggered during the meal. However from the SLT perspective, the concern was less tiredness than a *fatigue* effect that was directly linked to swallow function. The senior nurse explained the dilemma faced by the nurses:

> The nurses they didn't know what to do. In the end they fed the patient as she wishes to, but of course when the speech language therapist came they say 'no you shouldn't do that, you shouldn't do that', of course they understand, because they feel that the patient will be weak, will be this and this (…) so it becomes a big issue, a big issue, 'oh, you've fed the patient too much', but she's asking for it and she's not coughing and we can't see any problem [N5]

The learning that the investigating nurse took from this incident was that the role of the nurse was to do as advised, without question:

> The speech language therapist puts instruction there you have to follow them, no matter what the patient wants you know, so even if it's an uncomfortable situation you have to stick to that (…) they feel that if we've been given instructions and you don't follow or something happens (…) you will cause problems for everybody [N5]

It is evident from the nurse perspectives presented above, that information about swallowing was less concrete than SLTs perceived it to be. The 'rule book' referred to by the SLT earlier (section 9.1) involved limited options for nurses when circumstances changed and the instructions conflicted with their own assessment of risk. When faced with uncomfortable or emotionally challenging situations, and 'rules' that were out of date, nurses were compelled to find a way of managing the situation as they encountered it. Nurses needed information that remained usable when circumstances changed, to avoid potentially negative consequences from using their own judgment. The advice that SLTs left was restricted to actions to take if patients were not tolerating what had been recommended, not what to do if they were coping better than expected.

9.3 The Burden of Avoiding Harm

Nursing staff mostly demonstrated good awareness of the risks of aspiration or choking associated with swallowing. They commonly used language that indicated that they were fearful of the potential for harm. Nurses were held to account when food or fluids were offered that differed from what had been recommended. One of the nurses on

Brooke described herself as ‘terrified of swallowing’ due to previous experience of a patient choking, and others invoked the risk of death:

> If the nurse is not aware, the nurse doesn’t understand the background of the condition of the patient, we can put patient at risk; risk of aspiration, risk of choking, at really serious risk, you know, I’m not saying the other word, it’s scary enough [N3]

SLTs placed a lot of trust in nursing staff, as the people responsible for executing their recommendations. They encouraged them to take a cautious approach when risks were high:

> Because it’s on my head, like I’m the one who’s balanced the risk and decided what they’re to have, but (…) they’re the people who are carrying it out (…) if someone’s a bit borderline, I’ll be like, ‘please be very careful, if there’s any problems just put them nil by mouth’ [S6]

This same SLT went on to acknowledge that the intermittent presence of the SLTs on the wards meant that nursing staff were key to vigilance with recommendations because of their presence when patients were eating and drinking. SLTs across all the wards relied heavily on nurses. They needed to trust that the recommendations they made would be executed as intended and that nursing staff would advise SLT if patients were not tolerating the recommended consistencies. This is described below as a ‘heavy burden’, and this SLT goes further than others interviewed when she considers nurses to be *more* in charge than she is:

> They’re also feeding the patients more often than not (…) they’re the ones who have to educate the family as to ‘don’t bring in this, don’t do that, watch this, this is how you do this, don’t do that, if they’re coughing stop’, so they are much more in charge of dysphagia than I am I would say (…) after I’ve come and done my bit they’re in it, they’re doing it all, so I think that’s a heavy burden for them [S6]

The requirements of their role meant that SLTs needed to accept a certain level of risk. They felt accountable for the recommendations they made, and they managed risk by ensuring the information was handed over through multiple routes, or by introducing oral intake very cautiously. Because of the risk involved, SLTs took special care to

ensure the information was conveyed through multiple routes. For example, in a typical example on Brooke [FN180517], the SLT gave verbal information to both the bedside nurse and the ward manager, put a sign above the bed, and wrote an entry in the patient record. Specific instructions were given for the conditions of the trial (when patient alert and upright), the nature of the trial (no more than two teaspoons of syrup thick fluids), and signs to watch out for (stop if coughing). The nurse jotted key words onto her handover sheet whilst listening to the information.

The nurses could be reticent about recommendations associated with high risk, especially when patients had alternative means of feeding. Over one weekend on Shelley [FN211115], I observed all the handovers for a patient who had been recommended to receive oral trials. In each handover the recommendation was repeated, with cautions, for example one nurse handed over: 'sips of fluid, but they feel he's silently aspirating even with those sips of fluid, watch carefully'. However this patient did not receive any oral trials over the weekend, reflecting their reality that positioning patients for just a few teaspoons was time consuming and introduced a level of risk that some nurses were reluctant to introduce. SLT purpose in recommending oral trials was to keep the swallow mechanism active, however they were aware that oral trials were burdensome and I did not observe or hear any critical comment from SLTs with respect to nurses not carrying them out. In what might appear contradictory, nurses were sometimes heard to take advantage of oral trials as a route for medication when patients were pulling out NG tubes (see section 9.2.2). Given that SLTs introduced oral trials when patients were at particular risk, using trials as a route to give medication was not what would have been intended, however it could serve as a pragmatic solution to the nurse's pressing need to give medication.

In summary, both disciplines were concerned with avoiding harm for patients, but risk carried different meanings for them. The SLTs were often required to accept some risk as a means of progressing the swallow, however this required trust. SLTs needed to trust nurses to be vigilant and nurses needed to trust the SLT's judgment. As the professional specialised in swallowing, SLTs were accountable for the decisions made. Nurse accountability was more evident when risk was exceeded than when nurses acted more cautiously than advised. The majority of the recommendations the SLTs gave were not flagged as carrying an elevated risk, and in these more 'everyday' recommendations SLTs were concerned that nurses (and patients) did not always act as if they were mindful of the potential for harm if not followed.

9.4 Following Recommendations

SLTs routinely ended their swallowing assessments by suggesting recommendations that they would write in the patient record, summarise in a bedside sign, and, almost always, hand over verbally to a nurse. They commonly reported finding patients to be not adhering to the recommended advice for swallowing, either because they were declining, or because nursing staff were not sufficiently vigilant to what they were being served. When SLTs encountered non-adherence it presented challenges for the interaction. This is indicated by the uncertainty in the following extract in which the SLT is recounting an occasion when she went to assess a patient on Keats ward:

> I go and see her and she's literally got a massive sausage in her mouth and she can't chew, she's been there coughing and choking and she was supposed to be nil by mouth awaiting for speech therapy, and I sort of, I said to the nurses well why has, I was a bit like, what's going on, I don't particularly, I don't know whether, so the question is how do I approach it [S2]

The nursing staff considered swallowing recommendations to be important to their management of patients and they tried to make the time to hear them, and ensure they were adhered to. However, holding information could be challenging, particularly as SLTs were not the only professionals with information to share. The nurse in the following extract communicates her appreciation for the importance of the information, and explains how she manages capacity by seeking out the SLT later if necessary, but it is clear that there are significant time issues involved:

> When they come and give you the information, of course it's for the betterment of the patient, it's something they want to relay the information about, which I need to know, so (…) even if (…) I'm not able to (…) give them the time, I will always go back to them and I'll ask them what were they looking me for, and what was the information that they wanted to gather from me or give to me… you feel like, 'oh yeh, there's too much to take', but still, that's needed' [N22]

The next sections consider the influences on nurses' capacity to use recommendations in the way the SLTs intend. This includes their ability to do as advised in the context of a need to complete multiple tasks during the mealtime. Earlier discussion about nurse decision-making in times of uncertainty is extended to consider what happens when non-adherence to recommendations results in clinical incidents being raised.

9.4.1 Multi-tasking

SLTs made their recommendations on the basis of their assessment of the optimal safe eating and drinking needs of each individual patient, however the nurses owed a duty of care to all the patients in the bay they were managing, and the need to multi-task sometimes made it impossible to follow the advice in full. One of the nurses felt it would help if the SLTs spent some time walking in the nurses' shoes to better appreciate practical difficulties in following recommendations, adding:

> We are running around, we are on a time constraint most of the time… I was caring for a patient who (…) the SALT team advised, ok 'take time with her to feed her', ok that is fine with me, I could stay there the entire day feeding them, but say if the patient took two hours to get the food or the tablets taken, then theoretically you are looking after seven patients, and you don't have the time [N7]

SLTs appreciated that their recommendations were just one of the many demands on nursing staff, but were obliged by their own duty of care to advise what made swallowing safest for each of their patients:

> Our job is making other people's jobs harder in terms of 'this patient's risky you've got to sit with them at lunch', or 'every three hours you've got to give them two sips of drink', it's all extra things that people that are already very busy have to do (…) I don't like the idea of being that person that gives them more work, but it's part of everyone's role at the end of the day [S15]

The SLT comment that swallowing was 'part of everyone's role' can be viewed as a justification for making recommendations regardless of potential challenges nurses' experience in executing them. Empathy was communicated for the busyness of the nursing staff, but it is implied that they should find a way to do as advised because it is part of their role. I became aware through spending time observing nursing staff during mealtimes that the demands on them at these times were far greater than I had appreciated before. Thus SLTs may not appreciate that nurses' role in supervising mealtimes in strict accordance with the SLT advice is often untenable. For example, during an observation on Brooke [FN150517], the nurse was interrupted six times as she provided full assistance to a patient who was unable to feed herself. She was approached by two different members of staff to respond to questions, she opened containers for a different patient, supported the nursing assistant to encourage a

patient to eat, and dealt with a bed alarm that was going off in another bed space. It took 45 minutes to complete the meal. The nurse reflected later during interview that although she was unhappy about the impact of interruptions on the patient's feeding experience, she considered these conditions as 'part of the territory'.

Whilst recommended consistencies of food were usually adhered to, and the 'red tray' was respected (the tray colour identified patients unable to eat without support), nursing staff were commonly observed to follow recommendations in part only. They often assisted more than one patient at a time, increasing the potential for harm for patients who were able to feed themselves but needed supervision. In such circumstances nursing staff demonstrated awareness for safety by calling across reminders to patients or making a delayed intervention. For example a nursing assistant on Keats [FN121016] was observed to alternate between close and distant supervision for a patient who had a bedside sign recommending he eat slowly, under strict supervision. Whilst the assistant was busy with another patient and the nurse was occupied at the nursing station, the patient coughed three times. No one seemed to register the first cough; the second time the assistant looked towards the patient, and on the third cough the nurse went over and reminded him to eat slowly. The need for the nursing assistant to move between patients reduced the ability to respond quickly to signs of intolerance. This was not reflective of lack of knowledge or competence. I had observed the assistant earlier carefully explaining to the hostess why she needed to check the sign on the wall before offering tea to patients on this ward. On another occasion the assistant asked the SLT to change a bedside sign because it was written in biro and difficult to read. The inability to provide the level of recommended care thus suggested a systems level difficulty.

The recommendations usually included advice about consistencies of food and drink, and procedural advice about how to deliver them, such as providing help to steady hands for self-feeding. One of the SLTs told me that she didn't really expect this component to pass across shifts and another explained that she expected that nursing staff would vary in their appreciation for this procedural advice. The extract that follows indicates that this procedural advice (in this instance alternating mouthfuls of food with fluids) was not considered critical:

> So my sense is, I'm not sure that that's really going to be stuck to or appreciated in terms of it's significance (…) so I've got to be really sure that the

> patient might cope without it occasionally and if I think, 'no, it's so crucial that they have to have it' then I would restrict it to SLT led only trials [S9]

The recommendations thus appeared to have components that were, to some extent, optional and some that were more like instructions. This distinction was never made overtly, but all parties oriented to consistencies as being the most important. Thus although multi-tasking meant that the procedural components might be missed, attention was directed to ensure consistencies were correct. Lack of vigilance regarding consistencies could result in an incident being raised, and this perhaps suggests why nursing staff often used the word *instruction* to describe what SLTs referred to as *recommendations* or *advice*. The following section explores how decisions whether to report an incident were made, and the impact of incident reporting on relationships between SLTs and nurses. Whilst incident reports were intended as no blame instruments, the language respondents used when recounting them suggested that they were often perceived in this way.

9.4.2 Raising Incidents and the Impact on Relationships

When answering questions in interview about incident reporting, SLTs drew on their experiences across the hospital, viewing non-adherence and incident reporting to be a generic issue. However there were considerable differences in the number of incidents for non-adherence recalled by SLTs across the studied wards, ranging from two in the previous two months on Keats, to five or six a month on Brooke. The SLTs and nurses mostly said they considered reporting incidences of *potential* harm as necessary for improving care, and understood that reports were directed at incidents rather than people. However there was an interpersonal aspect, given that the direction of flow with swallowing incidents was usually towards another discipline. Although nurses did sometimes report on nursing errors, they more commonly reported on catering errors, and SLTs never had incidents raised against them. SLTs were aware that raising incidents could be detrimental to their relationship with nursing staff, and differed on an individual level in their approaches to reporting. One of the SLTs was quite new to the Trust, and she explained that she was still finding her feet as to when to report incidents. She found it uncomfortable, and related an experience on a medical ward of a nurse taking her to one side to express her unhappiness that the SLT had treated an event as an incident. The SLT justified reporting as follows:

> I was trying to explain that it's not about blame, it's not about pointing the figure at you but it's just trying to (…) bring round change and recognise the

> importance of what we're doing and the responsibility that you have, because if you don't follow them then the responsibility will lie with you (…) I feel bad doing it because I don't want to (…) make them feel like that, but it's a responsibility I suppose as speech therapists to try and fight our corner [S5]

Reporting was thus conducted in part to make a point about the importance of following swallowing recommendations. Reporting was also used to highlight systemic issues when a ward appeared not be appreciating the importance of the recommendations. In most cases, the incidents did not relate to *actual*, harm. This caused SLTs to have internal dilemmas over whether or not to act, based on what they imagined the nurse to be thinking. In the following extract the SLT indicates that when considering completing an incident report, part of her decision-making relates to wondering if because no harm has actually come to the patient the nurse will judge her actions negatively, and consider her overly cautious,

> I've sometimes felt that people are thinking 'oh why are you making such a big deal about this, they're obviously fine', but they might not have been [S3]

The SLT was more forgiving of wards that had not received much training about swallowing. She experienced frustration when incidents arose on wards where she had built a relationship, arguing that in such cases there was 'no excuse'. Another SLT considered incident reporting to be a grey area. She gave an example of an occasion on a medical ward where she became more inclined to view an event as a systemic failing because the ward manager had been dismissive of her concerns, adding that she would not have reported the event if the nurse had accepted responsibility:

> The reason I wouldn't is because of trying to maintain that relationship, which (…) doesn't feel that strong anyway, so that's kind of how I see the incident forms, like weighing up, you know, trying to maintain that relationship with the nurses [S15]

SLTs varied in the extent to which they expected reporting incidents would result in change in practice. High numbers of reported incidents on Brooke had led swallowing to become one of the priority risks for the hospital to address. This, and the outcome of a mealtime audit completed by the SLTs, had resulted in a leadership decision to encourage reporting. Reporting of clinical incidents was visibly encouraged in this Trust through emailed bulletins, for example statistics were presented in one of the bulletins

to show that reporting was down on the previous year, with the comment 'these are less than last year, so get reporting!' [FN070717]. This revealed strong encouragement at Trust level for staff to report incidents. It also suggested a perception that the lower figures indicated less reporting, rather than fewer incidents. It is difficult to say why this ward had more reported incidents than others, as in part it may reflect encouragement for reporting. Brooke was the only ward in which I noticed regular briefings from senior nurses to the nurses as a group about the learning outcomes from the investigations of incidents.

The following extract illustrates the dilemmas faced by SLTs in balancing faith in incident reporting as an instrument for change, with discomfort with reporting and the potential for strain in relationships:

> I think the perception is that it's pointing the finger, but if enough are put in, and this is where I feel like it's a bit of a moral dilemma, because (…) if there is a problem and that problem's being highlighted and raised enough times and it comes back 'well we were short staffed this day, this day, this day', then that means that there's more staffing on the ward and more cover, then that's gonna be great for everyone [S13]

The most experienced SLT in the study was the least conflicted in her handling of incidents. She explained her preference for a more local response for resolving issues, unless the problem was systemic. She recounted an example of a scenario on a surgical ward where she decided not to complete an incident report in consultation with the nurse in charge, who agreed to have a conversation with the nurse involved. The nurse later recounted to the SLT that that the nurse had been 'mortified' that she had placed the patient at risk and was confident that learning had taken place. The on-going working relationship of SLTs with the nursing staff was considered to be of central importance:

> I say to the staff (…) 'think about what you want to do, do you want to do a datix (incident report) which will take this matter out of your hands or do you want to resolve this right here and now, with this nurse', sometimes you can do both, but sometimes the problems with datix is that they are often seen as punitive, and where there is a need to restore something, to, teach something, to regain some skill and confidence there's maybe a better way [S9]

Underpinning the perspectives presented in this section are SLT-nurse relational issues. Across all the wards, the SLTs experienced a dilemma between taking action that could potentially lead to improvements in patient safety, and maintaining a relationship with nurses. Some association was evident between the quality of the relationships SLTs had with the nurses and incident reporting. The SLTs had particularly high trust in nurses' vigilance in following recommendations on Keats and reported incidents were low. SLTs and nursing staff on Brooke operated with greater segregation than on the other wards (section 7.2.1), perhaps impacting on their capacity to locally resolve issues. It may be that when relationships were less strong incident reporting was considered a more viable route to change than local resolution.

9.5 Chapter Summary

Interdependence was evident in SLT and nurse interest in sharing information about swallowing. Their roles were aligned and both disciplines were concerned to minimise the risks associated with impaired swallowing. Swallowing information could be communicated quickly and clearly, meeting the need for immediately usable information on the current shift. Following swallowing recommendations was much easier to accomplish when information was unambiguous. However the temporal-spatial context could introduce ambiguity to the advice and this created dilemmas for nurses. It was not possible to avoid ambiguity for a number of reasons. Patients' condition could change, there was potential for miscommunication across shifts, nurses needed to respond to patients in the immediate, and there were disciplinary differences in the framing of risk. Nurses' scope to resolve ambiguity in the moment of need was impacted by SLTs' intermittent presence and the authority held within the SLT role. This created decision-making dilemmas because not following recommendations could result in clinical incidents and strain on the SLT-nurse relationship. The following chapter considers sharing of information of a different kind. Communication information was more consistently ambiguous and of less immediate utility to nurses, affording it a lower profile and creating a different authoritative dynamic.

10. Communication Information

10.1 Introduction

The previous chapter explored where SLT and nurse interests in swallowing were aligned, and considered the impact of time and perspective on management of swallowing across the disciplinary boundary. The findings reported in Chapters 7 and 8 indicated that information for supporting patients' communication needs had a low profile across all information sharing routes. In comparison to information about swallowing, communication information was under-privileged and had less obvious alignment with nursing work. This was influenced by a temporal-spatial context that gave interactions the quality of interruptions.

This chapter explores SLT and nurse perceptions of their roles in relation to patients with stroke-associated communication difficulties, and how both disciplines oriented to communication information as being less impactful than swallowing information. SLTs adjusted the information they provided in accordance with perceptions that nurses were less oriented to communication information. Despite the low profile afforded to information about communication on the wards, when asked about their roles, SLTs considered communication to be as important as swallowing. Their attention to communication was most visible through lengthy entries in the patient record and summaries at MDMs. However, the context for information exchange did not appear to support them to share knowledge in a way that was meaningful to nursing work. The chapter concludes with exploration of circumstances in which communication information *was* afforded a higher profile by SLTs and nurses to address the final research question, which aimed to understand what could raise the salience of communication information sufficiently for it to be shared.

10.2 Roles in Communication

Participants were asked during interview to explain how they saw their roles and the roles of the other discipline in relation to communication. Assessing and managing communication difficulties across the lifespan is the core component of SLT pre-registration training, and SLTs were able to summarise their own role with ease. Nursing staff did not view their own work with patients with communication disabilities in terms of *role*, they viewed communication with patients as a taken for granted aspect of nursing care in relation to all patients. All the SLTs interviewed considered assessment and management of communication to be an integral component of SLT

work. Activities included assessment and diagnosis, advising and supporting patients, families, and other professionals, setting and working towards treatment goals, providing reports for the next stage of care, contributing information to meetings and documenting in the notes. SLT roles in assessment of communication, and sharing the outcome of assessments, were more evident than roles in intervention. SLTs reported that they might prioritise their diagnostic/prognostic role with communication over swallowing if the outcome impacted on decisions about discharge. Overall however, SLTs recognized that swallowing was afforded higher priority than communication on the wards. In the early acute stage their balance of activities was influenced by the audit target for comprehensive assessment of swallowing within 72 hours (Rudd et al., 2016). In order to understand what made communication sufficiently salient to nurses to warrant sharing information about it, it was necessary to explore how nurses viewed the SLT role and their own role with communication.

10.2.1 Nurse Perspective of SLT Role

When nurses were asked for their perception of the SLT role, most had quite a vague sense of what the SLT role with communication actually encompassed, in contrast to their more fulsome understanding of SLT role with swallowing:

> I don't know if we necessarily see that side to kind of what they're doing (…) I'm not always clear on that side of things, like the communication side of things
>
> [N13]

When nurses' responses to a question about SLT role in communication were accumulated, their answers together covered most aspects of the role. There were individual mentions of assessment, giving information to help nurses communicate with patients, use of picture boards, giving pen and paper, and doing therapy. Most (but not all) of the nursing staff were aware that SLTs had responsibility for communication. However, they had a narrow awareness of the scope of the role, and saw SLT work in this area as somewhat separate from nursing concerns. SLTs were aware of this, and during interview one SLT wondered if nurses perceived all therapist activity as 'a bit of mumbo jumbo behind the curtains' [S11]. In the following extract, the nurse gave a hypothetical example which acknowledged that the work SLTs engaged in might be relevant to patient's needs on the ward, however she did not indicate any sense of connection with that work. She described SLT role as:

> To help them communicate better and to express themselves as well, like maybe toilet, they want to go toilet and so they will practice with them to say like toilet, toilet, toilet, or even find different words to help them, but we're not that involved with that to be honest [N24].

SLTs were much more likely to actively seek out nurses to hear and give information about swallowing than about communication, reinforcing the sense that communication work happened behind the scenes and did not necessarily involve nurses. However as this extract illustrates, without the knowledge of how best to communicate with patients, nurses tended to provide care on the basis of assumptions about what was best for patients:

> I think mostly they emphasise on swallowing, but (…) working with someone who's not able to express their needs or who's not able to understand what you're saying to them, it's really difficult (…) the care should be patient centred (but) you end up doing things for the patient (…) because you don't know how to ask them, you don't know how they will respond or whatever, you just assume things [N21]

This nurse was particularly aware of her own need for increased knowledge to support communication. A search for similar cases in the data indicated that although other nurses were less forthcoming about gaps in their knowledge for supporting communication, they concurred that communication difficulties impacted on the likelihood that they would make assumptions about patient needs or wishes. For example, another nurse explained in interview that when patients were not able to say what they wanted from the menu, it was difficult to resist the temptation of not choosing certain foods on the basis of her own dislike for them [N4].

10.2.2 Nurse Perspectives of Own Role

Nurses did not think in terms of role when talking about their work with people with difficulties communicating, they did however consider it important to work towards understanding and meeting patients' needs, whilst attempting to maintain compassionate care. With respect to information sharing, nurses sometimes contributed their experience of patients' communication or cognition to the medical picture at handover, at MDMs, and occasionally in the patient record. Some of the nurses expressed discord between their values with respect to compassionate care and their ability to give the time needed to support patients with communication

impairments, in the context of their need to juggle the care needs of all the other patients in the bay. This was particularly difficult during busy periods, such as the first two to three hours of the morning and mealtimes. Properly accommodating the needs of patients with communication difficulties demanded time from nurses that they did not feel they had the capacity to give:

> When you have a lot of patients to look after (…) you need a lot of time with them you know, you need to say something, you need to give them time to digest it (…) but you don't have enough, so much time you know, to stay with them [N5]

Nurses explained that they would show care to patients with communication difficulties by talking to them as they performed tasks, explaining what they were doing, without expecting a response. They generally acknowledged that communication with these patients was not easy, and that patients could become frustrated when they were unable to communicate their needs. Nursing in these circumstances involved looking beyond words to try and understand what patients needed from them:

> So we show them we are together, whatever you are going through we're here for you (…) our job is to look at them as well, to look on their eyes, expression and then pick up some information from that (…) so if they can't say they're in pain and I see they become agitated, you start to look and do blood pressure, you try to find out if there is anything wrong (…) if there is medication on (the chart) you give their medication and see if it's going to help, so communication is more fundamental, but sometimes it's hard to get it right [N26]

When asked about supporting communication, nursing staff emphasised the importance of creating friendly relationships with patients and caring in such a way that eased distress at being in hospital, improved cooperation with care, and reduced frustration. They tended not to talk in terms of 'strategies' but acknowledged barriers to offering care at the level they would have preferred. The most frequently reported constraint was time, but knowledge of how to support specific communication difficulties and grasp of the language for describing communication were also constraining factors.

10.3 The Language of Communication Impairment

This section examines the language used by SLTs and nurses when talking about communication impairments. Consideration is given to the extent to which having a shared terminology matters, with particular consideration for the areas of confusion and receptive language, which SLTs found to be commonly mislabelled.

SLTs and nurses talked about communication using both diagnostic terminology and descriptions of how the difficulty presented. SLTs used the terms aphasia or dysphasia interchangeably to refer to disorders of language. Dysarthria referred to motor speech disorders, dyspraxia to oral or verbal coordination disorders and cognitive-communication to disorders of communication underpinned by a cognitive impairment. Nurses used aphasia and dysphasia, but were not heard to use the other labels, although many did use descriptive terms that demonstrated appreciation that speech might relate to language, articulation or cognition. Their descriptors were usually quite imprecise however and errors were common. For example, patients with aphasia were sometimes described as confused, patients described as having slurred speech might actually have aphasia, and dysphag*ia* was sometimes said in place of dysphas*ia*. On one occasion I observed a nurse on Shelley [FN171215] sharing with a receiving hospital that the communication difficulty of the patient was 'expressive dysphagia'. This indicates that inaccurate language on handover sheets could be repeated throughout a patient's stay and handed on to the discharge destination.

Challenges in neatly unpacking the essence of communication difficulties were revealed in how nurses conveyed information about communication during handover. In the following example on Keats the nurse moves between information from different sources to describe communication. This includes the GCS, the doctors clerking on admission and nurses' experience from nursing the patient:

> Handover (Sunday Morning): Still muddled up […] GCS is 13 or 14 […] she gets really anxious about her meds […] sometimes she makes sense […] sometimes she doesn't
> Handover (Sunday Evening): She's sort of 13 […] she's getting some of the words out
> Handover (Monday Morning): Nurse reads dysphasia from the clerking and says: dysphasia, which she still has […] confused
>
> [FN18/190916]

When a SLT approached a nurse two days later prior to seeing this particular patient, the nurse described her as confused. The SLT corrected her by saying that based on informal assessment the primary diagnosis was likely to be aphasia. Nurses' knowledge of different types of communication disorders was often quite loose. They reported that their understanding was generally picked up from experience of working with stroke, checking things out amongst each other, informally through interaction with SLT, using search engines, or from being taught in the past. They shared the knowledge they had acquired when mentoring others. One of the nurses explained to me how she taught the distinction between dysphag*ia* and dysphas*ia* to students using a mnemonic she herself had been taught, of g for gut and s for speech. This broad classification misses the distinction between articulation and language. Few nurses could recall having received any post registration teaching about these distinctions.

The SLT in the following extract explained how she took opportunities to informally educate nurses about terminology, illustrating a tentative approach and concerns that she might be over-stepping the mark by teaching known information.

> I'll say something like, 'so they've probably got aphasia, so they're having difficulty with understanding language or finding the right words', so just very short little bits of education, which they may well know, but so trying not to say it in a way that I'm you know teaching them something they knew, but just kind of just reinforcing something [S10]

SLTs did not have high expectations of nurses' knowledge of terminology, however they did not consider this to have much impact on the SLT information-giving role. They would tend to either use explanatory language, or use the correct terms accompanied by a brief explanation. Use of non-specific terms between nurses also appeared to have little effect on the meaning nurses took from nursing handover. The primary purpose for mentioning communication at handover seemed to be to flag a potential impact on nursing care, which nurses then assessed for themselves as they began working with the patient:

> I would then leave handover, go and see the patient and do my assessment and if (…) it comes up that the deficit is quite noticeable (…) then I'll clock it, then I'll think ah that makes sense that was in handover [N18]

Lack of specificity did however have some impact on how nurses contributed to discussions with SLTs on the wards and in meetings, and one of the nurses on Shelley reflected that such terms used in MDMs sometimes went over her head [N10]. There were two key areas where lack of shared knowledge about labels was considered important by SLTs, and led them to offer correction. These related to mislabelling aphasia as confusion, and mislabelling patients as understanding better or worse than indicated by assessment, errors that were made to varying degrees by other team members as well as nurses. SLTs took particular efforts to ensure that misinformation about confusion or level of understanding was not perpetuated across shifts:

> I think particularly if there's you know written down on the handover, aphasic, but when you meet the patient you're, you can see, from your assessment you know that they're say really dysarthric, and they're actually understanding everything you say, then making more of a point of talking through why I think they're not aphasic but they're dysarthric, and just making sure that that information is passed over between the various handovers [S10]

Correcting nurses' mislabelling of a patient's level of understanding created a relational challenge, due to SLT caution for teaching information that might be already known. There were also differences between SLT and nurse conception of what comprised understanding by patients. This can be illustrated through an example on Brooke [FN160517], where during an informal interaction following a SLT session, the SLT expressed disagreement with an evaluation by a nurse that the patient was able to understand, drawing legitimacy from having completed an informal language assessment. The nurse justified her perspective by adding that when she asked the patient to roll in bed he could do so. The nurse's judgment did not lead to further problem solving about the nature of the patient's understanding and the SLT position was left as the authoritative one.

In summary, SLTs usually assumed that nurses' understanding of the language of communication impairment was quite basic, and tailored the complexity of information accordingly. Nurses often used non-specific language. Although this was adequate for handover it was less meaningful for SLT-nurse discussion and limited the scope for shared problem solving. Although some nurses were more conversant with the language of communication than others, nurses on all wards demonstrated limitations in the language they used for talking about communication impairment.

10.4 Inattention to Information about Communication

Communication information was shared by SLTs in a variety of ways, however they had little expectation that nurses would attend to it, and many of the nurses found it hard to recall having had such conversations with SLTs. SLTs provided information in written and verbal form, with the patient record being the most comprehensive source. For some patients, SLTs put recommendations for supporting communication above the patients' beds. Verbally they contributed information to MDMs and handed over brief information to the nurses working with the patients. However both disciplines demonstrated a level of inattention to sharing this kind of information. This section explores SLT and nurse ambivalence about the value of information about communication and a tendency to treat it as similar in kind to swallowing information. This is followed by discussion of SLTs limited orientation towards seeking nurse experience of communicating with patients, and the inclination of nurses to work out for themselves how to communicate with patients.

10.4.1 Ambivalence about Communication Advice and Support

Communication information was handed over at the same fast pace as swallowing information, however the information was not well suited to this handling because of its more nuanced nature. The following extract is typical of how communication information was offered and responded to. In this example the SLT was observed to share two pieces of information in one very speedily delivered sentence, one about reading ability and the other suggesting how to check for patient understanding. The nurse acknowledges the communication information, but with a shift in emphasis to the patient's expressive ability and a swift move into discussion about medication:

> SLT: He can actually read short sentences, so if, when you ask questions get him to nod
>
> Nurse: (nurse concurs that hard to get what he is saying) He was struggling a bit with his medications this morning
>
> SLT: Was it crushed? (SLT suggests she try it with yoghurt).
>
> [FN070716 Keats]

It is difficult to see how this information could influence practice. The response of the nurse does not indicate that she has understood the SLT to be talking about the receptive abilities of the patient, and the SLT allows the discussion to move onto swallowing. Presenting information about communication without expansion could thus render it somewhat meaningless. SLTs were quite ambivalent about the advice they

offered about communication. This contrasted with their confidence that nurses were receptive to their advice about swallowing. SLTs were aware that their advice could be difficult for nurses to use in the absence of a strong foundation of knowledge. They also doubted whether nurses were interested in what they had to say. They persisted in offering information because they saw this as an integral part of their role, but their advice was usually at quite a basic level and was often delivered with little conviction:

> I sort of feel like I'm trying to give them information for something they don't really understand, so they don't necessarily take on board what I'm saying, and I almost feel like those conversations, it sounds awful, I sometimes feel they're redundant, but I feel like I've done my bit, which I don't actually quite like, but then I think there's a massive education need there, but you never get around to addressing it [S2]

SLT assessments provided the basis of advice they gave to carers, families and staff. However, the context through which SLTs derived their knowledge was quite different to the context of nurses' interactions with patients, and attempts to convincingly bridge this distinction were infrequent. Assessments were sometimes conducted indirectly through observations of other disciplines in interaction with patients, but more usually whilst comfortably seated and undisturbed. In contrast, nurses tended to interact with patients whilst completing other tasks, or whilst standing up, and these encounters were vulnerable to interruption. As a consequence, verbal information and the advice sheets SLTs sometimes placed above the beds after completing assessment were not well aligned with nurses' capacity to use them within their care giving roles. In the following extract, the nurse explains that when he tries to follow advice, such as to use questions that demand only a single word response, he perceives that SLTs would have more success than he does:

> What happens in the reality is different, SALT team does perfectly, but us when we read the question, 'oh ok, single word questions', ok, when we ask a single word question in reality the patient might not respond in a way that she responded to the SALT team' [N7]

The SLT advice referred to in the extract appears to involve assessment-derived knowledge of the patient's ability to understand transplanted directly into a concrete piece of advice for those communicating with the patient. Without additional support, this information is not seen as usable, limiting its potential to impact on practice. One

SLT, who was covering absence, was observed to offer comprehensive information with a level of explanation not usually seen. She gives a summary of the assessment, checks the nurse has understood and gives advice for how to support the patient:

> SLT: Mild to moderate aphasia […] when I say aphasia do you know what I mean?
> Nurse: When he didn't speak what he wants to talk?
> SLT: It's more using the words […] in your case it would be asking him in depth questions would be harder […] it's not all the time and that's why he looks better than he is (gives example of his difficulty in following point to shoulder and then knee). He could understand the instruction but not the word
> Nurse: Just process the word
> SLT: Your aim is to get a message across
> Nurse: Support him
> SLT: You can do it better than I can […] needs to see your mouth to do it […] instructions wise just keep it slow
>
> [FN130616]

The extract is an exceptional case. It is of interest because this SLT appeared to have an expectation that communication information was worthy of nurses' attention. This may relate to her usual work in the post-acute phase on a neuro-rehabilitation ward.

During interview, some of the SLTs indicated that they would welcome opportunities to work more closely with nurses to support communication but they did not see it as something nurses would value. Although SLTs were involved in a wide range of supported conversations with patients, such as for deciding onward care options, or capacity assessments, they seldom offered support of this kind to help nurses communicate with patients and nurses tended not to seek their help. One of the SLTs [S15] related an occasion where her offer to help a nurse explain what a patient needed to do to participate in a bladder scan was not taken up. Another [S13] was frustrated that a chart she had prepared to help the nurses talk through a patient's medication was not being used, despite repeated conversations with the nurses about using this prop. Without an underlying understanding for why and whether what SLTs suggested might work nurses were less likely to invest the time to support communication, and might focus instead on quickly completing the task. However this came at a cost to nurses' values for providing compassionate care:

> Even if they plan, and put it smart on the paper there, if they haven't like coached us on how to do it, then we still won't be able to communicate, we just go there and do and leave (…) because the nurse is also struggling on how to communicate, then you look like you don't want to talk to people, whereas you don't know how to communicate with a person [N21]

Similarly nurses were uncertain how to make use of communication ramps (such as picture charts) that SLTs sometimes put in place. One of the nurses related how she had found it difficult to grasp the SLT's explanation of the communication needs of a patient with apraxia, hence she was uncommitted and unsure of how to use the communication chart left at the bedside:

> She then made him a you know a chart, with the signs (…) it was a really, really busy day, and I just remember thinking I don't really know what this impairment is, I don't really know how I'm going to use this chart (…) I don't know if I've got the time to help him to get better in that way [N18]

Difference in perspectives with regard to the use of these charts was highlighted during an occasion on Keats [FN131016], where a patient was quite distressed and calling out for assistance. None of the nurses were available to attend to her, so as the SLT passed by, she went over to see what the patient wanted and the SLT pointed to a picture on the communication chart on her table (toilet), to clarify what she needed. Later in the day, I asked the nurse in the bay about the picture chart and she said the patient was unable to use it due to difficulty controlling her hand movements. It was apparent that whilst the SLT viewed it as a tool for the communication partner, the nurse viewed it as a tool for the patient. I asked the SLT for her perspective on the charts and she said she continued to give them out despite her perception that no one used them, because the nurses liked to feel they were doing something. Thus both disciplines appeared to need to *demonstrate* attention to supporting communication even in the face of ambivalence about effectiveness.

SLTs reported that the few occasions where they *were* able to support nurses to communicate with patients were a source of satisfaction. One of the SLTs was pleased to relate during interview an occasion when she was able to model communication strategies with the nurses, triggered through having a patient who was adamant that he would not consent to things without support to understand [S11]. However this was notable to the SLT because it was so unusual. In this instance the patient's insistence

played a role in making the supported conversation happen, suggesting that additional drivers were needed to overcome the more usual position of nurses working through difficulties without SLT support. Another facilitator was related to being close by at the moment of need. This can be illustrated through an occasion on Keats [FN310816] where the SLT and the nurse both had a role to play in giving medication, when they were both oriented towards the care needs of the same patient in the same time frame. The SLT had completed assessment and advised the nurse that the patient was safe to take the medication with some custard she had left at the bedside. A few minutes later she heard the patient explaining to the nurse why she was reluctant to take the aspirin and this led into a natural opportunity for the SLT to model communication support. In collaboration with the patient they agreed that the patient should have the medication after eating a banana. Overall, information sharing about communication was quite opportunistic, if a nurse happened to be close by as sessions began or closed there was more likelihood that information about communication would form part of the conversation. In contrast SLTs would make concerted efforts to seek out a nurse to share swallowing information.

Supporting patients to communicate was time consuming. For SLTs in session with patients, this was not usually a burden because it was part of their role. SLTs could legitimise communication with patients as work, and record it as audited therapy time. However, when nurses spent additional time in communication with patients, it impacted on task completion, and their capacity to provide care to the rest of the patients. Answering a call bell to a patient who was unable to express their needs might mean engaging in the time consuming process of working through the possibilities of patient need, and, as previously discussed (section 8.4.2), nurses considered 15 minutes to be an inordinate amount of time to spend trying to understand a message from one patient. The SLTs were very aware of constraints on nurses' time and did not really expect them to have the capacity to give much extra time to communication. One of the nurses explained during interview how she managed her need to provide care to all her patients, by leaving those with communication needs to last to allow more time [N28]. However she qualified this with 'if there's time', indicating that they might be left to last but still not benefit from any additional time for communication.

10.4.2 Seeking Nurse Perspective

As much as there was a level of inattention to the advice SLTs gave to nurses, SLTs often showed little curiosity about nurses' experience of patients' communication

abilities. Nurses did not generally have much recollection of having been asked about communication by SLTs, and SLTs tended not to probe for meaningful information. On one occasion, on Brooke [FN130617], I heard the SLT ask the nurse how a patient was communicating prior to seeing her for assessment. I had trouble hearing her brief reply, so afterwards I asked the nurse, and she said she had simply told her that the patient was rousable to speech (using the language of the GCS). The SLT accepted this small piece of information from the nurse and went directly to the see the patient. The nurse added, for my benefit, that the patient had also used gesture with her. Hence because the SLT had not probed further, she did not have the opportunity to hear additional information that may have been useful to her assessment.

There were a few occasions when SLTs *did* probe for more depth about nurses' experiences of communicating with patients, and these were notable because they had much more of a *sharing* than a *giving* quality to them. These conversations required the nurse to give attention and the SLT to ask pertinent questions. There was one particularly fruitful interaction on Shelley in which the SLT helped the nurse pin down how a patient was letting him know he needed the toilet by questioning the nurse about his experience. At the end of the conversation, the SLT gave the nurse some positive feedback about his persistence in trying to understand the patient, and left the nurse with advice specific to their discussion:

> SLT asks 'how are you finding communication', they step out of the bay and he replies 'getting a bit better' and gives example of this morning when he couldn't understand what the patient wanted, patient was saying 'water' and eventually he figured out that he needed the toilet. SLT asks 'did he attract your attention', nurse said the patient called him over (gestures how he did this), SLT asks if he is gesturing, nurse gives a demonstration of how the patient showed how he needed the toilet (vague gesture of waving arms around). SLT says that it's good that the patient is persisting in trying to understand what he wants and feeds back that she assessed his yes/no response and says 'it's usually but not always correct […] need to check you have it right when he says yes or no'. I asked her afterwards if this type of discussion is typical and she said no, not usual for the nurse to be available and give time to discuss communication in this way (essentially opportunistic). She wanted to give the nurse some reassurance that he was doing the right thing, and added that she herself found it difficult to communicate with the patient [FN031215]

The rarity of this kind of interaction was partly due to time restrictions, but it also appeared to have been facilitated by asking questions with a genuine spirit of inquiry. A further factor was related to having good quality relationships with observant nurses. In the extract that follows, the SLT explained how one of the nurses she had spent a few years working with, seemed to really 'get' communication, making her a 'safe advocate' for patients. She described how they worked together to understand the yes-no reliability of a patient:

> The nurse said 'he says no all the time', and then I said 'how do you know when no means no. No, are you in pain, no, are you not in pain (…) is he perseverating?' and she said 'I can tell by his facial expression when a no means a no, and a no means I've just said it', because she said 'he'll be more emphatic, and (…) he'll often say, if he says no and he doesn't mean it, there'll be something that he does that won't fit with the fact that he's just said no' [S9]

Discursive exchanges such as this were treated as exceptional by SLTs when related during interview. It was much more usual for SLTs to be in the role of giving nurses information than entering into discussion with them. Most of the SLTs were dissatisfied by this imbalance, but felt restricted by their perceptions of nurses' limited time or interest. SLT perceptions of disinterest were acquired through indicators such as observing nurses' body language, or noticing that nurses were more likely to write swallowing information onto their handover sheets than communication information. One of the nurses [N21] demonstrated particularly high awareness of communication need. She would try out ways of communicating with patients and share these at nursing handover and with SLT. However, she acknowledged in interview that most of her nursing colleagues did not share her orientation to communication, tending instead to focus on 'nursing things' when handing over patients. The few discursive examples that were encountered were characterised by SLTs asking more from nurses to understand their experience of communicating with patients on the ward, and by nurses giving their attention when SLTs approached them to share communication information.

10.4.3 Nurses' Figure Communication Out for Themselves

SLTs felt that nurses were quite good at working out for themselves how to communicate with patients. However, although nurses lent some support to this view and managed to provide care for their patients, they did not necessarily consider they were doing this in the most effective way:

> I've got a patient that is going today, he has speech issues and swallowing issues but we only know about the swallowing, I don't know anything about how to communicate to him properly, I know they've been talking to him, doing a lot of communication with him but I don't know how, the best way to communicate with him is, I just try and figure my own way (…) of doing it [N8]

Care giving by nurses was very immediate and required them to draw on their own resources in the moment of need. The nurse in the following extract explains how she works towards meeting patients' needs by listing suggestions until arriving at what the patient wants:

> I went through all the options of something I could help him with, because in a hospital sometimes patients just want small things and it's not that complicated, we just need to think through what have we done that the patient might need and we get there eventually [N15]

Overall, nurses tended to 'learn' the patient for themselves in the course of the tasks they carried out during the shift, or in longer stay settings from multiple shifts. This knowledge only tended to be passed onto the next shift if it impacted on task performance (such as the ability to indicate pain). The nature of the interactions between SLTs and nurses reinforced this focus on essential needs. SLTs could be reticent about offering nurses their expertise in communication and nurses rarely asked this of them. This contrasted with more open sharing with therapists:

> I don't want to undermine their ability, I don't want to step on other people's toes, and whereas maybe I'd feel (…) more comfortable doing that with therapists, say 'oh honestly I'm happy to help out, call me in', I'll just jump in and see if I can support them, whereas I think I wouldn't with nurses, or the doctors, I wouldn't want to stand on their toes and say like 'I can support this patient' [S15]

Nurses acknowledged that they experienced difficulties working with people with communication difficulties. However, as patients got used to the routines of care, their ability to understand what nurses' needed them to do increased. Nurses felt that patients could often get their needs met with quite minimal verbal communication, as long as the focus was restricted to execution of physical care tasks:

> What nurses do becomes routine, maybe when we're washing them, just to say, like 'turn to your right, turn to your left', they kind of obey (…) cause (…) they've been in hospital for a while (…) without even asking them, once you've finished doing something they will do that other thing [N24]

Although nurses seemed to get by without much information from SLT about communication, when questioned, it was evident that they found patients with significant communication needs challenging. Nurses often said during interview that they would welcome more support, however the advice-giving model did not seem well suited to meeting this need.

10.5 Elevating the Status of Communication Information

This section considers nurses' need to share information about communication for the purpose of meeting essential healthcare needs, before exploring how the emotional needs of patients created a compulsion by both disciplines to share that was somewhat different in nature. Time was a precious commodity on the wards hence neither profession was likely to allocate time to information sharing unless they could see that doing so could help them in execution of their roles. SLTs perceived that nurses had less of a need for communication information and used their windows of time for swallowing information, supplemented by succinct, quickly delivered pieces of communication information. Thus they did not usually give time to creating common understanding for the particular difficulties and ways of supporting communication for each individual patient. Communication became more salient as an issue for nurses when difficulties impacted on their ability to provide care. At these times they might share information, usually with their nursing colleagues, but on occasion more widely, through MDMs, the patient record and with SLTs.

The difficulties that most impacted on care giving seemed to involve refusal, agitation and confusion, in combination with communication difficulties that were both associated with stroke and lack of English language proficiency. For example one of the patients on Brooke was unable to speak English, had aphasia and was not engaging well with staff. The following information shared at nursing handover indicates the nurse's concern that she had been unable to discern the patient's wishes:

> Doesn't speak English… he's not communicating so we don't know what he really wants [FN090617]

Nurses often used ‘language barrier’ in a somewhat generic way to incorporate both English language proficiency and/or language impairment. The impact on nursing care of this patients’ difficulties was brought to the attention of the wider team at a team meeting later into his admission in explanation for why nurses had been unable to record the patients’ pattern of bowel movements as requested by the consultant:

> I asked him did you open your bowel, but because of the language barrier I couldn’t [FN270617]

Nurses reflected that patients could become frustrated or agitated when they were unable to get across their need for food, drink, pain or going to the toilet. They sometimes helped their colleagues on the oncoming shift by passing on information they had derived over the course of the shift through trying to work out patients’ needs. In the following extract, the nurse explained how she would hand over information about the steps she followed to determine whether a patient was in pain, in order to guide the oncoming nurse in what to look out for:

> When you tell them what you saw and what you did, they pick information, they know when he’s agitated, maybe he’s in pain, so next time when he’s agitated they start from pain killers, and the position, because all those make him feel agitated (…) you did blood pressure, they’re still (…) you see in their face they’re in pain, so when you see you can’t, then you give medication [N26]

Information about pain management had particular importance, not only because giving medication was a critical nursing role, but also because when nurses were required to record a pain score, specific self-reported information was needed. Another aspect of care that was impacted by communication difficulties was attracting nurses’ attention. The nurses were observed to highlight patients’ inability to use the call bell at handover, and in the patient record. Sometimes the only communication-related entry in the patient record was that the call bell had been positioned in reach of the patient, which suggests that the entry might be intended a short hand to flag expressive difficulties. Because nurses mostly exchanged information about communication amongst themselves, the overlap between SLT and nurse interest in communication was often not immediately evident. These points of need have importance however because they represent a currently under-exploited opportunity for developing interdependence with communication work.

Neither profession were commonly observed to share information about the emotional needs of patients. The focus of SLT advice about communication primarily operated at a transactional level, directed towards supporting the giving and receiving of messages, rather than need for humanistic interaction. Nurses evoked emotional needs when they talked about patients experiencing distress or frustration. They could be very caring in how they managed these needs. One of the nurses [N10] gave an example of how she managed a patient's agitated behaviours by advising colleagues at handover to ensure he was clean and in fresh sheets before doing any nursing tasks, a conclusion she had come to through giving him time to communicate his need for cleanliness. Nurses also occasionally made entries in the patient record when patients were frustrated or distressed by their communication difficulties.

Both disciplines could 'forget' about the value of communication for the purpose of human interaction, but when triggered it led to reflection on practice. The examples that illustrate this section were not commonplace, but what unites them is that they were triggered by affecting encounters that stirred clinicians into seeing patients in humanistic terms. When they talked about the encounters they spoke quite powerfully. One of the nurses was of the same nationality as a patient who had been upset during her shift and was compelled to advocate for her in the MDM [FN150915]. She expressed quite strongly to me her sense that professionals revealed a dismissive attitude to feelings when they used words like 'tearful' that failed to represent the expressions of sadness or abandonment that she had picked up from this patient. An SLT example was an occasion on Brooke [FN280717] relating to a patient who had been waiting for placement for several weeks. I had not heard or seen any information shared about his communication through any route for quite some time, however on the day he was due to be discharged the SLT supported him to understand that he would be going to a nursing home. This news was very upsetting for the patient, leading the SLT to also feel distress. She acted on this by sharing his support needs with the nursing assistant and expressing her feelings to me. In a further example, one of the nursing assistants became very animated when she talked about how a patient with significant difficulties had responded to her when she used a colloquial greeting in their shared language. She had shared this with her colleagues, and reflecting on this humanistic encounter during the interview reminded her of the importance of connection:

> Even though they're lying there in bed, and they cannot talk, it just to go and reach out to them, just go over and just say something to them, it really matters [N27]

Sometimes patients themselves elevated the focus on communication by making sure their voices were heard. There was a patient on Shelley with severe dysarthria, who found it very difficult to make himself understood, but who compensated well with writing. It was nurses rather than SLTs that made repeated entries in the patient record to emphasise the value of using pen and paper with this patient. He had a strong need to communicate and would often call people over to him, rather than sit passively. During my conversations with him, whilst seeking consent, he wrote: *'I breath* (sic.) *when some one talk to me'* [P4] and I found this very affecting. This was the only patient record, of the 19 viewed in the study, in which nursing entries included a strategy for communication. In contrast there was just one SLT entry that mentioned the patient's use of writing and this was written in the subjective (S) component of the SOAP notes, rather than as advice for others under 'P'. The SLT entries focused on his communication deficits and swallow safety. It is possible that I missed discussion about the effectiveness of writing because I was only present for two of the four MDMs where the patient was discussed and I am likely to have missed informal SLT-nurse interactions. However I had expected to see the SLTs promote the strategy through their entries in the patient record and at the MDMs I did attend. The need this patient had for communication with staff and the existence of a strategy that worked appeared to mobilise the nurses to share information through the patient record. However it did not have this effect for the SLTs.

The need to provide emotional support to people with communication difficulties was occasionally linked to safety. The senior nurses on Brooke sometimes used the brief period at the end of handover to provide informal education on the importance of emotional support. The information shared with the nursing team was linked to specific patients and reflected learning from reviewed incidents, for example emphasising a need to give time to a particular patient because 'if you don't have time for him he starts to be in tears' [FN240617] and associating the falls risk of a patient to communication by encouraging nurses to talk to him, stressing that if they ignored him when he was restless he would be more likely to put himself at risk by getting up from his chair [FN140617]. Another nurse made the connection between communication

and falls risk through the process of reflecting on the communication needs of a patient during interview:

> You know, what I've realised […] to what you've said, when the patient is able to mobilise we forget about the communication aspect of the patient, while the patient is walking we don't think of how he's struggling to communicate and that would be a clue for us to follow the patient, so that we haven't heard of any falls or anything [N28]

The patient the nurse referred to was mobile and had fewer direct care needs than other patients on the ward. This had led her to 'forget' about communication needs, however she was triggered to reflect on these needs through the interview itself:

> So I think we still need a lot, we still need a lot, even this chat that we are having now is like it's opening my eyes of how to deal with some […] so it's very helpful, I think it's more than going to the classroom [N28]

The examples presented in this section illustrate that there were occasions when the communication needs of patients became more salient and thus more likely to be shared amongst colleagues. This related to times when there was some need to share in order to perform essential nursing tasks, maintain safety or out of human compulsion. It is suggested that SLTs may take for granted disinterest by nurses for information about communication because current information sharing practice is not particularly meaningful to either discipline.

10.6 Chapter Summary

This chapter explored perceptions of SLT and nursing roles in relation to communication, the language they used to discuss communication difficulties, the attention they gave to information about supporting communication, and the conditions that elevated communication as an information sharing need. In comparison to swallowing, little interdependence was evident in how SLTs and nurses worked with patients with communication disability, and nurses did not view their work with communication patients in terms of role. Thus communication work formed part of a distinct role held by SLTs. The two professions did not appear to have the same need to share information about communication as they did with swallowing. This was reinforced by the context because meaningful interaction about communication was difficult to accomplish in brief pockets of time, and this was perpetuated by on-going

experiences of interaction. SLTs tended to self-limit on the basis of nurses' actual or imagined reception to communication information. The way SLTs asked for nurse perspective usually indicated that they had low expectations of what nurses could add. Although communication was more salient to nurses when it impacted on their ability to provide basic care, they tended not to look towards SLTs for help, and the information SLTs did provide was not easy to use in the immediate. Overall, SLTs appeared resigned to lacking impact in this area. Exploration of the emotional needs of patients indicated that whilst needs relating to human connection were uncommonly raised, both professions could be driven to share communication information when they were stirred into recognising these needs, suggesting this as a potential area where impact could be made.

11. Discussion

11.1 Introduction

The question this research set out to answer was 'what are the influences on SLT-nurse information sharing about the communication and swallowing needs of their patients on stroke units'. This was a broad question that was directed towards developing foundational knowledge for how the work of assessment and management of communication and swallowing was accomplished through interaction. Packaged inside that question were two aspirations. The first was that knowing more about the *how* would reveal clinically important insights about the processes through which communication and swallowing work was accomplished by SLTs and nurses working on stroke units. The second was that exploring the how in association with the *what* would develop new knowledge for the underpinnings of taken for granted understanding in acute stroke care that SLT roles with communication are less prominent than those with swallowing.

As a reminder the research aim was to explore how SLTs and nurses share information about the communication and swallowing needs of their patients on stroke units, with objectives as follows:

1. To synthesise evidence from qualitative studies about therapist-nurse communication in inpatient hospital settings, using meta-ethnography.
2. To identify through review of the literature where the clinical care interests of SLTs and nurses overlap in stroke unit care.
3. To conduct fieldwork on three stroke units (hyper-acute and acute) to understand how information sharing happens within the usual work routines of SLTs and nurses, across different time periods and in different spaces on the units, and through verbal and written information sharing routes.
4. To conduct interviews with SLT and nursing staff to understand perceptions of roles and interdependencies with respect to caring for patients with difficulties communicating and swallowing.

The first two objectives were accomplished through reviews of the literature about the processes (chapter 2) and content (chapter 3) of information sharing between SLTs and nurses. The systematic review and meta-ethnography reported in chapter 3 identified four contingencies underpinning communication: need, capacity, opportunity

and quality of relationships, and provided an additional lens through which findings were interpreted. In combination with the literature review reported in chapter 4, gaps in knowledge were revealed across a number of areas. These included: how SLTs and nurses engage with each other through different information-sharing routes; the extent to which they view information-sharing as a *need* for managing communication and swallowing; the impact nurses' capacity constraints have on SLTs' capacity to share information, and SLT-nurse relational practice. Knowledge was also lacking for how SLTs and nurses navigate information-exchanges in order for nurses to execute dysphagia management when SLTs are not present. In addition, with respect to their common clinical interest in patients with communication difficulties, a need was identified to extend cross-disciplinary research attention beyond its current focus on communication partner training. The final two objectives and the research questions were addressed during 40 weeks of fieldwork conducted over three wards across a two-year period. Data comprised field notes from participant observation across three stroke units (357 hours) and patient records (19), and interviews with SLT (15) and nursing staff (29). Field notes and interview data were the primary sources and were of similar importance throughout the findings.

Four secondary questions were addressed in the findings chapters: (1) how are different information sharing routes used to share information about communication and swallowing, (2) how does information sharing happen across different spaces on the ward and different periods in time, (3) how do SLTs and nurses perceive their roles and interdependence in management of communication and swallowing, and (4) what raises the salience of communication sufficiently for information about it to be shared. The overall finding from the study was that the temporal-spatial context impacts on how SLTs and nurses share information in stroke unit care. The temporal-spatial context was found to create the conditions through which (1) information sharing about swallowing difficulties is privileged over communication difficulties, (2) relationships between SLTs and nurses are hard to build, (3) ambiguity is introduced to swallowing recommendations that is associated with dilemmas for nurses, (4) structured routes for interprofessional information sharing are less useful to nurses than SLTs, and (5) there is little interdependence between SLT and nurse roles with communication.

This discussion draws on the theoretical framework of symbolic interactionism (Blumer, 1969; Mead, 1934) to extend understanding for how the temporal-spatial context shaped the information sharing practices of SLTs and nurses. Other philosophical frameworks and theories that will be drawn on include the principles of high reliability

organisations (La Porte, 1982), the humanising care framework (Todres, Galvin & Holloway, 2009), the principles of bioethics (Beauchamp, Walters, Kahn & Mastroianni, 2014) and professional socialisation theory (Abbott, 1988). The chapter begins with discussion of the temporal-spatial context of stroke unit care and the usefulness to SLTs and nurses of the various information sharing routes. The positioning of swallowing within narratives of patient safety will then be explored. This will be examined through discussion of nurses' on-the-ground realities of executing swallowing recommendations in situations of ambiguity and competing clinical and ethical demands. Finally, the contingency of need identified in the meta-ethnography is applied to suggest an explanation for why information for the purposes of supporting patients with communication difficulties featured so little in SLT-nurse interaction.

11.2 The SLT Nurse Boundary: A Temporal-Spatial Construction

The overarching finding of this study was that interactions in the temporal-spatial context of the stroke unit created the conditions through which swallowing information was privileged over communication information. There were two different dimensions of time and space that contributed to the information-sharing context. The first was the difference between the continuous presence of nursing and the intermittent presence of SLT. The second was that nurses' proximal position to patients restricted their capacity to talk to SLTs, and impacted on both disciplines' perceptions of what comprised *needed* information.

No previous research has been identified that explores the temporal-spatial aspects of SLT work on hospital wards, hence this study makes an important contribution to understanding how clinical discussion about communication and swallowing is put into operation in the context of stroke unit care. More is known about the nurse-doctor boundary. Ethnographic studies have revealed the impact of intermittent ward presence on how nurses and doctors enact clinical work through interaction (Allen, 1997; Fernando et al., 2016). Allen explored the actions that nurses took to balance their need to provide care in the immediate, with intermittent availability of doctors (Allen, 1997). The author expected to find conflict and negotiation at the nurse-doctor boundary, but instead concluded that 'non-negotiation' was the norm, and this appeared to relate to quiet acceptance by both disciplines that nurses needed to be responsive to patients when doctors were not there, even when legitimate authority to act rested with the doctors (Allen, 1997). A more contested boundary was indicated in a study involving trainee surgeons whereby the intermittent ward presence of the trainees was considered to have a negative impact on communication, with nurses

perceived as acting territorially with respect to ward space (Fernando et al., 2016). In the current study, the ward as a 'nurse owned territory' was less evident during therapists' working hours. It was therapists rather than nurses who had privileged access to spaces where interprofessional information sharing occurred, because bedside nurses needed to remain close to their patients. Outside of therapists' hours, legitimate authority for nurses to act autonomously with respect to actions recommended by SLTs was influenced by the possibility that acting in unsanctioned ways could result in clinical incidents being raised. The current study revealed temporal-spatial dimensions that were not considered in the doctor-nurse studies discussed above (Allen, 1997; Fernando et al., 2016). The work of the stroke units was similarly operationalized through a structure that necessitated intersection of professional groups with differences in ward presence. However, the current study revealed the impact of temporal-spatial differences on the clinical *topics* that were fore-fronted for discussion, and on alliances with similarly positioned professional groups, specifically SLTs and other therapists. The built environment created a structural influence on opportunities for interaction (Hall, 1993). However, space and time can be considered beyond their structural components. Nurses' proximity to patients in space influenced the time available for talk and shaped both how SLTs and nurses interacted and what they spoke about. Space and time are 'interdependent, coexistent, and mutually elaborated through social action'; they shape how different professionals act within organisations (Hall, 1993; 49).

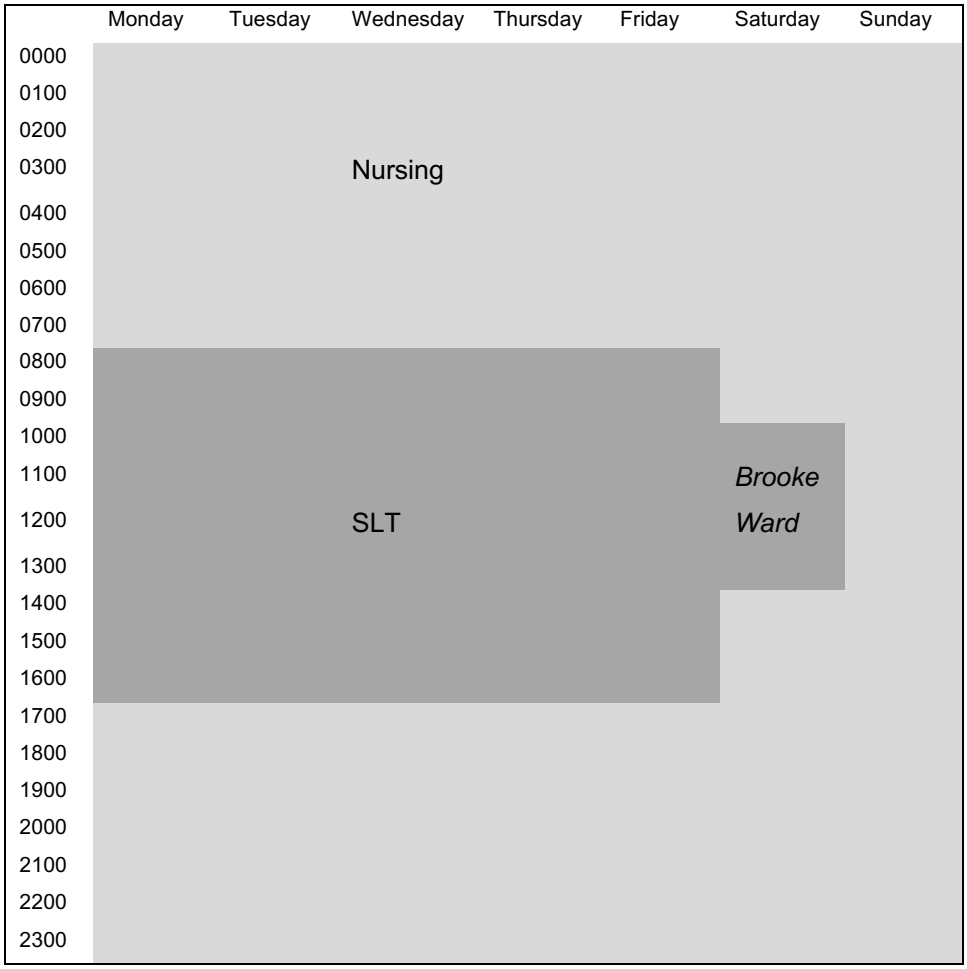
The various routes for communication comprised what has been named the 'hospital order' (Strauss, Schatzman, Ehrlich, Bucher & Sabshin, 1963). Strauss and colleagues suggested that professionals in hospitals achieve social order through working out who is doing what, how and with whom through interaction and negotiation. Previous international research has indicated that the various informal and structured routes through which professionals share information are important means by which interprofessional work on hospital wards is enacted (Miller & Kontos, 2013: Nugus, Greenfield, Travaglia, Westbrook & Braithwaite, 2010; Reeves et al., 2009). This study is the first to use ethnography to increase understanding of interprofessional practice between SLT and nursing as a disciplinary dyad. This provided more specificity for the 'who and what' of interaction in the hospital order than indicated in previous studies of interprofessional practice that considered therapists as a collective entity (e.g. Miller & Kontos, 2013). Focused attention made it possible to relate interactions to the job of meeting specific areas of patient need, and to examine the available routes for information in terms of their usefulness to the execution of the actions SLTs and nurses

needed to carry out. Central to symbolic interactionism is the tenet that the perceptions people hold about how useful things are, are based on the meaning they ascribe to them, with this influencing how they act towards them (Blumer, 1969). Different routes for information sharing differed in their usefulness to SLTs and nurses for accomplishing swallowing and communication management. The following sections discuss the inter-related structural and interactional dimensions that formed the temporal-spatial context for SLT-nurse interaction. This is explored through in-depth consideration of the impact of disciplinary differences in ward presence and proximity to patients on SLT-nurse interaction. The usefulness to each discipline of the various information-sharing routes is discussed.

11.2.1 Intermittent versus Continuous Presence

Time featured within all the findings as a substantial influence on interaction. It was evident from field notes and from interviews that nurses' time was bounded by shift working patterns and their need to stay close to patients. Similarly, in contrast to nurses' continuous availability to patients SLT time was bounded by 'office hours' and treating patients in specific time slots. The difference in SLT and nurse working hours was a taken-for-granted barrier that impacted on how information travelled across time. However although research often reflects on the continuous, or 24/7, nature of nursing work (e.g. Miller & Kontos, 2013) the distinction is not often made between care provided by nurs*ing* and individual nurs*es.* This distinction was important when exploring the working practices of SLTs and nurses because whilst individual nurses came and went according to their shifts, the SLTs allocated to the ward usually worked with the same patients up to the point of discharge, and thus operated with continuity of a different nature. The figure below illustrates the structural difference in temporal experience across the disciplines, with SLTs present for a very small proportion of a calendar week. With the exception of Brooke ward, which provided Saturday cover (four-hour shift by one SLT and SLTA), SLTs worked Monday to Friday (37.5 hours) and nurses worked three 12.5-hour shifts each week, across days and nights. At a structural level, although nursing was continuous, individual nurses were bound by working hours, just as SLTs and other therapists were.

Figure 11.1: SLT and Nursing Ward Presence



The main criterion by which nurses were allocated patients was the skill mix on the ward that day. Thus nurses were primarily accountable for the patient on the shift they were currently working on, and their information needs mostly related to the here and now. In contrast SLTs (in common with other therapists) were usually accountable to the same patient for their needs both in the here and now and over the full patient admission. This division of therapists' role between direct and indirect patient care associated with discharge related activity was also articulated in a recent stroke unit-based ethnography (Taylor et al., 2018), and systematic review (Taylor et al., 2015). The current study demonstrates that this distinction is rooted in the temporal-spatial context. Dual accountability by therapists for the here and now and the trajectory of the full admission meant that activities related to discharge were as central to SLTs day-to-day role as direct activities with patients. This meant that discharge oriented discussion in interprofessional meetings was useful to them in a way that was less evident for nurses, unless discharge was imminent. Nurses in the current study contributed more actively to meetings when the information they had to give and receive was more immediately useful. This extends the findings of previous research,

because in addition to revealing factors understood as problematic for participation by nurses in meetings, such as time constraints (e.g. Pryor, 2008), representing other nurses' patients (e.g. Deacon & Cleary, 2013), and discomfort (e.g. Atwal, 2002), the study highlights the importance of *need* as a driver for interaction (Barnard et al., 2018). Findings from a large interview study indicated that the two core competencies for collaboration are appreciation/understanding for the roles and responsibilities of others, and communication (Suter et al., 2009). The added dimension of information need as a contingency underpinning communication provides substance to the construct of role value that is prominent in the interprofessional literature (Barnard et al., 2018) by moving the construct from attitude into action. The symbolic interactionist perspective holds that in contrast to theories for social change at the level of attitude, there is the potential for change in the social order with each and every interaction, (Charon, 2010). Roles and responsibilities are more likely to be valued and understood when the need for information held within the role of another professional is clear. The temporal-spatial dimension is important because it provides an explanation for why nurses might have less to say about discharge concerns when they are far into the future, why they might deprioritise completing discharge oriented paperwork, and why they are full and active participants in contexts where discharge is *always* imminent, as seen in the hyper-acute setting.

This study provides a new contribution to knowledge about how information of clinical interest to SLTs and nurses travels through the nursing handovers that marked the start and end of shifts. Handover was an important mechanism for managing continuation of care and included information derived from disciplines that were present intermittently. When SLTs talked to nurses they were also acting as a potential source of information for the next shift and this impacted on what they shared. Nurses jotted down key words from SLT interaction onto their handover sheets and used these for the handover meeting. A previous ethnographic study highlighted the status of such notes as "a highly portable 'plot summary' of the status of individual trajectories" (Allen, 2014:133). Nurses need to make sense of large quantities of incoming information from diverse sources, and they do this by deciding which information to attend to and which to disregard, on the basis of their perceptions of the knowledge needed to perform their roles (Allen, 2014). In the current study, nurses' jottings sourced from SLTs usually related to swallowing recommendations, consistent with understanding for the primary purpose of nursing handover as being to transfer responsibility for patient safety (Siemsen et al., 2012). Information about communication was rarely framed in terms of risk, and when communication information did appear at handover it was more likely to

originate from nursing practice than from SLTs. Overall, whilst SLTs demonstrated that they expected information about swallowing to be passed into and out from handover this was not the case for information about communication. SLTs oriented to handover as a route for conveying information that was relatively concrete and related to risk. These characteristics were less associated with more nuanced information relating to communication, which has a 'less evident fit with safe and expedient execution of nursing tasks' (Barnard et al., 2018:8).

When SLTs intended information to travel through a community of nurses, they made determined attempts to incorporate redundancy into the process (section 8.3). This adds empirical support to the findings of a previous small-scale interview study in which SLTs reflected that they wrote extended entries in the patient record to compensate for limitations in the verbal route (Smith-Tamaray et al., 2011). The SLTs in the current study dedicated a lot of time to documenting in the patient record as a means of retaining the integrity of information across time. Additionally when they considered risks to be high they expended interactional effort towards exploiting multiple verbal and written routes. Previous research has indicated that introducing redundancy by supplementing verbal with written information can overcome potential inaccuracies arising from reliance on the verbal route, with a positive impact on safety (Lingard et al., 2007). The current study adds novel consideration for the converse situation when interactional effort is not expended. There was far less evidence of redundancy with respect to information about communication and this is revealing of SLTs perceptions of what nurses considered essential to their work in the here and now, and for sharing with the oncoming shift.

During interview SLTs identified themselves both by their discipline and as therapists, and their use of time and space was more closely aligned with therapists than nurses. Consistent with the findings of the meta-ethnography reported in chapter 2, SLTs and therapists had hours of work in common and occupied on and off ward spaces as a group (Barnard et al., 2018). SLTs reported sharing perspectives with therapists. They shared accountability for both the here and now and across the trajectory of the full admission for specific patients. Although nurses were a reference group to SLTs as fellow members of the stroke unit team, therapists acted as a stronger reference group in terms of shaping how they defined clinical situations and determined what actions to take (Shibutani, 1955). There was more evidence of need, capacity and opportunity in SLT-therapist interaction than in SLT-nurse interaction (Barnard et al., 2018). SLTs were frequently observed in opportunistic and planned patient related discursive

exchanges with other therapists for the purpose of setting patient goals, sharing information of immediate relevance to each other's sessions, and deciding discharge needs. SLT-nurse interactions were less strongly underpinned by contingencies considered important for communication (Barnard et al., 2018); capacity and opportunity were restricted and whilst need was apparent for information about swallowing, this was less the case for communication information.

In summary different working hours impacted on SLT-nurse working practices in distinct ways. Working shifts led nurses to direct their attention to patient needs in the here and now in contrast to SLTs' dual accountability to the here and now and the patient's full admission trajectory. Intermittent presence by SLTs created an imperative to ensure that information SLTs considered important travelled across nursing shifts, revealing the importance of nursing handover and the use of redundancy as a tool. Finally the shared temporal-spatial experience of SLTs and therapists had a beneficial effect on the contingencies considered to underpin effective communication, fostering collegial familiarity. The next section explores time and space through consideration of the impact of nursing proximity to patients on SLT-nurse interaction.

11.2.2 Proximity to the Patient

The work of direct caregiving nursing staff was characterised by prolonged periods of proximity to patients; an obligation for responsiveness that challenges their capacity to divert their attention from immediate care needs (Peter and Liaschenko, 2004). Nurses remained close to the bedside and available to meet a wide range of patient needs. Their attention to the 'whole' patient can be contrasted with SLTs interest in specialist 'parts'. Although SLTs were also concerned for the whole person, they primarily looked towards other therapists to 'reconstruct' the patient. According to Abbott's theory of professional socialisation, the exclusivity of individual professions is based on jurisdictional claims to specific areas of expertise, derived through professional training (Abbott, 1988). Therapist specialist knowledge of 'parts' appeared to have somewhat higher status as admissible evidence for the task of creating a combined picture of the patient (Abbott, 1988). This was facilitated by closer SLT-therapist role alignment and shared capacity to talk away from the immediacy of patient need. Nurses' need to remain close to patients impacted on interaction and relationships with SLTs in a number of ways. First, the need to remain responsive to patients brought into focus the distinction between SLT and nurse agency in attending to patient demands. Second, nurses' capacity to attend to informal interaction with SLTs was restricted, giving interaction the quality of an interruption to their flow of work. Third, nurses' capacity to

make full use of the structured routes available for sharing information with other professionals was limited by restrictions on their ability to leave the bay.

Proximity and Agency: SLTs had much more freedom to walk away from patients than nurses. It has been argued that specialism reinforces a reductionist view of the patient as a body with disconnected needs (Todres et al., 2009). This can legitimise decisions by professionals to decline when asked to help with tasks that don't immediately fit within their specialist role (Apesoa-Varano, 2013). Nurses' proximity to patients' bodies may lower their status in the eyes of others (Malone, 2003), and when professionals are reluctant to help with personal care tasks this may constrain nurses' enthusiasm for interprofessional working (Clarke, 2010; Long et al., 2002). When interviewed, the SLTs in the current study did not indicate that they considered their roles higher status than nurses, however they did exercise agency in walking away when patients demanded things from them outside of their defined purpose for being on the ward. My own experience of unease when patients occasionally looked towards me for assistance suggests that the reasons SLTs move from the bedside are not straightforward. Appeals from patients placed me in the awkward role of finding and interrupting a nurse busy with something else and I would avoid this by being out of the line of sight of patients where possible. Goffman introduced the metaphor of performances in front and back stages as an explanation for how people manage the impression they give to others (Goffman, 1963). The SLTs in the study were seen to retreat from front stage demands by returning to office space and switching to non-patient contact work. In contrast direct caregiving nurses were almost always available to the demands of patients.

Interrupting Nursing Work: This study is the first to explore the interactional challenges experienced by SLTs when they use informal routes to execute their information sharing roles. Previous research has indicated that informal, opportunistic interaction is the key mechanism through which interprofessional work is accomplished on hospital wards (Clarke, 2010; Burm et al., 2019). When these encounters interrupt nursing work, they can impair nurses' capacity to focus on the task at hand, and hold onto information (McGillis Hall et al., 2010; Lausten & Brahe, 2018). The current study extends previous research by also considering the impact of interruptions on SLTs, in their role of *interrupter*. SLTs were frequently observed looking for nurses or waiting for them to be free to talk. Thus interactions commonly arose out of strategic behaviours rather than opportunistic encounters (Burm et al., 2019). Time spent looking for nurses and waiting for an opportune moment to interrupt has not previously been identified as

a routine aspect of SLT role on stroke units. A previous study (involving doctors and nurses) has suggested that clinical difficulties are associated with spending time identifying and seeking out the right person (McKnight, Stetson, Bakken, Curran & Cimino, 2001). The current study indicates that waiting for brief windows of time to share information also shapes the clinical *content* that appears in interaction. Time spent looking and waiting placed a burden on SLTs that they appeared more prepared to carry for information about swallowing than communication.

Interruptions could be welcome or unwelcome depending on whether the nurse was aware of needing to communicate with SLT (see section 7.3). Findings from an interview study with nurse and doctor participants indicate that interruptions can shift from being perceived as disturbing or non-disturbing according to changes in contextual factors (Berg et al., 2016). One of the factors identified by the participants in the study by Berg and colleagues was the perceived relevance of the interruption to the task at hand. Less immediately relevant information was more likely to be considered disturbing in a context of high workload or multiple interruptions (Berg et al., 2016). In the current study, SLTs acted with awareness that they were just one of many professionals who approached nurses to share their specialist knowledge. Swallowing information was perceived by both SLTs and nurses as relevant, as well as being compatible with a maxim that interaction should be fast and functional.

This current study highlighted that SLTs found interrupting uncomfortable. Because so many of their interactions with nurses had the quality of a disturbance, they made judgments for what to share based on previous interaction as well as perceptions about the value of the information to the nurses' immediate needs. Mead considered that people use self-talk as a means of interpreting the meaning of the situations they encounter and it is through these interpretations that they decide what action to take (Mead 1934). Self-talk was evident in SLT responses to interview questions about what they thought nurses had the capacity and interest to hear from them, in the context of needing to remain responsive to patients. Geertz suggests that 'man is an animal suspended in webs of significance he himself has spun' (Geertz, 1973:145). The self-limiting that was evident in SLT sharing of information about communication could be considered a self-spun web. Through interaction SLTs came to view swallowing, but not communication, information as meaningful to nurses' work. The execution of professional role has been conceptualised as solving problems (Allen, 2014). The findings of this study indicate that the communication needs of patients may have lesser status as problems to be solved than their swallowing needs. Previous research

about the dominant position of swallowing in the acute setting (Foster et al., 2015; Foster et al., 2016a, 2016b: Rose et al., 2014) is extended by revealing the context of SLT-nurse interaction as a factor that appears to maintain the privileged status of swallowing. SLTs judged that nurses had more capacity to talk about swallowing because of its immediate relevance to meeting nutrition, hydration and medication needs and patient safety. In return, the information SLTs derived from nurses about swallowing was of immediate use to their own assessment and review tasks.

In summary, restrictions in nurses' capacity to talk at length with SLTs, and SLTs perceptions of what nurses needed, had a direct impact on the nature, quantity and quality of information that was directly shared between them. SLTs understood that meeting their own need to share information represented an interruption that could be disruptive to nurses' flow and overload capacity to retain or action information. They rarely demonstrated confidence that information about communication was of sufficient importance that they could implore nurses to temporarily suspend their busyness to attend to it. Thus they oriented to the small windows of time available for informal interaction as being spaces primarily for swallowing information. This raises a question about the current effectiveness of SLT roles in enhancing the experience of communication for patients on stroke units: if information about communication is so contingent on nurses' (actual or perceived) capacity to hear it, would there be any difference to patient care if SLTs ceased to offer it? Consideration for the context of SLT-nurse interactions could potentially indicate how the profile of communication information could be raised. The finding by Berg and colleagues that perception of interruptions can move between being disturbing and non-disturbing suggests potential ways to work with the context of interaction (Berg et al., 2016). This could include seeking ways to heighten the relevance of the information to the task at hand or identifying times when workload is reduced and interruptions potentially less disturbing to nursing work. In the current study for example the first few hours of the morning were particularly busy for nurses and interruptions could be more disturbing at these times.

Inequalities in Structured Routes: The distinction between nurses' need to remain proximal to patients and SLTs more distal relationship impacted on the respective usefulness of structured routes for interprofessional information sharing, with a minimising effect on the usefulness of information about communication. As previous research has indicated, the most useful routes for the nurses in this study were those that were compatible with their focus on the immediate needs of patients (Clarke, 2010;

Miller et al., 2008; Pryor, 2008). Direct caregiving nurses found it difficult to leave the demands of the bay to attend meetings, access the patient record or attend training. In contrast, SLTs had more autonomy to schedule time away from patients to participate in structured routes for information sharing. Swallowing information was privileged over communication information across all routes.

The routes SLTs invested time into for sharing information about communication were those that direct caregiving nurses found hardest to access. In addition, the nature of the information they shared in meetings and the patient record was weighted more towards diagnosis and prognosis than how the team could support patients' communication experience. During interview SLTs indicated that they used writing to overcome deficiencies in the informal route, consistent with previous research (Long et al., 2002; Pryor, 2008; Smith-Tamaray et al., 2011). However the nature of SLT entries about communication indicated that they were more oriented towards building a diagnostic picture of the patient than providing advice to support communication (see section 8.3 and Appendix 8). This finding concurs with a retrospective chart review of entries about communication (8 patient records) across acute and rehabilitation wards (Steel et al., 2019), and resonates with the prominent status of the medical model of care in acute settings (O'Halloran et al., 2017). The patient record represents a series of fragmented entries, written for both archival and informative purposes (Allen, 2014). The usefulness of SLT entries about communication as a compensatory route for informing nursing work in the moment of need was thus limited by the nature of the content, as well as nurses' difficulties in accessing the patient record.

The only education SLTs offered on the topic of communication difficulty was through the scheduled in-service training sessions that nurses rarely attended. Previous research has suggested that challenges faced by nurses in accessing training limits their potential to fully contribute as stroke rehabilitation professionals (Clark, 2014). However whilst time was a factor in the current study, nurses also indicated that they did not view the scheduled teaching as providing sufficient benefit to justify being away from patients. Nurses' interests were positioned as somewhat separate to therapists' interests, and only one of the nurses had taken a turn at presenting at one of these sessions, thus limiting opportunities to articulate to the team how nurses contributed to stroke unit care (Sommerfeldt, 2013). Scheduled routes for interprofessional education played a negligible role as a means of information sharing between the disciplines.

11.2.3 Summary

This study has provided new understanding for how the space and time dimensions that SLTs and nurses work within create the conditions through which priorities and alliances are made. Communication between SLTs and nurses was more transactional than relational across all information sharing routes. Although interactions were polite, respectful and friendly, information was not so much discussed as given, and was mostly characterized by nurses *informing* SLTs of problems, and SLTs *informing* nurses of the outcome of their assessments, usually in relation to swallowing and with respect for what was needed for the immediate shift. These findings are consistent with previous literature that positions nurses as recipients of therapists' recommendations (e.g. Miller & Kontos; 2013; Smith-Tamaray et al., 2011). The discussion thus far has argued that the temporal-spatial context privileged sharing of information about swallowing, however nurses experienced difficulties managing the risks of swallowing in the absence of SLTs. Regardless of the amount of interactional effort expended, information was vulnerable to degradation across shifts, such as when swallowing improved or deteriorated, when patients were dissatisfied, or due to miscommunication. The next section explores the impact of these challenges on nurses' experiences with managing swallowing, and on SLT-nurse interaction.

11.3 Swallowing and Patient Safety

The findings of this study relate strongly to patient safety and indicate a complex relationship between SLTs giving swallowing recommendations and the capacity of nurses to execute them. SLTs and nurses held a common perspective that information about swallowing was important to the care of stroke patients, and it was through interaction that management of swallowing was accomplished. Swallowing information had status because it related to core roles in risk management, was immediately usable in nutrition, hydration and medication management, and could be transferred in concrete language in small pockets of time. SLTs and nurses actively sought each other out to keep patients safe from harm and their alignment to this purpose featured on all wards. Alignment was particularly evident when nurses played an active role in the assessment process, through swallow screening. This section argues that the relationship between giving or following recommendations and swallow safety was not as straightforward as this alignment implies, and suggests a mismatch between patient safety narratives and nurses' patient-facing realities.

The study has enhanced understanding of the temporal spatial context for the enactment of swallowing as a human process. The findings (chapter 9) provided new

knowledge for what happens in periods of SLT absence from the wards. Chapter 3 drew attention to gaps in the literature surrounding the human processes involved in assessment and management of swallowing and revealed a lack of knowledge about how nurses act when waiting for SLTs to assess patients. No empirical research was identified that discussed how nurses acted in the period of time between SLT assessment and review. The reviewed literature was almost entirely associated with avoidance of harm as a consequence of impaired swallowing. This is unsurprising given what is known about the consequences when impairments are inadequately assessed and treated. The current study revealed a level of burden for nurses associated with following recommendations in conditions of restricted capacity, uncertainty and changes in the patients' condition.

SLT authority for making recommendations and ensuring they were followed created a subtle power dynamic. This study differs from research that has examined interaction in the context of status inequalities (e.g. Apker, Propp & Zabava Ford, 2005), because unlike doctors, SLTs and registered nurses enter their professions on the same pay band in the NHS hierarchy and thus have similar structural status. However subtle power differentials do manifest between professions, for example physiotherapists are commonly afforded higher status than other therapies (Nugus et al., 2010; Pellatt, 2005). In addition, professionals are not always aware of the power associated with the influences they exert through interaction, which can involve both cooperation and conflict (Nugus et al., 2010; Strauss et al., 1963). Authoritative power was evident in relation to swallowing recommendations and incident reporting. The direction of flow with respect to reporting clinical incidents about swallowing revealed differences in status, wherein SLTs reported incidents that related to nursing errors, and nurses reported incidents that related to catering errors. Nurses did not take issue with being on the receiving end of swallowing advice, instead having clear instructions helped them execute their roles in patient care, and they did not have time for extended discussion. However, there is an expectation that nurses defer to professionals granted status (Sommerfeldt, 2013), with expertise being one way in which status is manifested in teams (Poland, Lehoux, Holmes & Andrews, 2005). SLT recommendations had expert authority even when circumstances for the patient had changed, and this created dilemmas for nurses that will now be considered in the context of patient safety narratives in the NHS.

11.3.1 Patient Safety Narratives

In order to understand the impact of patient safety perspectives on how SLTs gave advice and acted on non-adherence to swallowing recommendations, it is necessary to appreciate the principles underpinning systems for patient safety in the NHS. National management of patient safety in the NHS is based on the premise that it is possible for organisations to come close to eliminating error (Cooke, 2009; Liberati, Peerally & Dixon-Woods, 2018; Tamuz & Harrison, 2006). This premise originates from the principles of high-reliability, which were developed through analysis of how highly reliable industries (such as the nuclear power industry) become safe, and by applying this learning to other organisations (La Porte, 1981). Highly reliable organisations have four key components: safety as central; learning from mistakes; built in redundancies, and dispersed authority for responding to risk (Cooke, 2009; Tamuz & Harrison, 2006). The NHS Improvement body manages the process of reporting and learning from incidents across NHS services by entering locally reported incidents into the National Reporting and Learning System (NRLS) (NHS Improvement, 2018). This is known as root cause analysis, conducted for the purpose of using experiences from the front line to provide management overview of the bigger picture (Tamuz & Harrison, 2006). A key way in which the NRLS shares learning is by issuing national alerts, for example, a patient safety alert was issued to introduce new standard terminology for describing food consistencies, following errors arising out of confusion over what constituted a 'soft diet' (NHS Improvement, 2018). The emphasis is on systems level learning from mistakes rather than individual blame. However, feelings of culpability are human reactions that are difficult to avoid at an individual level (Dixon-Woods, Suokas, Pitchforth & Tarrant, 2009). In the current study the language of blame was commonly used, although mostly in oppositional terms, as in 'it's not about blame but' (see section 9.4.2).

The principles of high reliability, as discussed above, appeared to underpin much of the information sharing work SLTs and nurses in this study directed towards swallow safety. Patient safety was central to the work of both disciplines, and most of the information SLTs shared with nurses oriented towards managing the risks associated with swallowing. SLTs expended considerable effort into incorporating verbal and written redundancy to information, particularly when recommendations were particularly high risk. However SLTs' need to disperse responsibility whilst also retaining authority for correct enactment of swallowing recommendations created a subtle imbalance of power. The SLTs in the study responded variably to organisational encouragement to report clinical incidents when they occurred, with some more

inclined towards resolution of issues through informal discussion at the ward level than others. Nevertheless, reporting was viewed as a legitimate route for pursuit of error reduction in management of swallowing, and this was sanctioned at an organisational level.

The nurses wanted clear information from SLTs, and viewed the bedside sign and entries in the patient record as a protocol for managing the risks associated with swallowing. Nurses have been reported as conceiving risk management in terms of following agreed policies or checklists (McDonald et al., 2003). However in the current study, uncertainty could often not be resolved through following the 'rules' laid out for nurses in SLT recommendations because ambiguity (e.g. improvement in patient condition) and competing demands (e.g. several patients needing help at mealtimes) were a routine aspect of nursing work with swallowing. This created the potential for patient harm, both in terms of safe eating and drinking, and with respect to meeting patients' wishes (see section 9.3). The limitations to high reliability principles are thus exposed at the intersection between following rules and being responsive to patients. Cooke (2009) argues that emphasis on *both* regulatory control (through following professional safety standards and protocols, and reporting incidents) *and* responsive, flexible ways of working (through learning from incidents) is not necessarily compatible with how patient safety is enacted. Risk controls informed by high reliability principles do not adequately account for the cultural context (Liberati et al., 2018). Understanding swallowing as a patient safety issue requires greater attention to the on-the-ground realities for nurses as they execute their roles.

11.4 Swallow Safety and the Context of Care

The operational issues experienced by nurses, whilst waiting for SLTs to assess or review patients, have been very lightly addressed in previous research, which included indicators that a level of burden is associated with the time needed to support patients to eat, conflicting priorities of care, and ensuring recommendations are adhered to (Kaizer et al., 2012, McCullough et al., 2007, Ross et al., 2011). In the current study, the temporal-spatial context could represent a burden to nurses because they were required to make decisions when SLTs weren't present. SLTs and nurses were interdependent in swallowing management, but nurses lacked specialist expertise and were not empowered to exercise control (Dixon-Woods et al., 2009). When nurses were aware that there would be a long passage of time before SLT would be able to review a patient's swallow, they experienced dilemmas over whether to take some kind of action on behalf of the patient or wait for the SLT to return.

This discussion is supported through bioethical principles and the humanising care framework. Bioethical principles include justice, beneficence and autonomy. These principles can operate in conflict with each other creating moral judgment dilemmas (Beauchamp, Walters, Kahn & Mastroianni, 2014), exacerbated by discordant disciplinary perspectives (Ewashen et al., 2013). The humanising care framework has its origins in the philosophy of the lifeworld introduced by Husserl (1970). The lifeworld can be summarised as 'a humanly relational world full of meanings', thus consideration for the lifeworld requires attention to relationships (Todres et al., 2009:55). The philosophy of the lifeworld has been developed to create a framework of values to support consideration for personhood and wellbeing as essential components of healthcare (Dahlberg, Todres & Galvin, 2009; Todres et al., 2007; Todres et al., 2009). The humanising care values framework includes binary dimensions spanning from humanising to dehumanising: insiderness; agency; uniqueness; togetherness; sense making; personal journey; sense of place; embodiment (Todres et al., 2009). The framework is intended to complement rather than replace concepts such as compassionate care through directing explicit attention to 'the importance of an existential view of being human and an existential theory of wellbeing' (Pound & Jensen, 2018:1213). Bioethical principles and the humanising care framework support this discussion by placing the moral dilemmas of nurses in the same frame as the impact of their decisions on their capacity to act in ways that humanise patients. This section explores the underpinnings of SLT and nurse perspectives about following swallowing recommendations through consideration of how risk is defined and operationalized based on disciplinary knowledge and the task before them.

11.4.1 Determining risk

Previous studies have indicated that different disciplines (and individuals) use different criteria for determining what constitutes risk and these have an impact on what is acted upon and reported (Dixon-Woods et al., 2009; McDonald, Waring & Harrison, 2005; Tamuz & Harrison, 2006; Trevino et al., 2017). In the current study, converse disciplinary definitions of risk were observed in relation to oral trials (tightly controlled trials of food or fluids for patients that were otherwise not considered ready for oral intake), which revealed higher acceptance of risk by SLTs, for the purpose of keeping the swallow mechanism active, and lower acceptance of risk by nurses, who showed some reluctance to carry out the trials when patients had alternative feeding routes in place. A previous ethnographic study that investigated risk-related decision making across four medical wards, suggested that the demands of the ward shaped how nurses reasoned what constituted risk and how to respond to it, with nurses inclined to

do what needed to be done even if that involved 'tolerating some trouble' (Dixon-Woods et al., 2009:367). Dixon-Woods argues that nurses have many potential risks to attend to during their work with patients and need to draw on norms and values when making decisions about risk, in a context of limited resources (Dixon-Woods et al., 2009). This resonates with the normative work carried out over mealtimes by nurses in this study (section 9.4.1). Despite holding values about the importance of giving patients a positive eating experience and following swallowing recommendations, nursing staff had a moral obligation to remain responsive to the other patients in the bay, and they treated some aspects of the recommendations as more critical than others. When more patients needed help than staff available the ethical principle of *justice* (fair distribution of resources) could conflict with the principle of *beneficence* (not causing harm or preventing harm). Nurses needed to allocate time and attention to all the patients in their bay, not just those that needed supervision with feeding. SLT freedom (*autonomy*) to distribute their attention through allocated time slots or sessions may reduce their awareness of the impact of the principle of justice on how nurses act. From a patient perspective this resonates with the sense of place/dislocation dimension of the humanising care framework, as the way in which nurses act at mealtimes influences the capacity of the ward to approximate a 'home-like' space for dining (Todres et al., 2009).

11.4.2 Acting for the Patient

When patients appeared to be coping better than expected they tended not to present as a dilemma to the nurses, unless they self-advocated for moving to a less restrictive diet. Most of the nurses said during interview, that when faced with a patient who was reluctant to follow a swallow recommendation, they would repeatedly explain to them that they should remain on what had been recommended until the SLT was able to review. However, when patients were particularly insistent, this could result in difficult conversations and created ethical dilemmas involving the principles of autonomy and beneficence. The decisions nurses needed to make about swallowing when SLTs were not present highlight difficulties nurses face in following professional standards of practice that require them to balance responsiveness to patient individuality and preference with keeping them safe from harm (NMC, 2018). Doing this effectively requires autonomy to act in ways they consider to be of most benefit to the patient. The stressors associated with ethical decisions impact on nurses' experiences of work. Respondents (n=422) to a US survey about nurses' experience of ethical challenges commonly reported feelings of tiredness, frustration and being overwhelmed (Ulrich et al., 2010). As experts in managing swallowing, SLTs may be less disposed to

encourage nurses to act with more autonomy due to their own conceptions of beneficence, which were less ambivalently linked to prevention of harm.

Patients who made their needs and preferences known brought their humanity into the dilemma for nurses. This can be understood through the dimensions of agency-passivity, and uniqueness-homogenisation in the humanising care framework (Todres et al., 2009). Rather than submitting to the authority of the recommended diet, patients were prepared to risk being labelled as non-compliant by attempting to assert control (Todres et al., 2009). In such circumstances acting with beneficence required nurses to balance patient safety directives with human need, however the need to respond to patients in the immediate could lead them to act in ways considered to be outside of their professional domain (Peter & Liaschenko, 2004). An ethical compulsion to deviate from hospital 'rules' when faced with patient need was found in the ethnographic study of nurse-doctor interaction reported earlier (Allen, 1997). However this compulsion can cause ethical dilemmas when accountabilities to the patient and to plans of care made by others are divided, affecting nurses' ability to do what they consider to be best for the patient (Barlow, Hargreaves & Gillibrand, 2018).

This study has made an important contribution to knowledge for how nurses' reduced scope to deviate from swallowing recommendations places limits on their options. It also highlights the extent to which nursing staff carry the burden of difficult conversations and hyper-vigilance in relation to swallowing. Ambiguity and uncertainty created issues for nurses in real time that they needed to resolve to be able to effectively perform their roles and preserve the integrity of the nurse-patient relationship. A scenario was presented in the findings (section 9.3) in which a clinical incident was raised after a nurse allowed a patient to eat more than the recommended quantity. The decision was taken on the basis of two things: First, the patient insisted that she wanted to keep eating, and second, the nurse judged that the swallow had improved because the patient seemed to be coping and was less fatigued. Thus the nurse acted with autonomy and beneficence, balancing the risks and benefits. However the SLT viewed the actions of the nurse as potentially harmful, based on her original assessment of risk. The response of the nurse who investigated the clinical incident demonstrated conflict between being responsive to patients and following safety advice that may not reflect changes in the patient's condition. When relating the incident during interview the nurse oriented to the ethical duty of *deontology*. Deontology is part of Kantian theory, which suggests that moral behaviour should be directed by a duty to follow rules (Beauchamp et al., 2014). The nurse suggested that

in future she would ensure that nurses act only as instructed, thus reinforcing limits on nurses' capacity to act autonomously. Acting in unsanctioned ways creates potential for risk to patients of aspiration or choking, but also to nurses' professional identity, in the event of an incident being raised (Dixon-Woods et al., 2009). However nurses' proximity to patients gives them a particular knowledge of relational ethics that may be less evident to other professionals (Wright & Brajtman, 2011), thus not taking action may impact on their relational work with patients.

11.4.3 Deciding what's Critical

With the exception of patients recommended to have full supervision, nurses were less consistent in following advice about *how* to support feeding than *what* consistencies the patient could tolerate. For example nurses were observed to call across to patients to remind them to slow their eating pace, rather than providing the close supervision the SLT had recommended (see section 9.4.1). It was evident during interviews that SLTs were somewhat ambivalent about the extent they expected nurses to follow *all* the aspects included in the written recommendations. However it was not clear from the written recommendations, which aspects the SLTs judged to be critical, and which were of more marginal importance. Dixon-Woods and colleagues suggest that although competing priorities sometimes cause nurses to cut corners, their likelihood in doing so relates to how tightly the action is coupled with an outcome, resulting in tolerance of some normative level of risk (Dixon-Woods et al., 2009). In the current study, offering patients food of the wrong consistency seemed to be more likely to result in a clinical incident being reported than a less tightly coupled action, such as providing distant rather than close supervision. The close connection between incorrect food consistencies and outcome featured in evocative stories raised by SLTs and nurses about choking incidents (see section 9.4). These took on a folk value as seen in *war stories* that elevate nurses' perception of risk (Trevino et al., 2017). In fact serious choking incidences in acute hospital settings do not appear to be particularly common. For example, none of the 17 serious adverse incidents reported across one NHS region over six years involved patients in hospital (Health and Social Care Board, 2018), however of the 17 incidents, 14 people died, reinforcing the relationship between risk and outcome. All the swallow-related incidents referred to in the current study related to potential rather than actual harm.

11.4.4 Medication as a Special Case

When a patient's swallow was worse than indicated by the recommendation, nurses were usually directed (via the bedside sign and the patient record) to make the patient

nil by mouth. However this was often not straightforward, as patients often pulled out NG tubes, creating problems for giving food, drink, and medication. When the oral route became unavailable nurses were strict about not using that route for the purposes of eating and drinking, but very occasionally gave medication orally with thickened fluids, judging this to be the most cautious approach. This occasional use of the oral route for medication when patients are otherwise nil by mouth was also a finding of the chart review discussed earlier (section 3.5.1) involving the records of patients discharged from acute stroke care (Kenny et al., 2016). However the oral route carries potential risks to patients in relation to aspiration, or slow transit of medication (Kelly, D'Cruz & Wright, 2009; Leder & Lerner, 2013; Warner et al., 2013). It has been suggested that when professionals act in routine ways, it can make the connection between the knowledge claimed by a profession and the work done by that profession less clear and vulnerable to 'poaching', a connection defined in Abbott's theory of professional socialisation as 'jurisdiction' (Abbott, 1988). The frequency with which SLTs recommended thickening drinks as a swallowing intervention may have led nurses to consider it normatively, as a safer option when they could see no other means for giving medication. However such recommendations are made by SLTs in the context of comprehensive assessment of the swallow and clinical experience (O'Keefe, 2018) that are less visible to nurses. The nurses on the stroke units did not appear to make autonomous decisions to thicken fluids outside of giving medication. When they gave medication in this way it was evident from the language observed on the ward and how the talked in interview that they recognised it as unsanctioned, or at the edges of their jurisdiction (see section 9.2.2). Thus the decision to act autonomously and accept some risk was taken as a last resort, and with awareness that it was based on expediency due to SLT absence from the wards.

11.4.5 Summary

The findings of the current study have provided new understanding for the relational component in the execution of swallowing advice, and the dilemmas for nurses in following swallowing recommendations. Dilemmas were associated with uncertainty and change, particularly when capacity to make in-the-moment decisions was impacted by restrictions on autonomy. Nurses' work in operationalizing swallowing recommendations was often not apparent to SLTs because they were present for shorter periods, and had freedom to be away from the bedside. Nurses might make SLTs aware of their challenges through urgent appeals for patient reviews. Nursing work has been described as invisible; it often happens behind curtains, and involves continuous but barely perceptible orchestration of the various elements that make up a

system of care from multiple professions (Allen, 2014). The current study indicates that it was nurses who had to manage the consequences of the recommendations and act to avoid negative outcomes for the patient or themselves (Peter & Liaschenko, 2004). The visibility of this work to SLTs was restricted by their reduced presence on the wards.

When patients pressed their desire to eat and drink against SLT advice, it could increase nurses' connection to them as humans with individual needs, potentially disrupting nurses' feelings of obligation to the swallowing advice. Nurses sought solutions through discussion with patients and with their nursing colleagues that remained hidden to SLTs, unless nurses were mobilised to seek them out. The lenses of bioethics and humanising care have illuminated the impact of ambiguity on both nurses and patients and resonate with a recently published report from the Beryl Institute, To Care is Human (Wolf, 2018). The report emphasises that healthcare has responded to care in general, and patient safety in particular, in ways that are more transactional than responsive to the relational nature of care (Wolf, 2018). The choice of words in the report are a play on the earlier highly influential 'To Err is Human' report which promoted learning from patient safety errors by US healthcare systems (Kohn, Corrigan & Donaldson, 2000). An important message from the new report is the reminder that healthcare is relational; patients want to be listened to in hospital at the same time as having confidence that those treating them can meet their healthcare needs and protect them from harm (Wolf, 2018).

SLTs were found to follow an approach to patient safety that whilst consistent with the high reliability principles sanctioned by the NHS (Tamuz & Harrison, 2006), was more transactional than relational. SLTs made swallowing recommendations that they expected to be carried out, and used the incident reporting system to support learning from errors. However high reliability principles are limited in their ability to address the routine ambiguities that present real time ethical dilemmas for clinicians (Liberati, et al., 2018). In the current study both disciplines adopted roles in monitoring patient safety, yet SLTs were able to adopt a more prescriptive and less ambiguous role than the nurses due to the combination of intermittent presence and their professional jurisdiction over swallowing. The To Care is Human report indicated that the providers and receivers of care are in fact aligned by the high value each places on communication and respect, and it suggested that attention should be more directed towards supporting healthcare practitioners to act in ways they know to be right than on protocol (Wolf, 2018). Although the humanising care framework was created for the

purpose of introducing a more humanising, relational approach to patient care (Todres et al., 2009), it is also relevant to interprofessional relations. The capacity to 'experience oneself as making choices and being generally held accountable for one's actions' (Todres et al., 2009:70) is important to the providers of healthcare as well as patients. SLTs, nurses and patients can thus be viewed as a triad.

The new attention the current study has brought to the on the ground experiences of nurses presents an opportunity to consider how nurses could be more empowered to meet patients' need to be heard whilst also protecting them from harm (Wolf, 2018). The following section considers SLT and nurses' work with patients with communication difficulties and discusses differences in how they conceptualise their roles in this area. Appreciation for factors that sustain these differences reveals where changes to practice could potentially benefit patients and the SLT-nurse relationship.

11.5 The Squeeze on Communication

Earlier discussion has explored how the temporal-spatial context created conditions that favoured exchange of swallowing information over communication information. This section explores how SLTs appeared to be socialised through interaction with nurses to attend less to communication than swallowing on stroke units and considers how this may have led them to accept a narrowed opportunity to share specialist knowledge about communication. This is followed by discussion of the low level of interdependence SLTs and nurses seemed to require for their roles with patients with communication disabilities and concludes by attempting to unpack what *could* bring information sharing about communication into stronger focus, through considering what it was that led SLTs and nurses to overcome the perpetuating features in the status quo and drove them to share information about patients' communication needs.

11.5.1 Becoming an Acute SLT

The experience of working on stroke units appeared to acculturate the SLTs in the study to self-limit sharing of communication information on the basis of a cycle of inattention. This led them to define roles with communication as being less valued than roles with swallowing, particularly with respect to supporting the communicative experiences of patients during their inpatient stay. Health care professionals can be considered to act on the basis of 'scripts' for how members of their professions are expected to act, with these scripts open to continuing revision through individual definitions of the situations they face (Charon, 2010). SLTs leave pre-registration training having experienced an education that is much more weighted towards

communication than swallowing, with respect to assessment and management of speech, language, and voice in adults and children (RCSLT, 2018). However according to the symbolic interactionist perspective, scripts shift over time as a consequence of repeated interactions with others and the experience of learning how things are done in the social world (Charon, 2010). In their seminal ethnography about how medical students became socialised through their training, Becker and colleagues described group perspectives as 'the ways of thinking or acting which appear to group members as the natural and legitimate ones to use' (Becker et al., 1961:36). The findings of the current study indicate that the privileging of swallowing information on the stroke units was perpetuated as natural and legitimate through a process of socialisation. SLTs appeared to reconcile their scripts with nursing scripts through acceptance of the limits placed by the temporal-spatial context of interaction.

SLTs demonstrated more confidence sharing information about communication when it contributed to picture building within a medical model of care than for the purpose of improving patients' experience of communicating in hospital. The SLTs were more likely to demonstrate conviction in conveying their assessment-derived knowledge about the communication abilities of patients during interprofessional meetings, in the patient record or with other therapists, than informally with nurses. The information contributed to processes through which fragmented knowledge from various professionals was assembled to create an accumulated team understanding of the patient's rehabilitation and discharge related needs. In circumstances where SLTs perceive that what is required from others is diagnostic labelling for classification or prognostic purposes it is likely that information considered irrelevant to that purpose will not be shared (Abbott, 1988), and acting in this way orients to a reductionist view of the body (Todres et al., 2009).

Previous studies in acute care from SLT perspectives have reported that communication is under-privileged in acute settings (Foster et al., 2015; Foster et al., 2016a, 2016b: Rose et al., 2014). It has been argued that SLTs derive professional esteem from working effectively within a medical model of care and that the role construct associated with 'being an acute SP' (SLT) may maintain practices that restrict development of a more expansive role in management of communication in the acute setting (Foster et al., 2016b: 602). In the current study, swallowing information was a comfortable fit with the medical model of care. When communication information related to diagnostic or prognostic information it could be accommodated within the same frame. However this was less the case with information for the purpose of

supporting patients to communicate in hospital. This finding resonates with the satisfaction that one of the participants interviewed by Foster derived from 'assessing (of) communication and working out what it is that they've got, rather than trying to fix it' (Foster et al., 2016b). SLTs in acute settings have reported a tendency to focus their assessment attention at the level of the language impairment (Foster et al, 2016a). The Inpatient Functional Communication Interview (IFCI) (O'Halloran, Worrall, Toffolo, Code & Hickson, 2004) was introduced as a tool for SLTs to direct their attention beyond the impairment, to patients' ability to communicate in the hospital environment, with an additional much shorter version designed for use by staff (O'Halloran et al., 2017). However such tools are not in common use. The vast majority of SLTs surveyed in Australia and New Zealand (n=174) reported preference for informal over standardised assessments of communication in acute settings and only 10.9% reported use of the IFCI (Vogel, Maruff & Morgan, 2010). Thus the assessment-derived information available for the composite picture building process leans more towards informally derived classifications of linguistic and cognitive deficits than the impact of deficits on communication with health care providers.

This study has extended existing knowledge for what underpins the taken for granted prominence of swallowing by suggesting that repeated experiences of interaction create and maintain its prominent position. A review of literature reporting on acute aphasia management indicated that what SLTs *know* to be best practice and what they actually feel *able to do* are discordant within the acute setting (Foster et al., 2013). SLTs experience tension because they are aware that they are not fully addressing patients' communication needs (Foster et al., 2016b). The SLTs in the current study also experienced discord between how they would have liked to act and how they acted in practice. Reticence about sharing information directed towards helping nurses support communication arose through SLTs' experiences of interaction. Conflict between professional values and ways of acting can lead to feelings of distress or burnout amongst healthcare professionals that have been much reported in nursing (e.g. Ulrich et al., 2010) and to a lesser extent in SLT (Byng et al., 2002; Galletta et al., 2019). The following quote from Byng and colleagues provides a strong illustration of the allure of the medical model and the cost to values for meeting patient needs:

> 'Being ambitious and competitive and never one to shirk a challenge I enjoyed the sparring with the consultants and the feeling of importance you get from wearing a white coat and having cranial nerves as the tips of your fingers as it were – that is, being able to speak their language and wear their clothes – but

> of course it doesn't necessarily help your clients. I'm not saying that those two things are necessarily bad but for me it made me take my eye off the ball and I cringe when I look back and think what I put some people through to be admired on the ward round' (Byng, Cairns & Duchan, 2002:94).

A status quo perpetuated inattention to communication information. Although SLTs did often extend effort to share communication information with nurses when they considered it to be definitive and unambiguously useful (such as when a patient could understand better than they appeared to), assessment-derived information was usually less clear-cut. For the most part both SLTs and nurses had low expectations for the usefulness of information about patients' communication that the other could supply for accomplishing the job at hand. SLTs tended not to challenge these perceptions, and instances where they demonstrated genuine curiosity for nurses' experiences of communicating with patients were infrequently observed. The balance of information SLTs shared was influenced by their perceptions that communication information was of less interest to nurses than swallowing information. One study was identified that indicated disinterest as a factor that impacted on SLT willingness to spend time educating nurses and other professionals to use supported communication techniques (Shrubsole, Worrall, Power & O'Connor 2018). On the whole however, the interactional basis that underpins the under-privileged position of SLT roles with communication has received little interpretative attention in previous research.

This study has emphasised the role of interaction in creating social order (Blumer, 1969). However, there was evidence that the scripts SLTs acquired through pre-registration education had some influence on how they perceived their roles, suggesting that role identity may also have an effect on how SLTs act (Stryker, 2008). They dedicated time to writing about communication in the patient record, and it was clear from how they talked in interview that attending to patients' communication difficulties was a valued aspect of their professional role and identity. SLTs interviewed by Foster and colleagues expressed similar values (Foster et al., 2016b). In addition the SLTs in the study who were able to recollect meaningful discursive exchanges about supporting communication with nurses reflected on them with much satisfaction. Thus whilst SLTs appear to be socialised to operate within medical models of care on stroke units, there may be scope for them to reclaim a more fulsome role consistent with their education and values, through appeals to their core identity as communication specialists (Foster et al., 2016b).

The roles of stroke nurses with respect to communication can be seen within the functions suggested by Kirkevold's original and updated practice theory (Kirkevold, 1997, 2010). Kirkevold suggested that nurses' roles in stroke are encapsulated by four functions: conserving, consoling, interpreting and integrating. The conserving function relates to basic care and involves 'maintaining normal functions, preventing complications and traumas, and meeting the patient's basic needs'; the consoling function encompasses emotional support; the interpreting function involves supporting patients to understand what has happened to them and the integrating function involves helping them to incorporate skills into usual tasks (Kirkevold, 2010:28). All these functions incorporate communication. However, although the relational component of caregiving was central to how the nurses in this study described their practice, they found it difficult to articulate this as a specific expertise with communication. There was little evidence that SLTs and nurses shared disciplinary understanding for where their knowledge about patients' communication needs overlapped. There are thus pervasive factors that led both disciplines to uncertainty for how information from the other could help them in execution of their roles for the benefit of enhancing patients' communication needs in hospital.

11.5.2 Lack of Interdependence for Communication Work

Both SLTs and nurses operated as though they could meet patients' communication needs without much input from the other. This raises questions as to whether interdependence between SLTs and nurses was actually required for achievement of outcomes relating to patients' communication abilities. Interdependence is defined as 'the degree to which team members depend on each other for both individual and team task completion' (West & Lyubovnikova, 2013:137). It was evident that SLTs and nurses depended on each other far less in relation to meeting communication needs than swallowing needs. The Clinical Guideline for Stroke states that SLTs working on stroke units should provide education and training to support healthcare professionals' competence to communicate with people with communication difficulties (Rudd et al., 2016). SLTs appear to be underperforming against these expectations. They considered it important to support patients and families with communication and were commonly observed discussing patients' communication needs with therapists. However SLTs recognised that the information they offered informally to nurses to help them support patients' communication was somewhat tokenistic and they did not offer any training. From a nursing perspective, their regulatory body includes an expectation that they make reasonable adjustments so they can support patients to access information and participate in decision-making (NMC, 2018). It was evident through

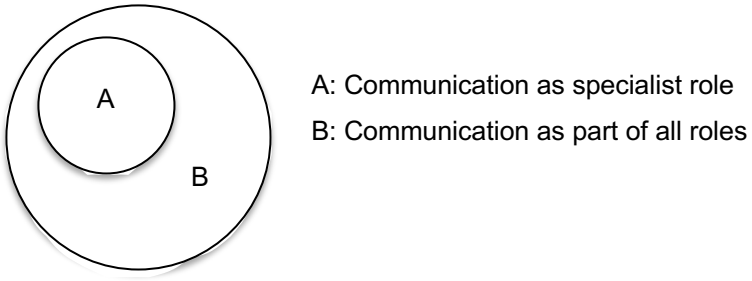
nurses' response to interview questions that they experienced difficulties meeting patients' needs when communication was challenging, however they rarely indicated a need for SLT input to help with this activity and viewed their priorities for interaction with SLTs as relating to swallowing.

It is suggested by some authors that interprofessional working requires boundaries between professions to become blurred (e.g. Baxter & Brumfitt, 2008; Long et al., 2002). However it is also argued that skill and authority differentiation is important for effective integrated working (West & Lyubovnikova, 2013). Clear knowledge by each discipline for the unique contribution of their own expertise to patient care can indicate where their tasks overlap (Rushmer & Pallis, 2003). In the current study, it was difficult to see where the boundaries actually were between SLT and nurse interests in communication. In comparison with how SLTs and nurses described their roles in swallowing, their respective responsibilities with respect to communication were more fluid. SLTs had a specific role, whilst for everyone else in the team communication was not fragmented in this way, it was the *conduit* through which they performed their clinical roles. It may be harder for SLTs to claim a jurisdictional boundary (Abbott, 1988) over supporting communication because the ability to communicate with patients is intrinsic to the professional responsibility of every member of the interprofessional team (Jensen et al., 2015; Simmons-Mackie et al., 2007). SLTs operated with sensitivity to the risk that by claiming expert knowledge for supporting communication they might undermine more generalist knowledge (Whitley, 2009), yet this does not explain why they displayed more reticence about sharing information for supporting communication with nurses than with therapists. Reasons to share information with therapists may be more apparent because of commonality of purpose across the trajectory of the full admission for individual patients. However, SLTs may also be driven to establish with therapists their position as an expert in a team of expert therapists (Stryker, 2008) through claiming jurisdiction over the 'part' of the body they are trained to care for.

The relationship between SLT roles with communication and those of nurses is illustrated in Figure 11.2 below (based on Rushmer & Pallis, 2003). The SLT role with communication can be pictured as a closed circle of SLT specialist knowledge positioned within a wider circle representing the broader knowledge held by nurses about communicating with patients with and without specific communication difficulties. Information fed in and out of the inner circle, but there was little disciplinary overlap. The primary information that was fed out of the inner circle originated from SLT

assessment, and was delivered across all information-sharing routes, but most strongly through meetings and the patient record.

Figure 11.2: Roles with Communication



SLT and nurse activities in relation to meeting patients' communication needs were weakly integrated. Converting this figure to a classic Venn diagram would require defined SLT and nurse responsibilities/expertise and areas of overlap agreed by both disciplines (Rushmer & Pallis 2003). These areas of overlap would be where need for information about communication might lie. The IFCI SQ is a validated tool that can operate within this hypothesised overlap through evaluation of the frequency of patients' ability to function in 15 communication situations that patients with difficulties communicating might find difficult in hospital. Nurses can be expected to recognise these difficulties when attending to patients' basic needs, information needs and feelings (O'Halloran et al., 2017). When considered against the functions of stroke nurses (Kirkevold, 1997), the items from the IFCI SQ relate mostly to conserving and interpreting roles. Conserving roles relate to the IFCI SQ domains of: gaining attention, following instructions, telling you about preadmission medical history, asking you questions about their care, telling you about any current medical concerns, telling you about pain or discomfort, asking for something, and calling for a nurse. Interpreting roles relate to the domains of: telling you what has happened to bring them into hospital, understanding the medical diagnosis or reason for admission, understanding the implications of the medical condition, and understanding descriptions about what is happening, going to happen, or has happened as they relate to hospital procedures. Two items on the IFCI SQ relate more to the consoling function: expressing feelings, and telling you about what they do/do not like.

Despite the increased familiarity with patients communication abilities associated with nurses' breadth of role, continuous care and close proximity, nurses did not claim specific expertise for communication, either in contributing to the diagnostic picture or

in supporting communication. At the same time, SLTs were concerned that pressing their skills for supporting communication with nurses amounted to 'stepping on toes' and they were cautious about pursuing this role. Thus neither discipline oriented to the other as important conduits for improving the communicative experience of patients on the wards. SLT and nursing roles with communication tended to coincide in an ad hoc fashion and nurses were often only vaguely aware of SLT specialist roles with communication. At the centre of this uncertain territory is the patient, whose communication needs may remain under-specified and under-supported.

11.5.3 Triggering a Need to Share

Communication became more salient as an information sharing need when it affected task performance or when patients' humanity triggered an emotional reaction. This section discusses how when time pressures affected nurses' ability to perform the conserving function it could act as a trigger for them to share information. SLT need to share information for supporting communication is then considered with reference to research from Communication Partner Training (CPT) interventions. The discussion concludes with consideration of triggers for sharing information for humanising purposes. Although there were few examples in the data of such triggers, they had power and made patients' human needs more visible.

The pressure of time was a prominent feature in how nurses spoke about their work, it was evident through observation both at the micro level with respect to the time they could give to interprofessional discussion, and at the meso level of day-by-day fluctuations in staffing levels. Nurses aimed to be friendly and attentive to all their patients. However, time pressures affected their ability to support patients with communication difficulties whilst also meeting obligations to the other patients in their care. The policy report, Safe and Effective Staffing: the Real Picture, indicates that dilutions in skill mix as a consequence of recruitment and retention issues have a profound impact on the ability of nurses to consistently deliver safe and effective care (Royal College of Nursing, 2017). Safety relates to missed care as well as reportable clinical incidents. A large-scale survey of UK nurses (n=2917) indicated that lack of time led 66% of nurses to report that 'comforting or talking with patients' was frequently left undone (Ball, Murrells, Rafferty, Morrow & Griffiths, 2014:116). Being short of time can lead nurses to focus on completing tasks. Consistent with research with patients with and without communication impairments, nurses in the current study reported balancing their primary focus with task completion with an attempt to retain a compassionate approach to care (Bridges et al., 2013; Chan et al., 2012; McCabe,

2004; Sundin & Jannson, 2003). During interview, nurses reported that communication difficulties presented challenges for provision of basic care, a finding that resonates with the perceptions of patients reported in previous research (e.g. Hemsley et al., 2013). When nurses experienced difficulties interacting due to communication impairment, they said that they either adapted their approach in ways that they could accommodate within their usual ways of working (such as attending more to non-verbal indicators from patients), or consciously used the same friendly approach (such as explaining what they were doing regardless of the patient's language ability), but always within the inherent time constraints associated with their need to attend to all the patients in their care.

When nurses had difficulties meeting patients' needs relating to eating, drinking, pain or going to the toilet, they arose within the process of care provision and were thus immediate. This inclined them towards self-reliance or sharing with their nursing colleagues. Previous research has similarly indicated a preference among nurses for collegial support for managing the emotional and physical aspects of care (Miller et al., 2008; Miller & Kontos, 2013). When nurses brought communication difficulties to the attention of their nursing colleagues or to structured information sharing routes it was most commonly subsumed within discussion of how factors such as agitation, confusion and refusal of intervention affected the conserving role. This resonates with the findings of an ethnographic study that found that resistance (by patients with dementia) became visible to nurses when it impacted on their ability to complete care during routines such as mealtimes, medication rounds and personal care tasks (Featherstone, Northcott & Bridges, 2019). The current study indicated that neither nurses nor SLTs were clear on what they needed from the other in order to effectively execute their communication roles with patients. In addition, the ways the SLTs in the study offered information were rarely compatible with nurses' needs for information in the here and now. It is perhaps unsurprising therefore that nurses did not seek out SLTs as a resource to help in their moments of need. Improved SLT attention to how they share information with nurses will require increased appreciation for nurses' need for information that they can apply in practical ways.

There is a developing awareness of a relationship between communication and safety (Hemsley et al., 2016, 2019; Kalish, Landstrom & Williams, 2009; Todres et al., 2009). SLT research has attempted to raise the profile of patients' communication needs by highlighting an association with adverse events, such as falls, in healthcare (Hemsley, Georgiou, Hill, Rollo, Steel & Balandin, 2016; Hemsley et al., 2019). This connects

communication difficulties to nurses' conserving role. In the current study nurses very occasionally raised a connection between communication disability and safety on the ward (see section 10.5). More explicit connections with patient safety could potentially increase awareness of the impact of communication disability on safety at an organisational level. This has potential to create a shared agenda for SLTs and nurses for leading this aspect of care for the healthcare team.

Previous discussion has indicated that SLTs provided information about supporting communication through brief interactions, written advice above the beds, the patient record and meetings, but that they questioned whether nurses found this information useful. The SLT role for supporting communication is a key component of the SLT pre-registration curriculum, which identifies 'promoting inclusion and access' as a core graduate capability, and lists a number of abilities expected of SLTs on graduation (RCSLT, 2018). These include creating environments that are facilitative of inclusive communication, and providing advice and training to enable other professionals to offer this support (RCSLT, 2018). It was evident through discussion of SLT identity (section 11.5.1) that SLTs consider the communication needs of patients to be important. Nevertheless there was a gap between how the SLTs in this study acted and the values they held for supporting communication, which is consistent with the findings of other research (Foster et al., 2016b).

Research attention towards SLT interventions for supporting communication is represented in research into CPT initiatives. As previously explained (section 3.4.5), CPT refers to a range of interventions (usually time intensive and away from the ward) directed towards teaching others to support communication (Simmons-Mackie, Raymer & Cherney, 2016). Such interventions are quite variable in the extent to which nurses are included as participants. For example, although some studies have included a high proportion of nurses (e.g. Horton et al., 2016), a recent hospital-based study comparing face to face with teleconference delivery of CPT did not include *any* nurses amongst the 55 HCPs involved (Cameron, et al., 2019). Previous research across three continents has revealed challenges in introducing CPT to acute care contexts relating to time pressures, medical priorities and short admissions (Horton et al., 2006; Jensen et al., 2015; Simmons-Mackie et al., 2007). The current study indicates that a challenge to introducing CPT that has not been adequately explored may relate to nurses' perception of need for information for supporting patients' communication. Analysis of need is an important precursor to training that is often neglected in HCP development initiatives (Holloway, Arcus & Osborne, 2018). CPT is usually initiated as

a response by SLTs to *patients'* need to be supported to access the communicative environment of the ward, rather than a need identified by *nurses*. On the face of it this is correctly patient-centred and important at an organisational level. However, if nurses do not own the training need their commitment is likely to be difficult to sustain, particularly given the temporal-spatial constraints identified in this study.

In the current study it was apparent that nurses viewed swallowing information as held within the SLT role but ascribed communication much more loosely. Thus nurses expected SLTs to provide training for swallowing much more than for communication. In addition nurses' inclination to look towards other nurses for support when having difficulties with communication indicates that consideration should be given to *who* nurses prefer to learn from. CPT interventions in acute stroke care may be more effective if they start from a place of self-identified nurses' need rather than SLT-identified need. One way of approaching this would be to frame discussion about patients' communication needs around nursing functions (Kirkevold, 2010).

The findings of the current study indicate that better synchronisation between SLT and nurse conceptualisation of their roles with communication is needed. CPT is more directed towards teaching *strategies* for revealing competence than the *ways of being* that feature in nursing research. The responses that nurses in the current study gave to questions about how they supported patients with communication difficulties resonated more with the literature reviewed (section 3.4.4) on the relational and existential needs of people with stroke (Bright et al., 2018; Loft et al., 2017a; Nystrom, 2009; Pound & Jensen, 2018; Sundin & Jannson, 2003) than with the language SLTs use to describe supporting communication, such as strategies and techniques (e.g. Hersh et al., 2016; Jensen et al., 2015). SLTs and nurses do not appear to have a shared frame for talking about communication, however there is potential for this to be developed through consideration of relational aspects of care. SLT and nurse skill differentiation may lie in the distinction between agency and vulnerability, patients want to act both as agents in their own care *and* have their vulnerabilities understood (Dahlberg et al., 2009). Communication support strategies provided by SLTs tend to be directed towards increasing agency and nurse proximity to patients gives them particular insights into patients' vulnerability. Patients feel 'unmet by interactions that emphasise one or the other' (Dahlberg et al., 2009:266), thus there is a need for SLTs and nurses to address both. In the current study SLTs drew little on nurses' experiential knowledge of patients and nurses drew little on SLTs specialism in supporting patients to be agents in their care. Acknowledging that each discipline may hold particular expertise for the agency

or the vulnerability side of the equation could potentially indicate where information exchange is needed to create a more complete understanding of the patient's needs relating to agency, personhood and wellbeing (Dahlberg et al., 2009; Todres et al., 2007; Todres et al., 2009). The advantage of role differentiation is that it can bring clarity. However, increased specialisation also has potential to dehumanise people into 'parts' (Todres et al., 2009), thus it is important to emphasise that what is suggested is appreciation for differences in the balance of expertise rather than a new jurisdictional boundary (Abbott, 1988).

Support for communication should meet patients' human needs in addition to more tangible care needs (Pound & Jensen, 2018). Information relating to human or existential need was seen infrequently across all information sharing routes, however those occasions carried emotional force. Patients who acted with agency by insisting on being communicated with, or who showed extreme vulnerability, generated a corresponding human response in both nurses and SLTs. The moments in which patients brought their existential needs and wellbeing to the fore triggered a sense of shared humanity between patients and staff and provided some compulsion for them to share what they had learnt about the person with others. Examples were presented in the findings (section 10.5) of occasions when patients' expressions of emotion 're-humanised' them as people with a past and a future and created feelings of connection that contrast with dehumanising dimensions such as isolation (Todres et al., 2009). Wellbeing has been described as 'a fundamental motivation within the human heart' (Dahlberg et al., 2009:271) and this may explain why the few examples of emotional awakenings of this kind had a mobilising effect. When they arose during fieldwork they immediately drew researcher attention and in so doing also drew attention to the more usual absence of references to existential or humanising need in interaction, within and amongst the disciplines (Dahlberg et al., 2009). For both disciplines a more consistently relational and humanised approach may support management of both communication and swallowing in ways that demonstrate respect for personhood over specialisation.

12. Conclusion

In the introduction I explained that the study was inspired by the conviction that closer working between SLTs and nursing staff had the potential to improve the experiences of patients with communication and eating and drinking on stroke wards. This chapter draws out why new knowledge for how SLTs and nurses work together is not only of benefit to these professionals but potentially of benefit to patient experience of care on stroke units. This is followed by discussion of the gaps in knowledge this study has addressed, with suggestions for future research. Implications and recommendations for clinical practice and education are suggested and the chapter concludes with final reflections on the impact of conducting this research as a SLT-researcher.

12.1 Overview of Findings

This study is the first to direct focused and sustained attention to the SLT-nurse dyad in operation in stroke unit care. The ethnographic approach facilitated in-depth exploration of differing relationships with time and space and understanding for how this impacted on how the disciplines interacted, what they talked about and professional alliances. That swallowing is privileged over communication in acute care is a taken-for-granted aspect of SLT practice, however the reasons suggested for why this prevails are mostly understood from the perspective of SLT respondents to survey or interview questions (e.g. Code & Heron, 2003; Foster et al., 2016a, 2016b). Combining interview with observation has supported a much deeper analysis of factors that might sustain the privileged position of swallowing on stroke units. In addition, an original contribution has been made to understanding that differing engagement with time and space had a direct impact on the length and depth of the interactions that took place between SLTs and nurses. The status quo was maintained through a temporal-spatial context that supported fast, functional exchanges of immediately usable information that both disciplines oriented to as important for keeping patients safe from physical harm. Communication information that contributed to the diagnostic or prognostic picture was offered more often and with more conviction by SLTs than information about supporting patients' communication abilities. Thus there was less attention to how impaired communication impacts on human needs for agency and connection and for vulnerability to be seen and responded to (Dahlberg et al., 2009). Information about communication became more salient and more likely to be shared when communication difficulties presented as a problem to task completion, or when patients pressed their need for their personhood to be met. However this happened infrequently and for the majority of the time SLTs and nurses attended to the

communication needs of patients without much recourse to sharing knowledge with each other. SLTs had an uneasy relationship with their expertise in communication. They acknowledged it as a specialist area but held back from sharing it with nurses for complex reasons, including perceptions of nurses' capacity and interest as well as fears of over-stepping the mark. In relation to information sharing amongst nurses, unless impaired communication presented a notable problem to task completion each nurse found their own way of communicating with patients as they progressed through their shift. There was thus reduced opportunity for the patient to benefit from either nurses talking amongst themselves or SLTs and nurses talking together to share what they had learnt about how best to support them.

This research makes a new contribution to understanding that the temporal-spatial context can have an impeding effect on relationship building between SLTs and nurses. As discussed in the previous chapter, the healthcare environment for interaction can be dehumanising to staff as well as patients. This chapter draws out the potential benefits of improved SLT-nurse working relationships to SLTs, nurses and patients as a triad. Findings from the meta-ethnography conducted as part of this study suggested that good quality working relationships are developed through opportunity to share space, time and capacity to talk, and a need to share information (Barnard et al., 2018). The SLTs in the study operated within the same temporal-spatial context as other therapists and this played an important role in sustaining intra-therapist relationships, which SLTs viewed as closer and more open and interdependent than relationships with nurses. SLTs relied on therapists for information to accomplish roles they had in common with respect to rehabilitation and discharge planning and viewed these problem-solving interactions as important for patient care. Considering the temporal-spatial context of interaction as an influence on relationships provides an alternative to more intractable acceptance of therapists and nurses as culturally different. That is, when culture is viewed as being *created* through interaction (rather than through more durable social forces) there is potential for it to also be *transformed* through interaction (Blumer, 1969). New understanding that temporal-spatial difference is at the heart of SLTs' weaker alliance with nurses than therapists makes it possible to seek solutions that also have benefits to patients. For example increasing opportunities for SLTs and nurses to interact around the same patient could potentially bring closer alignment to SLT-nurse relationships and this could encourage richer information sharing, benefitting patients in the ways advocated by research about effective collaborative working (e.g. Clarke, 2010).

One of the findings of the study was that with the exception of handover, structured routes for information sharing on the stroke units were less useful to nurses than SLTs. This gave nurses fewer opportunities than other professionals to participate in the whole sense-making picture and acquire in depth knowledge of the patient (Todres et al., 2009). It was evident that the temporal-spatial context was a significant factor limiting nurses' capacity to be full participants in meetings. The attending nurse could only offer directly gained knowledge about some of the patients, and the bedside nurse heard information from meetings second hand. If the nurse knew the patient, they had potential to feed holistic information into the meeting, but the information that made its way back to the treating nurse was more likely to relate to essential, condensed messages of an 'objective' nature. In common with much that has been reported in nursing literature (e.g. Sommerfeldt, 2013), the nurses in this study found it hard to articulate what their unique contribution to the team actually was. Nurses' disadvantaged position with respect to structured information sharing routes represented a loss of opportunity for their knowledge of patients to be comprehensively heard by others in the team. The potential consequence for patient care is that the professional closest to their care has the least opportunity to be fully engaged in problem solving ways of improving outcomes from their care.

A particular strength of this research is that it is the first study to observe how nurses manage domains claimed by SLT across the 24 hour, seven-day week. Fieldwork conducted outside of therapy hours was particularly illuminating with respect to nurses' lived experience as they executed the recommendations for swallowing provided by SLTs. Combination of observations of practice with perspectives of both professions on following swallowing recommendations led to the novel finding that despite each discipline perceiving that swallowing information represented a relatively concrete set of rules, the information could become ambiguous due to changes in the patients' condition or multiple demands on nurses' time. The impact of this on patients was particularly visible when they advocated for themselves, leaving nurses with a moral dilemma over following what they had been instructed to do or meeting patient need. Patient safety thus became a potentially contested space for humanising care (Todres et al., 2009), where rules could conflict with the sense of agency held by both nurses and patients.

Within usual practice, temporal-spatial differences make it difficult for SLTs to see with their own eyes how the clinical interests they have in common are enacted over the 24 hour, seven-day week. The capacity of the ethnographic approach for increasing

understanding for this was a real strength. However there are also restrictions on knowledge claims derived from the methodological and theoretical perspectives selected for this study. The strengths and limitations will now be discussed, before turning to the contribution of the study to practice and education, concluding with suggestions for future research.

12.2 Strengths and Limitations of the Research

This research addressed a gap in knowledge for how interprofessional work is operationalised through the interactions of a specific dyad in relation to specific aspects of patient care. Application of the contingencies identified through the published meta-ethnography (chapter two) provided a strong frame for understanding how need, capacity, opportunity and quality of relationships underpinned information sharing. The use of symbolic interactionism indicated that attention at the level of the interaction might hold more potential for change than emphasising discordance in professional role values (Charon, 2010). The bottom up approach to understanding society represented by symbolic interactionism can however be critiqued for its restricted attention to the influence of structural factors at the organisation level (Fine & Hallet 1993), and different theoretical lenses could have offered an alternative slant on the findings. The findings were also explored through other frameworks and theories. The principles of high reliability (La Porte, 1981) when considered against the framework of bioethics (Beauchamp et al., 2014) helped create new understanding that moral dilemmas can be associated with nurses' execution of swallowing recommendations. Professional socialisation theory introduced the concept of jurisdiction as a new way of understanding SLT-nurse role boundaries (Abbott, 1988). The humanising care framework provided a means to extend consideration for the dyad to a triad including the patient (Todres et al, 2009). However an acknowledged limitation of this research is that it did not seek the patient perspective, hence the application of the humanising care framework to patient experience is derived from how they are represented through SLT-nurse or nurse to nurse discussion.

This study makes a significant contribution to the very small body of SLT-directed research that has used ethnographic methodology, and appears to be the first that has focused on SLTs in interaction with other healthcare professions on hospital wards. The strength of the methodology was that it supported the collection of rich data in context and made it possible to analyse SLT and nurse interaction in depth. This was accomplished through long periods of immersion, triangulation of different sources of

data, and feedback sessions across the wards. In addition ethnography embraces the role of the researcher in knowledge creation.

My positioning as a SLT-researcher brought both strengths and limitations. Familiarity with the language and routines of team-based inpatient care eased the process of understanding what people were talking about and gave me common ground with staff as a fellow health care professional. Being unburdened by professional role increased my scope for openness to the perspectives of both disciplines. This was especially the case with respect to nurse perspective due to the unfamiliar experience of occupying nursing space as SLTs entered into it. I experienced feelings of comfort and discomfort as I moved between spaces where I felt more and less at ease. This heightened my awareness for the importance of spending time in the uncomfortable spaces in the first weeks of fieldwork as a way of increasing trust from the nursing staff. Ethnography requires discipline from the researcher to recognise presuppositions and keep them in check throughout the study. This is a socially constructed account and my particular disciplinary lens is likely to have influenced my interpretations. It is likely that a nurse-researcher would have asked different questions of those in the field and noticed things that I did not. More robust systems for nurse steerage would have enhanced the study and future studies would benefit from being conducted by SLTs and nurses as co-researchers. Processes to increase the credibility of the findings included keeping a reflexive diary, search for negative cases, supervisory discussion, return of findings to the wards, and critical discussion with PhD peers. Conducting the research across multiple sites created an additional moderating effect on disciplinary presuppositions. When fieldwork commenced on the second and third wards, suppositions about the practice of *both* professions derived from fieldwork on previous wards became more substantive influences on ways of seeing than the pre-suppositions I held when I commenced the study.

Rich description of the context and detail of SLT and nurse interactive work on the wards has increased the potential for readers to judge whether the findings have transferability to other stroke unit settings. Ethnographic accounts have resonance for clinicians when they can see themselves and their services in them (Bloor, 2001), and the capacity of the findings to transfer meaning is increased with the use of multiple sites (Hall, 2003). The three wards in this study represented different types of stroke unit in the same large UK city: hyper-acute stroke unit, dedicated stroke unit and a stroke unit embedded within two general neurological wards. The findings are thus relevant to different types of stroke unit, but may be more transferrable to other inner

city areas. The units of analysis in the study were SLTs and nurses, with the wards offering opportunities for different kinds of contrasts to be made at the level of the interaction. An alternative approach could have been to use the wards as the unit of analysis in a case study design. This might have made transferability of findings from one setting to another more obvious, for example hyper-acute to hyper-acute. It is a strength that prolonged engagement with the wards made it possible to understand the stroke units as places of change as people came and went. However, it is important to be aware that changes will have continued since the end of fieldwork, thus the findings of this study are situated in a particular time and place.

The presentation of the thesis as a finished product may give the impression that the study was conducted without much mishap, however some 'messiness' is considered to be integral to qualitative research (Dean, 2017). Some of the challenges experienced would need to be re-lived if completing this type of research again, whilst others can be more properly attributed to researcher inexperience. The first challenge was navigating an ethnographic study through an ethics process geared up for projects that present much more potential risk to participants and more certainty about research process (Murphy & Dingwall, 2007). With hindsight the study might have been enhanced by inclusion of a proxy consent process to include more patients in the study and thus increase access to conversations between SLTs and nurses in the bed space. Having more patients consented into the study might also have made it easier to complete audio recordings of interaction as intended. Recordings would have increased the reliability of the field note data, as it was sometimes difficult to write down everything that was said. However, field notes were sufficiently detailed to capture key content, and informal encounters often occurred unexpectedly and at great speed, thus it is likely that by the time the recorder had been activated the moment would have passed. The finding that the temporal-spatial context made it harder for SLT-nurse relationships to develop could have been extended if the perspectives of occupational therapists and physiotherapists had also been sought for comparative purposes. These enhancements might be more manageable in a future project involving more than a single researcher. Recruiting extra participants would have added demand onto the challenges involved in gaining consent, and increased an already very large corpus of data.

Difficulties experienced by nursing staff in giving time to participate in research represented a frustration in this study that is likely to be an unreported factor in other research involving nurses. Nurses were constantly pulled away as I talked through the

consent process and had little time to spare for interviews or hearing the findings (see section 5.3.1/5.6). Process difficulties featured prominently in my reflexive diary because they mirrored emerging findings about the influence of time and space on interaction between SLTs and nurses. Whilst it is likely that a nurse researcher would have created trust with nursing staff more quickly than I was able to, it is also likely that there is inequitable representation in research of the perspectives of those nurses who have the least capacity to leave the bedside.

The large volume of data collected placed restrictions on what to include within the narrative of this study. However, the benefit of the large corpus of data is that there is capacity for different elements of this research to be highlighted in future research publications. For example the aspects of the patient record included in the thesis were those that related to differences in emphasis and language with respect to advice for communication and swallowing. Further exploiting this data would expand a very small body of published research about the use of writing for recording and sharing information about communication and swallowing (Steel et al., 2019). The following section considers the implications of the findings of this study for future research.

12.3 Implications for Research

It is recommended that transferability of the key findings of this study be tested. This could be accomplished through survey or structured interviews with SLTs and nurses across a larger number of stroke units. However to provide meaningful outcomes, such research would need to be complemented by additional exploration of the specific clinical problems identified in this study. Further research in three key areas is suggested to develop the findings: extension of nurse autonomy for managing swallowing, SLT and nurse interdependence with communication, and exploring approaches to providing education about communication, both in-service and pre-registration. All of these directions would greatly benefit from joint leadership by SLT and nurse researchers.

Research is suggested to establish the feasibility of increasing nurse autonomy to act in the absence of SLTs. Existing research emphasises expansion of nurses' scope of practice in relation to swallow screening rather than in management of swallowing (e.g. Hines et al., 2016). The RCSLT interprofessional framework for dysphagia that is currently under consultation (IDF Draft for Consultation, 2019) does not name specific professionals, indicating that other registered professionals could potentially be trained to manage swallowing at the highest levels of competency. However, no empirical

research has been identified that reports on nurses' operating in expanded roles for dysphagia management, although there are indicators that such roles do exist. From the literature, one reference was identified that suggested a link nurse role as a means of improving adherence to recommendations (Rosenvinge & Starke, 2005). From email correspondence, the lead author of the IDF consultation document recalled having been involved in training nurses (and dieticians) beyond the basic levels of competency, estimating the number at less than twenty (L. Boaden, personal communication, May 2, 2019). There is clearly a need for empirical research in this area. A potential future study could involve training nurses to acquire competencies in dysphagia management in order to evaluate whether increasing autonomy through extended competencies was a safe and sustainable model for managing SLT absence. Any such research for extending roles would need to consider factors at macro-, micro- and meso- levels that help and hinder the process, such as issues related to funding, workload or role clarity (Smith, McNeil, Mitchell, Boyle & Ries, 2019). For example, nurses have reported that the introduction of extended roles for nurse prescribing has been both empowering and a burden (Dowden, 2016). Shifting the professional boundary of dysphagia expertise could impact on perceptions of professional identity (McNeil, Mitchell & Parker, 2013) in ways that might represent both benefits and losses to the two disciplines.

The finding that information about communication was more likely to be shared in moments of need suggests research directed towards increasing SLT and nurse interdependence with respect to meeting the needs of patients with communication difficulties. A potential intervention study would be for SLTs to work with nurses at points of care, such as during personal care tasks. Outcomes could be evaluated in terms of patients' experience of communication, nurse skills and knowledge for supporting communication, capacity to meet SLT-specific goals in this context, and feasibility with regard to temporal-spatial factors such as SLT hours of work and changes in nursing personnel across shifts.

Research is also indicated to develop more productive ways for SLTs to elicit useful information about nurses' knowledge of patients' communication. For example SLT requests for information from nurses an hour or so into a shift could be contrasted with requests at a later point in the day. In between these two time-points nurses could be primed to notice the communication abilities of patients during nursing care. The IFCI SQ is suggested as a possible measure that could be accommodated within the demands on nurses' time as it only takes about two minutes to complete and covers

communication situations routinely encountered in nursing practice (O'Halloran et al., 2017). The same questionnaire might also provide a tool to examine the transfer of information about patients' communication through nursing handover and into dialogue with SLT. This could improve understanding for how communication information can be usefully passed between different nurses, in order to increase knowledge amongst nurses and form a foundation for more meaningful SLT-nurse interaction towards meeting patients' communication needs. Such research would be strengthened by also including information that originates from nurses, perhaps based on the humanising care framework. This could facilitate exploration of how nurse-derived knowledge could increase understanding for the communication needs of patients. Another means of examining transfer of communication information through handover might be to compare current handover practice with more structured formats, such as including prompts on handover sheets (perhaps also based on the IFCI SQ) to trigger nurses to share information when communication has impacted on meeting basic or human needs and what helped or hindered interaction.

No training was offered to nurses about communication in this study, and in the interviews, the nurses demonstrated a loose knowledge of communication disorders. Research is recommended in relation to delivery and evaluation of training and education for work with patients with stroke-associated communication disorders, both in-service and pre-registration. Training is also suggested for SLTs to develop their knowledge and understanding of the humanising needs of patients and nurses' role in meeting these. It is suggested that different types of learning activities are compared. This could include focused, brief periods of ward-situated teaching, e-learning, or more formal learning away from the ward. Nurses have a pressing need to get on with the job at hand, limiting their willingness to engage with training (Dixon-Woods, 2011) and the issues involved in learning are multifactorial. For example, a literature review of teaching for nurses in dementia care indicated that although leaving the ward was a barrier to attendance at training, once staff were in a 'classroom' they benefitted from not having to balance learning with other demands, in addition, the staff in the reviewed studies felt they benefited most when training incorporated patient voice and could be applied in practical ways (Surr & Gates, 2017). The nature of the illustrative cases used in training is also important. Previous CPT research has indicated that acute-based clinicians found it harder to learn from cases that they did not recognise from their stage of the aphasia pathway (Simmons-Mackie et al., 2007). Evaluation of training thus requires mixed-methods approaches to give full consideration to both process and outcomes.

In addition to indicating directions for future research the study has implications for the practice of SLTs and nurses that could be reviewed at the service level in clinical practice and education and these will now be discussed.

12.4 Implications for Clinical Practice

The study has provided empirically derived understanding of the taken-for-granted ways of working in which SLTs and nurses operate within different dimensions of time and space. Knowing more about this increases capacity for SLTs to understand how nurses' capacity constraints and their need to stay close to patients have direct consequences on SLTs' own information sharing practices. Temporal-spatial factors help maintain a status quo where communication information is less freely shared than swallowing information. This indicates that SLTs may under-perform against the National Clinical Guideline for Stroke, which recommends the following:

> 'The carers and family of a person with communication problems after stroke, and health and social care staff, should receive information and training from a speech and language therapist which should enable communication partners to optimise engagement in rehabilitation, promote autonomy and social participation' (Rudd et al., 2016:66)

It is recommended that SLT services review the information and training they offer to help nurses support patients to communicate, and reflect on what limits SLT capacity to offer teaching about patients' communication difficulties and needs. The need felt by nurses to remain close to patients limited the usefulness to them of existing forums for shared in-service training. Any such teaching should thus be constructed in collaboration with nurses. The approach with most research support (CPT) operates at quite a distance from the temporal-spatial realities illuminated in this study. Better understanding that nurses' needs are mostly in the here and now presents an opportunity for nurses and SLTs to give careful consideration to what information they each need from the other and to how it should be delivered.

The way in which most SLTs shared information about communication did not register meaningfully with nurses, and SLTs themselves doubted the utility of the information they offered. Hence SLTs and nurses would benefit from directing joint attention to what they actually need from each other to effectively care for patients with communication difficulties. Assessment tools focused on the communication needs of patients in hospital have potential to shift the emphasis from identification of deficits to

seeking ways to support patients to communicate (O'Halloran et al., 2017). In addition consideration for humanising care by both disciplines could assist with developing a common language when talking about patients' communication needs. Information shared by SLTs about supporting communication might be more relevant and have more impact if SLTs routinely placed themselves in nurses' space whilst nurses cared for patients. This could increase the potential for assessment-derived information to be applied through routine tasks, as well as enhancing SLT knowledge about patients' communication abilities in different contexts. Working in this way is likely to make SLT role with communication more visible to nurses and could potentially lead SLTs and nurses to see each other as a resource more than they currently do.

SLTs could potentially help nurses with care tasks, whilst informally assessing or working towards SLT goals. This could bring them into closer alignment with nurses and potentially foster feelings of reciprocity and benefit relationship building (Barnard et al., 2018). SLTs working in nurses' space could also increase understanding for safe staffing concerns within nursing (Royal College of Nursing, 2017) and open up discussion for ways in which allied health professions might ease the burden on nurses (NHS Improvement, 2016). One of the case studies collected by NHS Improvement reported on an innovation in which a number of new band 5 physiotherapy and occupational therapy roles were created to incorporate aspects of the nursing role in order to reduce the impact of nursing skill shortages (NHS Improvement, 2016). These were personal care roles that are not usually associated with SLT, and the learning from the case study indicated that the initiative was more suited to occupational therapy roles. Nevertheless, it offers a starting point for discussion of whether SLTs *could* participate more in some aspects of personal care. This would increase their understanding of on-the-ground realities and be a route into integrating communication and swallowing interventions into nursing activities with patients in more meaningful ways.

This study indicates that there is scope for SLTs and nurses to learn from each other within clinical practice and at pre-registration level. The clinical interests that SLTs and nurses have in common with respect to supporting communication are very evident in the standards of proficiency both disciplines are expected to meet on graduation (HCPC, 2014; NMC, 2018). Both are expected to demonstrate skills and knowledge in providing care that is safe, informed and draws on the knowledge of other team members. The nursing standards include an annexe with three pages listing proficiencies required for effective communication, with specific competencies

expected in making adjustments for people with communication difficulties. However the identity of each profession is embedded in the language used, for example dignity, compassionate care and strength based care are terms seen in nursing but not SLT standards (NMC, 2018) and advice giving is seen within SLT but not nursing standards (HCPC, 2014).

Shared learning during the pre-registration stage could provide opportunities for SLT and nursing students to understand their disciplinary perspectives. A recent study reported positively on learning from pre-registration simulations of interprofessional practice with respect to appreciation of differing priorities and roles (Roberts & Goodhand, 2018). Student SLTs and nurses could participate in simulations around patient care that attempt to simulate aspects of the temporal-spatial context of interaction, such as managing interruptions. This could involve reflection on how it feels to interrupt or be interrupted whilst also pursuing professional goals. Within clinical placements, SLT and nursing students could be encouraged to shadow clinicians from both disciplines for a full shift and record the nature of information shared with other professions and the context in which the sharing occurs. Evaluation of such interventions has the potential to extend knowledge about the effectiveness of interprofessional education for developing collaborative skills across disciplines (Labrague, McEnroe, Fronda & Obeidat, 2018).

The humanising care framework views patients' communication needs as intrinsically connected to issues such as dignity and emotional wellbeing that are central to nurses' experiences when providing care. This creates opportunities for partnership working between nurses and SLT that are seldom discussed (Pound & Jensen, 2018). SLTs could reflect on how best to share their assessment-derived information, and nurses could reflect on what they could be sharing from their knowledge of the communication and humanising needs of patients. At the micro level it is recommended that SLTs more routinely invite nurse contribution to discussion about the nature of a patient's communication difficulty and specific needs, and provide education to support their ability to do so.

There is scope for the two disciplines to lead the rest of the team in understanding communication needs with respect to support for both transactional and relational aspects of communication. However this requires a change in thinking from both SLTs and nurses. There was little in the current study or in the wider literature that indicated that nurses view themselves as a source of expertise about communication for the

interprofessional team, and it was uncommon for the SLTs in this study to demonstrate genuine curiosity for nurses' experiences of communication with patients. Thus partnership working of this kind is quite an ambitious aim that requires both parties to have a clear understanding of how the knowledge of the other can help in execution of healthcare roles.

The finding that nurses experienced dilemmas in following swallowing recommendations at times of uncertainty and change has two important clinical implications. The first is that it would benefit SLTs to be more aware of on-the-ground realities for nurses in following recommendations. The second is that consideration could be given to ways of safely increasing nurses' autonomy to take action when SLTs are not present. SLTs could increase their awareness of nursing activity by experiencing full nursing shifts or observing nurses at work outside of times they are usually on the wards. This would offer SLTs an opportunity to share the ethnographer's experience of adopting the stranger perspective (Burns et al., 2012; Simmons, 2007; Thomsen, 2011) by watching for the sole purpose of understanding the demands on nurses' time and their real-time capacity to enact swallowing recommendations. This could provide a foundation for discussion between the disciplines about ways of increasing safety that include more agency for nurses than current advice to wait for the SLT to return. The suggestion that nurse autonomy could be increased would involve the SLT service taking a critical look at how they manage the distributed risk associated with swallowing recommendations. This could involve creating extended roles for nurses, as discussed in the previous section, or engaging in discussion within and across teams of preferred means of avoiding, managing, and learning from clinical incidents. Such discussion could perhaps draw on the To Care is Human report and its emphasis on balancing relational care with safe care (Wolf, 2018).

High quality relationships have been considered to be central to the contingencies that underpin effective communication between therapists and nurses (Barnard et al., 2018). This study revealed that SLTs felt that they had stronger relationships with therapists than nurses and suggested that this may be associated with the extent of alignment in the temporal-spatial context rather than an intrinsic *alikeness* of the disciplines. That is, that SLT and therapists' working practices and shared accountability for the full admission trajectory for individual patients gives them more activities in common and brings them into closer routine contact. Nurses' shift working patterns are an organisational constraint on capacity to achieve the same level of alignment in working hours. Nevertheless, temporal differences could be mitigated to

some extent by increasing nurses' continuity through enabling them to work with the same patients across shifts. It is suggested that nurse leaders consider increasing weighting to continuity when making allocation judgments, or more structurally, allocating nurses as key workers to patients with responsibility for being a point of contact across the full trajectory of the admission. The keyworker role appears to be more common in other areas of nursing, such as oncology (e.g. Ling, McCabe, Brent, Crosland, Brierley-Jones, 2017) than in stroke unit care, and in the current study it was therapists that took on this role. Patients report that continuity is important to feeling known and connected (Loft et al., 2017b; Featherstone et al., 2019). Continuity of nursing staff could facilitate interactions that are more discursive and meaningful because the same SLT and nurse could discuss the same patient on consecutive days. Bringing SLTs and nurses into better temporal alignment has potential to engender a positive humanising effect on the sense of 'togetherness' experienced between the professions, countering the more isolating effect of entering in and out of each others life worlds in disconnected encounters (Dahlberg et al., 2009; Todres et al., 2009). Being allocated the same nurse across shifts could thus bring humanising benefits to both patients and staff. In summary, attention to the context in which interactions take place during execution of stroke unit care has potential to increase capacity for relationship building and enhance patient care.

12.5 Final Reflections

Returning again to how I started this chapter, the thesis was inspired by the conviction that closer working between SLTs and nursing staff had the potential to improve the experiences of patients in communication and eating and drinking on stroke wards. The preceding discussion illustrates that viewing SLTs, nurses and patients as a triad may have humanising benefits to all three groups. I have explained how this research involved a great deal of reflexive work, which brings me, the researcher into the human equation. The experience of conducting the research placed me in the novel position of spending time with SLTs and nurses with a curious mind but no clinical goals to accomplish. In the early stages of fieldwork on each site I often felt extreme discomfort and a sense of displacement that transformed my professional sense of what it was to be a SLT. The following quote encapsulates this experience very clearly:

> 'How much does adopting the researchers' stance towards one's own social world change one's place and position within and towards that world' (Jenkins, 1992:56).

My reflexive notes allowed me to reflect on how what I saw and heard impacted on my professional self, and in this way challenged my pre-suppositions about the SLT-nurse relationship. Thus the findings represented here were empirically tested but also deeply *felt*. This brings an incentive and a responsibility to influence clinical practice through dissemination of the findings of this thesis. The key messages of which are that the ways SLTs and nurses engage with time and space directly influence the quality of their interactions, and that the contingencies of need, capacity, opportunity and quality of relationships underpin effective communication. It is recommended that discussions directed towards improving how SLTs and nurses meet their common interests in communication and swallowing begin with consideration of these findings.

References

Abbott, A. (1988). *The system of professions: An essay on the division of expert labour*. Chicago: University of Chicago Press.

Ali, P.A. & Watson, R. (2017). Language barriers and their impact on provision of care to patients with limited English proficiency: nurses' perspectives. *Journal of Clinical Nursing, 17*, e1152-e1160. doi: 10.1111/jocn14204.

Allen, D. (1997). The nursing-medical boundary: a negotiated order? *Sociology of Health and Illness, 19*(4), 489-520. Doi: 10.1111/j.1467-9566.1997.tb00415.x.

Allen, D. (2004). Ethnomethodological insights into insider-outsider relationships in nursing ethnographies of healthcare settings. *Nursing Inquiry, 11*(1), 14-24.

Allen, D. (2014). Re-conceptualising holism in the contemporary nursing mandate: from individual to organisational relationships. *Social Science and Medicine, 119*, 131-138. doi:10.1016/j.socscimed.2014.07.036.

Anderson, J., Malone, L., Shanahan, K. & Manning, J. (2014). Nursing bedside clinical handover – an integrated review of issues and tools. *Journal of Clinical Nursing, 24*, 662-671. doi: 10.1111/jocn.12706. Epub 2014 Oct 16.

Apesoa-Varano E.C. (2013). Interprofessional conflict and repair: a study of boundary work in the hospital. *Sociological Perspectives, 56*(3), 327-349. doi: 10.1525/sop.2013.56.3.327.

Apker, J., Propp, K.M. & Zabava Ford, W.S. (2005). Negotiating status and identity tensions in healthcare team interactions: an exploration of nurse role dialectics. *Journal of Applied Communication Research, 33*(2), 93-115. doi:10.1080/00909880500044620.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A. & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology, 8*(21). doi: 10.1186/1471-2288-8-21.

Atwal, A. (2002). Nurses' perceptions of discharge planning in acute health care: a case study in one British teaching hospital. *Journal of Advanced Nursing, 39*(5), 450-458. doi.10.1046/j.1365-2648.2002.02310.x.

Balandin, S., Hemsley, B., Sigafoos, J. & Green, V. (2007). Communicating with nurses: The experiences of 10 adults with cerebral palsy and complex communication needs. *Applied Nursing Research, 20*, 56-62. doi.10.1016/j.apnr.2006.03.001.

Ball, J.E., Murrells, T., Rafferty, A., Morrow, E. & Griffiths, P. (2014). Care left undone' during nursing shifts: associations with workload and perceived quality of care. *BMJ Quality and Safety, 23,* 116-125. doi: 10.1136/bmjqs-2012-001767.

Barlow, N.A., Hargreaves, J. & Gillibrand, W.P. (2018). Nurses' contributions to the resolution of ethical dilemmas in practice. *Nursing Ethics, 25*(2), 230-242. doi: 10.1177/0969733017703700.

Barnard, R., Jones, J., Cruice, M. (2018). Communication between therapists and nurses working in inpatient interprofessional teams: Systematic review and meta-ethnography. *Disability and Rehabilitation, 4*(18), 1-11. doi: 10.1080/09638288.2018.1526335.

Barreca, S. & Wilkins, S. (2008). Experiences of nurses working in stroke rehabilitation unit. *Journal of Advanced Nursing*, 63(1), 36-44. doi: 10.1111/j.1365-2648.2008.04648.x.

Baxter, S.K. & Brumfitt, S. (2008). Professional differences in interprofessional working. *Journal of Interprofessional Care, 22*(3), 239-251. Doi: 10.1080/13561820802054655

Beauchamp, T.L., Walters, L., Kahn, J.P. & Mastroianni, A.C. (2014). *Contemporary Issues in Bioethics*. Asia; Australia; Brazil; India; Latin America; UK/Europe/Middle East/Africa: Wadsworth Cengage Learning.

Becker, H.S., Geer, B., Hughes, E.C. & Strauss, A.L. (1961). *Boys in White: Student Culture in Medical Schools*. Chicago: Chicago University Press.

Blix, S. B. & Wettergren, A. (2014). The emotional labour of gaining and maintaining access to the field. *Qualitative Research, 16*(6), 688-704. doi: 10.1177/1468794114561348.

Bloor, M. (2001). The ethnography of health and medicine. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland and L. Lofland (Eds). *Handbook of Ethnography*. London: Sage Publications.

Blumer, H. (1969). *Symbolic Interactionism*. Berkeley; Los Angeles; London: University of California Press.

Bourdieu, P. (1990). *The Logic of Practice*. Cambridge: Polity.

Brady, M.C., Kelly, G., Godwin, J., Enderby, P. & Campbell, P. (2016). Speech and language therapy for aphasia following stroke. *Cochrane Database of Systematic Reviews, 1*(6). doi: 10.1002/14651858.CD000425.pub4.

Bray, B.D., Smith, C.J., Cloud, G.C., Enderby, P., James, M., Paley, L., ...Rudd, A.G. (2017). The association between delays in screening for and assessing dysphagia after acute stroke, and the risk of stroke-associated pneumonia. *Journal of Neurology, Neurosurgery and Psychiatry, 88*, 25-30. doi: 10.1136/jnnp-2016-313356. Epub 2016 Jun 13.

Bright, F.A.S., Kayes, N.M., McPherson, K.M. & Worrall, L.E. (2018). Engaging people experiencing communication disability in stroke rehabilitation: A qualitative study,

International Journal of Language and Communication Disorders, 53(5), 981-994. doi: 10.1111/1460-6984. 12409. Epub 2018 Jul 13.

Bridges, J., Meyer, M. & Meyer, J. (2010). Older people's and relatives' experiences in acute care settings: Systematic review and synthesis of qualitative studies. *International Journal of Nursing Studies, 47*, 89-107. doi: 10.1016/j.ijnurstu.2009.09.009. Epub 2009 Oct 24.

Bridges, J., Nicholson, C., Maben, J., Pope, C., Flatley, M., Wilkinson, C., Meyer, J. & Tziggili, M. (2013). Capacity for care: Meta-ethnography of acute care nurses' experiences of the nurse-patient relationship. *Journal of Advanced Nursing, 69*(4), 760-772. doi: 10.1111/jan12050. Epub 2012 Nov 19.

Burgess, R. G. (1984). *In the field: An introduction to field research*. London: Routledge.

Burm, S., Boese, K., Faden, L., DeLuca, S., Huda, N., Hibbert, K. & Goldszmidt, M. (2019). Recognising the importance of informal communication events in improving collaborative care. *BMJ Quality and Safety, 28*, 289-295. doi: 10.1136/bmjqs-2017-007441.

Burns, E., Fenwick, J., Schmeid, V. & Sheehan, A. (2012). Reflexivity in midwifery research: The insider/outsider debate*. Midwifery, 28*, 52-56. doi: 10.1016/j.midw.2010.10.018. Epub 2010 Dec 4.

Burton, C.R., Fisher, A. & Green, T.L. (2009). The organisational context of nursing care in stroke units: A case study approach. *International Journal of Nursing Studies, 46*, 86-95. doi: 10.1016//j.ijnurstu. 2008.08.001. Epub 2008 Sep 17.

Byng, S., Cairns, D. & Duchan, J. (2002). Values in practice and practicing values. *Journal of Communication Disorders, 35*(2), 89-106.

Chan, E.A., Jones, A. & Wong, K. (2012). The relationships between communication, care and time are intertwined: a narrative analysis inquiry exploring the impact of time on registered nurses' work. *Journal of Advanced Nursing, 69*(9), 2020-2029. doi: 10.1111/jan.12064. Epub 2013 Jan 13.

Charon, J. (2010). *Symbolic Interactionism: An introduction, An interpretation, An integration,* 10th edition. Boston: Prentice Hall.

Cichero, J.A., Heaton, S. & Bassett, L. (2009). Triaging dysphagia: nurse screening for dysphagia in an acute hospital. *Journal of Clinical Nursing, 18*(11), 1649-59. doi: 10.1111/j.1365-2702.2009.02797.x.

Clancy, L., Povey, R. & Rodham, K. (2018). "Living in a foreign country": experiences of staff-patient communication in inpatient stroke settings for people with post-stroke aphasia and those supporting them. *Disability and Rehabilitation, 27*(1), 1-11. doi:10.1080/09638288.2018.1497716.

Clarke, D.J. (2010). Achieving teamwork in stroke units: The contribution of opportunistic dialogue. *Journal of Interprofessional Care, 24*(3), 285-297. doi: 10.3109/13561820903163645.
Clarke, D.J. (2014). Nursing practice in stroke rehabilitation: Systematic review and meta-ethnography. *Journal of Clinical Nursing, 23*, 1201-1226. doi:10.1111/jocn.12334. Epub 2013 Sep 16.
Clarke, D.J. & Holt, J. (2015). Understanding nursing practice on stroke units: a Q methodological study. *Disability and Rehabilitation, 37*(20), 1870-80. doi:10.3109/09638288.2014.986588.
Clifford, J. (1983). On Ethnographic Authority. *Representations, 2*(Spring). 118-146.
Clifford, J. (1986). In J. Clifford & G. Marcus (Eds). *Writing Culture: The Poetics and Politics of Ethnography*. Berkeley CA: University of California Press.
Code, C & Petheram, B. (2011). Delivering for aphasia. *International Journal of Speech-Language Pathology, 13(*1), 3-10. doi: 10.3109/17549507.2010.520090.
Coffey, A. (1999). *The ethnographic self: Fieldwork and the representation of identity*. London; Thousand Oaks; New Delhi: Sage Publications.
Cooke, H. (2009) Theories of risk and safety: what is their relevance to nursing? *Journal of Nursing Management, 17*, 256-264. doi: 10.1111/j.1365-2834.2009.00994.x.
Crotty, M. (1998). *The foundations of social research*. London; Thousand Oaks; New Delhi: Sage Publications.
Dahlberg, K., Todres, L. & Galvin, K. (2009). Lifeworld-led healthcare is more than patient-led care: an existential view of well-being. *Medicine, Healthcare and Philosophy, 12*, 265-271. doi: 10.1007/s11019-008-9174-7. Epub 2008 Dec 20.
Davies, W.H. (1911). Leisure. In B.Hooper. *Time to stand and stare: A life of W.H. Davies with selected poems*. Peter Owen Publishers.
Cruice, M., Blom Johannson, M. & Isaksen, J. (2018). Reporting interventions in communication partner training: a critical review and narrative synthesis of the literature. *Aphasiology, 32*(10), 1135-1166. doi: 10.1080/02687038.2018.1482406.
Deacon, M., & Cleary, M. (2013). The reality of teamwork in an acute mental health ward. *Perspectives in Psychiatric Care, 49*(1), 50-57. doi: 10.1111/j.1744-6163.212.00340.x.
Dean, J. (2017). *Doing Reflexivity: An Introduction*. Bristol; Chicago: Polity Press.
De Jong, M., Kamsteeg, F. & Ybema, S. (2013). Ethnographic strategies for making the familiar strange: struggling with ‘distance’ and ‘immersion’ among Moroccan-Dutch students. *Journal of Business Anthropology, 2*(2), 168-186. doi:10.22439/jba.v2i2.4157
Delamont, S. (2004). Ethnography and participant observation. In C. Seale, *Qualitative research practice*. California; London: Sage.

Dithole, K., Sibanda, S., Moleki, M.M. & Thupayagale-Tshweneagae, G. (2016). Exploring communication challenges between nurses and mechanically ventilated patients in the intensive care unit: A structured review. *World Views on Evidence Based Nursing, 13*(3), 197-206. doi: 10.1111/wvn.12146. Epub 2016 Feb 9.

Dixon-Woods, M. (2010). Why is patient safety so hard? A selective review of ethnographic studies. *Journal of Health Services Research and Policy, 15*(S1), 11-16. doi: 10.1258/jhsrp.2009.009041.

Dixon-Woods, M., Suokas, A., Pitchforth, E. & Tarrant, C. (2009). An ethnographic study of classifying and accounting for risk at the sharp end of medical wards. *Social Science and Medicine, 69,* 362-369. doi: 10.1016/j.socscimed.2009.05.025. Epub 2009 Jun 15.

Dondorf, K., Fabus, R. & Ghassemi, A.E. (2015). The interprofessional collaboration between nurses and speech-language pathologists working with patients diagnosed with dysphagia in skilled nurses facilities. *Journal of Nursing Education and Practice, 6*(4), 17-20. doi: 10.5430/jnep.v6n4p17.

Dowden, A. (2016). The expanding role of nurse prescribers. *Prescriber*, 27th June. Accessed from https://www.prescriber.co.uk/article/expanding-role-nurse-prescribers/

Drury, P., Levi, C., McInnes, E., Hardy, J., Ward, J., Grimshaw, J.M., …Middleton, S. (2014). Management of fever, hyperglycaemia, and swallowing dysfunction following hospital admission for acute stroke in New South Wales, Australia. *International Journal of Stroke, 9*, 23-31. doi: 10.1111/ijs.12194. Epub 2013 Nov 10.

Edmiaston, J., Tabor Connor, L., Loehr, L. & Nassief, A. (2010). Validation of a dysphagia screening tool in acute stroke patients. *American Journal of Critical Care, 19*(4), 357-364. doi: 10.40377/ajcc2009961. Epub 2009 Oct 29.

Enderby, P. & Petheram, B. (2002). Has aphasia therapy been swallowed up? *Clinical Rehabilitation, 16*(6), 604-8. doi: 10.1191/0269215502cr5050a.

Engel, J. & Prentice, D. (2013). The ethics of interprofessional collaboration. *Nursing Ethics, 20*(4), 426-435. doi: 10.1177/0969733012468466.

Featherstone, K., Northcott, A. & Bridges, J. (2019). Routines of resistance: An ethnography of the care of people living with dementia in acute hospital wards and its consequences. *International Journal of Nursing Studies, 96*, 53-60. doi: 10.1016/j.ijnurstu.2018.12.009

Fernando, O., Coburn, N.G., Nathens, A.B., Hallet, J., Ahmed, N. & Conn, L.G. (2016). Interprofessional communication between surgical trainees and nurses in the inpatient wards: why time and space matter. *Journal of Interprofessional Care, 30*(5), 567-573. doi: 10.1080/13561820.2016.1187589. Epub 2016 Jun 17.

Fetterman, D.M. (1998). *Ethnography: Step by Step*. Thousand Oaks; London; New Delhi: Sage Publications.
Fine, G.A. & Hallet, T. (2014). Stranger and stranger: Creating theory through ethnographic distance and authority. *Journal of Organizational Ethnography, 3*(2), 188-203. doi: 10.1108/JOE-07-203-0015.
Foley, N., Teasell, R., Salter, K., Kruger, E. & Martino, R. (2008). Dysphagia treatment post stroke: a systematic review of randomised controlled trials. *Age and Ageing, 37*(3), 268-264. doi: 10.1093/ageing/afn064.
Foster, A.M., Worrall, L.E., Rose, M.L. & O'Halloran, R. (2013). Turning the tide: Putting acute aphasia management back on the agenda through evidence based practice. *Aphasiology, 27*(4), 420-443. doi: 10.1080/02687038.2013.770818.
Foster, A., Worrall, L., Rose, M. & O'Halloran, R. (2015). 'That doesn't translate': The role of evidence-based practice in disempowering speech pathologists in acute aphasia management. *International Journal of Language and Communication Disorders, 50*(4), 547-563. doi: 10.1111/1460-6984.12155. Epub 2015 Feb 4.
Foster, A., O'Halloran, R., Rose, M.L. & Worrall, L. (2016a). "Communication is taking a back seat": speech pathologists' perceptions of aphasia management in acute hospital settings. *Aphasiology, 30*(5), 585-608. doi: 10.1080/02687038.2014.985185.
Foster, A., Worrall, L., Rose, M.L. & O'Halloran, R. (2016b). 'I do the best I can': an in-depth exploration of the aphasia management pathway in the acute hospital setting. *Disability and Rehabilitation, 38*(18), 1765-1779. doi: 10.3109/09638288.2015.110776. Epub 2015 Dec 17.
Funk, A., Garcia, C. & Mullen, T. (2018). Understanding the hospital experience of older adults with hearing impairment. American Journal of Nursing, 118(6), 28-34. doi: 10.1097/01.NAJ.0000534821.03997.7b.
Fry, M., Arendts, G. & Chenoweth, L. (2017). Emergency nurses' evaluation of observational pain assessment tools for older people with cognitive impairment. *Journal of Clinical Nursing, 26*, 1281-1280. doi: 10.1111/jocn.13591. Epub 2017 Feb 9.
Galletta, M., Portoghese, I., Frau, N., Pau, M., Meloni, F., Finco, G., …Campagna, M. (2019). Association between burnout and sense of coherence among speech and language therapists: an exploratory study in Italy. *Acta Biomed for Health Professions, 90*(S4), 25-31. doi: 10.23750/abm.v90i4-S.8261.
Garcia, J.M., Chambers, E. & Molander, M. (2005). Thickened liquids: Practice patterns of speech-language pathologists, *American Journal of Speech-Language Pathology, 14*, 4-13.
Geertz, C. (1973). *The Interpretation of Cultures*. New York: Basic Books.
Goffman, E. (1963). *The presentation of self in everyday life*. London: Penguin.

Goffman, E. (1989). On fieldwork. *Journal of Contemporary Ethnography*, 18, 123. doi: 10.1177/089124189018002001

Gold, R.L. (1958). Roles in sociological field observation. *Social Forces, 36*, 217-223.

Goodwin, D. Ethical Issues. In C. Pope & N. Mays (2006). *Qualitative Research in Healthcare*, 3rd edition. Malden, Mass: Blackwell Publishing Ltd.

Gordon, C., Ellis-Hill, C. & Ashburn, A. (2008). The use of conversation analysis: Nurse-patient interaction in communication disability after stroke. *Journal of Advanced Nursing, 65*(3), 544-553. doi: 10.1111/j.1365-2648.2008.04917.x.

Grant, M.J. & Booth, Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information and Libraries Journal, 26*, 91-108. doi: 10.1111/j.1471-1482.2009.00848.x.

Green, E., McFarlane, M., Bax, L. & Miles, A. (2014). Staff perceptions following the introduction of a fiberoptic endoscopic evaluation of swallowing service for patients following stroke. *Speech, Language and Hearing, 17*(2), 70-79. doi:10.1179/2050572813Y.0000000030

Hall, P.M. (1993). Interactionism, social organization, and social processes: looking back and moving ahead. *Symbolic Interactionism, 26*(1), 33-55. doi:10.1525/si.2003.26.1.33

Hammersley, M. (2018). What is ethnography? Can it survive? Should it? *Ethnography and Education, 13*(1), 1-17. doi: 10.1080/17457823.2017.1298458.

Hammersley, M. & Atkinson, P. (2007). *Ethnography: Principles in Practice*. Oxon: Routledge.

Happ, M., Garrett, K., DiVirgilio Thomas, D., Tate, J., George, E., Houze, M., Radtke, J. & Sereika, S. (2011). Nurse-patient communication interactions in the intensive care unit. *American Journal of Critical Care*. doi: 10.4037/ajcc2011433.

HCPC (2014). *Standards of proficiency: Speech and language therapists*. Retrieved from https://www.hcpc-uk.org/standards/standards-of-proficiency/speech-and-language-therapists/

Health and Social Care Board and Public Health Agency (2018). *Thematic review: Report on the regional choking review analysis*. Retrieved from http://www.hscbusiness.hscni.net/pdf/Report%20on%20the%20Regional%20Choking%20Review%20Analysis.pdf

Heard, R., O'Halloran, R. & McKinley, K. (2017). Communication partner training for health care professionals in inpatient rehabilitation setting. *International Journal of Speech-Language Pathology, 19,* 277-286. doi: 10.1080/17549507.2017.1290137. Epub 2017 Mar 7.

Hemsley, B., Balandin, S. & Worrall, L. (2011). The “big 5” and beyond: nurses, paid carers, and adults with developmental disability discuss communication needs in hospital. *Applied Nursing Research, 24*, 51-58. doi: 10.1016/j.apnr.2010.09.001. Epub 2010 Oct 27.

Hemsley, B. & Balandin, S. (2014). A meta-synthesis of patient-provider communication in hospital for patients with severe communication disabilities: informing new translational research. *Augmentative and Alternative Communication, 30*(4), 329-343. doi: 10.3109/07434618.2014.955614. Epub 2014 Sep 17.

Hemsley, B., Georgiou, A., Hill, S., Rollo, M., Steel, J. & Balandin, S. (2016). An integrative review of patient safety in studies on the care and safety of patients with communication disabilities in hospital. *Patient Education and Counselling, 99*(4), 501-511. doi: 10.1016/j.pec.2015.10.022. Epub 2015 Nov 2.

Hemsley, B., Sigafoos, J., Balandin, S., Forbes, R., Taylor, C., Green, V.A. & Parmenter, T. (2001). Nursing the patient with severe communication impairment. *Journal of Advanced Nursing, 35*(6), 827-35. doi: 10.1046/j.1365-2648.2001.01920.x.

Hemsley, B., Steel, J., Worrall, L., Hill, S., Bryant, L., Johnston, L., Georgiou, A. & Balandin, S. (2019). A systematic review of falls in hospital for patients with communication disability: highlighting an ‘invisible’ population. *Journal of Safety Research, 68*, 89-105. doi: 10.1016/j.jsr.2018.11.004.

Hemsley, B., Wernick, M. & Worrall, L. (2013). “That really shouldn’t have happened”: people with aphasia and their spouses narrate adverse events in hospital. *Aphasiology, 27*(6), 706-722. doi: 10.1080/02687038.2012.748181.

Hersh, D., Godecke, E., Armstrong, E., Ciccone, N. & Bernhardt, J. (2016). “Ward talk”: Nurses’ interaction with people with and without aphasia in the very early period post stroke. *Aphasiology, 30*(5), 609-628. doi: 10.1080/02687038.2014.933520

Horton, S., Lane, K. & Shiggins, C. (2016). Supporting communication for people with aphasia in stroke rehabilitation: Transfer of training in a multidisciplinary stroke team. *Aphasiology, 30*(5), 629-656. doi: 10.1080/02687038.2014.1000819.

Horton, S. & Pound, C. (2018). Communication partner training: re-imagining community and learning. *Aphasiology, 32*(10), 1250-1265. doi:10.1080/02687038.2018.1482407

Hines, S., Kynoch, K. & Munday, J. (2016). Nursing interventions for identifying and managing acute dysphagia are effective for improving patient outcomes: A systematic review update. *Journal of Neuroscience nursing, 48*(4), 214-222. doi:10.1097/JNN.0000000000000200.

Institute for Health Metrics and Evaluation (2017). Retrieved from http://www.healthdata.org/united-kingdom

Jacobsson, K. (2016) Analysing documents through fieldwork. In D. Silverman. *Qualitative research* (Fourth ed.). Los Angeles: Sage.
Jacoby, S. F. (2017). The insight and challenge of reflexive practice in an ethnographic study of black traumatically injured patients in philadelphia. *Nursing Inquiry, 24*(3), doi:10.1111/nin.12172. doi: 10.1111/nin.12172. Epub 2016 Nov 15.
Jenkins, R. (2002). *Pierre Bourdieu*. London, New York: Routledge.
Jensen, L.R., Lovholt, A.P., Sorensen, I.R., Bludnikow, A.M., Iversen, H.K., Hougaard, L.L. & Forchhammer, H.B. (2015). Implementation of supported conversation for communication between nursing staff and in-hospital patients with aphasia. *Aphasiology, 29*(1), 57-80. doi: 10.1080/02687038.2014.955708.
Johansson, M.B., Carlsson, M. & Sonnander, K. (2012). Communication difficulties and the use of communication strategies: from the perspective of individuals with aphasia. *International Journal of Language and Communication Disorders, 47*(2), 144-155. doi:10.1111/j.1460-6984.2011.00089.x.
Jones, M., O'Neill, P., Waterman, H. & Webb, C. (1997). Building a relationship: Communication and relationships between staff and stroke patients on a rehabilitation ward. *Journal of Advanced Nursing, 26*(1), 101-110. doi:10.1046/j.1365-2648-1997.1997026101.x.
Juve-Udina, M.E., Perez, E.Z., Padres, N.F., Samartino, M.G., Garcia, M.R., Creus, …Calvo, C.M. (2014). Basic nursing care: retrospective evaluation of communication and psychosocial interventions documented by nurses in the acute care setting. *Journal of Nursing Scholarship, 46*(1), 65-72. doi: 10.1111/jnu.12062. Epub 2013 Dec 19.
Kagan, A. (1995). Revealing the competence of aphasic adults through conversation: A challenge to health professionals. *Topics in Stroke Rehabilitation, 2*(1), 15-28. doi: 10.1080/10749357.1995.11754051.
Kaizer, F., Spiridigliozzi, A. & Hunt, M.R. (2012). Promoting shared decision-making in rehabilitation: Development of a framework for situations when patients with dysphagia refuse diet modification recommended by the treating team. *Dysphagia, 27*, 81-87. doi: 10.1007/s00455-011-9341-5. Epub 2011 May 1.
Kalish, B.J., Landstrom, G. & Williams, R.A. (2009). Missed nursing care: errors of omission. *Nursing Outlook, 57*(1), 3-9. doi: 10.1016/j.outlook.2008.05.007.
Kelly, J., D'Cruz, G. & Wright, D. (2009). A qualitative study of problems surrounding medicine administration to patients with dysphagia. *Dysphagia, 24*, 49-56. doi:10.1007/s00455-008-9170-3. Epub 2008 Aug 8.

Kenny, T., Barr, C. & Laver, K. (2016). Management of fever, hyperglycaemia, and dysphagia in an acute stroke unit. *Rehabilitation Nursing, 41*, 313-319. doi: 10.1002/rnj.248. Epub 2015 Oct 14.

Khalaila, R., Zbidat, W., Anwar, K., Bayya, A., Linton, D.M. & Sviri, S. (2011). Communication difficulties and psychoemotional distress in patients receiving mechanical ventilation. *American Journal of Critical Care, 20*(6), 470-479. doi: 10.4037/ajcc2011989.

Kirkevold, M. (1997). The role of nursing in the rehabilitation of acute stroke patients: toward a unified theoretical perspective. *Advances in Nursing Science, 19*(4), 55-64.

Kirkevold, M. (2010). The role of nursing in the rehabilitation of stroke survivors: an extended theoretical account. *Advances in Nursing Science, 33*(1), 27-40. doi: 10.1097/ANS.0b013e3181cd837f.

Kohn, L.T., Corrigan, J.M. & Donaldson, M.S. *To err is human: building a safer healthcare system.* Washington (DC): National Academies Press.

Korstjens, I. & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice, 24*(1), 120-124. doi: 10.1080/13814788.2017.1375092. Epub 2017 Dec 5.

Krekeler, B.N., Broadfoot, C.K., Johnson, S., Connor, N.P. & Rogus-Pulia, N. (2018). Patient adherence to dysphagia recommendations: A systematic review. *Dysphagia, 33*, 173-184. doi: 10.1007/s00455-017-9852-9. Epub 2017 Sep 30.

Kvarnstrom, S. & Cedersund, E. (2006). Discursive patterns in multiprofessional healthcare teams. *Journal of Advanced Nursing, 53*(2), 244-252. doi: 10.1111/j.1365-2648.2006.03719.x.

La Porte, T. & Todd, R. (1982). On the design and management of nearly error-free organizational control systems. In D.L. Sills, C.P. Wolf & V.B. Shelanski (Eds). *Accident at Three Mile Island.* Boulder, Colorado:Westview Press.

Labrague, L.J., McEnroe-Petitte, Fronda, D.C. & Obeidat, A.A. (2018). Interprofessional simulation in undergraduate nursing program: An integrative review. *Nurse Education Today, 67*, 46-55. doi: 10.1016/j.nedt.2018.05.001. Epub 2018 May 4.

Leder, S.B. & Lerner, M.Z. (2012). Nil per os except medications order in the dysphagic patient. *QJM: An International Journal of Medicine, 106*(1), 71-75. doi:10.1093/qjmed/hcs044. Epub 2012 Mar 7.

Leiter, A. & Windsor, J. (1996). Compliance of geriatric dysphagic patients with safe-swallowing instructions. *Journal of Medical Speech Pathology, 5*, 289-299.

Lewin, S & Reeves, S. (2011). Enacting ‘team’ and ‘teamwork’: Using Goffman’s theory of impression management to illuminate interprofessional practice on hospital wards.

Social Science and Medicine, 72(10), 1595-1602. doi:10.1016/j.socscimed.2011.03.037. Epub 2011 Apr 13.

Lewis, P., Gaffney, R.J. & Wilson, N.J. (2016). A narrative review of acute care nurses' experiences nursing patients with intellectual disability: Underprepared, communication barriers and ambiguity about the role of caregivers. *Journal of Clinical Nursing, 26*, 1473-1484. doi: 10.1111/jocn.13512. Epub 2017 Feb 8.

Liberati, E.G., Peerally, M.F. & Dixon-Woods, M. (2018). Learning from high risk industries may not be straightforward: a qualitative study of the hierarchy of risk controls approach in healthcare. *International Journal for Quality in Healthcare, 30*(1), 39-43. doi: 10.1093/intqhc/mzx163.

Ling, J., McCabe, K., Brent, S., Crosland, A. & Brierley-Jones, L.K. (2017). Exploring the role of key workers in cancer care: patient and staff perspectives. *Clinical Nurse Specialist, 31(5)*, 252-260. doi: 10.1097/NUR.0000000000000319.

Lingard, L., Conn, L.G., Russell, A., Reeves, S., Miller, K., Kenaszchuk & Zwarenstein, M. (2007). Information work: Innovations in the use of the chart on internal medicine teams. *Journal of Interprofessional Care, 21*(6), 657-667. doi: 10.1080/135618207001731817.

Liu, W., Manias, E. & Gerdtz, M. (2014). Medication communication through documentation in medical wards: Knowledge and power relations. *Nursing Inquiry, 21*(3), 246-258. doi: 10.1111/nin.12043. Epub 2013 Jul 4.

Lofland, J., Snow, D., Anderson, L. & Lofland, L.H. (2006). *Analyzing social settings: A guide to qualitative observation and analysis* (4th ed.). Belmont, Ca: Wadsworth.

Loft, M.I., Poulsen, I., Esbensen, B.A., Iversen, H.K., Mathiesen, L.L. & Martinsen, B. (2017a). Nurses' and nurse assistants' beliefs, attitudes and actions related to role and function in an inpatient stroke rehabilitation unit – a qualitative study. *Journal of Clinical Nursing, 26*, 4905-4914. doi: 10.1111/jocn.13972. Epub 2017 Oct 1.

Loft, M.I., Martinsen, B., Esbensen, B.A., Mathiesen, L.L., Iversen, H.K. & Poulsen, I. (2017b). Call for human contact and support: an interview study exploring patients' experiences with inpatient stroke rehabilitation and their perception of nurses' and nurse assistants' roles. *Disability and Rehabilitation*. doi:10.1090/09638288.2017.1393698.

Long, A.F., Kneafsey, R., Ryan, J & Berry, J. (2002). The role of the nurse within the multi-professional rehabilitation team. *Journal of Advanced Nursing 37*(1), 70-78. doi: 10.1046/j.1365-2648.2002.02059.x.

Magnus, V. & Turkington, L. (2006). Communication interaction in ICU – Patient and staff experiences and perceptions. *Intensive Critical Care Nursing, 22*(3), 167-80. doi: 10.1016/j.iccn.2005.09.009.

Malone, R.E. (2003). Distal nursing. *Social Science and Medicine, 56*, 2317-2326. doi: 10.1016/s0277-9536(02)00230-7.
Martino R., Foley, N., Bhogal, S., Diamant, N., Speechley, M. & Teasell, R. (2005). Dysphagia after stroke: Incidence, diagnosis, and pulmonary complications. *Stroke* 36:12, 2756-2763. doi: 10.1061/01.STR.0000190056.76543.eb.
Materson, G. & Baudouin, S. (2016). *Guidelines for the provision of intensive care services*. The Faculty of Intensive Care Medicine. Retrieved from https://www.ficm.ac.uk/sites/default/files/gpics_ed.1.1_-_2016_-_final_with_covers.pdf
McCabe, C. (2004). Nurse-patient communication: An exploration of patients' experiences. *Issues in Clinical Nursing, 13*, 41-49.
McCullough, K.C., Estes, J.L., McCullough, M.S., Gary, H. & Rainey, J. (2007). RN compliance with SLP dysphagia recommendations in acute care. *Topics in Geriatric Rehabilitation, 23*(4), 330-334. doi: 10.1097/01.TGR.0000299161.44869.26.
McCurtin, A., Healy, C., Kelly, L., Murphy, F., Ryan, J. & Walsh, J. (2018). Plugging the patient evidence gap: what patients with swallowing disorders post-stroke say about thickened fluids. *International Journal of Language and Communication Disorders, 53*(1), 30-39. doi: 10.1111/1460-6984.12324. Epub 2017 Jun 16.
McGillis Hall, L., Ferguson-Pare, M., Peter, E., White, D., Besner, J., Chisholm, A., …Hemingway, A. (2010). Going blank: Factors contributing to interruptions to nurses' work and related outcomes. *Journal of Nursing Management, 18,* 1040-1047. doi: 10.1111/j.1365-2834.2010.01166.x. Epub 2010 Oct 4.
McFarlane, M., Miles, A., Atwal, P. & Parmar, P. (2014). Interdisciplinary management of dysphagia following stroke. *British Journal of NN/Stroke Association supplement, 10*(1), 13. doi: 10.12968/bjnn.2014.10.1.13.
McKnight, L.K., Stetson, P.D., Bakken, S., Curran, C. & Cimino, J.J. (2001). Perceived information needs and communication difficulties of inpatient physicians and nurses. *Journal of the American Medical Informatics Association, 9*, 64-69.
McNeil, K.A., Mitchell, R.J. & Parker, V. (2013). Interprofessional practice and professional identity threat. *Health Sociology Review, 22*(3), 291-307. doi: 10.5172/hesr.2013.22.3.291.
Mead, G. (1934). *Mind, Self and Society*. Chicago: University of Chicago Press.
Miller, K. & Kontos, P.C. (2013). The intraprofessional and interprofessional relations of neurorehabilitation nurses: A negotiated order perspective. *Journal of Advanced Nursing, 69* (8), 1797-807. doi: 10.1111/jan.12041. Epub 2012 Nov 16.
Miller, K., Reeves, S., Zwarenstein, M., Beales, J.D., Kenaszchuk, C. & Conn, L.G. (2008). Nursing emotion work and interprofessional collaboration in internal medicine

wards: A qualitative study. *Journal of Advanced Nursing, 64*(4), 332-343. doi:10.1111/j.1365-2648.2008.04768.x.

Miller, R. & Krawczyk (2001). Dysphagia training programmes: 'Fixes that fail' or effective inter-disciplinary working? *International Journal of Language and Communication, 36*(S1), 379-384.

Moher, D., Liberati, A., Tetzlaff, J., Altman, D.G. & The PRISMA group (2009). Preferred reporting items for systematic reviews and meta-analysis: the PRISMA statement. *PLOS Medicine, 6*, e1000097. doi: 10.1371/journal.pmed.1000097. Epub 2009 Jul 21.

Morris, D. & Matthews, J. (2014). Communication, respect, and leadership: Interprofessional collaboration in hospitals of rural Ontario. *Canadian Journal of Dietetic Practice and Research, 75*(4), 173-179. doi: 10.3148/cjdpr-2014-020.

Morse, J. & Savage, J. (2002). Participant observation, informed consent and ethical approval. *Nurse Researcher, 9*(4), 58-69. doi: 10.7748/nr2002.07.9.4.58.c6198.

Murphy, E. & Dingwall, R. (2007). Informed consent, anticipatory regulation and ethnographic practice. *Social Science and Medicine, 65*, 2223-2234.

NHS England (2017). *Accessible Information Standard*. Retrieved from https://www.england.nhs.uk/ourwork/accessibleinfo/

NHS Improvement (2016). *Safe sustainable and productive staffing: case studies*. Retrieved from https://improvement.nhs.uk/resources/safe-sustainable-and-productive-staffing-case-studies/

NHS Improvement (2018). *Resources to support safer modification of food and drink.* Retrieved from https://improvement.nhs.uk/news-alerts/safer-modification-of-food-and-fluid/

NICE Guideline (2019). *Stroke and Transient Ischaemic Attack in Over 16s: diagnosis and initial managment*. Retrieved from https://www.nice.org.uk/guidance/ng128/resources/stroke-and-transient-ischaemic-attack-in-over-16s-diagnosis-and-initial-management-pdf-6614166560326

Nuffield Trust (2018). *The NHS workforce in numbers*. Retrieved from https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers

Nugus, P., Greenfield, D., Travaglia, J., Westbrook, J. & Braithwaite, J. (2010). How and where clinicians exercise power: Interprofessional relations in health care. *Social Science and Medicine, 71*, 898-909. doi: 10.1016/j.socscimed.2010.05.029. Epub 2010 Jun 4.

Nystrom, M. (2009). Professional aphasia care trusting competence while facing existential issues. *Journal of Clinical Nursing, 18*, 2503-2510. doi: 10.1111/j.1365-2702.2009.02825.x. Epub 2009 Jul 8.

Nursing and Midwifery Council (2018). *Future nurse: Standards of proficiency for registered nurses*. 17 May. Retrieved from https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf

O'Halloran, R., Coyle, J. & Lamont, S. (2017). Screening patients for communication difficulty: the diagnostic accuracy of the IFCI staff questionnaire. *International Journal of Speech-Language Pathology, 19*, 430-440. doi: 10.1080/17549507.2016.1209560. Epub 2016 Aug 9.

O'Halloran, R., Shan Lee, Y., Rose, M. & Liamputtong, P. (2014). Creating communicatively accessible healthcare environments: Perceptions of speech-language pathologists. International Journal of Speech-Language Pathologists. *International Journal of Speech-Language Pathologists, 16*(6), 603-614. doi:10.3109/17549507.2014.894125. Epub 2014 Mar 25.

O'Halloran, R., Worrall, L. & Hickson, L. (2008). Environmental factors that influence communication between people with communication disabilities and their healthcare providers in hospital: A review of the literature within the International Classification of Functioning, Disability and Health (ICF) framework. *International Journal of Language and Communication, 43*(6), 601-632. doi: 10.1080/13682820701861832.

O'Halloran, R., Worrall, L. & Hickson, L. (2009). The number of patients with communication related impairments in acute hospital stroke units. *International Journal of Speech-Language Pathology, 11*(6), 438-449. doi: 10.3109/17549500902741363.

O'Halloran, R., Worrall, L. & Hickson, L. (2011). Environmental factors that influence communication between patients and their healthcare providers in acute hospital stroke units: An observational study. *International Journal of Language and Communication Disorders, 46(*1), 30-47. doi: 10.3109/13682821003660380. Epub 2010 Mar 26.

O'Halloran, R., Worrall, L., Toffolo, D., Code, C. & Hickson, L. (2004). *Inpatient Functional Communication Interview.* Bicester: Speechmark.

O'Keefe, S.T. (2018). Use of modified diets to prevent aspiration in oropharyngeal dysphagia: is current practice justified? *BMC Geriatrics, 18*, 167. doi: 10.1186/s12877-018-0839-7.

O'Reilly, K. (2005). *Ethnographic methods*. London; New York: Sage Publications.

Parker, C., Power, M., Hamdy, S., Bowen, A., Tyrell, P. & Thompson, D.G. (2004). Awareness of dysphagia by patients following stroke predicts swallowing performance. *Dysphagia, 19*, 28-35. doi: 10.1007/s0045-003-032-8.

Pellatt, G. (2005) Perceptions of interprofessional roles within the spinal cord injury rehabilitation. *International Journal of Therapy and Rehabilitation, 12*(4), 143-50. doi: 10.1080/13561820701195567

Peters, E. & Liaschenko, J. (2004). Perils of proximity: A spatiotemporal analysis of moral distress and moral ambiguity. *Nursing Inquiry, 11*(4), 218-225. doi:10/1111/j.1440-1800.2004.00236.x

Peters, M.D.J., Godfrey, C.M., Khalil, H., McInerney, P., Parker, D. & Soares, C.B. (2015). Guidance for conducting systematic scoping reviews. *International Journal of Evidence Based Healthcare, 13*(3), 141-146. doi: 10.1097/XEB.0000000000000050.

Poland, B., Lehoux, P., Holmes, D. & Andrews, G. (2005). How place matters: unpacking technology and power in health and social care. *Health and Social Care in the Community, 13*(2), 170-180. doi: 10.1111/j.1365-2524.2005.00545.x.

Pound, C. & Jensen, L.R. (2018). Humanising communication between nursing staff and patients with aphasia: Potential contributions of the humanisation values framework, *Aphasiology, 32*(10), 1209-1233. doi: 10.1080/02687038.2018.1494817.

Pryor, J. (2008). A nursing perspective on the relationship between nursing and allied health professionals in inpatient rehabilitation. *Disability and Rehabilitation, 30*(4), 314-322. doi: 10.1080/09638280701256900.

Quirk, A., Lelliott, P. & Seale, C. (2006). The permeable institution: An ethnographic study of three acute psychiatric wards in London. *Social Science and Medicine, 63*, 2105-2117. doi: 10.1016/j.socscimed.2006.05.021.

Radtke, T.V., Tate, J.A. & Happ, M.B. (2012). Nurses' perception of communication training in the ICU. *Intensive and Critical Care Nursing, 28*(1), 16-25. doi:10.1016/j.iccn.2011.11.005. Epub 2011 Dec 14.

Rapley, T. (2004). Interviews. In C. Seale, *Qualitative research practice*. Thousand Oaks, California; London: Sage Publications.

Rock, P. (2001). Symbolic interactionism and ethnography. In P. Atkinson, A. Coffey, S. Delamont, Lofland, J. & Lofland, L. (ed.). *Handbook of Ethnography*. London; Thousand Oaks; New Delhi: Sage Publications.

RCSLT (2018). *RCSLT Curriculum Guidance for the pre-registration education of speech and language therapists*. Retrieved from https://www.rcslt.org/-/media/Project/ /curriculum-guidance-2018.pdf

RCSLT (2019a). *Clinical Information*. Retrieved from https://www.rcslt.org/speech-and-language-therapy/clinical-information#section-1

RCSLT (2019b). *Interprofessional Dysphagia Framework Draft for Consultation*, March. Retrieved from https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwiM1bC33rTkAhUPYcAKHZxNBSsQFjAAegQIAhAC&url=https%3A%2F%2Fwww.rcslt.org%2F-%2Fmedia%2FProject%2FRCSLT%2Fidf-2019-consultation.pdf&usg=AOvVaw10LeeiYsR_GGr21V9MRFJY

Reeves, S., Rice, K., Conn, L.G., Miller, K., Kenaszchuk, C. & Zwarenstein, M. (2009). Interprofessional interaction, negotiation and non-negotiation on general internal medical wards. *Journal of Interprofessional Care, 23*(6), 633-645. doi: 10.3109/13561820902886295.

Roberts, F.E. & Goodhand, K. (2018). Scottish healthcare student's perceptions of an interprofessional ward simulation: an exploratory, descriptive study. *Nursing and Health Science, 20*, 107-115. doi: 10.1111/nhs.12393. Epub 2017 Dec 21.

Rock, P. (2001). Symbolic interactionism and ethnography. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland and L. Lofland (Eds). *Handbook of Ethnography*. London; Thousand Oaks; New Delhi: Sage Publications.

Rose, M., Ferguson, A., Power, E., Togher, L. & Worrall, L. (2014). Aphasia rehabilitation in Australia: Current practices, challenges and future directions. *International Journal of Speech-Language Pathology, 16*(2), 169-180. doi: 10.3109/17549507.2013.794474. Epub 2013 Jun 18.

Rosenvinge, S.K. & Starke, I.D. (2005). Improving care for patients with dysphagia. *Age and Ageing, 34*, 587-593. Doi: 10.1093/ageing/afi187.

Ross, L.J., Mudge, A.M., Young, A.M. & Banks, M. (2011). Everyone's problem but nobody's job: Staff perceptions and explanations for poor nutritional intake in older medical patients. *Nutrition and Dietetics, 68*, 41-46. doi: 10.1111/j.1747-0080.2010.01495.x.

Rowlands, S. & Callen, J. (2013). A qualitative analysis of communication between members of a hospital-based multidisciplinary lung cancer team. *European Journal of Cancer Care, 22*, 20-31. doi: 10.1111/ecc.12004. Epub 2012 Sep 12.

Royal College of Nursing (2017). *Safe and effective staffing: the real picture*. UK Policy Report, London: RCN. Retrieved from https://www.rcn.org.uk/professional-development/publications/pub-006195

Rudd, A.G., Bowen, A., Young, G. & James, M.A. (2016). National Clinical Guideline for Stroke: 5th edition. *Clinical Medicine*. Retrieved from https://www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines

Rushmer, R. & Pallis, G. (2003). Interprofessional working: the wisdom of integrated working and the disaster of blurred boundaries. *Public Money & Management, 23*(1), 59-66. doi: 10.1111/1467-9302.00342.

Ryen, A. (2011). Ethics in qualitative research. In D. Silverman (Ed.). *Qualitative Research,* 3rd Edition. Los Angeles, California; London: Sage Publications.

Saka, O., McGuire, A. & Wolfe, C. (2009). Cost of stroke in the United Kingdom. *Age and Ageing, 38*, 27-32. doi: 10.1093/ageing/afn281.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advanced Nursing Science, 16*(2), 1-8.
Seneviratne, C.C., Mather, C.M. & Then, K.L. (2009). Understanding nursing on an acute stroke unit: Perceptions of space, time and interprofessional practice. *Journal of Advanced Nursing, 65*(9),1872-1881. doi: 10.1111/j.1365-2648.2009.05053.x.
Shibutani (1955). Reference groups as perspectives. *American Journal of Sociology, 60*(6), 562-569.
Shrubsole, K., Worrall, L., Power, E. & O'Connor, D.A. (2018). Barriers and facilitators to meeting aphasia guideline recommendations: what factors influence speech pathologists' practice? *Disability and Rehabilitation, 41*(13), 1596-1607. doi:10.1080/09638288.2018.1432706. Epub 2018 Jan 29.
Siemsen, I.M.D., Madsen, M.D., Pederson, L.F., Michaelson, L., Pedersen, A.V., Andersen, H.B. & Ostergaard, D. (2012). Factors that impact on the safety of patient handovers: an interview study. *Scandinavian Journal of Public Health, 40*, 439-448. doi: 10.1177/1403494812453889. Epub 2012 Jul 13.
Simmons, M. (2007). Insider ethnography: Tinker, tailor, researcher or spy? *Nurse Researcher, 14*(4), 7-17. Doi: 10.7748/nr2007.07.14.4.7.c6039
Simmons-Mackie, N.N., A., O'Neill C.C., Huijbregts, M., McEwen, S. & Willems, J.C. (2007). Communicative access and decision making for people with aphasia: Implementing sustainable healthcare systems change. *Aphasiology, 21*(1), 39-66. doi: 10.1080/02687030600798287.
Simmons-Mackie, N., Raymer, A. & Cherney, L.R. (2016). Communication partner training in aphasia: an updated systematic review. *Archives of Physical Medicine and Rehabilitation, 97*, 2202-21. doi: 10.1016/j.apmr.2016.03.023. Epub 2016 Apr 23.
Skills for Care & Skills for Health (2013). *Code of conduct for healthcare support workers and adult social care workers in England*. Retrieved from https://www.skillsforcare.org.uk/Documents/Standards-legislation/Code-of-Conduct/Code-of-Conduct.pdf
Smith, T., McNeil, K., Mitchell, R., Boyle, B., Ries, N. (2019). A study of macro-, meso- and micro-barriers and enablers affecting extended scopes of practice: the case of rural nurse practitioners in Australia. *BMC Nursing, 18*(14), 1-12. doi: 10.1186/s12912-019-0337-z. eCollection 2019.
Smithard, D.G. (2016). Dysphagia management and stroke units. *Current Physical Medicine and Rehabilitation Reports, 4,* 287-284. doi: 10.1007/s40141-016-0137-2.
Smith-Tamaray, M., Wilson, L. & McAllister, L. (2011). Factors affecting dysphagia management and compliance with recommendations in non-metropolitan healthcare

settings. *International Journal of Speech Language Pathology, 13*(3), 268-279. doi: 10.3109/17549507.2011.573575.
SSNAP (2019). *SSNAP Results Portal*. Royal College of Physicians. Retrieved from https://www.strokeaudit.org/results.aspx
Sommerfeldt, S.C. (2013). Articulating nursing in an interprofessional world. *Nurse Education in Practice, 13(*6), 519-23. doi: 10.1016/j.nepr.2013.02.014. Epub 2013 Mar 18.
Spradley, J.P. (1980). *Participant Observation*. New York: Holt, Rinehart and Winston.
Steele, C.M., Alsanei, W.A., Ayanikalath, S., Barbon, C.E., Chen, J., Cichero, J.A., ...Wang, H. (2015). The influence of food texture and liquid consistency modification on swallowing physiology and function: a systematic review, *Dysphagia, 30*, 2-6. doi:10.1007/s00455-014-9578-x. Epub 2014 Oct 25.
Stroke Unit Trialists' Collaboration (2013). Organised inpatient (stroke unit) care for stroke. *Cochrane Database for Systematic Reviews, 9.* doi: 10.1002/14651858.CD000197.pub3.
Stryker, S. (2008). From Mead to a structural symbolic interactionism and beyond. *Annual Review of Sociology, 34*, 14-31. doi: 10.1146/annualrev.soc.34.040507.134649.
Strauss, A., Schatzman, L., Ehrlich, D., Bucher, R. & Sabshin, M. (1963). The hospital and its negotiated order. In E. Freidson (Ed.), *The hospital in modern Society*. New York NY: Free Press of Glencoe.
Stroke Association (2017). *Current future and avoidable costs of stroke in the UK*. Retrieved from https://www.stroke.org.uk/sites/default/files/costs_of_stroke_in_the_uk_report_-executive_summary_part_2.pdf
Stroke Association (2018). *State of the nation stroke statistics*. Retrieved from https://www.stroke.org.uk/sites/default/files/state_of_the_nation_2018.pdf
Sundin, K. & Jansson, L. (2003). 'Understanding and being understood' as a creative caring phenomenon – in care of patients with stroke and aphasia. *Journal of Clinical Nursing, 12*, 107-116.
Surr, C.A. & Gates, C. (2017). What works in delivering dementia education or training to hospital staff? A critical synthesis of the evidence. *International Journal of Nursing Studies, 75*, 172-188. doi: 10.1016/j.ijnurstu.2017.08.002. Epub 2017 Aug 12.
Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E. & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of Interprofessional Care, 23*(1), 41-51. doi:10.1080/13561820802338579.

Tamuz, M. & Harrison, M.I. (2006). Improving patient safety in hospitals: Contributions of high-reliability theory and normal accident theory. *Health Research and Educational Trust, 41*(4), 1654-1676). doi: 10.1111/j.1475-6773.2006.00570.x.

Taylor, E., Jones, F. & McKevitt, C. (2018). How is the audit of therapy intensity influencing rehabilitation on inpatient stroke units in the UK? An ethnographic study. *BMJ Open, 8*. doi: 10.1136/bmjopen-2018-023676.

Taylor, E., McKevitt, C. & Jones, F. (2015). Factors shaping the delivery of acute inpatient stroke therapy: A narrative synthesis. *Journal of Rehabilitation Medicine, 47*, 107-119. doi: 10.2340/16501977-1918.

Thompson, J. & McKeever, M. (2014). The impact of stroke aphasia on health and well-being and appropriate nursing interventions: An exploration using the theory of human scale development. *Journal of Clinical Nursing, 23*, 410-420. doi:10.1111/j.1365-2702.2012.04237.x. Epub 2012 Nov 17.

Thomsen, D. (2011). Ethnography: A suitable approach for providing an inside perspective on the everyday lives of health professionals. *International Journal of Therapy and Rehabilitation, 18*(1), 10-17. doi: 10.12968/ijtr.2011.18.1.10.

Thorne, S. (2016). *Interpretative Description*. London; New York:Routledge.

Thorne, S.E., Hislop, T.G., Stajduhar, K. & Oglov, V. (2009). Time-related communication skills from the cancer patient perspective. *Psycho-Oncology, 18*(5), 500-507. doi: 10.1002/pon.1418.

Todres, L., Galvin, K.T. & Holloway, I. (2009). The humanization of healthcare: A value framework for qualitative research. *International Journal of Qualitative Studies in Health and Well-being, 4*, 68-77. doi: 10.1080/17482620802642O4.

Trevino, P., Green, A., Middaugh, D., Heo, S., Beverly, Cl & Deshpande, J. (2017). Nursing perception of risk in common nursing practice situations. *American Society for Healthcare Risk Management, 37*(3), 19-28. doi: 10.1002/jhrm.21283. Epub 2017 Nov 15.

Ulrich, C.M., Taylor, C., Soeken, K., O'Donnell, P., Farrar, A., Danis, M. & Grady, C. (2010). Everyday ethics: ethical issues and stress in nursing practice. *Journal of Advanced Nursing, 66*(11), 2510-2519. doi: 10.1111/j.1365-2648.2010.05425.x. Epub 2010 Aug 23.

Varpio, L., Schryer, C.F. & Lingard, L. (2009). Routine and adaptive expert strategies for resolving ICT mediated communication problems in the team setting. *Medical Education, 43,* 680-687. doi: 10.1111/j.1365-2923.2009.03395.x.

Vidovic, M., Sinanovic, O., Sabaskic, L., Haticic, A. & Brkic, E. (2011). Incidence and types of speech disorders in stroke patients. *Acta Clinica Croatica (50),* 491-494.

Vogel, A.P., Maruff, P. & Morgan, A.T. (2010). Evaluation of communication assessment practices during acute stages post stroke. *Journal of Evaluation in Clinical Practice, 16*, 1183-1188. doi: 10.1111/j.1365-2753.2009.01291.x.

Wacquant, L. (2008. In R. Stones (Ed). *Key Sociological Thinkers*. Hampshire; London: MacMillan Press.

Warner, H.L., Suiter, D.M., Nystrom, K.V., Poskus, K. & Leder, S.B. (2013). Comparing accuracy of the Yale swallow protocol when administered by registered nurses and speech-language pathologists. *Journal of Clinical Nursing, 23*, 1908-1915. doi:10.1111/jocn.12340. Epub 2013 Sep 6.

Weinhardt, J., Hazelett, S., Barrett, D., Lada, R., Enos, T. & Keleman, R. (2008). Accuracy of a bedside dysphagia screening: A comparison of registered nurses and speech therapists. *Rehabilitation Nursing, 33*(6), 247-252. doi: 10.1002/J.2048-7940.2008.tb00236.x.

West, M.A., Lyubovnikova, J. (2013). Illusions of team working in health care. *Journal of Health Organization and Management, 27*(1), 134-142. doi: 10.1108/14777261311311843

Whitley, R. (2009). Mastery of mothering skills and satisfaction with associated health services: an ethnocultural comparison. *Culture, Medicine & Psychiatry, 33*, 343-365. doi: 10.1007/s11013-009-9140-8.

Williams, A.N., Dawson, S. & Kristjanson, L.J. (2008). Exploring the relationship between personal control and the hospital environment. *Journal of Clinical Nursing, 17*, 1601-1609. doi: 10.1111/j.1365-2702.2007.02188.x.

Wind, G. (2008). Negotiated interactive observation: Doing fieldwork in hospital settings. *Anthropology and Medicine, 15*(2), 79-89. doi: 10.1080/13648470802127098.

Wolf, J.A. (2018). *To care is human: the factors influencing human experience in healthcare today.* The Beryl Institute.

Wright, L., Cotter, D., Hickson, M. & Frost, G. (2005). Comparison of energy and protein intakes of older people consuming a texture modified diet with a normal hospital diet. *Journal of Human Nutrition and Dietetics, 18*, 213-219. doi: 10.1111/j.1365-277X.2005.00605.x.

Wright, D. & Brajtman, S. (2011). Relational and embodied knowing: nursing ethics within the interprofessional team. *Nursing Ethics, 18*(1), 20-30. doi:10.1177/0969733010386165.

Yoon, M.N. & Steele, C.M. (2012). Health care professionals' perspectives on oral care for long-term care residents: Nursing staff, speech-language pathologists and dental hygienists. *Gerodontology, 29*, 525-535. doi: 10.1111/j.1741-2358.2011.00513.x. Epub 2012 Mar 30.

Appendix 1: Included Papers: Common Care Interests

Author Year Place	Discipline Focus	Study Aim	Source Type Study type	Participants
Atkinson 2018 UK	SLT Swallow	Discuss individualised use of thickener	Discussion	
Ali 2017 UK	Nurse Comm.	Explore impact of language barrier on nursing care	Primary research Interview and focus group	Nurse (59)
Balandin 2007 Australia	Nurse Comm.	Understand hospital experiences of patients with cerebral palsy & CCN	Primary research Interview	Adults with cerebral palsy and CCN (10)
Bray 2017 UK	Doctor Swallow	Identify if delays to bedside screening and assessment associated with risks of stroke acquired pneumonia	Primary research Prospective cohort study	Patient (63,650)
Bridges 2013 UK	Nurse Comm.	Explore nurses' experiences of relationships with patients on acute wards	Review Meta-ethnography	
Bridges 2010 UK	Nurse Comm.	Explore views of older people & relatives on acute care experience	Review Systematic review & meta-synthesis	
Bright 2018 New Zealand	SLT Comm.	Understand how rehabilitation practitioners engaged people with communication disabilities	Primary research Observation and brief interview	SLT (5), nurse (7), other HCP (16), patient (3)
Chan 2012 Hong Kong	Nurse Comm.	Explore nurses' views on issue of time in the workplace	Primary research Repeat narrative interview	Nurse (5)
Cichero 2009 Australia	SLT Swallow	Develop and evaluate a dysphagia screening tool and training	Primary research Prospective quasi-experimental	Nurse (38) Patient (442)
Clancy 2018 UK	Clin. Psych. Comm.	Explore experiences of staff-patient communication in inpatient stroke	Primary research Interview and focus group	PWA (6) Carer (10) HCP (6) of which PT (3) Dr (2) nurse (1)
Cruice 2018 UK	SLT Comm.	Consider specification of CPT and describe how conducted	Review Critical review and narrative synthesis	
Dithole 2016 Botswana	Nurse Comm.	Identify communication challenges between nurses and mechanically ventilated patients in ITU	Review Structured literature review	
Dondorf 2015 USA	SLT Swallow	Discuss the importance of SLT and nurse collaboration for stroke associated dysphagia	Discussion	

Drury 2014 Australia	Nurse Swallow	Audit fever, hyperglycaemia and swallow dysfunction in acute stroke	Audit	Stroke units (19)
Edmiaston 2010 USA	Nurse Swallow	Design and validate a swallow screening tool to identify dysphagia and aspiration risk	Primary research Test-retest, reliability, sensitivity	Patient (300)
Foster 2016[2] Australia	SLT Comm.	Understand aphasia management pathway in acute setting from SLT perspective	Primary research Interview	SLT (14)
Fry 2017 Australia	Nurse Comm.	Explore emergency nurse perceptions of feasibility of use of a dementia pain assessment tool	Primary research Focus group	Nurse (36)
Funk 2018 USA	Nurse Comm.	Investigate hospital experience of older adults with hearing impairment	Primary research Interview	Patient (8)
Garcia 2005 USA	SLT Swallow	Identify practice patterns of SLTs in use of thickened fluids	Primary research Survey	SLT (145)
Gordon 2008 UK	Nurse Comm.	Explore how nursing staff and patients with and dysarthria communicate	Primary research Observation	Nurse (14) Patient (5)
Green 2014 New Zealand	SLT Swallow	Investigate perceptions post introduction of FEES	Primary research Interview	SLT (6)
Happ 2011 USA	Nurse Comm.	Describe communication interactions, methods and assistive techniques between nurses & nonspeaking ITU patients.	Primary research Observation	Nurse (10) Patient (30)
Heard 2017 Australia	SLT Comm.	Determine if e-learning CPT as effective as Supported Conversation for adults with Aphasia	Primary research Measures of effectiveness	Nurse (20) AHP (26) Doctor (2)
Hemsley 2011 Australia	SLT Comm	Determine full range of communication needs for adults with developmental disorders (DD) and CCN	Primary research Interview	Nurse (15) people with DD or CCN (15) Carer (15)
Hemsley 2013 Australia	SLT Comm.	Investigate recollections of adverse events in hospital	Primary research Narrative interview	PWA (10) Spouse (10)
Hemsley 2014 Australia	SLT Comm.	Synthesise research on communication in hospital for people with life long and acquired severe communication disabilities	Review Literature review	

Hersh 2016 Australia	SLT Comm.	Explore nurse interactions on acute ward with patients with and without aphasia	Primary research Observation	Patient (3)
Hines 2016 Australia	Nurse Swallow	Examine effectiveness of nursing interventions to manage dysphagia in adult patients with acute neurological dysfunction	Review Systematic review: update of previous review	
Horton 2016 UK	SLT Comm.	Understand causal mechanisms implicated in transfer of CPT to practice in post-acute rehabilitation	Primary research Focus group, interview, learning log, recordings of interaction	Nurse (9) NA (7) SLT (1) Other (9) Patient (13)
Horton 2018 UK	SLT Comm.	Critically review experiential and adult learning in CPT	Discussion	
Jensen 2015 Denmark	SLT Comm.	Outcome of training programme to nursing staff on acute stroke unit	Primary research Implementation project. Survey + Interview	Nurse and NA (31)
Jones 1997 UK	Nurse Comm.	Explore perceptions of communication between patients and staff in stroke rehabilitation	Primary research Interview	Patient (10) Unspec. HCP (14) Carer (unspec. no.)
Juve-Udina 2014 Spain	Nurse Comm.	Evaluate frequency of psychosocial aspects of e-charted nursing care	Primary research Retrospective chart review	Patient (150,494)
Kaizer 2012 Canada	OT Swallow	Introduce tool for clinician-patient discussion and collaboration re. assumed v real risk and promote shared decision-making in dysphagia care	Service development	
Kenny 2016 Australia	Nurse Swallow	Determine evidence-practice gap in management of fever, hyperglycemia and dysphagia in an acute stroke unit	Audit Retrospective chart review	Patient (53)
Khalaila 2011 Israel	Nurse Comm.	Examine association between communication and psycho-emotional distress re. mechanical ventilation in MITU and identify predictive factors for psych. outcomes	Primary research Correlational Structured interview	Patient (65)
Krekeler 2018 USA	SLT Swallow	Understand what is known about adherence in dysphagia treatment	Review Systematic review	

Leiter 1996 USA	SLT Swallow	Evaluate compliance with dysphagia recommendations	Primary research Observation	Patient (8)
Lewis 2016 Australia	Nurse Comm.	Describe how nurses experience caring for people with intellectual disability in acute care	Review Narrative review	
Loft 2017a Denmark	Nurse Comm.	Explore nursing beliefs, attitudes and actions re. function on inpatient stroke rehabilitation unit	Primary research Participant observation and interview	Nurse (8) NA (6)
Loft 2017b Denmark	Nurse Comm.	Describe patients experiences of stroke rehabilitation and perceptions of nursing roles and functions	Primary research Interview	Patient (10)
Magnus 2006 UK	SLT Comm.	Investigate staff and patient perceptions of communication difficulties on ICU.	Primary research Pilot study: Multi-centre survey	HCP (9) Patient (8)
Malone 2003 USA	Nurse Comm.	Discuss the spatial dynamics of nurse-patient relationships in hospital	Discussion paper	
McCabe 2004 Ireland	Nurse Comm.	Explore patients' experiences of how nurses communicate	Primary research Phenomenological Interview	Nurse (8)
McCullough 2007 USA	SLT Swallow	Examine self-reported compliance with SLT recommendations for safe feeding and swallowing and proper oral hygiene.	Primary research Survey + qualitative analysis of written comments	Nurse (77)
McCurtin 2018 Ireland	SLT Swallow	Explore post-stroke experiences of people with swallowing disorders and acceptability of thickened fluids	Primary research Interview	Patient (14)
Miller 2001 UK	SLT Swallow	Explore factors that impact on effectiveness of dysphagia training programmes	Discussion paper	
O'Halloran 2008 Australia	SLT Comm.	Review literature on environmental factors that influence communication between adults with communication disabilities and HCPs in acute setting	Review Literature review	
O'Halloran 2011 Australia	SLT Comm.	Identify environmental barriers and facilitators for patient-HCP communication in acute stroke units	Primary research Observation	Patient (65)

O'Halloran 2014 Australia	SLT Comm.	Explore SLT perceptions about working to create communicatively accessible healthcare settings	Primary research Focus Group	SLT (15)
O'Halloran 2017	SLT Comm.	Investigate scientific properties of the Inpatient Functional Communication Interview Staff Questionnaire (IFCI SQ)	Primary research Comparison of ratings IFCI + IFCI SQ	Patient (50) Nurse (50)
O'Keefe 2018 Ireland	Doctor Swallow	Examine discrepancy between use of modified diets in clinical practice and evidence base re. risks and benefits.	Discussion paper	
Pound 2018	SLT Comm.	Explore relevance and applicability of Humanising Values Framework to communication between PWA and healthcare staff.	Discussion paper	
Radtke 2012	Nurse Comm.	Describe nurse perceptions of communication intervention for non-speaking critically ill patients.	Primary research Focus group and interview	Nurse (6)
Rosenvinge 2005 UK	SLT Swallow	Determine compliance with swallowing recommendations and investigate effectiveness of changes in practice in improving compliance	Audit & Service development Pre and post intervention audit	Patient (85)
Ross 2011 Australia	Dietician Swallow	Examine staff awareness, knowledge and perceptions of the nutritional care of older patients on medical wards	Primary research Qualitative Focus group	Nurse (9) Dietician (5) SLT (2) Other (6)
Simmons-Mackie 2007 Canada	SLT Comm	Improve communication access to information and decision making for PWA in acute, rehabilitation and long term care settings.	Primary research Observation, focus group, interview	Nursing (6) SLT (5) Other (26)
Simmons-Mackie 2016 USA	SLT Comm.	Update previous systematic review describing effects of CPT on PWA and their communication partners	Review Systematic review	

Smith-Tamaray 2011 Australia	SLT Swallow	Investigate issues related to provision of dysphagia services in non-metropolitan area	Primary research Interview	SLT (8)
Sundin 2003 Sweden	Nurse Comm.	Illuminate meaning of understanding and being understood in care of PWA	Primary research Observation and interview	Nurse (5) Patient (3)
Thompson 2014 UK	Nurse Comm.	Explore impact of aphasia on health and wellbeing and inform nursing interventions	Discussion paper	
Thorne 2009 Canada	Nurse Comm.	Explore how cancer patients describe and explain effects of health care communication on their experience of time	Primary research Secondary analysis of interview data	Patient (260)
Warner 2013 USA	SLT Swallow	Describe outcome of teaching module and determine accuracy of screening protocol	Primary research Post-screen rating scales	Nurse (52) Patient (101)
Weinhardt 2008 USA	Nurse Swallow	Validate dysphagia screening tool, comparing nurse and SLT ratings	Primary research Comparison of pass/fail decisons	Patient (83)
Williams 2008 Australia	Nurse Comm.	Explore aspects in the hospital environment that patients perceive to influence personal control	Primary research Interview and participant observation	Patient (56)
Wright 2005 UK	Dietician Swallow	Compare dietary intake of older people eating textured with normal diet	Primary research Comparison of weight of food given and waste	Patient (55)
Yoon (2012) Canada	SLT Swallow	Explore perspectives on oral care held by nurses, SLTs and dental hygienists	Primary research Focus group	Nurse (6) SLT (6) Dental hygienist (4)

HCP Health care professional
PWA Person with aphasia
CCN Complex communication needs
CPT Communication partner training
Dr Doctor

Appendix 2: Field Note Extract

Saturday 20th May (1000-1300)

The SLT from the acute wards is covering today, I find her in the office, reading through the handover sheet from the SLTs, this is very clearly documented with priorities high, medium and low. She knows the ward well having just rotated off a few weeks ago, however all the patients she is down to see are different and she finds it difficult just stepping in and working with someone else's patient, says she doesn't want to 'break them'. The SLTA has not arrived and she wants to speak to her before going out, however by1015 she feels she has to go onto the ward. She enters one of the bays and a nurse she knows has just finished with a patient and says 'drowsy', SLT asks about a patient in another bay and the nurse advises her that she isn't in that bay, and that the nurse is in with a patient washing him. She goes back and checks the board again and then goes to the bay and sees the nurses are in the side room, she introduces herself to the patient then goes and makes some porridge to try him with, he refuses and she goes again to see if the nurses are finished, they aren't so she goes back in to continue her session, she looks in the side room window and the nurse comes out, SLT says 'I wanted to feed back but it's ok, I can wait til you're finished'. When the nurse comes out, SLT asks her how the patient has been getting on with what he's on, the nurse doesn't really know 'it's my first time working with the patient' and SLT asks if there was any information at handover, there wasn't and SLT says 'I'm going to upgrade him to quarter of puree meals' and she demonstrates the adapted spoon 'this goes over the cutlery like this', she adds that 'he gets out of breath so go quite slowly… if he's coughing then stop', the nurse repeats 'stop'. SLT then writes a sign to go above the bed:

¼ puree meals (texture C)
Meds: Via NG
Hand over hand assistance
GO SLOWLY
PROMPT TO SWALLOW

She returns to the office to write her notes, and I stay on the ward for a while.

General obs: As last Saturday it is quite calm on the ward, they are fully staffed and everyone is busy getting the patients washed. An alarm goes off loudly and no one is free to respond, the bay nurse is walking across with a bowl and water and says she will be there shortly. The nurses in the bay are negotiating their breaks, two of them want to go together and they persuade a third person (I think she is a nurse, but she doesn't seem to be working with patients) to stay in the bay and call them if needed. In another bay one of the nurses is encouraging another nurse to go for a break, he explains that he just needs to finish some obs. and get a patient a cup of tea. She offers to get the tea so he can be finished sooner. By 1130

all the patients are washed and the ward is calm, the nurse is at the computer.

I return to the office and ask about the SLTA, she hasn't turned up and the SLT has been in touch with band 7 SLT (at home) who says she should just do what she can. A little later she goes in to see the second patient on her list for a communication screen, checking in with the OT before she does so whether she has any swallowing problems (says no). She starts by reading the paper record, commenting that she finds it difficult to find the information (this is her first SLT post so her only experience since graduating will be EPR. Whilst she is reading she spots that the nurse is feeding a yoghurt to a patient on her list, she uses the opportunity to look across at how the patient is coping. She goes to see the communication patient, I can hear behind the curtains that she has only mild difficulties (dysarthria). As she is finishing, another patient in the bay stops her to say she needs the toilet. She looks around for a nurse and I tell her where to find her, she goes to the drugs room and passes on the message, the nurse replies 'later'. She goes straight back to the office. I ask her later if there was anything that she would handover and she says no, because communication is mild. The SLT writes her notes and stays in the office, she is waiting for the OT to be ready for her to do a joint session, she goes to look for her and they return together to the office, then go to see the patient together in the OT kitchen, after the session I don't observe any handover with a nurse. I stay on the ward a while longer, however there is tension in that two of the patients in the bay are needing attention, one with a family member advocating for him, the nurse can't manage and goes into the side room to tell the nurses in there that he needs help. I escape the tension by returning to the office (mirroring what I am free to do as therapist cf. nurse). The SLT finishes her notes and then goes to see a fourth patient. I follow her onto the ward but see a nurse I have been trying to get consent from and discontinue the shadow.

Themes and thoughts

I'm not sure I have learnt much that's new today. My observation last Saturday was that the SLT spent more time on the ward, writing her notes there, however this wasn't true of this SLT. Her comment about the paper record was interesting, given that EPR may be all she knows as a recently qualified SLT. The SLT gets involved in unrelated aspects of patient care just by being on the ward, this often involves passing on a message to nursing staff, ultimately they don't have to deal with the matter at hand and whilst the response from the nurse on this occasion sounded a bit uncaring she was in the middle of sorting out medication so didn't have the capacity to help at that time. What is the nurse really communicating when she says 'later'?

Methodological/Field relationships

I talk through an information sheet with a patient and then annoyingly realise I don't have any consent forms. I approach three nurses for consent, one says no – on discussion she agrees to be part of the study (the bit where I come and listen in when she is talking to the SLT) but declines when I then say she will need to sign a consent form, another nurse consents but

needs reassurance that it isn't just him I will be observing, and he declines to be recorded, and the third nurse is also happy for me to capture those conversations but has reservations about being observed for longer periods or being recorded, however she completes a consent form when I add that she does not have to consent to being shadowed. This is an unusually cautious shift. There is one nurse on the shift who has already given consent. It leaves me feeling quite flat and concerned about how I am going to get the interviews, as several of the nurses have said they don't want interviews recorded. I am struck again by the similarities between my role as researcher and my experiences of working on acute wards as a junior therapist, trying to get the nurses attention for them to hear about the study and sign a consent form is difficult, as they finish one task they move immediately onto another, when the hard physical work of getting patients washed is finished there is calm, but that is when they will tend to go for their break. And I can see better now why they really need that break at that point, from after handover at 0830 they spend a good 3+ hours getting patients ready. It looks like really physical work and when I am chatting to one of the nurses about working here, she acknowledges that working with stroke is hard and can be stressful but she describes her colleagues as 'a family' and this is the positive aspect.

Appendix 3: Interview Topic Guide

16th March 2015 (version 1)

CITY UNIVERSITY LONDON

Initial topic guide for semi-structured interviews with SLTs and nurses

Topics to include:

1. Background to experience on the ward; role, how long been there, previous clinical experience.
2. Perspective on extracts recorded by the researcher from observational work. Including questions about typicality and rationale for behaviours observed.
3. Comparisons with experience of SLT-nurse communication at other places of work.
4. Perspectives on clinical need for SLT-nurse communication.
5. Perspectives on current effectiveness of SLT-nurse communication.
6. Examples of positive experiences of SLT-nurse communication; discuss why this is so and consider how impact on patient care.
7. Comparisons with communication with other professional groups; SLT-AHP communication, nurse-other AHP communication.
8. Suggested improvements to SLT-nurse communication.
9. Education and training needs.

Appendix 4: NHS Ethics Approval

NHS
Health Research Authority
National Research Ethics Service

NRES Committee North West - Preston
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0161 625 7818
Fax:0161 625 7299

20 April 2015

Dr [redacted]
Division of Language and Communication Science
School of Health Sciences, City University London
Northampton Square, London
EC1V 0HB

Dear [redacted]

Study title: **An ethnographic study of speech and language therapist and nurse communication**
REC reference: **15/NW/0271**
IRAS project ID: **166663**

Thank you for your email of 17 April. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 30 March 2015

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Participant information sheet (PIS) [staff]	2	17 April 2015

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Covering letter on headed paper [Covering Letter]	1	16 March 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Provisional Indemnity Version 1]	1	16 January 2015
GP/consultant information sheets or letters [Information To Consultants Version 1]	1	16 March 2015
Interview schedules or topic guides for participants [Initial topic guide Version 1]	1	16 March 2015
Other [Patient flyer alerting presence of research Version 1]	1	16 March 2015
Other [Poster alerting staff, patients and visitors Version 1]	1	16 March 2015

Participant consent form [Staff Consent Form Version 1]	1	16 March 2015
Participant consent form [Patient Consent Form Version 1]	1	16 March 2015
Participant information sheet (PIS) [Patient Information Sheet Version 1]	1	16 March 2015
Participant information sheet (PIS) [Patient Information Sheet (adapted) Version 1]	1	16 March 2015
Participant information sheet (PIS) [staff]	2	17 April 2015
REC Application Form [REC_Form_17032015]		17 March 2015
Referee's report or other scientific critique report [Peer Review Version 1]	1	16 March 2015
Research protocol or project proposal [Project Protocol Version 2]	2	16 March 2015
Summary CV for Chief Investigator (CI) [Dr Madeline Cruice CV Version 1]	1	16 March 2015
Summary CV for student [Rachel Barnard CV Version 1]	1	16 March 2015
Summary CV for supervisor (student research) [Dr Julia Jones CV Version 1]	1	16 March 2015

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

15/NW/0271 **Please quote this number on all correspondence**

Yours sincerely

[redacted]

REC Manager

E-mail: [redacted]

Copy to: [redacted]

Appendix 5: SLT and Nursing Staff information Sheet

17th April 2015 (version 2)

[redacted]

Division of Language and Communication
City University London
Northampton Square
London, EC1V 0HB

[redacted]
Website: www.city.ac.uk

Hospital Address

Contact details of local collaborator

INFORMATION SHEET: SLTs and Nurses
A study of speech and language therapist and nurse communication

Do you want to join our research study?

Before you decide, we want you to understand….

- The aims of the research
- What it would involve for you

Please read this sheet carefully. We will spend about 10 minutes talking it through with you. Please ask if there is anything that is not clear or if you want to know more and consult with other people about it. Take time to decide if you want to take part.

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

PART ONE

Who is running the study?
The project is based at [insert ward] and will be led by a PhD student at City University London. Her name is Rachel Barnard. Rachel is a speech and language therapist by profession. She is supervised by Madeline Cruice (Division of Language and Communication) and Julia Jones (Division of Nursing) at City University London.

What is the study about?
The study aims to find out more about how speech and language therapists (SLTs) and nurses communicate about patients under their joint care. Existing literature shows that both professions want to improve how they work with patients with communication and swallowing difficulties. However there is

very little research about how SLTs and nurses actually communicate about patient care. This study uses methods designed to capture the experience of both professional groups in order to gain a rich understanding of the nature of SLT-nurse communication, what it looks like, how it happens and how SLTs and nurses feel about it. The ultimate aim is to create new knowledge that can support SLTs and nurses to develop the strong interprofessional partnerships needed to improve outcomes for patients.

Why me?

We are asking you because you are a SLT or a nurse working on [insert name of ward]. Rachel wants to observe all the SLTs and nurses on the ward as they go about their usual business. This will involve shadowing, watching what goes on from the nursing station, therapy offices and in meetings, and listening to and reading how you share information with each other about patients. She will also ask to interview you so she can better understand some of the things she has noticed and to seek your opinion about SLT-nurse communication.

Do I have to take part?

No, it is your choice, and declining to participate will have no effect on your employment. You can say 'yes' and then change your mind, without giving a reason. We will describe the study and go through this information sheet. If you agree to take part, we will ask you to sign a consent form. Rachel will check she still has your agreement when she asks something specific of you, such as shadowing you for periods of time. If you want to be left alone, Rachel will respect that without question.

What will happen to me if I take part?

Rachel will spend up to three months on [insert name of ward]. During this time she will:

- Observe what goes on from positions on the ward where SLTs and nurses can be expected to come into contact with one another and during meetings.
- Accompany you for periods of up to three hours as you go about your usual work. She will stay behind the curtains or doors during intimate care.
- Listen to how you share information with your SLT or nurse colleagues and will ask to record some of these discussions (with the consent of patients).
- View written communication intended for your SLT or nurse colleagues in the patient record (with the consent of patients).
- Ask to interview you for 30-60 minutes and to record it.

Methods

The method being used in this study is ethnography. The basic principle is that the researcher gathers data by entering the day-to-day lives of participants in their natural environment, which in this case is a hospital ward. By watching what they do and asking their views the researcher develops insights that are refined through a careful process of categorizing and interpreting the data. The main method of data collection will be the discreet writing of field notes during observations on the ward and in meetings. If you have a discussion about patients with your nurse or SLT colleague, Rachel will ask you if she can audio record the conversation so she can get detailed understanding of how you talk to each other. If you prefer not be recorded she will take notes instead. She will ask to interview you on a separate occasion and will seek your views on some of the things she observed as well as your thoughts about SLT-nurse communication.

What will I have to do?
You will be asked to let Rachel shadow you for up to 3 hours at a time and to be interviewed. You will also notice Rachel observing you from afar during her observations at the nursing station, in therapy offices and during meetings.

Is there any risk or inconvenience?
You might find it uncomfortable or tiring having someone observing you as you go about your work. Rachel will minimize the disturbance to you by not asking you to give a running commentary on what you are doing. She will ask you how you would like her to behave, whether you would prefer her to be a 'fly on the wall' or help you in some way.

Will the project help me?
There are no immediate benefits to you of taking part. However, the information collected during the research will help us understand more about how SLTs and nurses communicate about patients. This may help patients in the future. Once the study has been completed SLTs and nurses will be invited to attend an inservice training event at xxxx based on the findings of the study.

What if there is a problem?
If you are not happy you can talk to Rachel or her project supervisors or make a complaint. Please see part two for further details.

Will my taking part in the study be kept confidential?
We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part two.

Thank you for reading this information sheet.

Part two provides further information. Please read this before making any decision.

17th April 2015 (version 2)
PART TWO

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to Rachel Barnard who will do her best to answer your questions. The Chief Investigator of this project is [redacted]. She can be contacted by telephone on [redacted]

You can also contact (local collaborator), X is the local collaborator for the study and she can be contacted by phone on extension X or by email at X

If you remain unhappy and wish to complain formally, you can do this through the university complaints procedure. Contact [redacted], Secretary to Senate Research Ethics Committee, Research Office, City University London, Northampton Square, London, EC1V 0HB or email [redacted]. Or call [redacted] and ask to speak to the Secretary of the Senate Research Committee.

Are you insured if anything goes wrong?
In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for legal action for compensation against City University London, but you may have to pay legal costs.

What will happen to the results of the research study?
The findings of this study will be submitted as a PhD thesis to City University London. Findings will also be presented at conferences and submitted to journals for publication.

Will my taking part in the study be treated as confidential?
The study is anonymous with no names ever being used. When recording Rachel will ask you not to use patient identifying information so patient confidentiality is also protected. If names are used they will be replaced with pseudonyms during transcription. All recordings will be destroyed when the study is finished. Data collected for this research study will be stored securely at City University London for 10 years and then destroyed. Finally anything you tell us will be treated in confidence unless we are concerned about your safety or the safety of someone else or if we become aware of professional malpractice, in which case we would have to discuss our concerns with you and your manager. Pseudonyms will be used to protect your identity and that of the ward during any publications or conference presentations.

Who is organizing the research?
The study is being conducted in part fulfillment of a PhD study by Rachel Barnard at City University London under the supervision of [redacted] (Division of Language and Communication Science) and Dr [redacted] (Division of Nursing).

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NRES Committee North West – Preston.

17th April 2015 (version 2)

What now?

Thank you for reading this information sheet. We will give you a copy. If you decide to join the research we will ask you sign a consent form and give you a copy.

Further information and contact details

We realize that the information about the study given on this sheet is limited. Rachel has more detailed information, which she can pass to you. When not on the ward you can contact her by [redacted] or email [redacted]

Appendix 6: Patient Alert to the Study

16th March 2015 (version 1)

[redacted]

Division of Language and Communication
City University London
Northampton Square
London, EC1V 0HB

[redacted]
Website: www.city.ac.uk

Hospital Address

Contact details of local collaborator

Information about a study on the ward

My name is Rachel Barnard and I am a researcher from City University London.

I am doing a study about staff.

[redacted]

During your time as a patient on the ward you might see me watching what is going on.

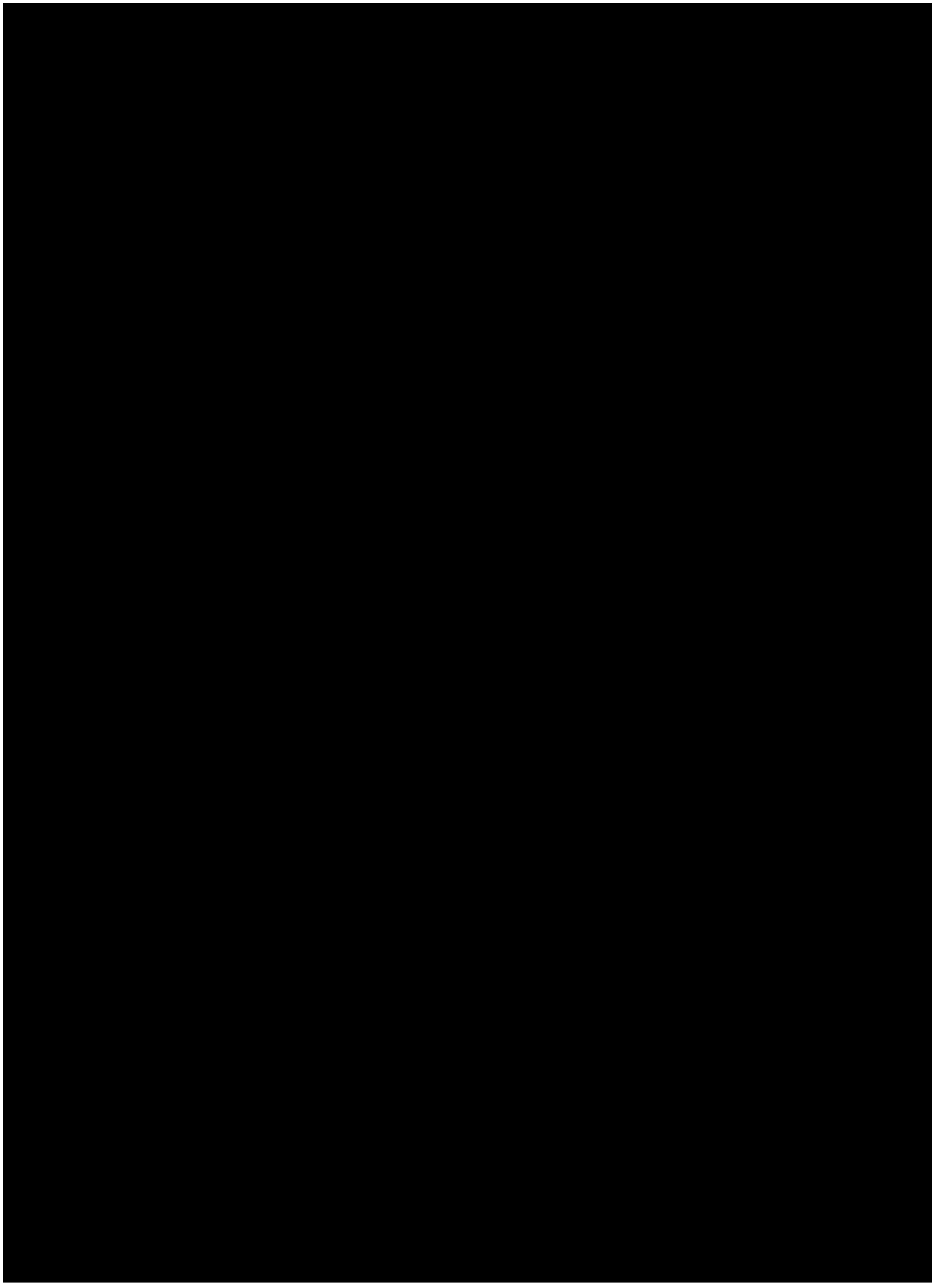
- The study is about how speech and language therapists (SLTs) and nurses communicate about patients.
- I will be watching SLTs and nurses when they work with patients and listening to them when they discuss patient care.
- Sometimes I will ask if I can watch when they work with you.
  - **You can say NO and I will leave you alone.**
  - **Saying no will not affect your care at all.**
- I will stay behind the curtains if what they are doing with you is private.

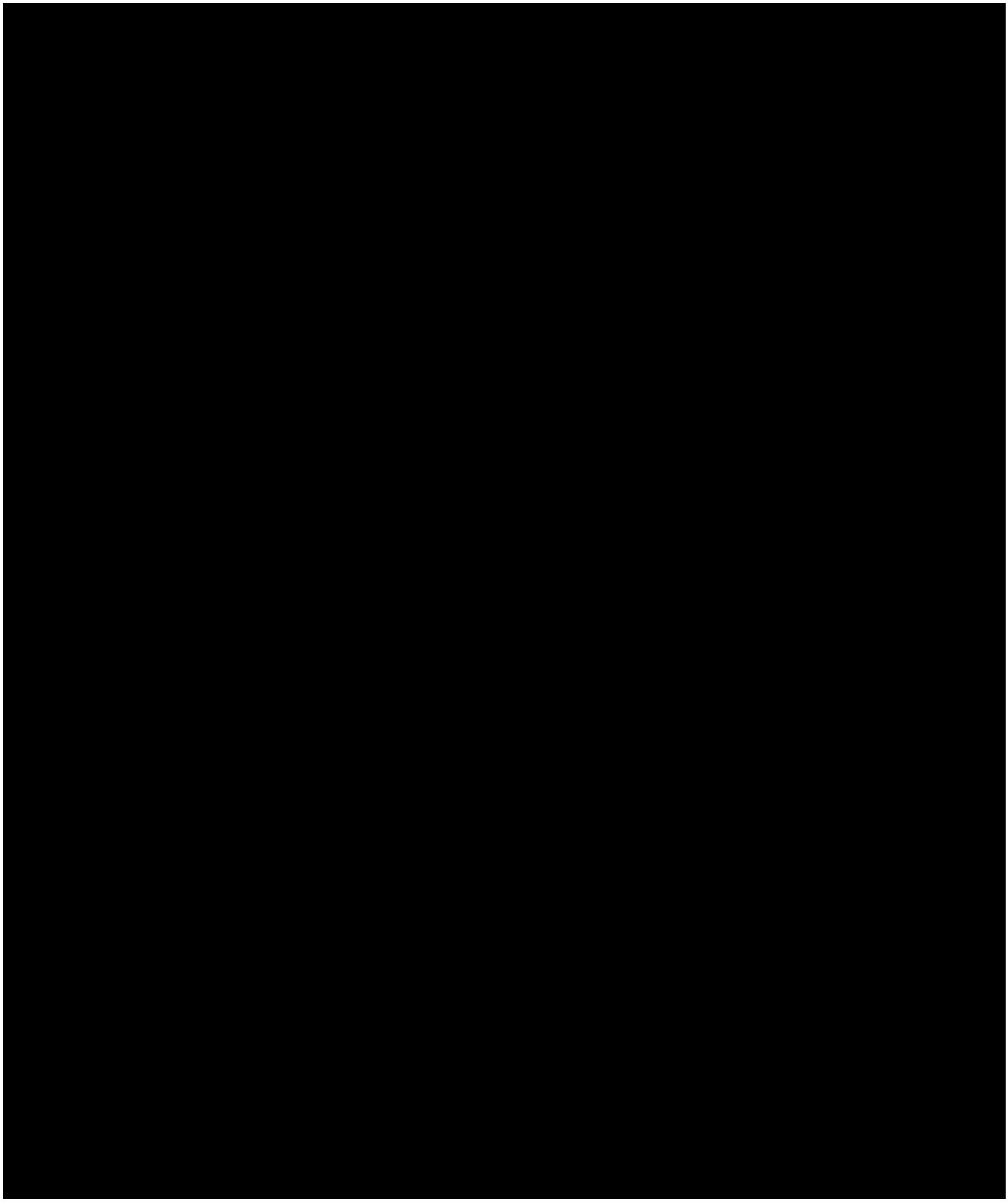
I might ask you to take part in the study. If that happens I will come back later to give you more information and ask your permission.

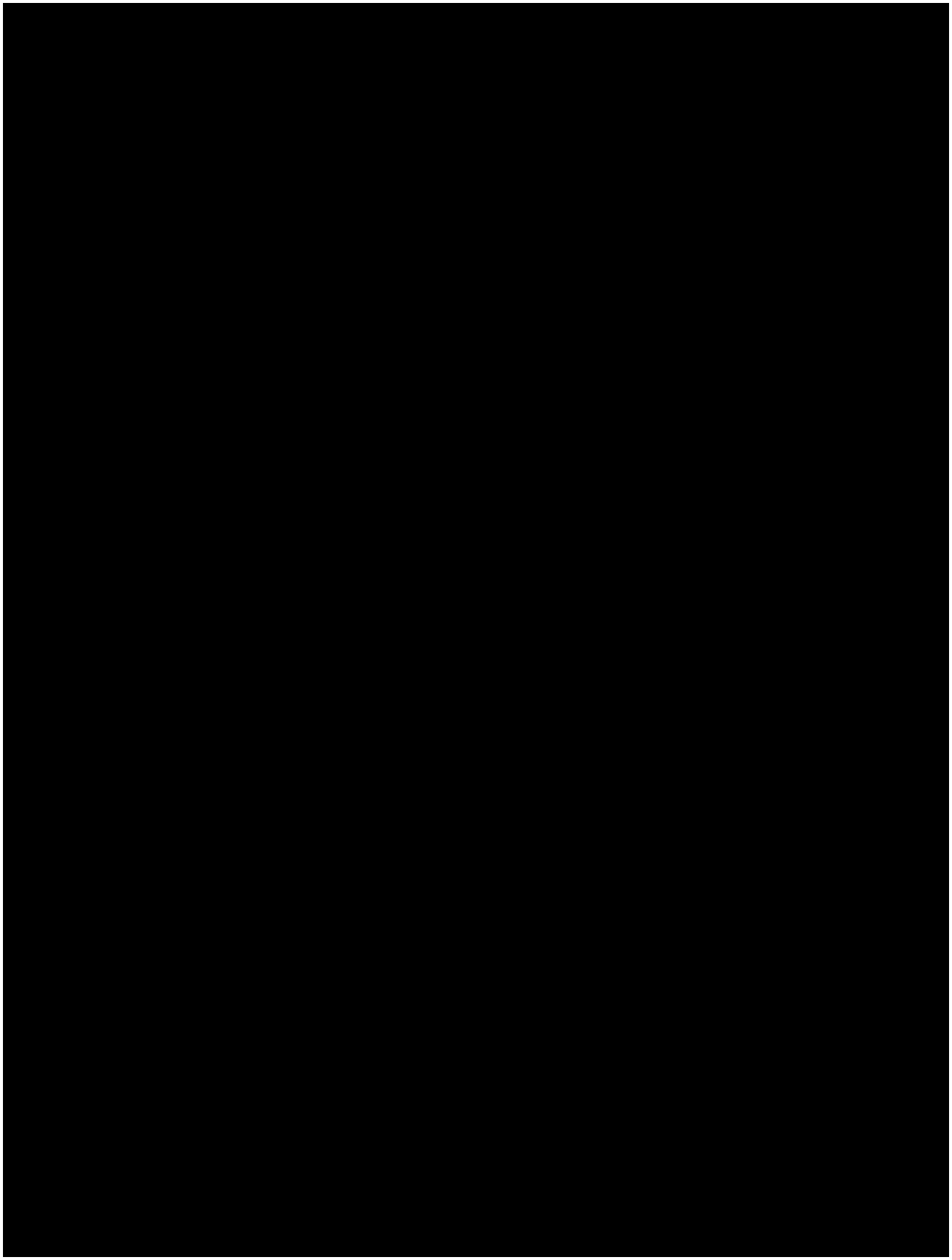
For more information please talk to me on the ward, or contact me by email or phone: XXX.
The hospital contact for the study is XXXX

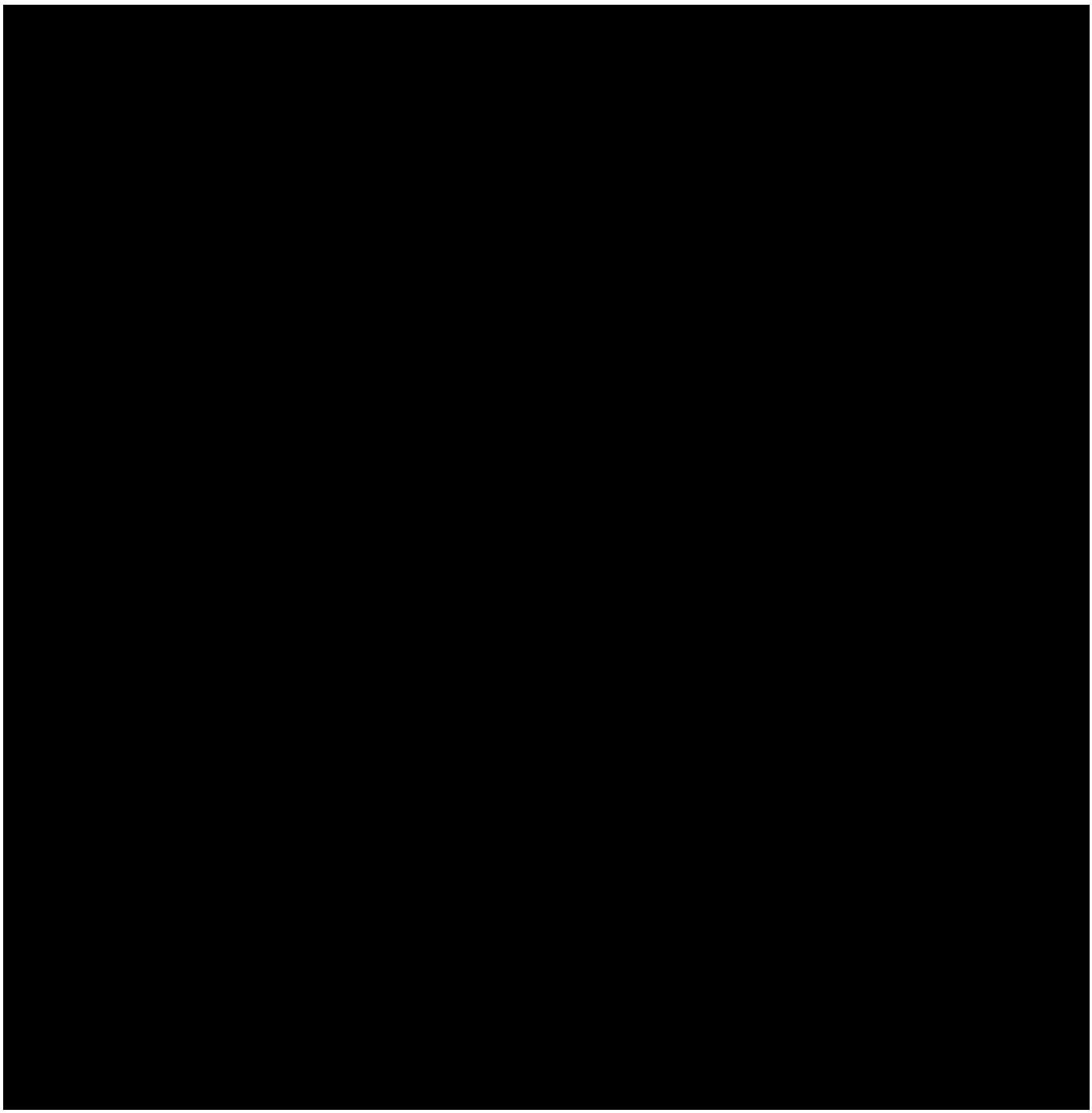
1

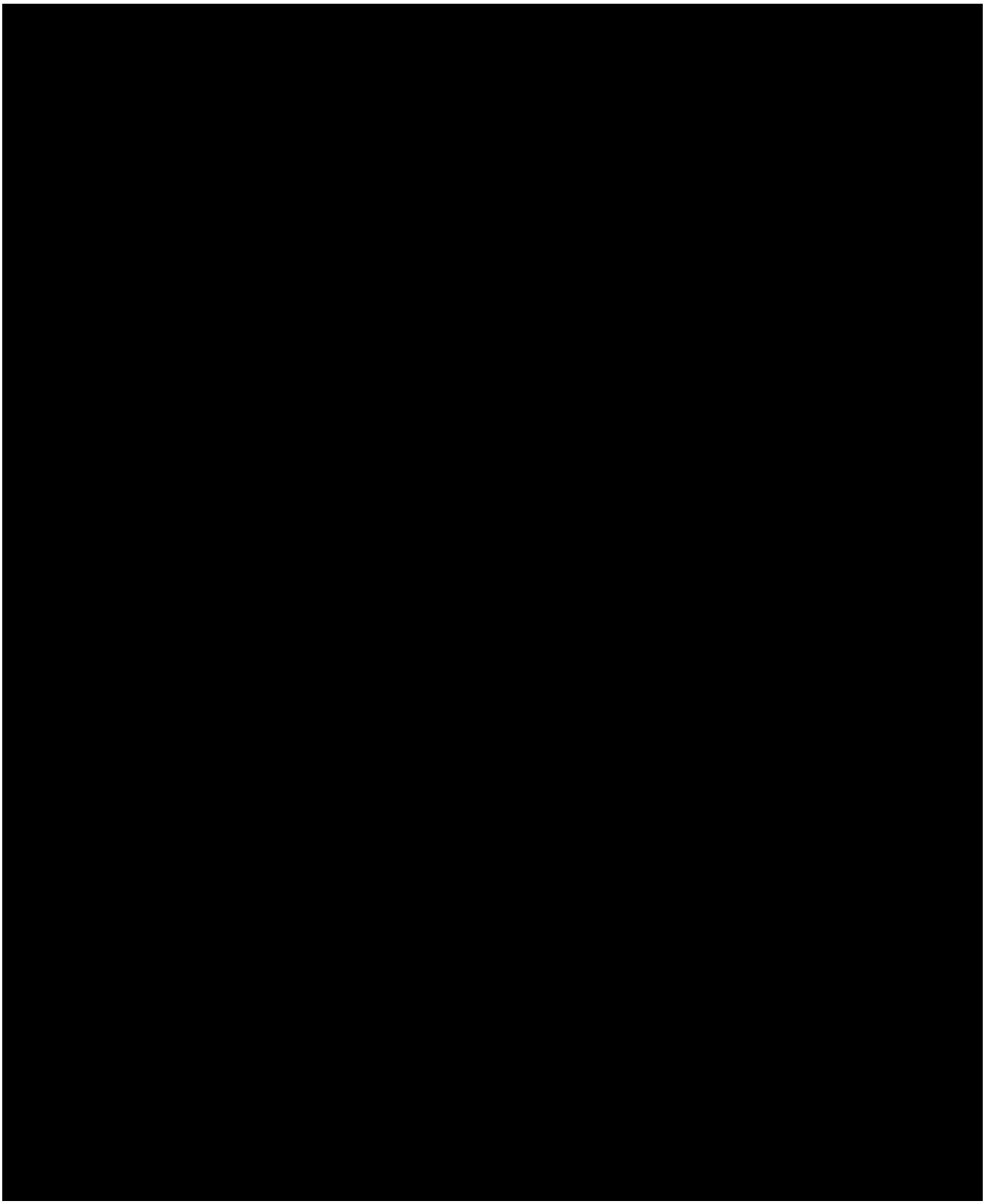
Appendix 7: Patient information sheet (accessible version)

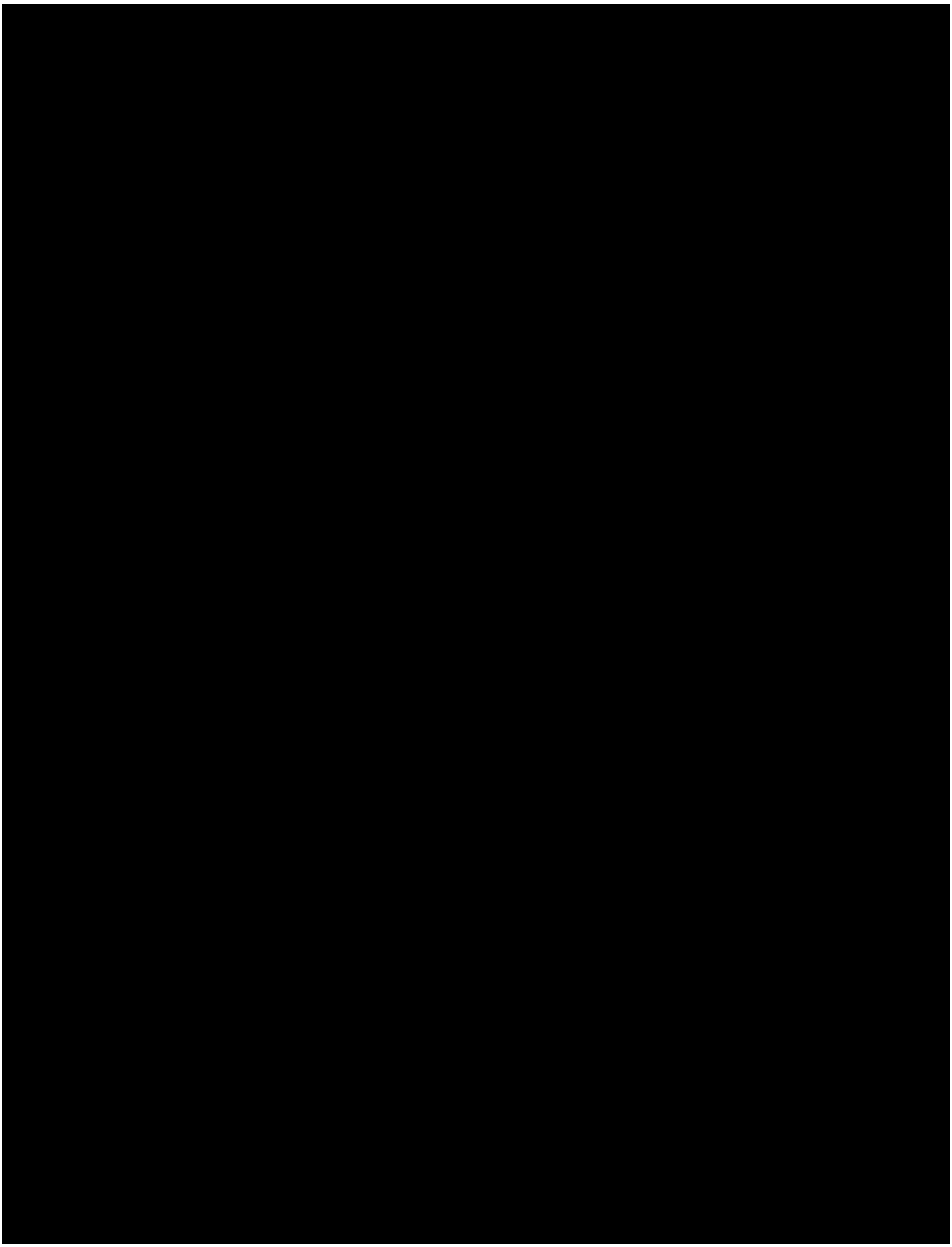












Appendix 8: Communication and Swallowing Entries in the Patient Record

Patient	Severity Comm. (C) Swallow (S)	Communication entry by SLT			Swallowing entry by SLT		
		Assessment information	Advice for HCP	Written in Plan or Recs	Assessment information	Advice for HCP	Written in Plan or Recs
P1	C Mild S None	1	None		N/A		
P2	C Mod/Sev S Severe	4	None		9	8	Yes (8)
P3	C Mod/Sev S Mod/Sev	3	1	No	5	5	Yes (5)
P4	C Severe S Severe	6	None		6	6	Yes (6)
P5	C Mild/Mod S Severe	4	None		6	6	Yes (4)
P6	C Mild S Mild	2	None		N/A		
P7	C Mod S Mod	2	2	Yes (2)	2	2	Yes (2)
P8	C Mild S None	2	2	Yes (2)	N/A		
P9	C Mild S Mild	1	None		1	1	Yes (1)
P10	C Mild S Mod	2	None		3	3	Yes (3)
P11	C Mod S Mod	1	1	No	2	2	Yes (2)
P12	C Mod/Sev S None	2	1	Yes (1)	N/A		
P13	C Mod S None	2	1	Yes (1)	N/A		
P14	C None S Mod/Sev	N/A			1	1	Yes (1)
P15	C Mod S Mild	9	3	Yes (1)	1	1	Yes (1)
P16	C Mild S None	7	None		N/A		
P17	C Mod S Mod/Sev	6	2	Yes (1)	17	17	Yes (13)
P18	C Mod S Sev	3	None		13	10	Yes (10)
P19	C Mild S Severe	4	None		5	5	Yes (5)
		61	13	8	71	67	61

Note: 'Advice for HCP' relates to entries written using language that indicates that the information is intended to advise HCPs reading the notes on supporting communication. It includes directions towards written guidelines placed above patients' beds.

Severities: Mod = Moderate, Sev = Severe.