An Ethnographic Study of District Nursing Work

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ABSTRACT

This thesis presents a qualitative study of district nursing work. District nursing is underresearched, and the existing literature comprises mainly quantitative studies, many of which are small scale, or historical and anecdotal accounts of district nursing. The contribution of this study is that it has provided detailed insights into the ways that district nurses manage their work. Prior to this there were reductionist accounts of the tasks performed by district nurses, but the contextual information about the process of caseload management was missing.

Participant observation and semi-structured, conversational style interview were the methods of data collection. 130 home visits were observed and 50 interviews were conducted with 37 district nursing sisters (grades G, H and one F). G, H and F grade district nurses were chosen for this study because they are the caseload managers and it was the decisions that these nurses made that were of interest. For the purpose of verification, seven younger disabled patients (aged < 65) were interviewed and six student district nurses who were undergraduates from a University Department of Nursing. The students were able to stand outside some of the issues raised in the data and to provide insights into the process of socialisation in district nursing. Analysis of the data by thematic content analysis was carried out concurrently with data collection. Theoretical sampling was conducted throughout, and continued until no new themes were being identified during analysis.

The data were collected at a time of immense upheaval in the health service, particularly in primary care with the introduction of GP fundholding and the community care component of the NHS and Community Care Act (DH, 1990). It was possible to assess the likely impact of the changing culture of the health service on district nursing which has, over the years, been comparatively untouched by health services policy.

The data showed that district nursing work was relatively ill-defined. There were many reasons for this, not least of which was the introduction of the social services carer who had re-classified certain aspects of nursing work as social care. The isolated context of nursing in the community had perpetuated differences in working practices. District nurses' respect for the autonomy of their colleagues had encouraged collegial intraprofessional relationships to develop and a non-challenging professional culture. The upshot was that caseload management had become highly idiosyncratic, with the important consequence that there was inequity in service provision. Amongst the recommendations of this study, it is suggested that there is a need for more precise eligibility criteria for the service, a clearer definition of district nursing work for the purchasers of services, greater overseeing of caseloads and a formal platform for peer review.

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Declaration

This thesis is the result of my own work. The material contained in the thesis has not been presented, nor is currently being presented, either wholly or in part for any other degree or other qualification.

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INTRODUCTION

Background to the study

The impetus for this study came from several years of working as a district nurse, from which it became apparent that there was much variation in practice between district nursing sisters in their management of what, to all appearances, were similar caseloads. Although district nursing is arguably at centre stage in the new primary care led NHS, the opportunities this role presents will be seriously diminished if district nurses cannot explain what they do and why. There is increasingly less room for widely diverse and idiosyncratic working practices in the recently reformed National Health Service (NHS) with its emphasis on cost-effective health care (Sheldon et al, 1993) and evidence based practice as a means to this end (DH, 1993b; 1993c). It was the purpose of this study to discover more about the working patterns of district nurses to begin to address these questions, paying particular attention to the changing policy context of their work.

This introduction reviews the state of the art of district nursing knowledge, although studies of district nursing are few in number and fewer still have been conducted rigorously. Relevant research that illuminates the data presented in this thesis is included in the findings chapters. This includes all of the methodologically robust district nursing literature and research from allied disciplines in the health and social sciences. To avoid repetition, the work of eminent researchers such as Hockey (1966, 1972) Kratz (1978) and Evers at al

(1988) is mentioned briefly here and elaborated on later in the thesis.

What do we know about district nursing?

Historically

The history of district nursing has been chronicled by a number of authors (Stocks, 1960; Hardy, 1981; White, 1985; Baly, 1986). The relevance of district nursing's history to the occupation today is that, in spite of various distinguished connections with for example the Rathbone family and the Queen's Nursing Institute, district nursing has been consistently politically disempowered (McIntosh, 1985; Dingwall et al, 1991).

Historically district nursing has been chronically underfunded, relying heavily on voluntary organisations before the inception of the NHS in 1948 and competing for local authority funds after 1948 (McIntosh, 1985). The previously limited education and training of district nurses highlights the occupation's marginal status particularly in comparison with health visiting (White, 1985). It was only in 1981 after much parliamentary lobbying that the new curriculum for a year's training for district nursing was introduced (Baly et al, 1987) bringing it in line with health visitor training.

Research base

Since the mid 60s and the 70s (Hockey, 1966; Carstairs, 1966; McIntosh and Richardson, 1976; Kratz, 1978) district nursing has been substantially under researched. There are a few notable exceptions to this, for example Battle et al's (1985) study of the curriculum implications of the changing role of the district nurse; Evers et al's (1988) community care project which looked at district nursing as well as other services for the elderly and disabled, and MacKenzie's (1992) ethnographic study of student district nurses. On the whole however the research base for district nursing, particularly in comparison with that for health visiting (Baker et al, 1987), is scant.

A comprehensive review of the district nursing literature revealed that studies of district nursing since the 70s have been mainly quantitative and usually very small scale, or subject to various methodological flaws. Apart from research that is transferable from other disciplines such as in the treatment of leg ulceration (eg. Cullum and Roe, 1995) our knowledge of district nursing, clinical or otherwise, is limited. Until very recently (eg. Kenrick and Luker, 1995) standard district nursing textbooks, although informative, have relied heavily on anecdotal evidence (eg. Lamb, 1977; Illing and Donovan, 1981; Antrobus, 1985; Baly et al, 1987).

There are some data available on what district nurses do but this has tended to concentrate on the tasks they perform (Coombs, 1984). Evidence has taken a reductionist "activity analysis" stance (McIntosh and Richardson, 1976; Dunnell and Dobbs, 1982; NHSME, 1992), yet it is suggested that the reality for most district nurses is that their role is highly complex (Kratz, 1982; MacKenzie, 1989). Data reported in Social Trends (DH, 1995a) and Health and Personal Services Statistics (DH, 1995b) is even more limited, covering no more than numbers of initial contact visits made by district nurses.

The context of district nursing

Perhaps most is known about the external influences on the role of the district nurse of which the introduction of the latest NHS reforms (DH, 1990) has probably had the greatest impact. The NHS reforms are discussed in the next chapter which addresses relevant policy issues to district nursing. It is worth mentioning here however that prior to the reforms, the nature of district nursing was being progressively altered by other factors. For example the commitment of successive governments to community care (DHSS, 1976, 1977, 1981a; DH, 1988, 1989b) has seen a dramatic decrease in the length of hospital stays. This has been coupled with increases in the amount of day case surgery, overall hospital throughput and hospital and ward closures, and a reduction in the numbers of long stay elderly care beds (DH, 1995a; DH, 1995b; Wistow, 1995). The cumulative effect is that the numbers of people requiring care in the community has increased. Theoretically this could increase the caseload of the district nurse, although in practice there does not seem to be much evidence of this (MacDonald et al, 1991; Harley, 1995). At the very least however, it might be anticipated that the content of district nursing caseloads would change even if the numbers of patients visited remained static.

The work of the district nurse has been influenced by demographic changes such as increases in the numbers of the frail elderly (DH, 1995a), who are the people that district nurses have most contact with (Moran-Ellis et al, 1985). Epidemiological changes in patterns of disease have led to a need for people with diseases such as HIV to be nursed at home (Turton and Orr, 1993; Carlisle, 1995). Because home care is now so much more acute, the procedures being carried out at home are increasingly complex such as the management of Hickman Lines, syringe drivers and parenteral nutrition (NHSME, 1992; Wilkinson, 1995; Woods, 1995). Technically complex patient care has led to a rise in the employment of specialist nurses who, it has been argued, have sometimes impinged on the role of the district nurse (Griffiths and Luker, 1994a).

The study

This study takes an in depth qualitative look at the contextual issues that have impacted on the role of the district nurse and thus provides a broader account of district nursing work than recent, rather more quantitative studies have been able to. The study therefore begins to fill a gap in the current literature which favours either historical and anecdotal accounts of district nursing work, or reductionist research.

Organisation of the thesis

The thesis is divided into nine chapters. The first two chapters address aspects of health services policy that are most relevant to the work of the district nurse. The first chapter provides a background to the policy changes that have had the greatest bearing on the district nursing service, and the second chapter considers the impact of the reforms on the professional aspirations of district nursing. The third and fourth chapters describe the theoretical underpinnings of the methods used in this study, and a description of both the working methods and data analysis. The next four chapters present the findings of the study, incorporating a review of relevant literature. The final chapter presents a discussion of the findings, with particular reference to the policy context of district nursing work.

CHAPTER 1: POLICY BACKGROUND

Introduction

The 1990s have so far been a time of unprecedented change in the health and social services. This study was conducted at a time of immense upheaval in the services beginning, as it did, immediately after the NHS reforms embodied in the NHS and Community Care Act (DH, 1990) had been officially introduced in April 1991. Data collection for the study not only straddled the delayed introduction of the community care component of the reforms in April 1993, but was conducted in the wake of the Audit Commission's controversial review of district nursing skill mix (NHSME, 1992) which had met with a mixed reception from the profession.

The NHS reforms

The NHS reforms which were committed to paper in *Working for patients* (DH, 1989a) and *Caring for people* (DH, 1989b) and embodied in the NHS and Community Care Act (DH, 1990) were an attempt by the government to lift the health service out of the financial crisis of the 80s. In order to achieve this, other than by purely injecting more money into the service, the government created an internal market in the NHS, the key component of which was the purchaser provider split. The idea was that separating the roles of purchasing and providing services would create competition between providers, which would result in a service that was more cost-efficient and responsive to the needs of the consumer.

The main purchasers were district health authorities, the providers were for example community units and trusts, although there were a few anomalies such as fundholding general practitioners (GPs) who continued to combine the two roles.

It is not the intention of this chapter to revisit the minute details of the NHS reforms which have been well documented by a number of authors (Drummond and Maynard, 1993; LeGrand and Bartlett, 1993; Robinson and LeGrand, 1993; Ovretveit, 1995). It is the purpose instead to review those aspects of the reforms that are most relevant to the district nursing service as a contextual backdrop for subsequent chapters. These are GP fundholding; trust status for community units; and the community care component of the reforms.

GP fundholding

Fundholding GPs are an anomaly in the sense that they both purchase and provide services. Amongst the complex and seemingly inexhaustible NHS reforms, the rapidly expanding numbers of GP fundholders (GPFH) have possibly been the most significant recent development for district nursing. The new arrangement permits larger general practices and consortiums of smaller practices to hold their own budgets and buy in a growing number of services for their patients which, since April 1993, has included the district nursing service.

The rhetoric of the reformed NHS places patients at the centre of health care planning. Patient centred reasons for the introduction of fundholding were to increase the quality of the service, to stimulate hospitals to be more responsive to the needs of GPs and for GPs to develop their own practices for the benefit of their patients (Leese and Drummond, 1993). But as Light (1995) has observed most of the advantages of fundholding are double edged. For example fundholding puts purchasing in the hands of the people who are in direct contact with the public, but GPFHs can keep their in-year savings to spend on the practice as they choose. This may benefit patients as one recently reported GP funded "hospital at home" scheme has highlighted (Elliott, 1995), or it may not. The savings could instead have been spent quite legitimately on structural improvements to the practice premises.

Although they know their territory better than health service managers who are distanced from the patients, GPFHs are not trained in the management skills required for population based planning, contracting and management (Light, 1995). GPFHs have thus had to devote a lot of time to bureaucratic procedures such as managing budgets and administration at the expense of time spent with the patients. Another criticism is that in making contracts for services and providing an increasing number of services themselves, GPFHs have succeeded in forcing hospital consultants to be more responsive to patients' needs but can create mayhem in hospital services either by duplication of effort or dismissing secondary services altogether.

Other disadvantages are that GPFH has channelled resources into areas of least need as initially only the big innovative practices joined the scheme and first wave fundholders received a more favourable budgetary allocation than subsequent waves. This has widened the gap with small inner city practices (Leese and Drummond, 1993) and has contributed to the potential for a two tier system for patients. There is also the temptation to discriminate against expensive patients who require costly drugs and treatments (Glennerster et al, 1993) otherwise known as "cream-skimming" (Le Grand and Bartlett, 1993). Expensive patients are often the elderly and the chronic sick who are the people that comprise a substantial proportion of the district nurses' caseload.

The particular problems of GPFH for district nurses as Ross (1990) points out are firstly, that low priority vulnerable groups such as the chronic sick might suffer neglect or even be completely ignored in the competition between acute and chronic services; and secondly that the increase in bureaucracy and burgeoning list sizes could reduce the time available for the continuing care needs of patients, case conferences and joint initiatives with district nurses and social workers.

Another crucial issue relates to the district nurses' relationship with the GPs which could become increasingly subordinate. District nurses could either be priced and contracted to GPs as in the current arrangement of block contracts with provider units, or there could be more direct purchasing of nurses by GPs (Ross 1990). Primary health care team work has been at the centre of numerous reports about effective primary health care for a number of years (eg. DHSS, 1981b; DHSS, 1986; Welsh Office, 1987; QNI, 1991; DH, 1993a), a key component of which is recognition of the undifferentiated status and equal contribution of team members. GP attachment was introduced in the 60s to facilitate teamworking (CHSC, 1963; Hockey, 1966) and although the district nurses subordinated themselves to some extent to the GPs to whom they were attached (McIntosh, 1985), at least they were answerable to their own community nurse managers. The future for primary health care teamwork now that GPs are effectively employing DNs is unclear. It could be that after years of struggling for equal status they will be subordinated again, via the employer employee relationship.

GP contract

Direct purchasing of nurses by GPs need not necessarily include district nurses, who have been consistently under threat from being usurped by practice nurses since the 1980s (DHSS, 1986) when they were so heavily subsidised by the government that they were extremely cheap for GPs to employ. The recent GP Contract (Health Departments of Great Britain, 1989) which like *Working for patients* (DH, 1989a) came into effect in 1990, has created greater incentives to employ practice nurses as there are considerable cash inducements for GPs to reach certain targets such as immunisation, vaccination and cervical screening (Pursey and Luker, 1994). In addition GPs now have a statutory requirement to provide over 75 screening which the need for training notwithstanding, practice nurses are often best placed to provide (Lightfoot et al, 1992).

Community trusts

Working for patients (DH, 1989a) offered hospitals and community units the opportunity to opt out of health authority control by becoming self governing trusts with direct accountability to the Department of Health. Of immediate concern for district nurses was that if the acute and community units were to combine to become trusts the community unit would be marginalised in the process (Ross, 1990). Other implications of trust status for staff are that trusts have certain freedoms such as deciding about the remuneration of staff and skill mix (Bartlett and Le Grand, 1993) although as recent disputes about local pay and skill mix have highlighted, directly managed units have had a certain amount of freedom in this direction anyway. Perhaps of greatest concern to district nursing staff that are managed by NHS trusts, is the alienation from management - and distance from the "caring" ethos of the service - that they experience when their managers adopt the internal market place "speak" of the reformed NHS (Traynor, 1994). The effect of the planned merger of FHSAs and DHAs in April 1996 on the district nursing services is as yet unknown, but it could lead to an even greater sense of political disempowerment.

Caring for people

As mentioned, successive governments have been committed to the move towards community care for decades. The motivation for this was mainly to remove patients from the warehousing approach to care which was the hallmark of the large impersonal Victorian institutions. The impetus for the community care component of the 1990 NHS reforms detailed in *Caring for People* (DH, 1989b), was quite different however. It has been argued that the driving force behind the white paper was the need to cash limit social security spending on residential and nursing home care (Wistow, 1995).

The community care part of the reforms was concerned mainly with local authority social services departments (LASSDs) and is now considered to be largely separate from the rest of the NHS reforms (Wistow, 1995). Like fundholding GPs, the LASSDs were to retain their dual status of purchasers and providers of services, but were to be discouraged from providing all care services themselves. The role of the health authority component of community care was in theory to remain the same although there was to be a clear division between health and social personal care, with the latter falling to the social services departments with their newly appointed home carers. Although many of these new workers were formerly employed as home helps, their lack of training was not considered to be a problem because they were to carry out strictly non-nursing personal care. The way that the health and social care divide would be managed was discussed in the Griffiths report (DH, 1988) and re-appeared virtually unchanged in *Caring for People* (1989b); the divide is widely recognised to be somewhat artificial and arbitrary.

In common with the health service reforms, a budget was devolved to LASSDs to be spent in this case by care managers on "seamless packages of care" for clients. Services were to be provided by a "mixed economy" of voluntary and private sector services with the new LASSDs as "enabling agencies" rather than straight forward purchasers (DH, 1988). In summary, the key objectives of the community care reforms were:

> *To promote the development of domiciliary, day and respite services to enable people to live in their own homes where ever feasible and sensible*

> *To ensure that service providers make practical support of carers a high priority*
>
> *To make proper assessment of need and good case management the cornerstone of high quality care*
>
> *To promote the development of a flourishing independent sector alongside good quality public services: social services authorities should be "enabling" agencies in this respect*
>
> *To clarify the responsibilities of agencies to make it easier to hold them to account for their performance*
>
> *To introduce a new funding structure for social care that will be a disincentive to placing people in nursing and residential home care*

In order to achieve these objectives, local authorities were to assume responsibility for needs assessment in collaboration with other community workers such as GPs and district nurses, and to develop community care plans. The service was in essence to become needs as opposed to resources led with local authorities as the lead assessors.

The philosophy of maintaining people in their own homes has been welcomed over the years (DHSS, 1986). The main criticism of community care is that so far it has been seriously underfunded. The devolved social services budget is by no means a bottomless pit, so there has inevitably been some shortfall between the needs of individuals and the local authority's ability to meet those needs (Wistow, 1995). The new philosophy has had a considerable impact on the district nursing service in re-naming certain aspects of the district nurse's work as "social care" and devolving them to social services staff. This is discussed in more depth in the next chapter on the ideology of the nursing profession and arises again in the findings.

This chapter has detailed some of the main policy developments that have affected the district nurse as a preamble to the next chapter which evaluates how policy issues conflict with the professional aspirations of the district nurse.

CHAPTER 2: PROFESSIONAL IDEOLOGY

Introduction

The contention of this chapter is that two parallel developments in the reformed NHS have had the most impact on district nursing to date. It is argued that these are the community care component of the reforms - the introduction of the social services carer in particular - and the requirement of the Audit Commission to evaluate services to improve cost-effectiveness within the NHS (NHSME, 1992). Using the framework of the "new nursing" (Salvage, 1990), it is possible to demonstrate how the NHS reforms impinge on district nursing's ability to meet the ideals of the nursing profession. With its long standing tradition of an arguably more holistic approach to patient care, district nursing is ideally placed to highlight the disparity between the aims of the government and the ideology of the profession.

"New" nursing and "old style" district nursing

"The new nursing" is a term used by Salvage (1990) to describe the post 70s ideology of nursing practice developed mainly in university and polytechnic departments of nursing, where the therapeutic nurse-patient relationship assumes central importance when providing nursing care. It describes an approach to nursing that is in direct contrast to the traditional task based approach to care on hospital wards, which has been delivered in a fragmented way by an hierarchy of staff.

Drawing upon Salvage (1990) and Beardshaw and Robinson (1990), the "new nursing" is characterised perhaps somewhat idealistically by: the centrality of the patient in a therapeutic one on one nurse patient relationship, with that relationship objectified as beneficial to the patient *per se*; the rise of patient advocacy and both patient and nurse autonomy; a sound scientific knowledge base; individualised needs based care; the promotion of patient independence to replace the dependent patient as a passive recipient of nursing care; and an holistic approach to patient care inherent in the new style primary nursing, where a patient's needs are attended to by one person, which means that qualified staff will give less technically skilled care such as bathing, washing and dressing patients.

The extent to which the new nursing has been, or more controversially, should have been adopted by the nursing profession remains uncertain in the absence of research evidence. Because the integration of the new nursing into clinical practice has been rather inconsistent, research evidence about its efficacy remains patchy. It is interesting however that with the exception of the prerequisite of "a sound scientific knowledge base", it could be argued that many of the new nursing ideals describe old style pre-reformed district nursing. For example patient independence is crucial when most of the time the district nurse is not there, and traditionally district nurses have been considered to work relatively autonomously. All grades of staff have often carried out all care as espoused by proponents of the new nursing; and it is a characteristic of district nursing that long term "therapeutic" nurse-patient relationships have flourished. The means of achieving the new nursing on hospital wards is also reminiscent of the organisation of district nursing work: the hallmark of primary nursing is a flattened hierarchical structure, devolved managerial responsibility to frontline workers and the nurturing of more collegial intraprofessional relationships (McMahon, 1990; Manthey, 1992). This is the way that district nursing has traditionally operated (Jupp, 1971) and still does to some extent, although increasingly less since the arrival of skillmix and alternative management structures.

NHS reforms

It is demonstrable that the NHS reforms although they are in agreement with the new nursing ideology in some respects, are at odds with it in others. The main point of agreement is the rise of the voice of the consumer which the nursing profession wholly endorses. An important area of disagreement for district nursing however is the arrival of skillmix and the new social services carer, which have militated against the holism espoused by the new nursing and the profession.

The Audit Commission skill mix review

To increase the cost effectiveness of the health service the Audit Commission was contracted to carry out a systematic review of the service (Audit Commission, 1992). One of the earliest services to be reviewed was the district nursing service where after an analysis of who was doing what in district nursing teams, they recommended that the numbers of qualified district nurses could be cost effectively halved.

District nurses are an expensive commodity costing £260 million per year (NHSME, 1992); yet it is known that district nursing establishments have been historically based (Lightfoot et al, 1992; Oszlewski, 1992) with no rational planning of grade mix (NHSME, 1992). The Audit Commission report argued that the work being carried out by D and E grade nurses was virtually the same as that of district qualified G and H grade nurses, who were considerably higher paid. They also argued that there was some overlap between the roles of trained but unqualified A and B grade staff and other grades of staff. This was considered to be a gross wastage of nursing skills and an inappropriate use of an expensive resource.

It is evident that the Audit Commission viewed district nursing solely in terms of tasks. Parallels can be drawn with the Taylorist principle of matching the person to the task as closely as possible in order to increase cost-efficiency in industry (Taylor, 1911 cited by Huczynski and Buchanan, 1991). The nursing profession would argue however that dividing nursing into tasks in this way is misleading because there are certain cognitive differences between the same task provided by nurses with different levels of training (For a fuller discussion see eg. Dylak, 1991 on dependency measurements; and Essr and Tutton, 1991; Manthey, 1992 on primary nursing).

The significance of the skill mix review for district nurses depends on the extent to which the community units take the Audit Commission's recommendations on board. The new self governing community trusts are in a strong position to dictate the wages and skill mix of staff and irrespective of whether the community unit has trust status or not. If the block contract the community unit is offering a GP fundholder is not as competitive as that of another community unit down the road, the GP may take his or her custom elsewhere.

Education and training

Perhaps the service should not have been too surprised by the outcome of the Audit Commission report because district nurses have been slow to embrace change in some respects. This is illustrated by the history of the education and training of district nurses which has been a troubled one, with district nurses frequently arguing that they have been overlooked (McIntosh, 1985).

District nurses have fought long and hard for the current one year course in district nursing which brought it into line with the year's preparation for health visiting. They have argued repeatedly that it is a field of nursing practice that requires extra training. Yet when district nurse managers employed qualified district nurses it would appear that they gave them the same tasks to do as less qualified, lower paid staff. Without underestimating the qualitative differences that might exist between the roles this has been known - and highlighted - as a problem by leaders in the field for years. For example Hockey (1972) talked about it in relation to the role of the District Enrolled Nurse (DEN) in a study entitled "Use or Abuse", and later the work of McIntosh (1979) and Wastling (1986) reached very similar conclusions. The profession has frequently complained that the DEN has been abused by management because in many respects her role was indistinguishable from that of the considerably higher paid and more thoroughly prepared DN sister.

The argument for extra training for district nurses is arguably even more difficult to sustain these days now that community care is so much more acute. As mentioned in the previous chapter the move towards care in the community has resulted in increased throughput, closure of long stay beds and an increase in day surgery (DH, 1995a, 1995b). The patients being nursed in the community are much sicker and it could be argued that nurses in hospital are the ones who are best equipped to carry out certain more technical procedures in the home. Recent increases in the numbers of outreach nurses from hospital based consultants are testimony to this.

The results of the Audit Commission review have met with hostility from district nurses not least because the recommendations are wholly at odds with the beliefs of the profession embodied in the new nursing paradigm. New nursing argues that skilled nurses should carry out all care and that bathing and washing and dressing someone are components of the holistic care of that patient. The audit commission report with its reductionist, ostensively Taylorist stance argues for quite the opposite and a clear separation of management and hands on care. This leads to fragmentation of care where personnel take on those aspects of a patient's care that are within the upper limits of their range of skills. The patient is divided up again as in the old system of task allocation on hospital wards. If G and H grade nurses are to be assessors and re-assessors only as recommended by the report (NHSME, 1992), then the therapeutic nurse-patient relationship will inevitably be somewhat jeopardised.

District nursing is being fragmented further still by other recent developments. The most important and with the greatest impact for district nurses, is probably the arrival of the social services carer as a result of the community care component of the NHS and Community care act (DH, 1990).

Redefining district nursing: Caring for people

The basis of the community care component of the reforms embodied in *Caring for People* (DH, 1989b) and its predecessor the Griffiths report (DH, 1988) is the division between health and social care, with social services departments becoming the lead agencies for care in the community. Although the marginalisation of district nursing in the white paper is of crucial importance to district nurses, of more immediate concern is the arrival of the social services carer.

In another bid for the cost-effective use of resources, those aspects of a person's care that are deemed to be "social" are taken on by social services carers. This includes bathing, washing and dressing patients and other personal care. These are precisely the elements of nursing work that new nursing believes qualified nurses should be carrying out as part of the total care of a patient. They are also what district nurses have always been doing as the Audit Commission report showed (NHSME, 1992), so district nursing work is effectively being renamed and deskilled and divided into tasks. The arrival of the social services carer could quite justifiably be seen as role erosion by district nurses.

Specialist nurses

Other recent developments have compounded the problem of redefining the role of the district nurse. There has been an increase in the employment of specialist nurses - sometimes as an outreach service *from* hospital based consultants - who it could be argued have creamed off certain skilled aspects of the district nurses' traditional, more generic role such as terminal care, stoma and diabetes management (Griffiths and Luker, 1994a).

Although it has been argued quite rightly that nowadays there is plenty of work in the community for everyone (Ross, 1989) it is also clear that if specialist nurses are available health authorities have less incentive to send their district nurses on updating courses. The role of the district nurse could therefore become much less generic. Certain categories of care require the input of a specialist nurse, such as renal nursing or the home management of a child with cystic fibrosis, because they are encountered infrequently in the day to day work of the district nurse. Other more common everyday occurences arguably fall within the ambit of generalist district nurses with the specialist nurse as an invaluable resource for updating their knowledge.

The need for a sound knowledge base within nursing, medicine and allied health professions has been highlighted in several recent reports (eg. DH 1993a, 1993b, 1993c). Although the requirements of the Post Registration Education and Practice Project (UKCC, 1991) go some way towards meeting this, it is clear that district nurses will continue to rely on the conscientiousness of their managers to send them on courses and increasingly perhaps, on the clinical nurse specialist in a more consultative role.

Practice nurses and the GP Contract

Another development is the increased employment of practice nurses whose role, it could be argued, overlaps with and detracts from the role of the district nurse. For example practice nurses have taken on the bulk of the clinic work that the district nurses used to do. This was a problem that was highlighted in the Cumberlege report (DHSS, 1986) when it was noted that practice nurses were so heavily subsidised that GPs could employ them for an outlay of as little as £8 a week. The numbers of practice nurses have increased dramatically since 1986, with the introduction of the GP contract in 1990 which gave GPs targets and monetary incentives to carry out immunisation, vaccination and cervical cytology for example. The GPs employed increasing numbers of practice nurses to help them reach their targets.

The GP contract also gave GPs the remit to carry out over 75 screening which has meant that practice nurses are now carrying out home visits which were the exclusive domain of the district nurse and health visitor. The over 75 assessment which is carried out by practice nurses or other qualified community nursing personnel is another example of fragmentation of patient care: the district nurse and practice nurse or whoever is doing the assessment often visit the same patients, because many of the patients visited by district nurses are over 75 years of age.

GP fundholding

Although again there is probably enough work for all community nurses, since the arrival of GP fundholding GPs might choose to employ increasing numbers of practice nurses to visit patients in the home, particularly if they have some area of expertise such as leg ulcer management or terminal care. There are disadvantages to this however. A major disincentive for GPs is that they would then have to sort out the pensions, national insurance and terms of employment of their nursing workforce which they do not have to do when they hold block contracts with community units. But there are other distinct advantages. Although the merging of FHSAs and DHAs in April 1996 might alter this, GPs have much more control over the work of a nurse they directly employ. Historically, the different management structures of nursing and general practice have caused problems because nursing management and health authority policy can, and have, decided what nursing staff will and will not do. This has often been different from what the GPs expected of them.

Defining a role

The issues raised by hiving off aspects of district nursing work to other personnel is important for another reason than the fragmentation of patient care. It is well established that all nurses have consistently had difficulty describing what their role entails (Beardshaw and Robinson, 1990; Cowley, 1995) and district nurses are no exception to this. They could quite reasonably ask what the devolvement of aspects of their job to other disciplines has left for them to do. From an academic "new nursing" perspective it is probably unimportant that district nurses cannot define their role so long as they are responding to the needs of the patient and fostering a therapeutic relationship; although it does raise questions about the professional status of the occupation. From a political perspective however, it is crucial that district nurses are able to answer this question in order to sell their service to potential purchasers: currently DHAs and GPFHs.

Although the NHS reforms have arguably led to fragmentation and an identity crisis within district nursing, and a move away from the new nursing ideals of the profession, they do have certain characteristics in common. The issue of patient centred care is pivotal to both.

Patient centred care

Irrespective of whether rhetoric matches reality, *current* legislation emphasises the central place of the consumer. The patient is no longer to be a passive recipient of care dependent on health service staff but is to become more independent and have greater control over his or her health care. This is also a characteristic of the new nursing.

None of this is particularly surprising because patient "partnership" or perhaps more realistically patient independence, is clearly double edged. While the rise of the voice of the consumer which is evident in several recent reports (DH, 1989b; 1993a) is to be applauded, the move to community care inevitably requires the patient to become more independent. Patients are on their own and self caring for most of the time when they are nursed at home, and it is also a lot cheaper if they can be mostly self caring or if they can rely on caring relatives. The largely invisible and economically indispensable workforce of carers filling the gaps in community care has been well documented over the years, if largely unacknowledged by politicians (Brody, 1981; Equal Opportunities Commission, 1982; Parker, 1985; Hicks, 1988; Twigg, 1992).

The health needs assessment

The health needs assessment that is required of purchasers of health services serves both masters: the internal cost-effective market of the NHS and the needs of the patient (or the NHS reforms and the new nursing philosophy). It places patients at the centre of health care planning. Purchasers need to know what it is that patients require from their local health service in order to commission services from provider units because to commission something that is inappropriate is a waste of resources. Whether the services that are required by the public can be met within existing resources is another matter, but needs assessment acknowledges the voice of the consumer and, it would appear, district nursing and other community nurses potentially have an important role to play in finding out what the needs of the local community are (DHSS, 1986; Lightfoot et al, 1992).

Summary

To summarise, the ideals of the nursing profession of holistic care, patient independence and the centrality of the nurse-patient relationship are arguably what district nursing has always been about. The NHS reforms have begun to change this however, with the arrival of other community personnel who have taken on aspects of district nursing work. The rationale for this is the cost-effective use of resources, but accompanying it is the potential to fragment patient care. The emphasis of the trained district nurse is now far more on the clinical management of caseloads and overseeing the work of the district nursing team, as recommended by the Audit Commission's skill mix review.

CHAPTER 3: METHODS

Theoretical underpinnings

Introduction

The purpose of this section is to explain the research philosophy that underpinned the qualitative methods used in this study. The approach taken was broadly ethnographic or to be more specific, "practitioner ethnography". Categorising qualitative research in this manner is not entirely relevant however, as it is a field which is rapidly expanding and becoming ever more complex (Hammersley and Atkinson, 1995). Definitions are diverse therefore, and neither stable nor unitary. What is important is to articulate clearly the beliefs and assumptions that underlie the approach to qualitative enquiry taken by the researcher, so that the reader of the completed text can relate the findings to the methods of data collection and data analysis, and reach an informed conclusion about the study's relevance and possible wider application.

The following discussion reviews the various approaches to social enquiry, to demonstrate where this study fits into the broader picture. The reason for providing the ensuing, somewhat descriptive account is that it would be only a minor exaggeration to suggest that there are as many interpretations of qualitative methods as there are pieces of qualitative research. It was considered expedient therefore to offer the author's understanding of the various paradigms within qualitative enquiry, to demonstrate why certain methods of data collection and analysis were chosen. In this sense the discussion which follows also serves as an aid to interpretation for the reader and to a lesser extent, as a validity check for the findings of the study.

Perhaps the most significant recent development in the field of ethnography is a recognition of the relationship between the researcher and the research findings. Quests for objectivity or "naive realism" (Hammersley, 1992; Atkinson and Hammersely, 1994) have been largely abandoned therefore in favour of a more relativist stance. The frequent use of the first person singular in the following discussion reflects this new understanding.

Qualitative methods

In parallel with other social relations research, qualitative methods are gaining in popularity in the discipline of nursing. Qualitative research methods emphasise an 'emic' approach to social enquiry, the premise of which is that the point of view of the research participant is sought and the context in which actions occur assume a high priority. An early example of a qualitative approach to enquiry in district nursing is found in the work of Kratz (1978) who used qualitative methods to study care of the long term sick in the community. More recently MacKenzie (1992) used qualitative methods to conduct an ethnography of student district nurses.

Qualitative and quantitative approaches to social enquiry

The advantage of a qualitative approach to the research of a given phenomenon is the depth of exploration it affords and the complexity or 'richness' of the resulting data. Qualitative methods are sometimes chosen when little is known about a problem or issue and theory generation or detailed, "thick" description of the phenomenon is the aim of the study (Geertz, 1973).

It has been noted previously that studies of district nursing are few in number. It is also clear that where data exist there has been an emphasis on a reductionist "task analysis" approach to finding out what district nurses do (eg. Dunnell and Dobbs, 1982; NHSME 1992). It is my belief that while "quantitative" or rather more reductionist approaches are helpful where there is existing theory or description of a phenomenon - or where such data are being collected simultaneously - some social situations are so complex that they are not receptive to being measured in any meaningful way. I would argue that many aspects of district nursing work fall into this category, such as casting a "trained" eye on someone whilst bathing them or concurrently providing health education advice or a "trained" listening ear.

Philosophically I err towards the "realist" stance that there is a real world out there which can be studied. I would contend however that it is difficult to arrive at a "true" understanding of any given phenomenon and I accept Hammersley's (1992) assertion that qualitative methods may be just as subject to different types of error as their quantitative counterparts. But I do believe that there are ways of getting closer to the "truth" and that listening to and reporting with integrity the insiders' voice is likely to achieve greater proximity.

While quantitative research is described as taking a "deductive" approach to research enquiry, qualitative research is often described as inductive in its approach as theory is generated via ongoing analysis of the findings. This distinction is misleading however because in most qualitative studies concepts that are generated from the data are then tested out deductively with either the same or other study participants which, it is argued, contributes to the methodological rigour of the research study (Strauss, 1987; Strauss and Corbin, 1990).

As qualitative studies are conducted with relatively few study participants, the trade *off for rich* description is that the findings are not usually considered to be generalisable to other populations. This is the opposite of quantitative studies where large numbers of subjects are enrolled to enable generalisation of the results. Although some researchers would argue that the philosophies underpinning qualitative and quantitative approaches to research are incompatible and that methods should not be mixed (Leininger, 1994), others contend that the two are not mutually exclusive and a study can profitably employ both, a process sometimes described as methodological triangulation. Methodological wars between qualitative and quantitative factions are arguably becoming increasingly less common with the two sitting more comfortably side by side, compensating for the inherent weaknesses and capitalising on the strengths of each. The emphasis seems to be increasingly on using the right tools for the job, what ever those might be. Multiple methods are used by qualitative researchers therefore which has led to their description as "bricoleur".

Paradigms within qualitative methods

The many philosophies within qualitative research influence the way that a study is conducted and the findings are analysed. These range from ethnography to ethnoscience, symbolic interactionism, grounded theory, interpretivism, critical theory and feminism, to name several. The list is long and frequently baffling due to subtle semantics. Put simply, each theory or philosophy is characterised by the extent to which it embraces a positivist, interpretivist or critical stance. The value of looking at each of these paradigms is that the manifold philosophies of qualitative researchers are neither discrete, nor have they evolved independently of and without the influence of one another. Ethnography for example has moved away from its positivist roots into a more interpretivist paradigm.

Positivism

Positivism in qualitative research alludes firstly to the extent to which it is believed that the social world can be studied objectively and there is a social reality out there with "social facts" (Durkheim, 1964) that can be discovered and described; and secondly, to the process of data collection and analysis, and the extent to which this can be described as systematically rigorous or 'scientific'. Positivism, in this sense, is perhaps more usefully defined as 'post-positivism' because it is arguable that any qualitative technique is to some extent a reaction to the positivist stance of quantitative research. Positivism is about proving that relationships or concepts exist as an objective reality; post-positivism is about the weight of evidence that suggests the probability of an objective reality, but with the concomitant possibility that existing theory could be wrong.

A scientifically rigorous approach to data collection and analysis is found in Grounded Theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990). Glaser and Strauss developed their method to counter accusations of quantitative methodologists that qualitative researchers often failed to demonstrate how they arrived at their findings, thus calling into question the 'validity' of their research. A similarly rigorous approach to data collection and analysis in the general discipline of qualitative research is suggested by Miles and Huberman (1984, 1994), and in cultural anthropology by Bernard (1994). Both Strauss and Corbin (1994) and Huberman and Miles (1994) agree that there is an objective reality out there although each would resist a "positivist" label. Huberman and Miles describe themselves as "transcendental realists" and Strauss and Corbin, who also have realist tendencies, emphasise the part played by interpretation in describing the real world.

Interpretivism

Interpretivism is embraced within a phenomenological approach to data collection and analysis which has its roots in social psychology. Researchers who hold this philosophy do not believe that it is possible to be objective in the collection and analysis of data: the subjective interpretation of the researcher will always come into play. Rather than attempting to eliminate 'bias' as a positivist would endeavour to do, the interepretevist acknowledges it and describes the stance of the researcher in terms of his or her biography and preconceptions before entering the field. In hermeneutics, these preconceptions are sometimes described as the researcher's 'pre-understandings'. In acknowledging and describing these preconceptions, the interpretevist 'brackets' them in the acceptance that they will influence subsequent analysis of data. Concern about accuracy of interpretation leads to an emphasis in analysis of findings on the meanings given to certain words and concepts by the study participants. Although the honesty that interpretevism champions is a welcome addition to qualitative methodology, I would tentatively argue that there is inherent risk that taken to extremes, relativist researchers end up saying very little about the social world they have studied or at best adding nothing new, merely another interpretation.

Critical theory

Critical theory is a political philosophy. A critical theorist attempts to represent a minority group or persons who could be conceived of as oppressed in some way. Marxism and feminism fall within this paradigm. Feminism has influenced the development of methods in nursing research (eg. Williams, 1990). Feminist research essentially holds that 'objective' qualitative research has adopted a classically masculine stance of the 'self', as researcher, describing the world of the 'other', as participant or informant, in an unequal power relationship that reinforces oppression. Objectivity in interviewing technique is viewed as creating unacceptable inequality within the relationship of the interviewer and interviewee. The feminist researcher believes in reciprocity in interviewing style, which affords the interviewee as much opportunity to control the dialogue as the interviewer. Like interpretivism, critical theory can be applied unadulterated in a research study or tenets can be adopted by researchers in other fields. Yet in its unadulterated form, it could be argued that it is difficult to execute. Biography, educational background and ability to publish papers, immediately puts the researcher on a different footing from the person being researched, even if the style of interviewing and method of reporting is non-oppressive. It could also be argued that the final report will be inherently 'biased' to use a positivist interpretation, if the researcher has set out to advance a certain cause.

Ethnography

History

Ethnography has its roots in anthropology and is about the study of culture. It has become popular in nursing research (eg. Melia, 1984; Field, 1983; MacKenzie, 1992; Callery, 1995) ostensively perhaps because nursing has been strongly influenced by sociology, and sociology has been influenced by anthropology where ethnography originated. Some authors prefer to define a separate discipline of ethnography when applied to nursing research as "ethnonursing" (Leininger, 1994). Nursing is an essentially practice based discipline where research is carried out by the nurses themselves so there is inherent logic in developing a unique style of ethnography for nurses, but ethnography has evolved and been re-defined to such an extent that it is hard to see how, precisely, ethnography in nursing differs.

From a purist's point of view, 'ethnography' is the term used by anthropologists to describe the end product of their fieldwork, be it a film or documentary or written text of some description. The first ethnographies were produced by anthropologists describing the cultures of nationalities other than their own (eg. Malinowski, 1916 cited by Denzin and Lincoln, 1994). They were characterised by long immersion in the field - often a year or years - and participant observation. Study participants were, and still are, described as 'informants' because after a period of immersion in the culture, the anthropologist selects them as the most approachable and appropriate participants to facilitate access to the study group and provide detailed 'insider' information. The approach of early anthropologists to the objective description of the culture of the 'other' is now seen as fairly paternalistic or perhaps even racist. The term 'going native', to describe losing objectivity by identifying too strongly with the group being studied, is decidedly post-colonial. Latterly, the influence of critical theory and interpretivism have rendered the term largely redundant (Denzin and Lincoln, 1994).

In the 1920s and 1930s sociologists at Chicago University began to recognise the potential for the application of an ethnographic approach to the study of their own culture. This movement was led by Robert Parks and colleagues and has become known as the Chicago school. Herbert Blumer, social psychologist and an early proponent of symbolic interactionism is associated with Chicago at this time (Blumer, 1969). Characteristically, the groups from their 'own' culture that these ethnographers described were socially disadvantaged, and often of a different nationality to the researcher. Again immersion in the field for long periods of time and participant observation with informal interviewing were the methods of data collection. The researcher engaged in the objective discovery of 'social facts' (Durkheim, 1964) about informants and their culture. An early and well known example of this type of ethnography is William Foote-Whyte's study of Street Corner Society, in which 'Doc' was the major informant who facilitated Whyte's access to the study participants, and provided detailed 'insider' information about the culture of the group (Whyte, 1943).

Ethnography as journalism

One of the major criticisms of ethnography has been its emphasis on rhetoric and story telling at the expense of a detailed account of the methods employed, particularly in the analysis of data. There has been a reluctance to describe techniques in terms other than those personal to the researcher, which include an ability to conceptualise and a natural aptitude for ethnographic enquiry. This is a point on which Goffman (1971) willingly conceded. In his defence, he stated that any approach to social enquiry that steered away from a traditionally scientific, reductionist paradigm was an improvement and besides 'scientific' methods were frequently flawed. Although the ability to present data in a coherent, persuasive and ultimately readable way should not be undervalued (Atkinson 1990), acceptability of ethnographic accounts as accurate representations of the field under study are enhanced by explicit descriptions of method.

Glaser and Strauss (1967) developed Grounded Theory as a solution to this problem and in a later text, Strauss and Corbin (1990) argue that it should be within the realms of any researcher - whether or not they have an aptitude for qualitative enquiry - to carry out a grounded theory approach. It is not surprising therefore that grounded theory is described in considerable detail by the authors who provide a relatively comprehensive step by step approach. It is also not surprising that qualitative researchers, nurses in particular, have adopted grounded theory as a panacea for analysis and conceptualisation in qualitative research. My main reservations about Grounded Theory are firstly that there is a tendency for nurse researchers to think that they are carrying out a grounded theory study when they are not, which relates to my second point, that grounded theory is very difficult to execute. The reason for this is not as some would argue (eg. May, 1991) that it is impossible to go into the field without preconceptions - Strauss and Corbin (1994) explicitly allow for this - but that done properly, it is very time consuming. I am also not sure that it is possible to develop theory in the manner described by the authors without making a few very personal conceptual leaps that are not grounded in data. But even if it were, there are practical implications of transcribing and analysing each interview before embarking on the next; it might not be within the time frame of the researcher and the study participants.

Since the publication of Glaser and Strauss's original text and the many revised editions, other authors have produced detailed texts on the analysis and interpretation findings in qualitative research (eg. Miles and Huberman 1984, 1994; Silverman, 1993). My principal concern with these highly structured approaches to data analysis is that they seem to pander needlessly to the requirement of positivists for "scientific enquiry". Qualitative research evolved partly to move away from the quasi-scientific "faceless" study of social life, yet Miles and Huberman (1994) with their methods for deriving "causal inferences" within qualitative data seem to be inching towards it again. That is not to suggest that I think that methods for data collection and analysis should not be explicit, but that I suspect certain methodologies of attempting to gain respectability for their "art" by couching it in "scientific" language borrowed from quantitative research, rather than using their own criteria for gauging a study's worth.

The 'other' in ethnographic research

A second major criticism of ethnography relates to the relative positions of the researcher as 'self', and the participant as 'other', a debate which Fine (1994) describes "reworking the hyphen". Traditionally, the 'other' has been construed as an entity distinct from the researcher, the 'subject' in quantitative language, of objective research. It is the contention of Fine and interpretitivist colleagues that the two are "knottily entangled", that they meet and intertwine at the "self-other" hyphen. The influence of interpretivism which acknowledges the complex subjectivity of social research has led to a movement in ethnographic research which has been variously described as 'post-ethnography' and 'post-structuralism'. Rather than viewing the interactive relationship between the self and other as a methodological flaw, researchers make it explicit and use it as a tool for evaluating the validity of their findings (Miles and Huberman, 1994). Proponents of critical theory take it one step further and capitalise on the interaction between researcher and participant in an attempt to induce social change.

Validity in ethnographic research

There has been much debate about validity in qualitative research, particularly in ethnography. This is the third of the three main criticisms that are levelled most often at ethnographic enquiry. The validity of a piece of research is determined by the extent to which it measures, or reports, what it purports to measure or report. In qualitative research the question is whether the theory or detailed description derived from the data is accurately representing what was there, albeit temporally. Some authors prefer not to use the term 'validity' which comes from quantitative research methods, arguing instead that we should be using qualitative criteria to evaluate qualitative research (Leininger, 1994). Strauss and Corbin, for example, prefer to use the concept of "verification" (Strauss and Corbin, 1994). As the terms validity and verification seem to have very similar meanings, the two are used interchangeably in this text.

The validity of developing theory will be verified to some extent by the method of data collection. Analysis in qualitative research is ongoing, a process described variously as analytic induction and 'constant comparative analysis' (Strauss and Corbin, 1990). In this sense qualitative methods are both inductive and deductive because concepts derived from the data are tested out at subsequent interviews or during periods of observation. This serves as a constant validity check (Miles and Huberman, 1984; Bernard, 1994). It is argued that validity of research findings can also be achieved by making the methods explicit, which includes the strengths and weaknesses of the research design and a relevant biography of the researcher including his or her research perspective. If these measures are taken then the reader is in a sufficiently knowledgable position to evaluate the research and decide whether the findings are representative of the study population or not. Other measures to secure validity include feeding transcripts and interpretations back to the participants to see whether evolving theories ring true for them. Although this is also good practice ethically, it will inevitably influence future data collection.

Another validity check is to give transcripts to other researchers for secondary analysis, to see whether they find similar themes in the data. The use of numbers is also considered by some to be good practice because although counting the number of respondents who said or did something may not be in the spirit of qualitative enquiry, it is argued that it helps to produce patterns in the data and promote honesty in data analysis (Miles and Huberman, 1994). It encourages the researcher to remain aware of the mundane in the data, rather than latching on to some exciting finding that assumes inordinate - and unrepresentative - importance.

Reliability is less of an issue in qualitative research than it is in quantitative research. Qualitative research is necessarily temporal due to the period in time when it was collected and the many conditions that were operant then which might not be at some time in the future. It makes no claims for generalisability because it is highly context specific and the extent to which contextual issues assume importance is regarded as a strength.

Practitioner ethnography

The position I adopted in the current study accords with the somewhat middle of the road approach to qualitative research advocated by Hammersley (1992; Hammersley and Atkinson, 1995), who steers a course midway between interpretivism on the one hand and naive realism on the other. The term "practitioner ethnography" is borrowed from Hammersley (1992) who used it in a rather more precise sense than I use it here, to imply research carried out by the non-academic members of an organisation. As a "hybrid" practitioner researcher (Reed and Proctor, 1995) or "a district nurse researching district nurses" in a work setting other than her own, I feel justified in amending the term to distinguish my position from that of a complete outsider researching the culture of district nursing.

I was aware of the probable impact of my biography on the district nurses I researched and on the way that I analysed and interpreted the findings. I reflected on this throughout the course of the study and have endeavoured to be open about the problems that I encountered. I do not believe however that this renders my final thesis merely *one* interpretation of many disparate interpretations of the district nurses' world. I took a highly reflexive and methodologically rigorous approach to data collection and analysis and I would contend that the ensuing "ethnography" is an honest account of the reality of the nurses whom I studied.

A further comment is required on the critical stance that I took in the interpretation of the findings of this study. I realised that as a practitioner researching fellow practitioners I hoped that the information I gleaned about district nurses' working practices would highlight areas where practice could be improved. I was also aware that I had a desire to be constructive about district nursing practice, particularly in the wake of the rather damning publicity district nurses had received following the Audit Commission report into district nursing skillmix (NHSME, 1992). Although I had no intention of being dishonest about what I found, I was aware that it would be all too easy to concentrate on the negative in the data and "nurse bash", but to what end? A timely publication by Reed and Procter (1995) provides insight into this dilemma which is peculiar to practitioner researchers:

> "For practitioners, then, the aim of the research, either implicitly or explicitly is to improve practice with all the judgemental, normative agenda that this implies. Because of this agenda, practitioner research has an inbuilt inherent bias towards good practice, however this might be defined. To a social scientist such a starting point for research is heretical because all such notions of 'good' or'improvement' are in themselves questionable and, by definition, problematic, ie. what do we mean by *good?* or *improvement on what?* Although this maybe the end point of research, it can never be the starting point. There is, therefore, a subtle but important difference in the aims of social science research as against practitioner research because it influences the subsequent direction of the research at each stage of the process." (p15. my underlining, their italics)

Practitioner research or "practitioner ethnography" has a rather different intent therefore than simply the production of knowledge or theory for its own sake. The position taken is somewhat akin to that of the feminist researcher or critical theorist because the nurse researcher is in effect championing a specific cause ie.

improvement in patient care, and findings often have policy implications. I believe that the result of reflecting on these issues was that it facilitated a rather more reflexive and purposive analysis of the data than might otherwise have been possible. The working methods are described in the next chapter.

CHAPTER 4: METHODS

Working Methods

Introduction

The purpose of this chapter is to provide a comprehensive description of the methods used in this study. Data were collected in two phases using the traditional tools of the ethnographer of participant observation and semi-structured, conversational style interviews. The unique position of the practitioner researcher is given particular attention in the following account.

It has become something of a tradition to describe the relevant biography of the researcher. This is to enable the reader to assess the likely impact of the researcher's background on the research process, from the generation of the initial research question to data collection, data analysis and writing up the findings (Denzin and Lincoln, 1994). Accounts of ethnographic research have thus become increasingly personalised - subjective even - with the researcher acknowledging his or her role as the research instrument. The relevant part of my biography is that I have been practising as a district nurse for the past seven years on and off, and was working as a bank district nurse throughout the course of this study albeit in a different location from those studied in this thesis.

Generation of the research question

Phase one: aims

The data for this study were collected in two phases. The original research question that guided data collection in Phase one was born of two separate but interrelated observations in the field. When I was practising as a full time district nurse I noticed that district nursing sisters often managed ostensibly similar caseloads in quite different ways. Further to this, caseload management appeared to be both individualised and idiosyncratic. Musing on why this might be, I became conscious of certain behaviours amongst district nurses that seemed to encourage these variations or idiosyncracies in working practices.

There appeared to be invisible rules or etiquette about the ways that district nurses interacted with one another that ensured that they did not interfere with each other's work. When substituting for a colleague if the colleague was off for the day, the nurses were reluctant to change or openly challenge the colleague's care if something was perceived to be wrong. In this sense it appeared that *maintenance* of the status quo had led to inertia in the service and often to less than satisfactory care. With these observations in mind, the aims of Phase one of the data collection were phrased as follows:

1) Is the caseload management of district nursing sisters highly individualised, and personalised, in other district nursing teams?

2) Do invisible rules exist in these teams that guide the interactions of district nursing sisters, and if so, what are they and what is the impact of these rules on caseload management?

Miles and Huberman (1994) describe generation of the research question in qualitative research as the first stage of data analysis. Data analysis, they suggest, is a process of data reduction that starts before the researcher enters the field. This is quite different from certain grounded theory studies where the researchers begin fieldwork with no preconceptions about what they will find or, more realistically perhaps, with a less clear statement of the research aims. In the current study the original research question delineated the field of research but, as is usually the case in ethnography, the questions that I started out with, or originally thought were important, were not the questions that I eventually travelled with. The direction that qualitative research takes is rarely immediately clear, and the current study was no exception.

Phase One of the data collection lasted for six months and was followed by a six month period of data analysis and reflection, when the aims of the second phase of data collection were developed. During this period it became clear that although highly individualised practice was a feature of the district nurses in this study, invisible rules or etiquette between nurses were only one reason for this. It would have been possible at this stage to use etiquette as a focus of the remainder of the study and to explore the concept further. I did not do this for two reasons. First, the issues raised by a discussion of etiquette are contentious so it is difficult to talk about just these issues when interviewing district nurses and second, it became apparent that other issues were of more immediate concern to the district nurses.

The study was conducted in the wake of the audit commission report into district nursing skill mix (NHSME, 1992) and had straddled the delayed introduction of the community care component of the NHS reforms (DH, 1990). The district nurses wanted to talk about these events and how they had affected the way that they worked. As the audit commission report was highly reductionist and the community care reforms had not been explored in district nursing - because they were so new - it seemed in the spirit of practitioner research, and the logical way forward to me, to take an in depth look at these issues. I therefore travelled with the concept of idiosyncratic practice, with the notion of invisible rules or etiquette taking more of a back seat than originally anticipated.

Phase two: aim

The aim of Phase two was therefore much broader than the aims of Phase one. This is the opposite of classic ethnography or grounded theory where a funnel shape describes the way that the study becomes more focused over time. I would argue however that an inverted funnel is more likely to occur in practitioner research, where the researcher enters the field with a specific question generated from his or her practice and re-evaluates this as the study progresses. Phase two of the data collection was entered with far fewer preconceptions than Phase one. This is reflected in the single broad aim of the second phase of data collection which was:

"To explore the contextual influences on the caseload management of the district nursing sister"

Details of the sample

In Phase one I carried out participant observation with 13 G and H grade district nursing sisters over a course of 13 days ie. one day per nurse (see table 1). Later I conducted semi-structured interviews with all 13 nurses plus three other G grade district nursing sisters who I had not had the chance to observe, a total of 16. The 16 nurses came from two sites (Sites A and B) which were located in different trusts (table 2). In addition to this I opportunistically observed and interviewed one staff nurse who was a student district nurse on supervised practice at site B. Supervised practice is the final stage of district nurse training, and the student held her own caseload.

Table 1: Participant Observation

	No. Nurses	G Grade	H Grade	No. Days	No. Visits
Site A	3	2	1	3	36
Site B	10	8	2	10	94
Total	**13**	**10**	**3**	**13**	**130**

Table 2: Phase One Interviews

	No. Nurses	G Grade	H Grade
Site A	5	4	1
Site B	11	9	2
Total	**16**	**13**	**3**

In Phase two I re-interviewed 13 of the 16 original nurses from the two sites, plus the remaining five G grade district nursing sisters from site B. I also interviewed six G and H grade sisters from site C, which was in the same trust as site B; four G and H grade sisters from site D and six G and H (and one F) grade sisters from site E. Sites D and E were in a third trust. I therefore carried out 34 interviews in Phase two (table 3). In total therefore in Phases one and two I carried out 50 interviews with 37 district nurses, excluding the student district nurse.

Table 3: Phase Two Interviews

	No. Nurses	G Grade	H Grade	F Grade
Site A	5	4	1	-
Site B	13	11	2	-
Site C	6	4	2	-
Site D	4	3	1	-
Site E	6	4	1	1
Total	**34**	**26**	**7**	**1**

In Phase two in addition to the interviews with *district* nurses, for the purpose of verification I conducted interviews with younger disabled patients and undergraduate student district nurses. I carried out ten interviews with seven young disabled persons, who were defined as persons with physical disabilities aged less than 64 years, plus two carers (the mother and father of a young disabled girl sat in on the interview with her). Two of the patients were interviewed twice. I interviewed six student district nurses from a nursing degree course at a North West university for their outsider perspective.

Characteristics of the sample

I have decided not to give details of individual biographies because there were so few nurses at each site that they and possibly their patients could easily be recognised. Omitting this detail does not detract from the findings of the study. The most relevant aspect of the nurses' biographies was when they trained. Where this is important to the findings I have included it in the text. For a broad indication of the range of nurses who took part in this study in terms of this characteristic, see table 4 (overleaf).

Table 4: Characteristics of Sample: Years Trained

	No. Nurses	Newly qualified <2 yrs	2 - 5 yrs	6 - 10 yrs	11 - 20 yrs	> 20 yrs
Site A	5	-	4	-	1	-
Site B	16	2	9	3	1	1
Site C	6	1	1	1	2	1
Site D	4	-	-	1	1	2
Site E	6	2	1	1	2	-

The study sites

Site A was located in a relatively affluent area, parts of which were semi-rural. Sites B and C were neighbouring locations in a less affluent suburb of a North West city. Sites D and E although they were in the same community trust were quite different from one another. Site D was the least affluent and could be described as inner city, and Site E was the most rural of the five. The separate sites are not referred to in the findings because the location of the nurses appeared to make very little difference to the issues they discussed at interview. The nurses can be more usefully conceptualised as separate case studies in this sense.

Gaining access

The sampling process: Phase one

The sample of district nurses was initially one of convenience although as the study progressed theoretical sampling took place until no new themes and ideas were detected in the data (Strauss and Corbin, 1990). Theoretical sampling simply means that sampling has a purpose: there are theoretical reasons why future participants are chosen. The reason that my sample were G and H (and one F) grade district nurses was that these were the team leaders and the decision makers and it was the decisions that led to differences in working practices that I was interested in.

Site A was not the first site I approached to take part in the study, it was actually the fourth. The first two sites approached to take part refused access because the nurses had been directly affected by the outcome of the district nursing skill mix review (NHSME, 1992) and their managers felt that they did not need any further disruption. As an interim measure, whilst awaiting a reply from the third site approached, I asked my own district nurse manager whether I could conduct some participant observation in my own health authority (Site A: now a trust). She agreed and I spent three days in participant observation with three district nurses who I had not met before. In the meantime the third site approached (site B) granted me access to their G and H grade district nurses.

I telephoned the two district nurse managers of site B who became my main study group and arranged to meet them and the two H grade community practice teachers (CPTs) who also had a coordinating role at site B. At this meeting I explained that I was interested in the ways that district nurses worked together and how they managed their caseloads. The two CPTs agreed to arrange a timetable with their nursing colleagues for participant observation. I requested that I spent no more than two or three days a week in participant observation to enable me to reflect on the data I was collecting and to engage in preliminary analysis.

As it was unclear at this stage what I would encounter when I was out with nurses, the district nurse managers insisted that I attended a manual handling course to update my lifting and handling skills. Participant observation at site B was therefore delayed until I had completed this.

Before moving on to a description of participant observation it is worth mentioning that it was on my first day of participant observation at Site A (my own health authority) that I realised what a crucial issue the NHSME skill mix review was. The first nurse I went out with could talk about little else and appeared to be very anxious about the future of the district nursing service. The value for money team from the audit commission had in fact shadowed her and her colleagues. Of the two other sites that were studied by the team, one of the others was a North West trust that had refused access to their nurses: their refusal to grant me access was perhaps less surprising therefore. Data from the very first day of fieldwork have been included in the findings chapters of this thesis because the nurse concerned (DN1) was instrumental in shaping the remainder of the data collection. I would describe my data collection as iterative therefore in spite of being collected in two phases, and have chosen not to delineate some of it as exploratory work and the rest as the main study.

Participant observation

As described, thirteen full days were spent in participant observation with thirteen nurses, totalling 130 visits which averaged ten visits per nurse per day (table 1). I met the nurses at 8am in the morning as their day started and shadowed them all day to patients' houses, meetings, and mealbreaks.

Participant observation is the dominant technique of the traditional ethnographer. It is sometimes argued that it is an essential feature of ethnographic research, and that without it, the resulting account is not an ethnography. Participant observation is not separate from interviewing however. Traditional anthropologists who never sat down formally to interview informants still asked questions during episodes of field work; in other words they conducted informal interviews.

A continuum can be described in participant observation from complete participant to participant as observer, observer as participant and complete observer (Gold, 1958; Pearsall, 1965). Researchers decide on the extent to which they wish to become part of daily lives of the group being studied and if objectivity is of central concern, the distancing role of complete observer may make this easier to attain. I initially adopted the role of observer as participant but in order not to over burden the patients, after a few days in this role, and with the consent of the district nurse managers, I decided to don my uniform. Where the nurses performed double-ups, which is where two nurses visit a particularly heavy patient, I became the second nurse and carried out nursing care.

Ethical Issues

Ethical issues were raised by the participative role I played during periods of observation. Firstly, as I was dressed in uniform it was easy to deceive patients by passing myself off as a district nurse. I was careful to explain who I was therefore in addition to gaining their spoken consent for me to take part in their care. Sometimes I saw examples of poor practice and I was left with the ethical dilemma of what to do about this. The line I took was that unless something was either life threatening or highly dangerous I would say nothing so if for example a lifting technique was unsafe for the nurse, or a leg ulcer dressing was inappropriate I turned a blind eye. I am not comfortable about this and the inherent irony of it in the light of the findings of this study will become clear; in this sense it was data in its own right.

Gaining Trust

District nursing involves a lot of intimate hands on care and it seemed fairer to the patients to eliminate the third person in this setting when there were already two nurses at the patients' home. It was also my way of giving something back to the nurses who were being very generous with their time; and it was an invaluable opportunity to develop a rapport which proved to be indispensable later at interview. The interviews with nurses I had been out with often flowed more easily than the interviews with nurses I had not observed in the sense that contentious issues could be raised more naturally and the interviews were usually very in-depth.

It could be argued that the more participative approach I took was less objective, but objectivity was not my aim. The fact that I was a district nurse was no secret to the study participants and had helped me to gain access in the first place, and the nurses were speaking to me as a district nurse before I put my uniform on and joined in. The more participative role I adopted was certainly easier for the patients to understand as well. I was introduced to the patients as a nursing colleague which was the nurse's suggestion rather than mine and no house was entered without the district nurse gaining the patient's spoken consent. In most cases this was the day before my visit to allow the patients time to think about it. They were usually very pleased to see a new face however, so refusal was never an issue. My participation *per se* might have raised ethical issues had I been studying the patients but I was not, it was the nurses I was interested in.

The value of participant observation is usually that when nothing or very little is known about a group, immersion in their day to day lives provides the researcher with contextual data, helps him or her to develop a rapport with participants and to devise relevant research questions which can then be explored in the field or during follow up interviews. The nurse researcher is in a special position however because the culture being explored is not an alien one. This is especially the case when research is taking place in an area of practice in which the nurse has already worked which was the position that I was in as a district nurse researching district nurses. I quickly became familiar with the surroundings in which interactions were taking place and there was no difficulty in understanding the language of participants. The period of time required for participant observation was greatly reduced by these factors, but I also soon felt that I had stopped seeing things because the setting became familiar so quickly. This is a problem common in practitioner research that both Reed (1995) and Field (1991) recognise. Field (1991) points out that while gaining entry to a study group, and developing rapport and trust, may be facilitated by the fact that the researcher is a nurse, issues arise when studying one's own culture. For example it is important that the nurse does not overlook the obvious, and any assumptions are recognised and challenged. For me this was greatly assisted by discussing transcripts with my supervisor who was more distanced from the data and challenged me on many of my assumptions, particularly in the early stages of data collection during Phase one.

Field notes

I took field notes in a fieldwork diary during participant observation and elaborated on them immediately after leaving the field, to ensure that time lapse did not lead to important details being left out (appendix 1). If a grounded theory approach had been taken, in theory everything that was observed would have been recorded. Miles and Huberman (1994) suggest however, that the researcher acknowledges their prior knowledge of the setting and formulates research questions before entering the field, thus avoiding what they describe as the "pitfall" of recording everything and ending up with a mountain of unmanageable data. I found that I quickly engaged in a process of selectively recording observations pertinent to my research questions.

The field notes recorded a description of events, but I also compiled theoretical and methodological notes or memos as recommended by Schatzman and Strauss (1973). The theoretical notes were the first stage of analysis of the data: the patterns and themes that were beginning to appear; and the methodological notes described the logistics and practicalities of data collection such as the best times to carry out observation, which in this case was the morning when the nurses did most of the work. Analysis of fieldnotes at this stage was informal therefore, where the main purpose of the notes was to develop an interview schedule.

The next stage in the process was to set up interviews with the nurses to explore and test out in more depth the themes that were arising from the data.

The decision to interview

The reason that I conducted interviews with the nurses after a relatively short period of participant observation was firstly, because I was beginning to miss things due to my familiarity with the setting; but more importantly, because at this stage in the research I was interested in the invisible rules that operated between colleagues. Although observation of the nurses enabled me to develop a rapport and to observe differences in working practices, the isolated context of their work did not allow me to witness their interactions. Or if I did, this was comparatively infrequently and I soon realised that getting the nurses to talk about their work at interview could be more fruitful. For these reasons, the observational data, although it informed the course of the research, is not drawn on explicitly in the findings chapters.

Phase one: interviews

In qualitative research, interviews are usually unstructured or semi-structured. Unstructured interviews are useful when little is known about the field of study and the interviewer can ask what Spradley (1979) describes as "grand tour" questions which will familiarise the researcher with the setting. As I was familiar with the research setting and had conducted informal unstructured interviews during participant observation, I entered the interviews with preconceived ideas about the sorts of questions that might elicit relevant information. I adopted a semi-structured style of interviewing where I used an interview guide to the areas I wanted to cover (appendix 2).

Although unstructured or semi-structured interviews are conducted in a conversational style, the stance of the researcher will vary according to the philosophical approach taken. In feminist research, for example, reciprocity is an important part of the interviewing process (Webb, 1992). The traditional ethnographer however would endeavour not to give anything away about his or her own opinion in order not to lead the interviewee and to retain a level of objectivity (Spradley, 1979; Hammersley and Atkinson, 1995). The approach I adopted was somewhere between the two. Whilst I did not want to put words in the mouths of the interviewees, there was no avoiding that I too was a district nurse and the issues that concerned these nurses were important for me too. If I had been sitting in their seat instead of mine as the researcher, I would have had something to say about the various issues from a personal perspective.

With this in mind I was careful not to influence the nurses and was often non-committal when they asked me for my opinion or waited until the end of the interview for a chat. The reason for this was less to secure objectivity, which I do not think is possible, but because as the research progressed I was increasingly aware of how diverse a group of individuals district nurses were and I, as a district nurse, was as different as the next person. This is reflected in the fact that what I had originally thought was important in district nursing, was not necessarily what the study participants thought was important, hence the broadening of my research question in Phase two.

The ethnographic interview is not standardised. Although the same subject areas are likely to be covered, data collection is iterative so one interview will inform the questions to be asked at the next and as Schatzman and Strauss (1973) point out, any attempts at ordering questions disrupts the conversational style.

Interview techniques

The interviewees were ensured of the confidentiality of all information they shared with me and had a choice about whether the interview was taped. None of the nurses objected to being taped and they reported that after an initial period of being conscious of the tape recorder they forgot it was there. In an effort to minimise the anxiety of the study participants I engaged in general chat with them before the tape recorder was turned on and for a few minutes at the beginning of the interview. The interviews lasted from between three quarters of an hour and an hour and a half ie. one or two sides of a C90 audio cassette.

Referring to interviewing techniques Schatzman and Strauss note that:

> "We can barely begin to tell of the many diverse forms the interview may take particularly when the interviewer quite deliberately exercises only moderate control over its course"

They go onto to discuss ways of coping with different interviewees which they describe variously as "stimulating the inarticulate" "loosening the tongue tied" and "steering the runaways". The point they are making is that there is no set procedure for interviewing: "there can be no cook book recipes for interviewing. Those would be more crippling than helpful". The only techniques that all of the interviews I conducted shared was that I iteratively tested out emerging themes with all of the study participants.

Gaining trust

I dressed for the interviews in a way that I hoped played up our similarities in order to gain the nurses trust. I looked smart but deliberately informal and the nurses often commented that they liked something I was wearing. I presented myself to each nurse in different ways according to their reaction to me which on reflection is the way that I present myself to patients when I am district nursing. The interviewing skills that health professionals can bring from their work to research setting is now acknowledged (Reed and Procter, 1995). My approach was therefore very instinctive: sometimes I mirrored their speech in the sense that if some one was softly spoken I tended to speak to them slowly and softly; at other times I made a deliberate attempt to come across as a rather more impersonal researcher. This was usually when I sensed that the interviewee was likely to open up and I adopted this stance to use a more challenging line of questioning. The interviews often had a reciprocal element especially if any of the nurses had had a bad day and welcomed the opportunity of discussing it with another district nurse who was not one of her immediate colleagues. I also gave tentative careers advice when I was asked for it and advice about courses and higher education.

As mentioned, in the first round of interviews I interviewed the nurses I had been out with plus three other nurses who had not been available for observation (one of them worked on the evening service). The staff nurse I observed and interviewed was about to qualify as a district nurse at the time of the study and held her own caseload and was therefore a decision maker. She was able to describe the slightly different experience of a neophyte district nurse and shed light on certain issues particularly in relation to hospital nursing which was a more recent experience for her. The sister who worked on the evening service was interviewed to see whether her perspective of district nursing differed at all.

Informal analysis

The hallmark of data analysis in qualitative research is that it is ongoing. Qualitative data analysis constantly flits between the emic and the etic perspective, and both inductively and deductively builds either theory or an in depth description of events. As mentioned, Miles and Huberman (1994) argue that it is essentially a process of data reduction, and that this starts at the pre-data collection phase when the formulation of a research question immediately reduces the field. Analysis during field work was conducted therefore by constant comparative analysis. Themes that were derived from both the field work data and the interview data were preliminarily coded and then tested out with other study participants.

I spaced the interviews out as far as possible so that I would have time to at least listen to the tapes once and make notes if not to transcribe them in full before I moved on to the next interview. But as the interviews were conducted at the nurses' convenience they were not always as spaced out as I would have liked. Although I usually conducted a maximum of two interviews a day, on at least two occasions I interviewed three nurses consecutively.

The process of analysis at this stage was similar to the informal analysis of the field notes (appendix 3). I made theoretical and methodological memos in the margins of the notes. The theoretical memos drew attention to emerging theory and the issues to be raised with subsequent study participants; the methodological memos noted the mechanics of the interview process and highlighted points at which I had perhaps led the interviewee too much or phrased a question awkwardly. When I was interviewing in rapid succession and there was no time to make notes, I found that I was able to make sufficient use of any new issues arising from the previous interview to avoid any major methodological problems.

Transcribing the data

At the end of this first round of interviews any remaining tapes were transcribed in full mostly by me but with the help of two specialist secretaries who had done this sort of work before and understood about the importance of confidentiality. I checked the typed transcripts against the original audio cassettes and corrected any errors.

Ethical issues

To ensure the confidentiality of the study participants, names and places or anything that might identify them were left off the typed transcripts. The tapes were locked away in a filing cabinet so that only I had access to them and they have since been wiped. There was a male nurse in the sample but I have deliberately described all study participants as "she" to protect his identity.

Formal Analysis

Following the first phase of data collection I spent six months formally analysing and reflecting on the data. The first stage of the formal analysis was coding the raw transcripts from both the fieldnotes and the interviews.

Coding

There are many theories about coding such as whether it is possible to do it alone a *cappella* (Stern, 1991), and whether to use a computer programme such as NU•DIST (Richards and Richards, 1994) or ETHNOGRAPH. I decided to code in a way that put me back in touch with the data because some of the tapes I had listened to but not personally transcribed. I felt that I knew the data from the interviews that had been transcribed by the secretaries less well. On the original transcripts I colour coded the themes that fell into similar categories in different coloured felt tipped pens. The colours denoted the broad themes and I wrote in the appropriately coloured pen the name of the constituent category where it appeared in the data. For example a broad theme in the early stages was "teamwork" (which became collaborative working). I went through the data line by line and where teamwork issues arose I highlighted the text in the appropriately coloured pen (yellow). A constituent category of teamwork was "changing care" (which became challenging care), which was therefore written in the margin in yellow pen. Thus the entire transcript became colour coded according to themes and categories. Sometimes data fell into several themes or categories so I would encircle the highlighted text with the appropriate colour. For example the following extract from the interview data straddles three themes in the data: describing nursing work, collaborative working and rationing care:

> DN29: I don't find that people are particularly demanding. I find that patients accept what you say really and I think that might be one of my difficulties because I'm a bit of soft touch...If they kind of suggest things I usually go along with it fairly much really *(describing nursing; rationing care)* ...there's one I took on, a bone of contention with the others as well *(collaborative working)*, 40 year old, possibly terminal...spinal tumour... and this man actually requested that we help him to get dressed in the morning. He goes to work still, his wife's an occupational therapist. They have marital problems and he doesn't want to feel dependent on anybody... he actually phoned me and said "will you come and change my leg bag?" What leg bag? He hasn't got one, never had one but worrying about one... I said of course we can come *(rationing care)*...This was before I went half time and I don't think anybody much likes going *(collaborative working)* but to me he's district nursing *(describing nursing)*... Oh I cleaned his shoes this morning *(describing nursing)*...To me it's district nursing but I don't think he is much to any body else.

I eventually used this as an example of the differences in definitions of nursing work but it would have fitted equally well under collaborative working and the way in which the needs of the individual are balanced against the wishes of the team; or under rationing care and the ways in which nurses decide how to distribute their finite resource.

Other categories were moved such as "patient trust (in the nurse)" which was moved from autonomous practice to collaborative working; equally, "(the nurses') confidence to practice" was moved from collaborative working to autonomous practice. Mapping the data, using rough diagrams in coloured pens, helped me to decide which theme the category eventually fitted under most logically.

Once the transcripts were colour coded, I wrote out the coded data on index cards pertaining to categories. It was an extremely long and laborious process but I felt that if I simply cut the transcripts and pasted the sections onto cards I would not stay in touch with the data. I also sensed that using a computer programme which would have been labour saving, would have had a similar distancing effect for me.

Counting

As I reported those issues in my findings that were raised most often by the district nurses, so in this sense I counted the incidence of certain categories of information in the data. Whether counting cases should be used in qualitative analysis is a subject that is widely debated. I have tended to adopt the middle ground. I have not used figures in the text because this is somewhat meaningless where the findings are not going to be used to make predictions about the wider population, as in quantitative research. Rather, I have used words and with some consistency, a continuum of "all, most, some, one of..". I have been careful to prefix all quotes with an indication of the weight of evidence that there was in the data to support it. However I would argue that just because only some of the nurses said something *it does not follow that it is unimportant, hence the* nonsense of counting to decide which data to include. This is where it is argued that experience and prior knowledge as a practitioner comes to the fore (Meerabeau, 1995).

Negative case analysis

Negative cases or cases that contradicted the main body of the findings were used in two ways. Firstly I used them to direct data collection, because exceptions often highlight areas that require fuller exploration. And secondly, where there was a lot of discrepancy about an issue in the data I either chose not to report it if it appeared to be unimportant, or if I judged that it was important, I was careful to report all the variations on the particular theme. Several examples of this are found in the first findings chapter on describing nursing work (chapter 5). There was a lot of disagreement about what district nursing was and what it was not, and the findings reported the diversity of responses. I actively sought negative cases in the data to promote honesty in reporting in other words and I was careful in presenting the data to report the negative case or opposing view where it was expressed.

Gaining access: Phase two

Theoretical sampling

Detailed analysis of the first phase of interviews and fieldnotes from participant observation took approximately six months, during which time I did not conduct any field work. My ideas evolved considerably during this six month period, when I also read around the themes identified in the data to see whether anything had been written by others that would aid my analysis. I decided to re-interview as many of the nurses from the Phase one as possible (in the event 13 out of 16) to test out my ideas and to catch any of the nurses that I had not managed to interview the first time around. Again I spaced the interviews out as far as was practicable, mindful of both my time frame and the time frame of the nurses. By the end of this wave of interviews I had interviewed the entire population of G and H grade district nurses at Site B.

I then decided to theoretically sample (Strauss and Corbin, 1990) to test out the evolving themes with nurses from different locations (appendix 4). This was to explore whether the themes that were arising from the data reflected the experiences of nurses in other areas. Via one of the Community Practice Teachers (at Site B) I approached the district nurse manager at another site (Site C) within the same trust. I contacted the manager by telephone and she arranged for me to meet the district nurses which I did during one of their lunch hours. At this interview I arranged to interview as many of the nurses as possible (table 3).

Via a contact I had in another local area I was introduced to the district nurse managers of two clinics within another local trust (Sites D and E). Whereas parts of the second trust were relatively affluent and the sort of area that lecturers and students from the local colleges lived, of the two areas selected in the third trust one was a rural area and the other was a relatively non-affluent city suburb. By the time that I had interviewed the nurses at Site E it became clear that the issues raised by the nurses at sites A and B were constant across locations, and no new themes were arising from the data. It was for these reasons that I decided to end Phase two of data collection.

Phase two: Formal and informal analysis

Formal and informal analysis of the interviews were the same as in Phase one. I transcribed as many tapes as possible throughout data collection but the majority were transcribed by the same two secretaries as in Phase one after data collection was complete. Concurrent analysis during data collection was informal as in Phase one and formal analysis which took the same format as before was conducted after all the interviews had been transcribed (appendix 5).

A further note about ongoing analysis is required. Analysis in qualitative research does not end when the data have been coded and allocated to themes, and categories within those themes. It continues throughout writing up the research, right until the final discussion. Each step in the writing up process moves the analysis on a stage.

Validity

Many separate measures were taken to assess the validity of evolving themes in this study. Perhaps the most important contribution to the validity of the research was provided by interviews with outsiders. As a district nurse I was an insider, and the nurses I interviewed provided an insiders' perspective of district nursing. For these reasons I decided to interview patients to get a user perspective on the issues raised by the nurses.

Interviewing younger disabled people

I was granted ethical committee approval to interview a small sample of younger disabled people. I accessed the patients via their district nurses, all of whom were from Sites B and C. I interviewed seven younger disabled patients (< 65 years), one of whom was interviewed with two carers (her mother and father). Four of the seven interviewees allowed me to tape record the interview and I took detailed notes during the remaining three. Two of the patients were interviewed twice because they had a lot to tell me and I was loth either to direct the interviews too much or to cut them off if they wanted to talk. Again the interviews were semi-structured and I had an interview guide (see appendix 8). I received written informed consent from each person I interviewed (appendices 6 & 7). The reason for choosing this particular patient group was that there was evidence in the data that where these patients came on to the books they were heavy users of services and straddled the health and social care divide. They were also described as particularly articulate and "demanding" by the district nurses so it seemed that they might be able to provide an alternative perspective on some of the issues raised in the data. The seven patients were in fact all very different from one another and did not conform to any particular type. The seven interviewees were thus seven separate case histories. The data from these interviews has been used throughout the findings to both verify and enrich the district nurse data.

As the data were for the purpose of verification I used the same codes as I had done for the nurse data (see appendix 10). Again, the interviews were transcribed by me and the two secretaries. I ensured the patients that the interviews and transcripts were strictly confidential and that anything they had told me would in no way affect their future care

The undergraduate district nurses

I also interviewed six student district nurses on placement who were undergraduates at a North West university department of nursing. Like the patient data the aim of this was to provide a validity check for the findings. Although it could be argued that student nurses are novices to district nursing and perhaps unaware of some of the professional issues, I would argue differently. The undergraduate nurses were outside the organisation as they did not work with the any of the qualified district nurses interviewed, so they were able to offer an outsider perspective on some of the issues. They were also very new to district nursing so it was hoped that they might be able to shed some light on socialisation into district nursing culture. The interview schedule I used with the student nurses was very similar to that of the qualified district nurses as I was aiming for verification - or refutation - of the issues raised by the qualified district nurses (see appendix 9).

I handled the data in the same way as before and as with the patient data, because I was looking for verification in the student nurse data, I used the same codes as I had developed from the nurse data (appendix 11).

Other validity checks employed in this study were as follows. I handed uncoded raw transcripts to two other experienced heath services researchers to see whether they came up with similar codes, which they did. I fed my findings back to the nurses I interviewed in a formal group meeting and as individuals to see whether the themes that I had identified as important were equally resonant for them. I worked as a district nurse throughout the course of the study and reflected on my practice and the practice of my colleagues to see whether my findings rang true. I discussed my findings with my district nursing friends and colleagues, and I published two papers on my early findings and received feedback from the academic community. I presented my ideas in seminars. I read widely and have drawn parallels in the findings with literature from other fields, where it exists, to support - or refute - my findings. As a final measure, in order to give the reader maximum opportunity to judge whether my interpretation of the data is well grounded, I have quoted extensively from the interview data in the findings chapters.

In the sense that I conducted rigorous validity checks throughout this study, I would argue that every measure was taken to present an accurate picture of the world of the district nurses I studied. The world is revealed in the next four chapters.

CHAPTER 5: FINDINGS

Describing Nursing Work

Introduction

For decades, nursing theorists have differentially defined the discipline of nursing (eg. Nightingale, 1859; Peplau, 1952; Henderson, 1966; Roy, 1976; Orem, 1985). Descriptions have varied according to the social context of nursing work (Dingwall et al 1991), the individual stance of the nursing theorist (eg.Roy, 1976; Orem, 1985), and the broader philosophy of the health service such as user involvement in care decisions (DH, 1989a; DH, 1989b).

The struggle to define nursing has gathered momentum as the occupation has sought to differentiate itself from medicine and medical models of nursing work, but also from lay care which is another term that defies a unitary description (Kozier and Erb, 1988). Further to this, the debate about definitions of nursing work are increasingly moving from the academic to the political, especially in the community: if nursing is an elusive concept, then district nursing is perhaps more so for a variety of reasons.

In the home, the patient has many visible needs, arguably more so than in hospital where some of the contextual information is missing about the patient's family and their home circumstances. Working out which of these needs should be met by the district nursing service was frequently difficult for the study participants, but patently necessary. The wider political context of recent legislative, financial and service imperatives requires a clearer definition of nursing work for selling the service to GP fundholders (DH, 1989b), an understanding of the boundaries of social care for the social services departments (DH, 1989a) and the proper delineation of specialised areas of care for clinical nurse specialists (Griffiths and Luker, 1994).

District nurses "used to do everything"

When the study participants were asked how their role had changed over the years, the two most common issues raised were the imminent introduction of skill mix (NHSME, 1992) and the Community Care reforms (DH, 1990). The implication of skill mix for G and H grade district nurses is that they will be expected to take on a more managerial role than *before*, with an emphasis on assessing, re-assessing and planning care. The intention of the new role is that it reflects their level of pay and their skills and training in relation to other colleagues in the nursing team. This is in contrast to a time when, according to the study participants, G and H grade district nurses, or their equivalent, "used to do everything" as the following excerpt illustrates. This nurse trained more than 15 years ago, which is interesting because almost 30 years ago a survey of district nursing work by Hockey (1966) found that nurses were carrying out work for which they were over qualified:

> *"At one time there were many more G and H grades and trained district nurses so you were actually doing everything. You were doing more general care and what have you"* DN10

Although DN10 agreed that the work of G and H grades nurses should reflect their training and pay, she was uncomfortable with the prospect that in her more managerial role, she was now accountable for work that she was no longer carrying out:

> *"You've got to hand things over, then you are responsible for something that you are having nothing to do with"* *DN10*

For most of the nurses however, accountability for unseen work was a small price to pay for being able to hand nursing work over to colleagues. In the next quote one of the nurses, who trained over 20 years ago, remembers a time when the work she carried out was so all-encompassing and generalised that it was reflected in her title. Rather than being given the prefix "Sister", which would have drawn attention to the fact that she was a nurse, she was called "Mrs":

> *"A long time ago I mean we did everything. We didn't have staff nurses... in fact we weren't called "Sister", we were called "Mrs"...I think we had the SENs and an odd auxiliary, we didn't have a lot of auxiliaries, and we did everything. But it's better in that respect now because you can delegate quite a lot"* *DN34*

So although it was acknowledged many years ago that district nurses should not be carrying out non-nursing duties for which they were over qualified (Hockey, 1966; McIntosh and Richardson, 1976), a lack of staff to delegate to or policy to ensure that nurses only carried out nursing work, meant that "extra" care, as this non-nursing work has been described (Evers et al, 1991), was left at the discretion of the individual nurse. The nurses frequently described traditional district nursing as "everything" or "everything and anything", and as skill mix was at the planning stage at the sites studied, this was often still the case. Indeed one nurse reported that on the day that she was interviewed she had polished a patient's shoes (DN29). This was the exception however: for most of the nurses, the role had changed quite substantially as another of the nurses who trained more than 20 years ago explained:

> *"I just think it's so different now...When I did my training in Oxford, there was no home help service at the weekends so if I went in to say to do a dressing on somebody at a weekend, we might end up getting the lady's lunch as well because while we might be doing a dressing, the person had nothing to eat"*
> *DN36*

It is likely however that the role of the district nurse as defined by the service has changed rather than the expectations of the patients. There is evidence in the literature (Ong, 1991) that patients still expect district nurses to carry out non-nursing work as a "symbolic gesture of treating a person with recognised individual needs" (p646). The difference now is that if they choose, individual nurses have the legislative backing to refuse in the form of the community care reforms (DH, 1990).

Although district nursing was described by study participants as "so different now", for reasons that will become clear the nurses had difficulty describing what the job now entailed. Almost the easiest way for the nurses to describe what district nursing was, was what it was not, and how certain aspects of the job were being progressively passed over to personnel from other disciplines. In this sense, skill mix in nursing teams might not have much impact on definitions of district nursing because the work is still "nursing" but divided up more appropriately, it has been argued, according to level of skill (NHSME, 1992). The G and H grade nurses officially assume the role of assessor, not that they had not always assessed patients anyway (McIntosh and Richardson, 1976), and other nurses take on some of the day to day running of the caseload.

Something which had had a far greater impact on their role at the time of this study was the way in which traditional nursing work, such as bathing, washing and helping patients to dress, had been re-defined as "social care" (DH, 1988; DH, 1990). Social care, in theory at least, no longer fell to any member of the nursing team any more including the care assistant or auxiliary.

Definitions of social care and nursing care

The government white paper *Caring for People* (DH, 1989b) embodied in the 1990 NHS and Community Care Act, was finally introduced in April 1993. One of its main influences on district nursing was, and remains, the somewhat artificial divide described in the Griffiths Report (DH, 1988) between social and nursing care. For some of the nurses however, the boundary between the two was fairly obvious: it was something they had always had to think about when delegating work to nursing auxiliaries as the following excerpt illustrates:

> *"We don't have any set down documentation on what is nursing care and what is social care, but you know what you need your qualification for and what an unqualified person could do because we've always had that with using auxiliaries you know: we always had to sort out care into what they could do and what needs a qualified nurse"* DN9

The crucial point here is what exactly was it that required a qualification and was therefore nursing? For most of the nurses, "social care" was either bathing patients or helping them to get up in the morning and washed and dressed, sometimes described as general care. Yet some would argue that bathing or washing someone is nursing work, or, at least, an invaluable opportunity to cast a professional eye over a patient and assess their general condition. It certainly accords with the traditional role of the nurse described by theorists such as Henderson (1966) and proponents of the new style primary nursing (eg. Pearson, 1988; Manthey, 1992). DN8 espoused this view:

> *"Some of the tasks we did like bathing, when you've got the skills we've got you can discover a lot more about that person, you can pick things up very early and really get to know somebody well " DN8*

Getting to know somebody well was seen by all of the nurses as central to their role, and something which is identified in the literature as a key component of "the relationship" between nurses and patients (May, 1992). Its importance in community nursing was highlighted by Chalmers and Luker (1991) in relation to health visiting, and in district nursing by MacKenzie (1992) who in her interviews with student district nurses found that "getting to know" patients was a core reason for entering the community. In the next quote, another of the nurses suggests that through the intimate procedure of bathing somebody, it was also possible to meet their "psychological" and "health education" needs:

> *"I feel that you can get a lot from washing somebody, that you can see a lot about the patient, how they move, what their skin's like. I think if you've got a relationship with somebody it's not just washing them, I don't feel it is. It's doing a bit of health education, psychological care whatever" DN6*

Some of the nurses acknowledged this view point but still felt that the work could and should be done by social services carers. Others believed however that simply washing someone was not and had never been "nursing", that their role had neither been redefined or re-named and the district nurses were simply shedding extra care that was not theirs in the first place:

> *"I personally don't think you need an RGN to give somebody a wash...I feel we are doing a lot more of what we are supposed to be doing which is actually nursing and not social washes...a lot of people don't agree, they say you may be doing a wash but you are looking for things, you are a trained eye, you are looking for other things" DN10*

The bathing issue

Bathing was a contentious issue that had become a symbol for the uneasy divide between nursing and social care: it was usually the first topic that study participants raised when asked about the community care reforms. In recent years, however, bathing was seldom performed by qualified nurses anyway, falling mainly to unqualified nursing auxiliaries. This is interesting in view of the observation of Badger et al (1989b) several years prior to the reforms, that patients who fell into this category were often the most vulnerable and dependent on the caseload. It was believed then that their needs could be met by unqualified nursing staff and now, presumably, by trained but nevertheless medically unqualified social services carers.

Although social services were in theory taking over a lot of the bathing, they did not assume responsibility for medical baths. The term "medical bath" was a fairly elusive concept: one nurse gave the example of an "arthritic (patient) who's been stable for years" (DN6) as someone she would have been happy to hand over to social services. Another of the nurses agreed that if the patient had worked their life around a problem, in one sense, they might not require nursing:

> *"As far as the chronic sick are concerned it's* ***a way of life****, the same as your MS patients. It is a way of life for them therefore is it a nursing problem? People that have had strokes it's a way of life, it's something they get used to. If it's something they can overcome and they can manage it and they only need a little bit of help do they need a qualified nurse to look after them?" DN28*

It is interesting that if a patient's medical condition was seen to be a "way of life" it might not be defined as a nursing problem: in the community, patients are on their own most of the time without medical or nursing support and it could be argued that for all of them, their illness is a way of life. Someone whose condition might change however, was more likely to be described as needing a medical bath:

> *"Social services would only (bath) people who are sort of disabled or unable to sort of care for themselves. Whereas we are still doing it for the sick, which are the ones who are more important as regards ongoing assessment " DN21*

So it would appear that the term "sick" was defined by whether a patient's condition might change. Having said that, a "stable" patient with Multiple Sclerosis (MS) was bathed every day by DN21 and her team and it was the qualified nurses who did this, not the nursing auxiliaries. This is particularly interesting because another patient with MS, who was attended by the same team of nurses, was bathed just three times a week, and by social services carers. It could be that the relative popularity of the two patients, which is now recognised to be a highly arbitrary concept (Kelly and May, 1982; Johnson and Webb, 1995) was significant here.

It could be argued that anybody who is unable to get in and out of a bath has some sort of medical complaint. For example one of the nurses (DN22) said she would give a medical bath to someone who had had a stroke in the past but was now stable. She also admitted that "other" baths "slip through the net", perhaps because the criteria are so ill-defined, or maybe she adopted a fairly passive stance when assessing patients:

> *"It's quite a touchy subject. Some district nurses don't do baths... I do take on the odd bath it just depends really on the patient's circumstances. If they've had a stroke for example in the past then I would probably put them on the books, if it's just a social bath then I would say no but somehow they slip through the net and they end up on the list anyway" DN22*

Other nurses would not bath anyone unless it was in exceptional circumstances. DN12 was amongst these:

> *"Really I don't see that there are any reasons for somebody needing a medical bath, medical being that you need to be a qualified nurse or have some nursing training to actually go in and do that... I don't think there's any baths that come under that category. We sometimes have a few people say they have broken their arm or leg or whatever, and we may go in just because it's short term, you know something has happened to them like that and they need some assistance there if they are on their own, but those people are very very rare. If there is any family or whatever then I don't take them on" DN12*

DN12 implies that the existence of other family members might to some extent define whether a bath would be deemed to be medical or not, which raises an interesting point about the use of carers as a resource. The issues around defining baths were complex therefore. Some patients preferred to have a bath from a nurse rather than a home carer, as DN8 pointed out:

> *"People like to have nurses rather than carers, it's a fact of life, even for a bath they'd rather have a nurse than a carer, just because of the title, no difference in the bath, I've found that quite a bit" DN8*

DN8 implies that the mechanics of bathing someone are the same whether or not that person is qualified, although she does not infer that an experienced eye cannot be cast over someone whilst the bathing is being carried out. There is another good reason for patients preferring to be washed or bathed by a nurse or nursing auxiliary than a social services carer, which is that patients frequently pay for social care but not for medical care. If a bath is defined by the nurse as "medical" and therefore taken onto the caseload, it is effectively free at the point of delivery. This is true for all social services care, "general" washing and dressing also: patients usually pay. This raises an important ethical point which exceeds wranglings about definitions. If, as the data suggests, the division between social care and nursing care is fairly arbitrary, it is the luck of the draw to some extent whether your district nurse has flexible criteria for bathing, or whether there are even the resources to provide nursing care as one of the nurses pointed out:

> *"I think there's been times when I've handed them over and I'd have been prepared to keep them myself if I'd had the nurses" DN36*

Table 5: Pre-conditions for the nurse to describe a bath as 'medical'

Medical Bath	Social Bath
• Condition might change	• Condition stable
• Flexible nursing criteria	• Strict nursing criteria
• Sufficient nursing staff	• Shortage of nursing staff
• Popular patients	• Unpopular patient
• Absence of family members	• Absence of family members
• Heavy patient	• Light patient or lifting aids available

Division of Care

Where nurses believed that the criteria for assessing whether someone required nursing care or social care were arbitrary, they sometimes entered arrangements for shared care. In these circumstances, any gaps in the carer's knowledge could be addressed as one of the nurses explained:

> *"It's a very thin line isn't it? (between nursing care and social care). Some of the nurses were involved with teaching the home helps, you know what to look for or aspects of care, and also sort of there is a joint visit with ourselves and social services and so like when you are there you are pointing out various things when you are washing somebody: just look for the pressure points and relieving the pressure points and standing with them as well, you know supporting them, so it's ongoing teaching" DN33*

It would appear therefore that the social services staff had no training before taking on their more caring role. This is interesting given that a lot of nursing work such as general care, has been re-named as social care. There was often a reluctance therefore to hand a patient over to social services "lock stock and barrel" as DN5 explained:

> *"I don't regard a situation where you hand a client or patient over lock stock and barrel to social services anyway because you are recognising nursing needs and you are supervising those areas, things like pressure areas or whatever irrespective of whether social services are going in. But I tend to look at things as a division of care" DN5*

So the new model of district nursing is moving away from the holistic approach espoused by the profession (eg. RCN, 1990; Manthey, 1992) to a return to task orientation perhaps, where the patient's needs are divided up amongst the services:

> *"Part of me thinks well we've moved over to this concept of total care, in fact I think we're moving back towards tasks because district nursing is now getting to be very task orientated I think" DN8*

Although the nurses said that they would continue visiting patients to perform nursing "tasks", definitions again were very arbitrary. The example many of them used was when someone had a catheter: opinion varied about whether or not this was a nursing problem:

> *"Is it a medical problem or is it social? A very fine line. Yes that man with a catheter can go to social care because he never has any bother with it, but his one we have bother with all the time and he gets sore sometimes: it's much more ours. Social care for the other one probably" DN11*

DN9, on the other hand said she would always define catheter care as nursing care, and pressure area care also:

> *"I would hand somebody over if they had a catheter in situ for general care, but then you would have to keep contact for catheter care and supervision of that catheter, but if it was purely social care you know washing dressing then I wouldn't,*

> *but if there was any reason for me to have input and any kind of nursing implications whatsoever then I would. Sometimes you have to keep patients on maybe if they have a pressure sore or pressure areas or are susceptible to pressure areas, if they have a catheter in situ, if they need a dressing done"* *DN9*

The discussion so far has assumed that if patients or clients are perceived to have social as opposed to nursing needs they will be referred to social services who will take them on. This was not always the case however and a lot of nurses described how they would hold on to a patient until such a time that social services had the resources to meet that need, if ever. Because all care was at one time described as nursing care, the nurses often found themselves "filling the gaps" in social services care.

Filling the Gaps

When a need was defined as social, the nurses frequently filled the gaps until social services could take over. As Evers et al (1991) point out in their discussion of the role of the district nurse and social services departments, "nurses are *par excellence* that group which seldom says 'no'". DN21 explained:

> *"What I do is refer to social services and at the bottom of the referral I'll put we will visit until they are able to take care of it"* *DN21*

By offering to visit until social services could take over, DN21 was effectively offering them a get out clause and an excuse to delay if they needed to. Another of the nurses commented that when a patient is discharged from hospital and it is established prior to discharge that the needs are social, it was sometimes engineered so that the district nursing service would feel obliged to meet those needs. This was achieved by referring to the nursing service directly:

> *JC: "So they are not actually going through a care manager, they are coming straight to you?"*
>
> *DN9: "Yes they will come straight to us. Even though it's purely for social care they will ask for a nursing assessment so they know they will get somebody because social services prioritise them and it could be up to three weeks before they get a visit from social services whereas they know if they say a time to us we will go...We would always refer them. If it was for a carer I would carry on the service until that carer was able to take over if I felt the patient couldn't manage without"*
>
> *JC: "So you do take that on?"*
>
> *DN9: "You are almost obliged to if you do the first visit and assess a need. You fill that need until someone else is able to fill it"*

The referral agents were relying on the good will and conscience of the nurses to some extent, possibly borne of the fact that until quite recently, all care was nursing care anyway. This contrasts with reverse of De la Cuesta's (1993) description of gap filling in health visiting. She found that health visitors filled in the gaps or carried out "fringe work" where service provision was lacking, which sometimes subsequently became policy and therefore part of the health visitor's role. Filling gaps therefore served the function of highlighting deficits in the health visiting service. The next quote from DN26 illustrates the district nurses' dilemma further. When faced with the prospect of leaving a patient without a service, the nurse's "natural instincts" become involved:

> *JC: "Is there ever a situation where you identify a need for social care and there is a gap between when they can come in? (DN26: yes), and if there is a gap do you carry on going in? Carry on visiting?"*

> *DN26: "We do carry on visiting and really we have this ongoing thing as to whether it's social care or whether it's nursing care and because we have the problem with the resources we do continue to go in to see these patients because you simply can't leave them. I suppose your natural instincts become involved and you say well if this was my mum or dad or brother or sister or whatever you would want them to have the best care they could get and I find it works you know, but you do carry on going into them until something is up and in... there are medications we really don't need to be giving that a carer could go and give. There's the home help service might not go in that morning and you might end up making breakfast. You might end up making sandwiches ready for lunchtime because you know they are not going to come in or you don't know whether they are going to come in...so rather than leave the patient without you would do things like that, which is really where the home help service falls down,. There should always be somebody there to cover if somebody isn't there. It is always the case that district nurses will go in, you know 'the district nurses will sort it out'. Quite often you have social care patients on your books because you can't pass them over anywhere"*

The risk here is that by filling the gaps where service provision is lacking and providing "extra care", the nurses were effectively masking shortfalls in the service that will not come to light. This was how some of the nurses coped with the ethical dilemma they found themselves facing when there was unmet need which they could possibly take on. They felt that in the long term, by not taking on the work that other services should be providing for a particular patient, the service in question might improve to the ultimate benefit of all patients. DN5 espoused this point of view:

> *"I understand the fact that they have terrible resource and organisational problems but I'm very clear in my own mind that that's not my problem... I mean I would like people to get good services but I don't feel personally responsible for the fact that they are not. I can tackle it in my own mind. I don't feel guilty" DN5*

DN13 agreed with this but found it impossible to carry it through. She attributes this to the time that she trained, which was 15 years before DN5:

> *"I can't possibly go in and see somebody needs washing and dressing and be prepared to leave it a week or two until social services take over that care, which is what is happening... that's not good enough for me because I've been trained that if somebody needs care they have it...but that defeats the object because social services will never see the depth of the problem unless we say look this is yours you should be seeing to this not us. So I can actually see both sides but what I can't do is live with it" DN13*

Another way in which the social services departments appeared to get around the resource issue, because they undoubted did not have the resources to meet the demand, was by using stalling tactics. An example of this is found in the lifting and handling of patients. Since the EEC lifting and handling regulations became statutory in January 1993 (Health and Safety Commission, 1991), the employer is legally obliged to train staff in lifting techniques. While it was apparent that nursing managers had taken every measure to achieve this, social services had been slow to train their staff who were therefore unable to visit "heavy" or immobile patients, as the following example illustrates. In this extract, another stalling tactic was employed in addition to the lifting issue: the nurses became involved in social care when they agreed to supply equipment:

> *"We've gone to one situation where basically in the beginning we shouldn't have been involved, it should have been a straight carer situation, but we became involved when the social services were unable to supply various equipment straight away so they asked the district nurses to try and get the equipment. That's how it started. I was actually away on holiday at the time and when I came back, we have now got this young disabled lad on and basically he just needs help transferring in the morning, and really it's not I don't feel in our remit and carers are sort of...... tried to get involved but they keep quoting all the legislation about lifting and handling which is the same for*

> *us as it is for them...It was a crisis situation and something had to be done, so you know we stepped in and now trying to get it back across to them is very difficult and I'm actually meeting the social services chap this afternoon at the patient's house to try and work out what's going to happen. And I made the decision in my mind that we've got to withdraw. Whether we can stick to that or not and whether it's going to come out like that I don't know. It's an ongoing battle between myself.. I mean I feel right we shouldn't be involved, the carers should be involved. The carers are there sort of waiting for the go ahead to go in yet at the end of the day it's the lad who's suffering, you know in the middle of it and all the messing around. So it's quite a difficult ongoing one" DN12*

This highlights the well documented difficulties that have existed historically between the health service and social services departments, where collaboration remains a significant problem (Sheppard, 1986; Dalley, 1991; Higgins et al, 1994). It would appear in this example that the nurse's opinion might not carry much weight: DN12 pre-empts the possibility that although she intends to hand this patient over to social services, the social worker might well block the referral. Patients were sometimes also handed back from social services to the district nurses if it was perceived that a nursing problem had arisen. At first sight this appears to be a sensible precaution, and sometimes it was, but it was also used to relieve the pressure on social services as DN18 explained:

> *"We had one person who was being looked after general care by social services and whose skin had broken down and they had somebody off sick in social services and they rang up and said "look could you come in as their skin is breaking down, we've got problems". In actual fact the skin wasn't but they just had no staff to cover that care" DN18*

Another of the nurses found herself "picking up" a patient who needed bathing that she had handed over to social services, again because of the Manual Handling Regulations:

> *"I think we do pick up, fill in. With this community care thing it seems like they'll just stop doing something and it's "finish" no warning...we nurses are of such a nature that we couldn't say sorry it's not our job you're a social services case now, we never do it, where as social services will do it...Now suddenly they've all been told they must be retrained in lifting techniques and now they've just stopped bathing her ...we just do it because it's got to be done, you can't just leave people" DN8*

The nurses would carry out "illegitimate" bathing, washing and so on because it was formerly their role anyway and something some of them were reluctant to let go of, as DN11 explained:

> *"It can be very unpleasant actually losing them...the care can't be the same it just can't be. No disrespect to them at all but how can it be the same from somebody who's you know worked for 20 years as a nurse, how can the care from somebody who's just been a home help be the same? It can't be and perhaps they ought to ask our advice more often and not wait for crises to crop up" DN11*

DN11 raises the issue of whether basic *nursing care is of as high a quality if it* is carried out by untrained staff. Although evidence to support her supposition remains equivocal (McKenna, 1995), DN11 expressed belief widely held amongst her colleagues that the care of untrained personnel "can't be the same".

If re-defining nursing work as social care has removed certain patients or potential patients from the district nurses' caseload, then what has it left them more time to do? Most of the nurses felt that the factor that had increased their workload the most was shorter hospital stays and earlier discharge of patients from hospital.

Hospital at home

Although there is some evidence that the reduction in acute *hospital services has* had little impact on the caseload of the district nurse (MacDonald et al, 1991; Stott, 1992; Harley, 1995), it would appear that the technical complexity of district nursing work has increased considerably since hospital stays have shortened and many of the local cottage hospitals have closed. The present government's commitment to caring for people in their own homes has meant that district nurses are far more involved in the management of the acutely ill, as DN28 explained:

> *"A lot of people coming out (of hospital) now need far more care in the community, they are coming out with lines and things like that. Central feedings which they would never have come out with at one time, they would have been in hospital" DN28*

District nurses are now involved in immediate post-operative care, as DN6 pointed out in her list of the changes to her caseload:

> *"The patients are being discharged early from hospital ... "not well" patients that have been post-operative, a few days after surgery, not given proper advice to come home with like carry on taking your analgesics so you can move around... more terminal patients at home, a lot more syringe drivers, a lot more technical procedures, gastrostomy feeds, naso-gastric tube feeding, a lot more elderly, isolated elderly...they don't want to go into hospital and there isn't the social services to support them" DN6*

The post-operative patient that DN6 was referring to was a man who had had a day case repair of an inguinal hernia. She had visited him 24 hours after he had returned home to find him in bed, afraid to move, he had not taken any analgesia and was in retention of urine. The issue that she raises of the "isolated elderly" is partly demographic but is also due to the closure of small cottage hospitals and a shortage of bed space in the larger general hospitals. One of the study participants who qualified as a district nurse in 1968 remarked on this:

> *"We didn't have the highly dependent patients that there are now. If anybody needed the level of nursing care that some of our patients are receiving they had to go into hospital or an old people's home" DN19*

An area of work that some of the nurses were keen to devote more time to was what they described as "supervisory", "pop-in" or "obs(ervation)" visits. It became apparent during fieldwork that these terms belied the complexity of the visit which usually comprised a combination of re-assessment, psychological support and health education. These visits were often undervalued in the sense that if time was at a premium, they were cancelled first because the nursing input was not hands-on and was therefore less visible. The types of patient who were likely to receive supervisory care were people who had perhaps had a stroke in the past, "the isolated elderly" as DN6 described them, who fell between services, or terminally ill patients.

Supervisory Care

Although supervisory care, under that heading, has always been part of the role of the district nurse (Hockey, 1966), the nurses had difficulty deciding whether it was nursing or not because it was not hands-on. DN34 was amongst those nurses who were less likely to take on such care, not least because supervision was fairly time consuming:

> *"Observation visits...you're not actually doing any hands on nursing, you're just sitting and chatting. Those visits can last longer than if you were going in to do a full general care ...If they need support, well if it's a visit like that sometimes I refer them to social services if they don't really need nursing care but they need something (if) I don't consider it a nursing problem I will refer them to social services to see if they can go in and do an assessment" DN34*

Although it is encouraging that this nurse was prepared to refer a patient on, the problem with referring to social services is that it was not necessarily within their remit either or, as with district nursing, of a low priority when time was a scarce resource. Another of the nurses (DN8) discovered this when she attempted, unsuccessfully, to refer a patient to social services for "support". The patient concerned was Asian, a group who are underrepresented in district nursing caseloads (Dunnell and Dobbs, 1982) and whose needs, because they often fit less tidily into the nurses' remit, are sometimes neglected (Cameron et al, 1989; Hek, 1991). Eventually DN8 took the patient on to her caseload:

> *DN8: "A 41 year old lady. She's originally from India and she's got pulmonary TB and one of the blood dyscrasias...there's nothing physically to do, no nursing tasks as it were...she's got a lot of family problems I suppose you'd call them and really she needs a counsellor but she's not well enough to go to a counsellor because they have counselling facilities at the*

> *surgery. And I was there an hour and a half and I've been there today and I was there over an hour with her and I've told her that I will go weekly. Now I'm not absolutely sure that she is for district nursing'*
>
> *JC: 'Is district nursing quite ill-defined in that respect? (DN8: yes, yes) You're not quite sure what fits into your role?'*
>
> *DN8: 'Yes because I'm quite happy to do it but I've got to think of the team'*

Because district nursing is variously defined, DN8 was concerned that her colleagues might not describe "listening" as district nursing and would be reluctant to visit the patient when she was unavailable. Another of the nurses (DN5) was faced with a similarly complex situation when it was felt that in terms of nursing input, a daily visit could not be justified to an elderly woman who was immobile and highly anxious. The patient's son, however, was adamant that she either required daily visits or should be in a nursing home or hospital. Although the son was not a carer - in the sense that he did not live with his mother - DN5 clearly wanted to take his needs into account when assessing his mother's nursing needs:

> *'A lady with gross oedema and impaired mobility in a big way...There are decisions to be made about the level of input. You feel perhaps you should be visiting everyday because those anxieties exist even though purely in terms of intervention it doesn't warrant that. In a way I feel the decision not to go in every day was quite a difficult one to make' DN5*

Although DN5 eventually decided not to visit this patient daily, this is an example of the way that empowerment of the service user can influence definitions of district nursing. The process by which patients were able to influence service provision is discussed further in chapter 8 of this thesis, but it is interesting that this patient's son was taken into consideration, given current doubts about the viability of "user involvement" in community care (eg. Caldock, 1994; Carr-Hill, 1994).

Some of the nurses unreservedly took on observation visits; DN29 was amongst these. The reason that she was happy to describe supervision as district nursing was that she did not see the role of the district nurse clearly and had no problem with that:

> *"I have sort of a laissez-faire attitude if you like, and if I've got somebody on the books who is old and we've been asked to visit when they've been discharged from hospital I'll perhaps keep them on the books as an observation visit and other nurses will just take them off immediately...I assume those nurses see things very clearly and I don't see our job clearly at all...I don't think district nursing can be clearly defined and yet some people do see the job very clearly and see things as black and white: we should be doing this and we shouldn't be doing that and I don't think that anybody fits into that category" DN29*

The *laissez-faire* attitude that DN29 refers to is a double edged sword. Although a flexible and responsive approach to patient assessment might lead to greater user empowerment or "voice" in decision making, if nurses cannot describe their role clearly it is difficult for them to sell their service to potential purchasers such as fundholding GPs.

Nurses who believed that observation or supervisory visits were unnecessary were in the minority: DN20 was amongst them. She described how when she took over a caseload from somebody else, she pared the list down by reducing superfluous visits. In the following description, she implies that it is the popular patients who are kept on the books:

> *DN20: "I tended to cut quite a few off, because she (colleague) had lots of observation visits which I don't think we should be doing"*
>
> *JC: "How would you describe an observation visit?"*
>
> *DN20: "Again, some nurses keep people on the books who they might have nursed at one point, they weren't quite happy to discharge them and it might be that they can't go over to the elderly care team. If they've had a good relationship with the patient you tend to find they're kept on a bit longer than they should be. Also patients who've been diagnosed with cancer, they say it's terminal but I've know people live for ten years and they're supposed to be terminal... If they're still enjoying life, I think quality of life should go on, you don't need a nurse to come in every five minutes unless the patient particularly wants it"*

The observation visits that DN20 refers to are similar to the patients described by the district nurses in Badger et al's study (1989a) who got "stuck" on the books: they no longer required nursing care but the nurses felt unable to discharge them. There was one category of patient however where observation visits were rarely seen as unnecessary, which was the terminally ill.

Terminal Care

Terminal illness for most of the nurses sanctioned doing things that might otherwise be described as illegitimate. Bathing and washing patients were increasingly seen as illegitimate since the community care reforms, but if someone was dying it was part of the role to do this. The same was true of supervisory visits: they were a legitimate way of getting to know someone before hands-on care was necessary in the final stages of the illness. Nurses frequently said that they enjoyed terminal care because they could "do everything for the patient" (DN2), or it was "very satisfying", as in this quote from DN9:

> *"I think in a way it's a very satisfying area. You feel like your nursing skills have been put, you know, properly. I think it's an important area" DN9*

Her colleague (DN21) described terminal care as "very moving":

> *"I find it very moving, it's the only thing that moves me these days, especially if there's a caring family involved" DN21*

The reason that terminal care was so enjoyable for many of the nurses was that it allowed the nurses to take on their more traditional, pre-reforms role of the total care of a person and their family in their own home. This is perhaps why collaboration between district nurses and MacMillan nurses is sometimes problematic, as has been discussed elsewhere (Griffiths and Luker, 1994a):

> *"It's all your nursing instincts rolled into one - caring for their mind, their body and the family. It's just the ultimate district nursing I think, there's so much you can do" DN11*

Patients tended to be referred as soon as the terminal illness had been diagnosed. When this happened, and if the patient was able to be cared for entirely at home until death, it was seen as particularly satisfying. The nurses were able to provide legitimate support visits and legitimate hands on care, as well as the more technical aspects of the work such the management of a syringe driver in pain control. DN20 described how sometimes "you get the really nice compact one" that fits into the ideal model that is satisfying for the nurse:

> *"We tend to get them fairly early before they need any nursing tasks usually when it's just for supervision and support...which is nice because you get the really nice compact one that starts off on a monthly then goes on a weekly, then you end up going four times a day towards the last and you feel at the end you've done a good job"* DN20

The early "support" visits were still quite difficult for some of the district nurses to justify however. It could be that this was partly because the counselling skills the nurses had were fairly intuitive in one sense, and not something that they formally recognised. Parallels can be drawn here with the work of Kratz (1978) who studied district nurses' interactions with stroke patients, and developed a continuum of care from focused to semi-focused, semi-diffuse and diffuse care. She found that when the aim of the care was known it was more likely to be valued or focused around the patient's needs, and when the aim was unknown, it was undervalued or "diffuse" in terms of the extent to which patient needs were met. Where the nurses in the current study were unsure of the immediate aim of these counselling sessions with the terminally ill, the care could be described as either semi-focused or semi-diffuse. In other words the aim of the care was either known within certain limits or thought to be known, it was valued within these constraints but did not necessarily meet the patient's needs. They were sometimes quite happy to surrender this part of the care to the MacMillan nursing service, therefore, who were perceived to have more "time" and "skills". The next fairly extensive excerpt from the interview data encapsulates the anxieties that some of the nurses expressed about these early "support" visits :

> *DN21: "The MacMillan Nurses have more time to sit and talk... often I haven't got the time to sit for hours waiting for them to*

> *give me an answer really....ofcourse there are skills, I mean the time and the skills, well I've had other patients who've said they don't want the MacMillan nurse going back again, but perhaps they are able to deal with things perhaps in a certain way. If there's something physical that we can do then often we will just carry on going, but I mean more and more we have referrals to go to patients and we are just sitting on the sofa chatting to them and I'm thinking well this realllly isn't our job you know, even when you work in a hospital you don't just sit around chatting to patients do you? I mean it's not your job to do that.. I was talking to (DN9) about this the other day because I had a patient who had lung cancer and he obviously knows, but what do you talk about really? I talk about umm, how they are feeling after the chemotherapy, umm I tell them to ring us if they are starting to feel really sick, not that I know what I am going to do if they are really sick, and I say what we'll do is pop in for a short time say once a week, once a fortnight or whatever just to see. I was talking to DN9 about this the one and she said well you might as well just come out with it at the beginning and say we're coming to watch you die, you know and just making sure you know us. Which is basically what we are doing, we are introducing ourselves because we are not a counselling service, we are basically introducing ourselves so that when they do need us we are not complete strangers"*
>
> *JG: "Sort of befriending in a way then?"*
>
> *DN21: "Yes, it's just that first visit is quite difficult. But what amuses me is the patient accepts it very well. I've spoken to people at large about this and we all feel the same way, we feel uncomfortable that first visit but then the patient says "oh nice to see you, thanks for coming" and you think well I've not done anything. I've not said anything worthwhile but they do seem to appreciate it, I think it's just getting things off their chest sometimes"*

DN21 appears to be saying that by "sitting and chatting" she is not counselling patients as such. She does not have an agenda for the visits and by avoiding certain taboo topics about death and dying, engages in "mutual pretense" (Glaser and Strauss, 1965). Although the patients and their relatives appreciate these support visits, the semi-diffuse nature of her input, to use Kratz's (1978) term, meant that she undervalued them to some extent although she did not discontinue visiting.

The nature of terminal illness is that the patient's condition deteriorates: there is always the possibility that there will be some change between visits, which is how the nurses justified their involvement in washing and dressing or bathing patients. The unknown and the unseen were also unquantifiable however, and created uncertainty. The nurses often wrestled with their consciences when devoting what they perceived to be an inordinate amount of time in the early stages:

> *"I think sometimes I'm a bit keen with terminal patients. Again that's something I've perhaps realised with hindsight. There is one of the other Sisters who covers when I'm not there and I do the same for her and whenever she goes in and does a new terminal they tend to go on to once a fortnight whereas I tend to put them on once a week if there's no sort of dressing or whatever involved and I think perhaps I ought to reduce those visits because perhaps I'm a bit keen from that point of view...We've got one patient at the moment who we go in to weekly and really there's not an awful lot going on at the moment and I mean initially he was daily and then twice weekly because he had bad diarrhoea at the beginning, now that's resolved itself and as I say there's not a lot going on and the week comes around very very quickly and I don't sort of feel a lot has happened in between that time, but they are always very keen for us to go the following week so whether there's an awful lot that goes on between the week I don't know" DN12*

When the early support visits were seen simply as an important period of getting to know someone, or befriending them, there was often less anxiety about the time spent or the nature of the nursing input. This was possibly because the aim of the visit was known and had been articulated, and care was "focussed" (Kratz, 1978):

> *"It is important that we get to know them so that when they come to need the hands-on care they know us and we know them and the transition period is a lot more smooth than if suddenly somebody turns up you know "I'm your district nurse". You've got the poor man flaked out there in the bed and he's embarrassed, he doesn't know you and you don't know him and you've suddenly just come in to take over and it's much easier if they know us and we know them" DN28*

DN28's use of the phrase "to take over" is revealing, as it implies that the patient can expect limited involvement in his or her care. The idea of "getting to know" the patient in the early stages could be considered to be a luxury of district nursing, because it is not something that would happen if the patient was being cared for in hospital or a hospice. The necessity for it could be questioned perhaps, in the same way that Luker (1982) questioned the need for health visitors to get to know clients before asking them detailed and intimate questions on initial contact. For one of the nurses (DN28), getting to know the patient was where the role of the MacMillan nurse fitted in:

> *"The MacMillan nurses can go in that bit more often and they will sit and talk to them a lot longer... I think it's a tremendous role for the MacMillan nurses.. I think they are far more genned up on pain control and counselling than we are. A lot of that is involved in the course that they do, there is a lot of that" DN28*

DN28 does not appear to resent the extra time and skills that the MacMillan nurses can offer to patients. This is in spite of the fact that before the arrival of the specialist community nurse, all aspects of terminal care would have been considered to be within her capabilities and the additional training of the MacMillan nurse that leads to her expertise, is not on offer to the generalist nurse (Griffiths and Luker, 1994a). The lack of resentment is possibly because there is a significant amount of unmet need in the community in relation to terminal care (Bergen, 1991) which the MacMillan nursing service can help to reduce.

The other way in which befriending a terminally ill patient and their family made sense to some of the nurses was when it was acknowledged that this served the interests of staff as well as patients:

> *"We prefer to get them early on, we prefer that time to build up that relationship with them and their families and it allows us time to get our heads round it really as well. Because it's quite an emotional time as well for staff, not only for the families"*
> *DN26*

The reciprocity described by DN26 in this extract is reminiscent of the findings of Chalmers and Luker (1991), that health visitors build relationships with clients to receive something in return, namely continued access to the household and "opening up" about problems. In this case, the district nurses were allowing themselves time to come to terms with the death before the deterioration of the patient. This may be necessary if they consider it important to keep their emotions under control and deal efficiently with the death.

Certainty

For most of the nurses, then, there was slightly more certainty in terminal care about what the nurse's role was - particularly in the final stages - than in areas that frequently defied description such as "social" care. They were prepared to provide "social" care such as washing or dressing, and in fact would not surrender it to social services carers. One of the nurses described a very rare occasion when this happened, because she had been unavailable to assess the patient's needs:

> *DN37: "Last year we had a man who had a brain tumour and I felt it was important for us to go in rather than the home care aides - they seemed to dominate it really - they wanted to go in at first. I think it was better in the end that we went in because they saw how he was deteriorating"*
>
> *JG: "Do you often use social services carers for terminal care then?"*
>
> *DN37: "Last year, this all happened when I went into hospital for an operation. I'd come back and they'd moved in and I thought "oh they're going to take over" because this is what happened with that gentleman and I didn't like it. I thought "oh no they can't be doing this" I don't think they do it much now but I think I got the impression that that's what they set out to do, as well as the elderly, but I've not seen it happen much since...I think it's nice to look after (terminally ill) people, washing them and seeing to everything for them"*

DN37 implies that the reason that this happened was due to teething problems with the liaison between social services and the nursing service. It was unlikely to happen again therefore once ground rules had been established about which patients should be visited by whom.

Some of the nurses acknowledged that the reason they were able to provide intensive hands on care or psychological support in terminal illness was because "*you know it's going to end*" (DN11). One of the nurses was very aware of the resource implications of redefining social care as nursing care when someone was dying:

> *"You could argue again that you are talking about resource implications rather than something you philosophically thought out in terms of, or academically thought out in terms of nursing and social care...I mean it's possibly a bad thing but I think people find it easier to put psychological input into something*

> *that's acute as opposed to chronic, which clearly terminal care is, acute in a sense as the end is in sight and there isn't ongoing commitment to that kind of psychological care that may present itself as washing people or whatever, you know relieving carer's stress by doing things above and beyond the call of duty"* DN5

It is interesting that DN5 defines "psychological input" in this context as providing physical care above and beyond the call of duty to relieve the carer's stress, which is possibly because the nurses had not been formally trained in counselling skills. Certainly during fieldwork, the nurses were not observed providing counselling to patients and relatives, although this might have had something to do with the intrusive presence of the researcher.

The role of the lay carer in all aspects of district nursing work was an interesting one, and was another example of the way in which nursing work was described by the work of others.

The role of the lay carer

If definitions of nursing work and social care were difficult to arrive at when work was being delegated to social services, this was perhaps even more the case when relatives were involved in caring. If a lay person could carry out the work then was it nursing, and how much could the carers be expected to do anyway? There was consistency in the data about what lay carers could be expected to provide, which was, within reason, as much or as little as they wished. That is not to say that the nurses did not grumble "backstage" when carers refuse to help, but that they would never pressurise a reluctant carer. To use Twigg's (1992) typology, carers were viewed either as a resource, a co-worker or co-client. The patients and carers observed during fieldwork fell into the categories of co-worker or co-client because carers as a resource - the largest category of carers in the UK (Twigg, 1992) - are by definition largely invisible to the health and social services. Carers who were co-workers were observed to carry out a wide range of nursing tasks such as catheter care including changing the catheter, pressure area care, lifting, medications and many other areas of care that would not be seen as part of the role of a social services carer. DN10 explained:

> *"I think it's very much up to the individual. I think some people feel better for doing things, actually giving care, whereas others feel better if it was given by professionals. I think that very much depends on the individual case" DN10*

Use of carers as co-workers has important resource implications which will be discussed in more detail in the chapter eight, but for the time being it is interesting to explore how input from relatives can redefine the nurse's role. Sometimes relatives did very little for the patient in terms of nursing care, as DN21 discussed:

> *"The number of times I've said to people do you want to just wash their hands and face before we get there and they still don't do it...We've go a lady who's had a very bad stroke and she's skin and bone and lives with her daughter...but she still doesn't wash her in the morning...She'll change her pads but she wouldn't take her pyjamas off and wash her..you know quite frankly it's harder to take the pads out and change those than it is to wash her hands and face but maybe it's our fault. Maybe we've never suggested that she should. Maybe we feel it's our duty to do that because if we didn't do that what would we be doing? We'd be getting her out of bed in the morning and sitting her in a chair" DN21*

It is interesting that the comments of DN21 echo the findings of Kratz (1978) that unless the patient who had had the stroke was about to die, the relative was expected to provide care. The difference is that although the relatives in Kratz's study would provide care whether they were felt able to or not, where relatives were reluctant to give physical care in the current study, the nurses usually acknowledged that there might be a reason for this and would take it on themselves as DN30 explained:

> *"I think I would just encourage families but it's not very easy. I mean I personally can do things for patients that I can't do for my own mother and I'm most aware of that when I'm asking relatives to care. If the daughter doesn't want to do personal things for her father and quite often for her mother then I respect that...For personal reasons they are quite happy to do the cleaning, shopping, the other duties but not actual hands on care and I think we should respect that" DN30*

DN30's comment concurs with the findings of Hunt (1991) in a qualitative study of five Symptom Control Team nurses, that any expectations that the nurses had of the carers of terminally ill patients, were irrespective of the gender of the carer. This runs contrary to a large body of literature that suggests that daughters, because they are female, are frequently expected to take on the role of carer of elderly parents (Equal Opportunities Commission, 1982; Brody, 1981; Parker, 1985).

One of the nurses used to expect a lot more input from carers at one time until she had to care for her own mother. Bowers (1987) articulated the situation she describes as the role reversal inherent in parenting one's parents:

> *"I was guilty of that myself, I used to think if they'd got a daughter... because my sister's disabled and I do a lot for my family. It wasn't until my mum had actually broken her arm and she couldn't wash and dress herself and I had to do it and I thought it was totally wrong to wash my mother, whereas before I used to think if there's a daughter in the house why can't she wash her mother... I didn't like it and my mother didn't like it either"*

More of an issue for the nurses was that sometimes the relatives wanted to take on too much of the nursing care of a patient, as DN11 commented:

> *"Usually they're doing too much I think...when you've done something for so many years: you see daughters with fathers or mothers, you know their entire life's looking after them, it's become the norm. And although I'm not going to barge in and say "this isn't normal and stop doing it" everybody's entitled to a bit of a life and if the services can relieve them of some of the strain them so be it" DN11*

Nolan et al (1995) however, warn against the assumption that the carer is necessarily reluctant to give this level of support. They suggest that caring is usually either explicitly or implicitly reciprocal, and argue that the issue of reciprocation is missing from Bower's (1987) description.

The boundary issues raised so far about definitions of nursing such as whether someone's care falls under social or nursing services, and the role of the lay carer suggest that there was no standard assessment in district nursing for any type of care, which was in fact the case. The district nurses concluded that because there were so many factors to consider when deciding what the input to a patient should be and from whom, there was "no standard assessment" (DN15).

Assessment

In theory at least, if practice is to be evidence based and if there is to be equity in care provision, two patients with a similar condition should receive approximately similar nursing input. DN5 explained why this was unlikely to be the case:

> *"You could say that any district nurse should be able to visit any given patient because there's that much consistency, everything is so solidly based in scientific fact or research, that there's a push button response to any given problem, but it's not like that because people bring themselves to it and it's about people interacting and when you meet somebody either professionally or socially the interaction can work well or it can work not so well and while there does have to be a framework for it working on certain terms I think the perfect relationship is impossible to guarantee because it's about people interacting"*
> *DN5*

DN5 implies here that how well the nurse gets on with the patient is a factor in the assessment, which raises the issue of "the popular patient" again and who that might be, but perhaps more significantly, she acknowledges that nursing is in essence a social interaction. Social interactions are not predictable or scientific and an assessment of one person by another is unlikely to be the same as an assessment of that person by someone else. It has been recognised for some time that visits from district nurses can vary tremendously in both duration and content (Hockey, 1966; McIntosh and Richardson, 1976; Badger et al, 1989a). There is no formal assessment as such because although nurses can use a history sheet, they rarely do as DN11 pointed out. She described the intuitive element of assessing a patient's needs, which at first sight is somewhat akin to Benner's (1984) description of the "expert" practitioner:

> *"While I'm looking at the patient I'm listening to the carer, maybe the tone of his voice or his agitated state. I'm smelling with my nose, I'm seeing with my eyes. I can tell she's not had a bed change for 3 days because of my nose - nobody has to tell me that and I don't have to ask the question. So an assessment isn't a string of questions, it's a lot of sensations that come to you - years ago I'd take the whole assessment form with me but I don't have to do that now"* DN11

What DN11 appears to be saying however, is that she is so familiar with the assessment process that she now has a mental map to guide her through the nursing assessment, which is more in line with Luker and Kenrick's (1992) explanation of intuition in district nursing which they refer to as knowledge re-defined. DN29 explained why she thought formal assessments "do not work":

> *"I'm not really into formal assessments. I don't think it particularly works and often if you do have that approach, when you're about to leave, you perhaps admire a plant or something like that and it's then that you get the problems come out, not with straight questions"* DN29

The following quote was typical of a consensus amongst the nurses that everyone assessed differently:

> *"I think each nurse assesses differently anyway. I mean I can tell you in that room nurses assess in different ways. Some nurses still like to take on the social care element and we're not supposed to...if they've been in employment a long time it's very difficult to change...a lot of them still like the hands on whereas you shouldn't really do that"* DN20

Another recurring theme was that there was no right or wrong in the assessment of someone, just a different styles: as one nurse commented "there's more than one way to skin a rabbit" (DN10). The following quote is from an F grade Sister:

> *"I mean you don't always agree with the way they (G and H grade colleagues) assess patients. I mean it's not wrong what they've done, it's not wrong what I've done, it's just assessing in different ways and I've got different ideas" DN37*

If everyone assessed differently because there were so many factors to take into account, then when the number of variables was reduced, it could be assumed that assessments would follow similar lines. Wound care might be one example where there are now research based guidelines for practice (eg. Kenrick et al, 1991; Cullum and Roe, 1995; Nelson, 1995), but during fieldwork it was apparent that few of the nurses were conversant with these so there was still much variation in practice. Lifting was perhaps the best example because all of the nurses were familiar with the recent legislation on manual handling and had recently been formally updated on lifting and handling techniques. Interestingly, because the nature of nursing is that it is a social interaction, there were still inconsistencies: some nurses stuck to the guidelines rigidly and others ignored them completely. DN24 was amongst those who said that they would never lift if it was not safe to do so:

> *"I think health and safety at work needs looking at.. It's always a high priority with me. I would put the risk to the patient and the risk to the staff very high.. a lot of patients are resistant to hoists...if I though there was a danger to the patient or the staff then I would argue and if necessary bring the managers in 'you will have' sort of thing" DN24*

The paternalistic tone of "you will have" is interesting in this quote because it illustrates the extent to which this nurse was able to distance herself from the patient's wishes. DN21 on the other hand said that she lifted heavy patients manually "all the time because it's easier", and if she refused to lift someone who was too heavy she would feel that she was not doing her job properly:

> *"Officially you're not supposed to ...(but) then you feel very unprofessional and you feel well what am I doing here? That's something I can't cope with really. I either do the job properly or I don't bother to do the job at all, you know you have to give the full care really"* DN21

One of her colleagues agreed with this:

> *"I've never refused to lift... the reason why we are nurses is because we care and if we don't lift that patient, that patient is laying down or not in a good position. I think it stems from how we are really rather than what we are" DN10*

The example of ignoring guidelines on lifting reflects a lot of district nursing practice: when faced with a situation in a home, the nurse will quite often go ahead and sort it out whether or not it is within her remit: as Evers et al (1991) pointed out, district nurses rarely say "no". The nurses are still giving "social" care by any other name and some of them perhaps always will do as DN20 suggested earlier: "if they've been in employment a long time it's very difficult to change". The difference with lifting however, is that it is very dangerous to carry out certain outmoded practices for both the nurse and the patient. The nurses in this study had been recently trained in safe handling techniques which raises issues about how receptive they were to new information and ideas.

The reason that the nurses worked differently, and that variation in practice was permissable, was partly due to the isolated context of their work. When a workforce is invisible as in the district nursing service, it is difficult to pass knowledge on. The invisibility of the nurses practice and the level of autonomy that this afforded will now be explored in the next chapter.

Summary

When a patient is in the home environment many needs come to the nurse's attention which she may disregard, meet or refer on. Working out which of these needs could or should be met by the district nursing service was frequently complex for study participants. Defining the role of the district nurse inevitably meant ignoring some needs that did not fall within the remit of the service, and passing on other aspects to colleagues who might or might not take on them on board. This was particularly difficult for some of the nurses who had trained at a time when district nursing was almost anything the patient said it was, from bathing, polishing shoes and preparing meals, to all aspects of terminal care. The role of the social services carer was crucial in defining the role of the district nurse and, to a lesser extent, the role of the lay carer.

CHAPTER 6: FINDINGS

Autonomous Practice

Introduction

The context of district nursing practice in the community means that district nurses are relatively isolated compared with their hospital based colleagues. This affords a sense of autonomy, which was amongst the reasons that the study participants gave for leaving hospital to enter the community. The data presented in this chapter explore the extent to which the nurses were genuinely autonomous, or autonomous by default as a result of the context in which they worked. District nurses are dependent on referrals from other agencies which means that the individual nurse's control over her caseload is effectively limited to the way she organises it and the priorities she sets. It is evident that this constraint, coupled with the organisation of care in the community both financially and conceptually, renders the individual nurse relatively powerless in many respects. In spite of this, the illusion of the "autonomous district nurse" persists for a variety of reasons.

Working alone

Much of the work of the district nurse is unseen, in that it is carried out in the patient's home and is not overlooked by colleagues. This was a feature of district nursing that the study participants valued as it conferred a sense of autonomy that was in direct contrast to the hierarchical management and overseeing of the hospital ward. For example, during fieldwork one of the nurses said that she would "hate" to go back into hospital now where she would resent "being told what to do" (DN3); and another of the nurses summarised the reasons she left hospital for the community as:

> *"The freedom.. and there are fewer structures than in hospital"*
> *DN5*

Although freedom and autonomy are not synonymous, the two are inextricably linked (Holden, 1991) and while district nurses are possibly less autonomous than other community nurses such as health visitors (Symonds, 1991), they have always been viewed as more autonomous than their hospital colleagues (Dingwall et al, 1991). Although skill mix is being introduced to district nursing which is imposing a hierarchy of different grade staff (NHSME, 1992), the hidden nature of the one *on one relationship with patients, and the physical distance* from other colleagues disguises this to some extent. It is perhaps unlikely therefore that skill mix will *detract from the nurses' sense of autonomy. Some of* the nurses used the word "autonomous" to describe their practice, and others used the language of autonomy as the following extracts illustrate:

> *"You can do your own thing" DN3*
>
> *"I think you have far more responsibility* at a *clinical level and you are far more in control about what care you give to the patients...So you are far more able to utilise the skills and expertise that you've got than within the confines of the hospital situation" DN1*
>
> *"I like working alone quite a bit and having that sort of freedom to make my own decisions to a large extent..." DN8*

The extent to which the nurses had the freedom to make their own decisions refers to the choices that they made when they were in direct contact with the patient. The nurses were still constrained however by organisational issues such as the other team members commitments and abilities. DN8 continued:

> *"...although working in a team you have to sort of consider what the team will be able to do, can do, or will do: will my colleagues agree with my prescribed care and so on" DN8*

Another constraint was the unpredictability of the flux of referrals and requests from colleagues in other disciplines. District nurses are unable to *control the flow* of their work to any major extent as they are highly referral dependent, and the public have only limited direct access to the service. The number and type of referrals from the GPs and the hospital were not constant and could arrive in the request book at the surgery or on the answerphone at the clinic at any time of the day. It could be argued that this creates an interesting tension in the wake of the new market place ideology of the health service, where the district nursing service is increasingly required to sell itself to potential purchasers (DH, 1989b). For example GP fundholders have to know what it is that district nurses do - or are prepared to do - for them to make the referral in the first place. The discussion in chapter five illustrated how variable the role of the district nurse is, and it has been suggested previously (Griffiths and Luker, 1994a) that increasingly, the generalist district nurse is oscillating somewhere between the two poles created by the clinical nurse specialist and the social services carer.

Invisible work

The extent to which the district nurses' day to day work was invisible to everyone except the patient and/or family is exemplified by the following quote:

> *"If you've got six patients and it takes you till one o'clock somebody might say "you've done a couple of general cares there and an insulin and a dressing, how come it's taken you so long?" But it can take you that long if you've got the time to spend with people, but it's not easy to say what you've done all morning. You haven't got any paperwork to show" DN27*

In this example the autonomy of the nurse to allocate her time at her discretion - which has always been a feature of district nursing (McIntosh and Richardson, 1976) - can be attributed to invisible work. Perhaps it was because she was unseen, that DN27 was free to decide how much time she devoted to individual patients. This extract also illustrates the difficulties experienced by the nurses in describing their work, particularly those aspects that were not only unseen but virtually impossible to quantify. It was a source of anxiety for the nurses during fieldwork because the presence of the researcher increased the visibility of their work and study participants felt compelled to justify their nursing input to each visit. An extract from the field notes illustrates this point:

> *2/12/92, DN1, visit 8: Male patient, described in car before visit as: "old" neurosyphillis, Ca lung, "chest complaint", "very withdrawn". Nursing input described as a support visit for his wife. DN1: "it wouldn't matter really if I didn't go up and see him really, it's his wife that needs the help". On entering the house, DN1 went upstairs to see the man very briefly and then went downstairs to spend the remainder of the visit with his wife, who was very anxious about her husband's lack of appetite. DN1 gave the wife a lot of information and reassurance about diet and nutrition. It was clear that the wife felt a lot better for DN1's visit: she was effusive with her gratitude. When we had left the house, DN1 asked "what did I do in there?" implying that she had not "done" any nursing tasks, but that she actually knew that the visit was worthwhile. She had actually "done" a great deal to support the wife*

A degree of adaptability at the nurse-patient interface is inherent in this example because although the nurse ostensively visited the house to provide terminal care, she decided that her time could be put to better use offering support and health education to the patient's wife. Although compartmentalising care in this way runs counter to the ideal of "holism" (Welsh Office, 1987; RCN, 1990), this flexibility, which is essential to caring for families, might contribute to district nursing's sense of autonomy. It is interesting therefore that DN1 appeared to undervalue her expertise. Arguably, someone less qualified or informed could not have allayed this woman's anxieties, because it was information and advice she required about nutrition. It was evident that the reason DN1 was able to provide on the spot advice on this occasion is that district nurses are generalists with a broad knowledge base, yet DN1 seemed oblivious to her expertise to some extent, because earlier in the day she said "I can't describe what it is that makes my job a G grade, why you need a qualified nurse. If I can't describe it and I do the job what hope is there?". It is perhaps not surprising therefore that the Audit Commission's review of district nursing skill mix (NHSME, 1992) which took place in DN1's community trust, made recommendations for a reduction in the numbers of qualified staff.

An alternative explanation for DN1's unease about the visit is that she was unable to provide counselling to either the patient or his wife, either because the researcher was present or because she did not have the skills. Her reaction therefore was to give practical information, and avoid the topic of the imminent death of this woman's spouse.

Problems inherent in invisible work

The invisibility of solitary working could be lonely initially, as the student nurse data verified. The staff nurse recalled that:

> *"... the loneliness was the worst. That was the very worst I think...I really hated it. I used to live for about half an hour in the morning and half an hour at lunchtime when we were doing the books and stuff, because I found it really difficult"*
> *Staff Nurse*

One of the undergraduate nurses (SN2) who was considering working in the community, recognised that the opportunity to practice more "autonomously" was closely allied to solitude in district nursing:

> *"The autonomy appeals in that your decision sticks most of the time on things like wound care and that sort of thing...what doesn't appeal is it's quite lonely" SN2*

Unlike on a hospital ward, the district nurses were unable to see all of their patients, so they could not check on them and prioritise their work accordingly. A lot of speculation or educated guesswork went on therefore, and the nurses were never quite sure what they would find when they walked through the patient's front door:

> *"You don't see your patients every day which you do on the ward. You walk down in the morning and you say "good morning" to them all and you know exactly how everybody is that day...If I think back to the wards then yes it was peculiar that I couldn't look down the ward and see all the patients"*
> *DN11*

The fact that patients were also invisible to one another could potentially create difficulties, especially when the nurse had a heavy caseload that day. One of the nurses (DN21) discussed a young woman with multiple sclerosis (PT4) who was perceived to be oblivious to the unseen work of the nurse. She described tactics for increasing the visibility of her work when she was particularly busy:

> *"I mean she'll say "I know you're busy but I still have to have my bath" and "it's more important than anybody else" is her attitude...I've learnt now by knowing her well enough how to make her feel guilty. I'll go in late deliberately and make a point of telling her I've got three more to do after her and if anything, I don't know, not mentioning any names, if anything really horrendous happened I would tell her just how sick and bad other people can be...she'll go very quiet then. Just to remind her from time to time" DN21*

The tactics that DN21 describes for increasing the visibility of her work raise several interesting points. Firstly, the approach that DN21 took with this particular patient is relatively unassertive and indirect, which could be considered to be quite excluding from the patient's point of view. The issues of patient empowerment or user involvement in care decisions are raised therefore, and whether they are likely to remain an elusive ideal. It could be that nursing "autonomy" in this sense, is not particularly compatible with patient autonomy.

Secondly, conveying a sense of urgency to patients might be a useful tool for ensuring that the nurse's time can be divided more equitably amongst the caseload, but it also illustrates the extent to which the nurses were unable to control the flow of their work. Verification that a sense of urgency was successfully conveyed to patients was found in the interviews with the younger disabled patients, who described the nursing staff as "always in a rush" or "chasing their tails all day long". For example the patient that DN21 was referring to (PT4), made the following point about the evening service:

> *"There are lots of ways you can make a patient feel uncomfortable - that a nurse can make a patient feel uncomfortable - without actually doing anything...It's very easy to come in and say "we have lots of other patients, we can't spend too long with you etc etc etc" or "it won't go any better than that, it won't get any less creased, it won't go any lower" when you're asking for certain things to be adjusted: the bed clothes or something, or "that's as good as it will ever be" you know. It's a refrain to me words like that"* PT4

Patient 4's comments illustrate the extent to which she felt excluded when some of the nurses took an indirect approach to negotiating a shorter visit. In contrast, other patients had become so aware of the pressure the nurses were under, that they were concerned for their safety and well-being. The following extract is from an interview with a young tetraplegic man (PT7) who became disabled following a road traffic accident. PT7 appeared, somewhat paradoxically, to be more concerned about the nurses' welfare than he was about his own:

> *"Well I have literally seen nurses who at one time they could come in, they could do the job, they could ask a certain number of questions on general health and so on and make notes and go and do the job quite thoroughly and also keep a regular recorded check. Now it's a case of their basically flying in, doing what they've got to do, scribbling down a single line on a sheet of paper and that's it, they're off, because they've got to join somebody somewhere else... the girls they're having to rush, it's making things dangerous because these girls cannot be driving within safe speed limits, you know, to get round the amount of clients they've got to do and yet it is part of their job, and yet they want to carry on doing their job to the best of their ability...if it wasn't for the fact that people are so bloody dedicated. I mean you've got to be dedicated to be a nurse...It's bloody hard work, it's lousily paid and you don't get the recognition you deserve..."* PT7

This extract illustrates the extent to which it was apparent to patients that the nurses' time was dictated by external pressures. PT7 assumed that the nurses were under pressure, that they had his best interests at heart and were not just rushing to get through the work and off home. The nurses who "fly" in an out of this patient seemed to engender pity which PT7 framed as respect for their dedication, not that the two are necessarily incompatible. It is interesting that he commented on the increased time pressure on the nurses, which later in the interview he attributed, rather non-specifically, to "the community care reforms". So although this patient appears to have some understanding of the context of district nursing work, he remains disempowered to do anything about it.

During fieldwork it was observed that it was not only the patients who were made aware of the pressure of nursing work. The nurses also attempted to increase the visibility of their work to their peers. Far more common than discussions about care, were monologues about how much they had "done" that morning and how much there was "left to do". Monologues were often described by the nurses as dialogue or "discussion" about a patient, but this was observed to be infrequently the case. One of the student nurses (SN4) made a similar observation about the team of district nurses she worked with:

> *"They've got a bit of a communication problem because you'll go in there and they're all in that one big room - and I've really noticed this several times - they won't wait until they've finished their sentence, someone will be talking and the other person will just butt in...So say there were six or seven people in the room in the morning, they would all be talking at once to each other and they'll cut in...they don't sort of really wait for each other to finish" SN4*

The nurses in this team apparently did not have team meetings, so although they were apart for a lot of the time and therefore had plenty to say to one another, there was no formal platform where this could take place.

Factors that promoted a sense of autonomy

In addition to isolated context of their work, other factors promoted a sense of autonomy. One of these was the nurses' physical distance from management which had the effect of empowering the front-line workers, as previous authors have discussed (Jupp, 1971; *Kratz, 1978). This was particularly the case in the* evening, as a nursing sister (DN16) from this service explained in the next extract:

> *"It's very much on your own and you make your own decisions. You haven't got any management around except I know my management. I've only had to call them once and that was for a drug abuse when someone took some diamorphine and had it themselves. You're very much on your own and when you come across something it's up to you. To me that's old nursing rather than the days like today when you're thinking "is there someone around I can ask for their advice?" " DN16*

It is possible that the evening Sister was reframing the isolation of working unsocial hours in a more positive light: management are largely unavailable in the evenings anyway so it is convenient to some extent that she preferred to work alone. DN16 equates the evening service, somewhat nostalgically, with her memories of "old" district nursing when there were fewer teams, nurses were relatively geographically isolated (Hockey, 1966) and they were out of necessity more autonomous, or appeared to be. Perhaps the context of their work *did* render the evening service more autonomous than the day service, but distance from management was perceived by many nurses to be similar during the day, and contact with peers was also quite limited.

Many of the nurses alluded to issues of "control" and "power to make decisions". This, it appeared, had a lot to do with the flexibility afforded by the invisibility of one patient from another, and the comparative inaccessibility of the nurse when she was visiting other patients. If the nurses chose to spend extra time with a patient in the morning, then one or more visits could and often would be postponed until the afternoon:

> *"You're your own person and you can do what you want when you want which is part of the joy of district nursing really. I say to people it's the closest thing to intensive care nursing you can get and if I ever went back in hospital I'd go back in intensive care because at any one time at any one day you're only looking after one person, it's just centred on them. That's partly why I left the hospital because you've got six people saying "Sister, Sister, Sister" and the porter's demanding this and the cleaner's demanding something else and the students all need teaching and you can't do it all at once whereas in the community you can spend as little or as long with that one person as you like and do what you want within reason obviously" DN20*

It is interesting that DN20 should draw an analogy between intensive care nursing and community nursing, because the two could be considered to be at polar opposites of acute and chronic nursing care. Similarities lie in the one on one relationship with patients and their relatives, and the comparative length of time that the nurse is involved with each individual. It is unlikely that being alone with a patient in the community and free from immediate external pressure is analogous to complete control over the management of someone's care, but the isolated context of caring certainly contributed to this sense of autonomy and to some extent facilitated it.

Respecting colleagues' decisions

Another factor that encouraged autonomy was the respect the nurses had for their colleagues' clinical decisions. A sense of collegiality permeated the nurses' discussions about their colleagues which might, in part, be attributable to the historical context of district nursing. Until the arrival of skill mix, nurses in the community have by and large been of a similar status to one another which has encouraged collegial intraprofessional relationships to develop.

In the literature, collegiality is variously depicted as a positive and negative feature of relationships between same status colleagues. Collegiality as a positive attribute is perhaps best defined as "collaborative" collegiality. For example in a study by Feiger and Schmitt (1979), interrelationships in multi-disciplinary health teams were described as "collegial" when there was no hierarchical differentiation in the participation of team members in decision making. Using quantitative measures of collegiality and patient outcomes, the authors concluded - reservedly - that higher collegiality scores were related to more successful patient outcomes. More recently, McMahon (1990) described the impact on hospital nurses of the collegial intraprofessional relationships inherent in new style primary nursing. In a study which compared the organisational structure of four hospital wards, McMahon described an undifferentiated hierarchy in primary nursing where the balance of power was held collectively - or vested in individuals - rather than in the hands of a minority. This, it was argued, led to greater autonomy for the nurses both individually and professionally. Parallels can be drawn between the flattened hierarchies of primary nursing in hospital (Ryan, 1989) and district nursing in the community, where it would appear that collegial intraprofessional relationships have afforded a similar sense of personal autonomy.

One of the nurses expressed the respect for colleagues' decisions inherent in a more collegial approach as non-interference :

> *"Well usually with either of the team (members) I don't interfere with how they do their care and they don't in turn interfere with how I plan my care"* DN30

The implications of non-interference have rather more negative connotations than "collaborative" collegiality, and are reminiscent of the suspicions of authors such as Freidson (1975), Strong (1979) and Wilding (1982) of medicine, that collegiality can lead to a non-challenging culture where professionals do not comment on each other's work and are apt to close ranks. One of the nurses was eager to frame non-interference however in a more positive light. She equated it with valuing difference per se, in the same way that racial differences should not be seen as wrong:

> *"I think there is a certain willingness to accept other people's abilities to assess the problem, a certain respect for it as well...I like to respect people for their differences. I mean it equates to kind of racial questions in a way that I see people being different as a healthy thing"* DN5

Respecting people for their differences is also part of the UKCC code of conduct for the nurse midwife and health visitor, where again it is viewed as a positive attribute (UKCC 1987).

Accountability

So it would appear that because same status colleagues had a similar level of training, they were considered to be equally responsible for their clinical decisions. It follows therefore that if the nurses were working in isolation and making relatively free decisions uninhibited by interference from others, they would perceive themselves to be accountable for their actions, which is another requirement of the UKCC's (1987) professional code. DN30 commented:

> *"I think one thing you've got to remember is that it is that Sister's caseload after all, she is the Sister who is accountable for it so I think by rights we should really do what it says on the careplan" DN30*

The words "accountable", "the buck stops here" and "responsible" were used in one form or another by all of the study participants. It would appear therefore that nurses in the community had a heightened sense of accountability due to the context of their practice:

> *"When all's said and done it's their responsibility that patient" DN27*
>
> *"I like the responsibility as well being out in the community... the fact that you're 100% responsible for the actions that you do" DN12*

The heightened sense of accountability - and autonomy - in district nursing was verified by the student nurse data. This is perhaps best explained by the fact that what ever the nurse's grade or qualifications, solitary working, an apparently important determinant of "autonomous practice", is an inescapable fact about working in people's homes. One of the undergraduate district nurses believed that even as a student "you're your own boss" (SN3), and the staff nurse from Site B who was on supervised practice commented:

> *"The buck stops with you basically because you're doing the work out there"* *Staff Nurse*

GPs encouraging autonomy

Another factor which promoted autonomy was the relationship that the nurse had with the GP. Although the nurses relied on the GPs for referrals, it was in the GPs' interest in some circumstances to "allow" the district nurses to work autonomously:

> *"I think in the hospital it is very much the consultant and his team have the power over all aspects of the care of the patient, whereas out in the community you are allowed to develop your own expertise and decide on what aspects of nursing care need to be implemented and I think GPs find it easier to allow you to do that. I mean maybe that's because they haven't got the time to be involved so much in the nursing side of patient care, but I think a lot of it is they trust the district nurses to do that"*
> *DN1*

The concept of "allowing" the autonomy of the district nurse, was particularly the case where dressings for wounds were concerned: the nurses were effectively prescribing treatments although as yet they did not have the legal power to do so. For example during fieldwork the researcher observed many instances of district nurses either writing out or printing prescriptions for the GPs to sign, or leaving a list of dressings which the GP would then copy on to a prescription.

The majority of nurses believed that the GPs they worked with had an insufficient understanding of wound care and dressings. This was frequently the case in the management of patients with leg ulceration. For many years, the treatment of leg ulcers has formed a substantial part of the district nurse's caseloads (Journal of District Nursing Survey, 1987) and, until fairly recently, leg ulceration was an intractable problem that neither the nurse nor the doctor had much idea how to deal with (Callam et al, 1985; Roe and Luker, 1992). Although the effective management of leg ulceration remains a problem for many district nurses (Roe et al 1993a, 1994; Luker and Kenrick, 1995), clear guidelines for practice are increasingly available which, in this study, were usually via recently established leg ulcer clinics.

It could be argued that it has suited GPs for many years to hand this complex area of care over to district nurses, whether or not the nurse had the knowledge to successfully treat the ulcer. It is interesting therefore that in the following quote, the nurse delighted in the autonomy she was "allowed" when it came to wound management, in spite of the fact that all the evidence suggests that wounds, especially leg ulcers, have been treated with only moderate success for years:

> *DN9: "Thankfully I've got some GPs who, I mean half of them are quite approachable and don't care what I put on as long as I go in and put something on so they are quite amenable really...the position at the moment is we usually dictate to GPs what we want and they write the prescription"*
>
> *JG: "And don't ask any questions?"*
>
> *DN9: "Not usually no. They're quite willing to accept what you've decided. We've still got some GPs who maybe don't even look at the leg and just prescribe sofratulle for everything so we usually leave a little prescription note in the surgery and ask them for alternative dressings. They don't usually question, so if we could prescribe it would be a lot better. It would not so much be easier, but it would get the treatment going a lot quicker"*

The language is interesting here. DN9 leaves a "little prescription note" as a "little telling off!" almost, demonstrating how indirect she is with the GPs that she works with. During fieldwork, it became clear that this particular nurse had limited understanding of the effective management of leg ulceration and many of her patients had been "on the books" for years, yet she valued the freedom to prescribe afforded to her by the GPs' lesser knowledge. Evidence for lack of interference from GPs was supported by the student nurse data. The staff nurse from Site B believed that the GPs she worked with were particularly "disinterested", but again this was reframed in a more positive light as the freedom to prescribe:

> *"I mean if the GPs are that disinterested in us they're often disinterested in what we're doing so we have pretty free rein anyway so you can sort of get on and do what you want" Staff Nurse*

It would appear that the Staff Nurse was autonomous by default therefore when choosing products for wound care. Parallels can be drawn with the work of Hughes (1988) who studied nurse doctor-nurse relationships in a casualty department. He discovered an encouraging level of collegiality that he might not have expected from the literature on doctor-nurse interrelationships (eg. Stein 1967). The heightened sense of autonomy that the nurses experienced was attributed to the fact that many of the casualty officers were either young and inexperienced, or from overseas and therefore overcoming cultural and language difficulties. It could be argued that the casualty nurses were also autonomous by default.

The boundary between nursing and medical work

A sense of superiority almost was described by the nurses when GPs appeared to be less experienced than them in an aspect of care, which might be attributable to the relative status of the two occupations of nursing and medicine. Alternatively, because district nursing is relatively ill-defined, it could be that experience in an area of care begins to delineate nursing work. One of the nurses (DN2) said that she was often asked to take blood samples from patients because the GPs were "scared of" the new vacuutainer closed system for venepuncture that had been recently introduced. This is an interesting example because ordering blood samples and interpreting the results are diagnostic procedures that are traditionally within the medical domain. Although it was the doctors who usually ordered blood tests, the nurses were often observed to initiate this and on one occasion, a nurse (DN1) was observed to take blood from a patient who "looked anaemic" without a request from the GP.

The nurses were also observed to accept a lot of requests for routine bloods from the GP. Whether or not this is an efficient use of nursing time was raised as an issue some twenty years ago by McIntosh and Richardson (1976), but the question remains unanswered. The answer possibly lies in the employment of district nurses by fundholding GPs, who it is likely will increasingly dictate what falls into the nurses' role.

Another example of the sometimes indistinct boundary between nursing and medical work is provided once again by the nursing management of wounds. In the next extract, another of the nurses (DN29) explained that because it appeared that the GPs she worked with did not understand the first principles of wound care -"they like scabs and things"- prescribing wound care was left up to her. The dressing Granuflex that DN29 refers to, creates a warm, moist healing environment which it is now established is the ideal condition for wound healing: scabs were found to delay the healing of open wounds as long ago as the late 1950s (Winter, 1962):

> *"We are usually more up to date with wound care. GPs are very frightened of things like Granuflex. They're never quite sure of it because it goes yucky, they really worry about that, they don't think it's doing any good, they like scabs and things and if you've got a good relationship with them they will let you use things like that even if they're not quite sure, kind of thing" DN29*

Although the day to day management of wounds is well within the remit of the district nurse, prescribing products and systemic antibiotics remains, for the time being, the role of the doctor. Lack of interference in the treatment decisions of the nurses could be seen as respecting a colleague's expertise and autonomy; or on the other hand, it might have been an excuse for the GPs not up-dating clinically in an area that is not particularly glamorous and notoriously difficult to manage.

District nurse - GP collegiality

Other nurses supported the view that some GPs relied "heavily" on the district nurses. For a minority of GPs, this extended beyond the occasional clinical procedure:

> *DN11: "I think some GPs find life very hard especially ones who are single, on their own, they've no colleagues to discuss matters with. I think they rely very heavily on the district nurse and her opinion of situations"*
>
> *JG: "So you think there's more of a colleague relationship where you've got a single handed GP?"*
>
> *DN11: "Again with district nursing more intense than hospital, I think the GP/district nurse relationship can be very intense when there's only one GP"*

It could be, then, that collegial relationships and respecting autonomy are a useful means of stress reduction for some GPs. One of the nurses (DN18) gave an example of this with reference to a new partner at the practice:

> *"We've just had a young partner come into the practice and he's quite "oh nurse can you do this?" particularly things like bowels and things which you're more experienced in or treatments and care. You have to sometimes say "look we do have experience and this is the best thing in my opinion" and help him along because otherwise he's got this doctor-nurse thing. Quite often I think he found it quite stressful at first because he felt he should be making decisions all the time about patient care and letting us know what he wanted to do for a patient and it was a while before he realised that we do actually assess them" DN18*

There are parallels here with hospital nursing, where there is evidence that the experienced nurse is an invaluable resource for less experienced medical staff and the "doctor-nurse thing" that DN18 alludes to is beginning to fade (Hughes, 1988; Porter, 1991).

Autonomy, or more autonomous working patterns were of benefit to the nurse, however, irrespective of the advantages to other colleagues such as GPs. "Non-interference", as some of the nurses described it, was one solution to the problems inherent in working alone. In order to practice effectively, the nurses felt that they had to rapidly build up tremendous self-confidence, which was something that none of them found particularly easy having left the ward environment, where they were surrounded by peers, for the invisible work of nursing in the community.

Confidence in self

Confidence to practice was essential to the district nurses studied. In order to build their self confidence it was important that to some extent they were left to their own devices, without interference from others. One way around the issue of attaining confidence might have been to hold regular meetings with open discussion of caseloads, but this did not happen in any formal sense in the district nursing teams studied. The problem was compounded by the fact that unlike their hospital based colleagues, the nurses had no one to immediately check in with when making a decision about a patient's care:

> *"Some people are natural district nurses, some people are natural hospital nurses. It's a different personality... more confident I think. I think you have to be...You have more freedom but with that freedom comes the aloneness that if you're not confident you'd crumble under and you wouldn't like it. There's no one to say "and what do you think about this". You've got to do something at that immediate moment in time because you're the one person in the house"* DN11

This nurse endorses the rather archaic view that district nurses are "born and not made", which Hockey discussed in the 60s (Hockey, 1966). Perhaps people who choose community nursing are more confident, but all of the nurses described their early experiences as "nerve-wracking" or alluded to this in some way:

> *"It is nerve-wracking when you first go out because in a hospital you've got your colleagues, but to actually go knocking on someone's door..."* DN27

The difficulties caused by the lack of immediate peers were verified by the student nurses who had more recently left the environment of the hospital ward. One of the undergraduate nurses said she would not work in the community when she qualified for precisely this reason:

> *"I don't feel confident enough really to act autonomously"* SN1

Another of the undergraduate students agreed with this, acknowledging the extent to which she relied on peer support in hospital:

> *"You're out there on your own aren't you? You haven't got people to turn round to who are like within 100 yards of you, 200 yards, to turn around and say well this is happening...I know there are situations where I've gone and haven't felt confident and I'm sure it must have shown especially when I first started in the first two weeks, like you don't know where to start, you just walk into this house..."* SN6

The staff nurse from Site B who found district nursing "very lonely" when she first started recalled similar difficulties with the lack of peer support. It is interesting therefore that when she did have the opportunity to check in with her peers, she suggests that they were likely to agree with the decisions she had made:

> *Staff Nurse: "When I first came out I found it really lonely. Another thing was not being able to turn round and say to someone "I think this, what do you think?" Just having someone else's opinion, even like when you're in hospital and you know what you're going to do and you knew that something should be done, I think you don't realise how much you turn round to someone and say "oh do you think we should do that?" knowing full well that's what you're going to do"*
>
> *JG: "Does that go on much in the community? Do people ask each other's opinion?"*
>
> *Staff Nurse: "Yes I think it does but it's more when you come back and say "I went to so and so this morning but she wasn't too good, I've done this what do you think?" and they'll say "fair enough". But I do think you rely on people a lot in hospital to ask them for back up. I don't think you realise how much you do until you come out and you're by yourself"*

The idea of checking in with peers although the decision had already been made relates to the suggestion made earlier that "monologues" were sometimes a foil for discussion between colleagues. It is also something that might be expected within a collegial relationship, as has been suggested in relation to doctors (Gillon, 1990) where uncritical support of colleagues is the norm of the group. Checking in with peers was something that the qualified nurses talked about, as the following quote illustrates:

> *"It took me a year to get over the differences....well first of all the working alone a good proportion of the day because I'd always worked in institutions where there were people around, doctors other nurses and so on and I felt the responsibility of it, you know making decisions on my own. There was noone to really turn round to and say "is this alright?" kind of thing, although you probably don't do it, but you know that the back up is there so I found that difficult at first, a bit unnerving maybe" DN8*

It could be therefore that non-judgemental support of colleagues was essential to attaining confidence, as the following quote suggests:

> *"You are very vulnerable... I feel you need the support of your colleagues but I also think you've got to be confident in your own decisions, your own decision making, your own assessment and your own plan of care, I think you've got to be really confident in that"* DN30

One of the older district nurses who had trained over 20 years ago remembers a time when it was considered to be a "weakness" to ask other people for their opinion. Now, however, she has a "good working relationship with colleagues" so is able to canvass the opinions of others. She was not exceptional in this respect, but few nurses were able to consult colleagues to the extent described here:

> *"I was very nervous, I mean it's nerve-wracking working on your own...It was hard and I used to worry a lot, I used to think "have I done the right thing?" but of course with experience that goes... you can't teach that you know to the younger members of staff. I think that comes over the years...I mean then we didn't actually work in teams. Now we can talk about it (the visit). Well you didn't have that sort of relationship you know years ago. Sometimes it was looked on as a weakness as well if you were turning round to somebody all the time and saying "I don't quite know what to do here". But now you can say that you can say "will you go to that one tomorrow and see if there's anything I've missed" which is good... I've done that many a time. I've said I'm lost here... but like I say we've got a very good working relationship"* DN34

Because the nurses were so aware of their colleagues' need to practice confidently, and the role they had to play in this, it was unusual for them to threaten it in any way. This was partly because they hoped that the arrangement would be reciprocal, as the data cited earlier on "non-interference" suggests. So what were the consequences for both nurse and patient if the nurse's confidence was shaken? Examples in the data were few but in one fairly extreme case, a nurse described the effect on her practice when she felt that she was "being picked on for everything":

> *DN10: "I was in a situation 18 months, two years ago where I was being picked on for everything and I was so busy looking over my shoulder I wasn't seeing what was in front of me, until I went higher and said if this doesn't stop I'm taking action and it stopped"*
>
> *JC: "And you felt that the care of all of your patients was being affected?"*
>
> *DN10: "Yes. My life was being affected, not just the care of the patients. My life was being affected and I was so busy being careful what I was saying I wasn't functioning properly"*

The implication here is that an unconfident nurse will experience difficulty in caring for all of her patients and will doubt the decisions she is making. The issue appears to be that criticism was on an informal, interpersonal level because there was no platform for the nurses in this study, for clinical peer review. Although it is increasingly suggested that nurses become involved in peer review in order to increase their personal accountability and to maintain clinical standards (eg. DH, 1993a), it is has never part of culture of health service.

Informal overseeing

Although the nurses worked in isolation, a limited amount of overseeing of their practice was inherent in the organisation of their work. This was particularly the case at weekends when they substituted for colleagues:

> *JC: "At weekends then you obviously see other people's patients?"*
>
> *DN27: "That's right. I think that helps as well because you can get to see other people's ways of doing things and other treatments and things that maybe you wouldn't be aware of during the week. Just by going to see other people's patients it's an education in itself sometimes. You can see what they're doing wrong and what you're doing wrong. I think it keeps you on your toes a bit more...You do try to keep things up to date more because somebody might be watching"*

The extent to which it was possible to comment on something that was perceived to be "wrong" is discussed in depth in the chapter seven, but it is interesting that DN27 suggests that it was the risk of being found out, rather than her professional responsibility to the patient, that encouraged her to keep up to date.

The role of management in both overseeing caseloads and increasing the visibility of the nurses' work was possibly even more ad hoc, as the next extract illustrates. This nurse's comment was a typical response to the question "to what extent are your caseloads overseen by management?":

> *"They're not really. Occasionally we're asked for numbers but not really dependency and if we're asked for dependency that seems to mean time rather than dependency... Clinical supervision? Perhaps managers think they do it but really there isn't any" DN29*

There are obvious implications here for evidence based practice as espoused by the department of health and the profession (DH, 1993b, 1993c), and the extent to which district nurses have access to resources.

The role of the student

Informal overseeing was perceived by the nurses to be an important role of the student nurses who sometimes accompanied them on visits, which was an interesting case of role reversal. In the next extract one of the community practice teachers (DN10), described how via the students she kept herself up to date with current research and practice:

> *"Somebody such as myself has a heavy turn over of students. One, it makes you keep yourself up to date otherwise you soon look very silly, and plus all their ideas that are passed on keep you updated as well, and I think learning is a two way thing, student to teacher, I don't think it's just teacher to student" DN10*

It appeared that for many of the nurses, students were a vital source of information about recent research and recommended practice, which concurs with the similar findings of White et al (1993) in relation to project 2000 nurses. Although the nurses enjoyed the lack of interference or "autonomy" that isolated practice in the community conferred, they were invariably pleased to take students out with them therefore, for what could be described as informal clinical supervision:

> *"I do find they question what you do and it does make you think have I done this right in the cold light of day?...although they might agree with what you've done...You'll get students who won't stop talking and ask mega amounts of questions which is great you know" DN26*

It could be argued that students are fairly non-threatening because although they can offer new ideas, their stay is brief and they are not in a position to do anything with the information they come away with. If a patient is being either "over-visited" or "under-visited" according to perceived need, or a dressing procedure is not up to date, the students can offer an opinion but that is about the extent of their influence. This is in direct contrast to overseeing by same status peers which could be perceived as quite threatening. For example, one of the nurses predicted the reception of her colleagues to a formal system of clinical peer review:

> *"I think everybody would get very defensive about it and see it not as peer review and benefitting them, how they can proceed better, they would see it as a very bitching situation I think" DN12*

The student nurse perspective

Although the undergraduate student nurses interviewed had not actually worked with any of the district nurses in this study, their perspective was interesting in that it differed from the accounts of qualified staff. The following quote from SN2 typifies this:

> *"You don't really want to tell someone who seems to be more senior to you that they are doing something wrong, or there is a better way because you are not sure how it's going to be accepted really...these two (the district nurses she works with) are particularly set in their ways, and I wouldn't say even if something was wrong because I think even if I did say, you know, "research suggests we do it this way" I don't think it would change their practice" SN2*

It could be therefore that it was the district nurses who were receptive to new ideas who would encourage the students to give information. According to their self reports, all of the district nurses in this study *fell into* that category. The implication of this however, is that if students were reticent about offering new information and ideas, or if the district nurses were unreceptive, this "valuable resource" for updating themselves would be lost, which creates an interesting paradox. Ryan (1989) suggests that the hospital ward needs to be ready for the student in order for them to learn and put their ideas into practice, a reciprocal arrangement that would appear to be mirrored in the community.

The issues raised by "autonomous practice" lay important foundations for the next chapter where non-interference in collaborative working can be seen to exclude the patient from decisions about his or her care.

Summary

Although it could be argued that district nurses are increasingly constrained by the organisation of their practice and the current system of referral, it is apparent from the data that a degree of autonomy is experienced in community nursing. The GPs frequently promoted a sense of autonomy in the nurses because it freed them from decision making in certain aspects of care, and some single handed GPs were perceived to value the presence of another medically qualified colleague per se. Autonomous practice helped the nurses to work confidently in isolation and enabled nursing colleagues to delineate their lines of responsibility.

CHAPTER 7: FINDINGS

Collaborative Working : *Collegiality in district nursing*

Introduction

In spite of the comparative isolation of their practice, or perhaps because of it, the nurses in this study endorsed the concept that collaborative working or teamwork was worth striving for. In this context, the team was the immediate nursing team comprising a varying number of district nurses of different grades working with the same General Practitioner or group of General Practitioners; although at the time of this study the mix of skills was rich and each team had a preponderance of G and H grade nurses.

Although some of the nurses felt that they were also part of a wider Primary Health Care team of health care workers from other disciplines, this was the exception, and the word team was usually used to describe their immediate nursing colleagues. It is profitable therefore to explore collaborative working amongst nurses, rather than across disciplines, because that is where the concept existed for the study participants. Where *interprofessional* collaboration with other disciplines, such as GPs, was described by the nurses, examples will be used where they elucidate the issues raised by intraprofessional collaboration. Perhaps the most far reaching of the conclusions drawn in this chapter are the issues surrounding collegiality between same status professionals, and the implications that this has for patient empowerment.

The Team

When the district nurses in this study spoke about teams, teamwork and their colleagues, they were almost invariably talking about the district nursing team. This was the nurses that they worked with on a day to day basis visiting a group of patients registered with the GP or GPs to whom they were attached. One reason for this reluctance to describe anyone other than their district nursing colleagues as "the team" was the comparatively infrequent contact the nurses had with other disciplines, with the possible exception of the GPs. Comments such as "we have a primary health care team in name only" (DN1) were not uncommon. That is not to say that the nurses did not contact colleagues from other disciplines when they felt that the need arose, but that there appeared to be a lack of commitment to utilising a multidisciplinary approach in any structured way.

Policy context

It could be that the imminent introduction of skillmix to district nursing (NHSME, 1992), and the provisions of the NHS and Community Care Act (DH, 1990), had contributed to this perception of the team as immediate nursing colleagues. Historically, district nurses were considerably more isolated than they are now, with few colleagues to delegate work to apart from nursing auxiliaries whose remit was more or less restricted to bathing, and district enrolled nurses who, although their role was not particularly limited in scope, were far fewer in number than district nursing sisters (Hockey, 1966). The sisters tended to do most of the work themselves handing a limited number of patients over to same status colleagues if they were off duty, as the following excerpt from the interview data illustrates. This district nurse qualified over 25 years ago:

> *JC: "If you cast your mind back, in 1970 did you go into other people's patients, was there some overlap?"*
>
> *DN34: "Yes, but not a lot, because I mean in those days they were very strict about what you left on, on your day off. And if you left anything it would be questioned, you know, by the senior nurse. She would say "do you really need to leave that one on?" But with all the patients, if you left a general care on, the relatives had to wash the hands and face so that when the nurse went in she only had to do his pressure areas, you know, washing down below, do his pressure areas. But definitely no hands and face, oh no. But now, I mean it's not like that now. I mean if a patient needs visiting for a dressing or an injection, anything, you leave it on, but you do try to cut it down"*

In recent years there has been a steady increase in the employment of staff nurses, with concomitant emphasis on both the clinical management role of the district nursing sister (NHSME, 1992), and her role in 'care management', particularly in relation to the frail elderly (DH, 1989b; Bergen, 1994). In addition, nursing auxiliaries can now be trained to take on the expanded role of the health care assistant, so that nursing work such as simple dressings, eyedrops and "general nursing care" can be delegated to them. In turn, it is now possible to hand much of the traditional work of the nursing auxiliary, such as non-medical bathing and general care, over to social services carers. District nursing sisters increasingly have access to a system of delegation, or hierarchical "team" therefore, so perhaps this is why the nurses who took part in this study ignored, to a large extent, the wider primary health care team and concentrated discussions about teamwork on their intraprofessional colleagues.

Multidisciplinary working

Whilst acknowledging that it might have been the organisation of their work that led the nurses to refer to their immediate nursing colleagues as "the team", there was ample evidence in the data of a lack of commitment to, or ambivalence about, structured approaches to multidisciplinary teamworking. This was not surprising for a variety of reasons. Multidisciplinary locality or practice meetings are an obvious starting point for *interprofessional* collaboration, but for the majority of participants these either did not take place or suffered from poor attendance:

> *"We used to have locality meetings at one time which were very good because we all got to know names to faces which was quite good because knowing people by telephone, you don't seem to click as much. We used to have these localities very regular but they seem to have diminished "* DN22

Another of the study participants (DN7) described how unsatisfactory practice meetings were at her surgery, where out of the seven GPs, only four regularly attended. To illustrate how disparate the potential primary health care "team" was at this particular practice, she explained that although she had worked at the practice for two years, she had yet to meet two of the seven GPs. Her colleague (DN9) who had been attached to the practice for ten years was recently asked by one of the receptionists "excuse me, are you the district nurse?" This nurse was equally disatisified with the practice meetings:

> *"I think sometimes the meetings just end up like a prescription gathering meeting rather than an actual discussion on community topics. I think if they were more structured, maybe*

> *if we had an agenda for them...also if all the GPs attended - not just the GPs - if people attended on a regular basis and were more committed to the meetings then it would be better, I mean it's not just the GPs it's the nurses as well"* DN9

It would appear therefore that the problems with collaboration that were in theory to have been addressed by GP attachment (Central Health Services Council, 1963; Hockey, 1966), remained unchanged for some of the nurses. This is reflected in a number of recent community nursing reports where multidisciplinary teamwork in primary health care continues to be promoted as the way to overcome existing difficulties with collaboration between services (Welsh Office, 1987; Queen's Nursing Institute, 1991; DH, 1993a).

Collaborative units

The nurses' perception of *inter*disciplinary collaborative working tended to concur with the more flexible description of teamworking espoused by Bond et al (1985), who in preference to the primary health care team described "potential collaborative units". These units could be anything from a partnership between a GP and a district nurse to a much larger unit comprising many disciplines. The potential collaborative unit is created to address a particular problem in primary care, and disbanded if or when the problem is satisfactorily resolved. One of the nurses who was particularly adamant that the primary health care team in its wider multidisciplinary sense is "unnecessary" (DN11), offered an explanation of why she believed attempts at formal multidisciplinary meetings often failed:

> *"You don't need a primary health care team. The team isn't involved in many patients. There are plenty of patients who've never seen a physiotherapist or social worker or CPN so they're not involved, so it would be of no benefit having a meeting*

> *with all the disciplines when they're not involved in the care...There is a benefit when we share the patients, yes there is, but unless we're actually sharing the patients, and we know when we are, the patient will tell us or we'll have asked for that other discipline to go in or indeed they might have asked for us to go in...I don't see a need for a big huge primary health care meeting when you're not involved in the same patients'*
> *DN11*

Although this is quite valid, it could be argued that without primary health care meetings it might be difficult to establish which services colleagues from other disciplines have to offer, and exactly where everyone's roles and responsibilities lie. It could be that nurses will not know that they can refer to a health visitor, dietician or speech therapist for example, when they encounter problems that they feel ill-equipped to deal adequately with themselves. Certainly few of the nurses in this study referred for input or advice to other disciplines to any great extent, with the exception possibly of the MacMillan nursing service.

Relationships with GPs

Contact with the GPs was far more frequent than with other disciplines such as social workers, physiotherapists and specialist nurses, and often occurred on a daily basis. This is something that has changed dramatically since the sixties when Hockey (1966) researched district nursing practice. She found that 41% of GPs never or rarely met the district nurse who looked after most of their patients. Contact with GPs is not, however, synonymous with collaborative working between the two disciplines (Armitage, 1983; Bond et al, 1985). Supporting the findings of Gregson et al (1992), participants reported that contacts where there was straightforward passing of information between themselves and the GPs were relatively common - sometimes in written form in a note book - but full collaboration was less so. In Gregson et al's study, out of 148 potential collaborative units between pairs of GPs and district nurses who worked together, only a quarter were considered to be fully collaborative. Full collaboration as opposed to simple 'contact' with GPs was considered to have occurred when the opinions of each party had been sought, respected and attended to, and there had been joint working towards a shared goal. Non-collaborative contact might be little more than a request from one party to the other to visit a patient. An example of a 'non-collaborative' contact was given by DN12:

> *"It is the doctor-nurse relationship. We don't have any contact with him bar him sort of saying "please visit my patient and do this that or the other" or something like that. He doesn't see that the rest of the team can benefit him in any way. These people are his patients and he is the doctor. If we sort of suggest something he takes it a bit funny" DN12*

Differing expectations

Not all of the study participants held the view that collaboration had only occurred when there had been reciprocal information giving and opinion seeking towards a mutually agreed goal. During fieldwork, the researcher witnessed many interactions between nurses and GPs that comprised little more than unidirectional information giving but when asked about the relationship later at interview, the nurse in question often described it in favourable terms. One of the nurses offered an explanation for this:

> *"There's an extent to which you feel that your relationship with your GPs reflects your own practice, so I don't think that people can treat it purely objectively in the sense that you want to*

> *have good communication with your GPs and that perhaps would weigh your answer more in favour of saying that you do have. There are surgeries that I've worked in that other people would describe as situations of good communication but I don't. I think people are satisfied with a very poor level of communication. People will say 'I've got great GPs I can go to them any time and they'll write me a scrip' and I'm not sure if that in itself is a sign of great communication' DN5*

It certainly appeared that the nurses' expectations of collaboration with GPs started from a fairly low baseline, where politeness and cooperation were perceived as a sign of a good relationship. There are several possible explanations for this. Nursing has traditionally been viewed as subservient to medicine, so maybe the nurses did not expect anything more from their relationships with GPs, or, perhaps because they were working on their own, they did not anticipate or demand the level of interaction with medical colleagues that they were used to in hospital A third explanation is that some of the GPs in every locality were notoriously uncooperative with nursing staff and any nurse not working with one of them was likely to regard her relationship with her own GP as "very good", as this nurse suggests:

> *'I can go and mention anything to them you know, have a chat with them about the patient, but there are GPs I know of that don't want to, mine they are very good' DN4*

Successful collaborations

When meaningful collaborations occurred with GPs in relation to a specific patient problem, they were often judged to have been highly successful. Such collaborations were described most frequently in terminal care where nursing and medical input were usually valued and a team approach was important for a successful outcome. For example, one of the nurses described how a relatively brief collaboration between the district nursing team and one of the GPs, provided a successful solution to a complex problem:

> *"There was recently a terminal lady who had throat cancer which was really pretty grim and we all seemed to pull together. Doctors, nurses, well one particular doctor. She wasn't actually his patient but he knew the family and the family were more comfortable with him than this newer GP so he tended to deal with them. It was a particularly tricky problem, the trachy and the sinus and so on, but I thought we dealt really well with it...the family were comfortable with the way their relative had died and she had a very peaceful death"* DN8

It is interesting that in this example ownership of patients was not an issue for the GPs. The patient was registered with one GP but managed by another because this was considered to be more appropriate. The GP or GPs concerned appeared to be fairly flexible about who the patient officially 'belonged to', thus empowering the patient to exercise choice. This flexibility might have been due, in part, to the advantageous position of the patient because the family had forged a close relationship with the GP, but also because terminal care appears to afford a relatively high priority. District nursing is far less flexible in this respect. In similar circumstances, it is highly unlikely that a patient could choose to see a different district nurse or team of nurses if desired.

Uncooperative GPs

The quality of GP nurse contacts or "potential collaborations" as described by the district nurses was variable however. The following is a typical description of those relationships that were problematic:

> *"With some of the GPs you feel you are getting in the way and when you want to see them and discuss patients you feel they haven't really got time for you"* DN30

This dismissive attitude perhaps explains why the GP was sometimes seen as an opponent of the nursing team rather than as a member of a wider team. In spite of this, the nurses had to work with the GPs and gain their cooperation because they relied on them for referrals and medical input, notably prescriptions. The nurses talked about "getting round it" when they worked with an uncooperative GP, which usually involved some sort of compromise on a personal or professional level. Parallels can be drawn here with the findings of Pursey and Luker (1994) that practice nurses would "work a way around" GPs to avoid confrontation in difficult situations. The following extract from the interview data is a typical example of this:

> *"I can remember one patient desperately needing a syringe driver and the GPs hadn't got a clue, and it's just the relationship that I've got with one of the GPs that I know that if I go in and word it in such a way that he thinks it's been his decision and it was his idea then he'll give me the earth, so I don't care how I go around getting it from him. If he thinks it's his decision, then that's fine by me as long as I get what I want"* DN15

Although there is some evidence that nurses have become more assertive in their relationships with doctors in recent years (Hughes, 1988; Stein et al, 1990; Porter, 1991; 1992), the above example is reminiscent of the original "doctor-nurse game" described by Stein (1967). The object of the game for the nurse is to "be bold, have initiative, and be responsible for making significant recommendations while at the same time she must remain passive" . Indeed, some of the nurses referred to their relationships with the GPs as "a game", even those who believed their relationship was good. Some of the nurses admitted to waiting until an uncooperative GP was off for the day so that they could legitimately approach another more cooperative partner or locum with a problem. This emphasises the extent to which the nurses relied on their medical colleagues in certain circumstances. One of the nurses (DN17) described her behaviour as "sometimes downright flirtatious" in order to get her own way with a particular male GP. Another of the nurses recounted how she subordinated herself to an uncooperative GP in order to "get round" a problem, by being "bubbly": a passive and overtly feminine tactic:

> *JG: "Was it a bit daunting when you knew that these were GPs who were notoriously quite difficult and you knew you were taking on the practice, or weren't you aware of that?"*
>
> *DN27: "Yes I knew that. They (colleagues) said just go in there and be quite bubbly. All the staff were amazed at what was going on. So I wasn't arguing with him I was just laughing at him sort of "are you coming to this patient or not?" it was that sort of thing, but he was trying to build it up to a big argument. He was testing me to some degree. I said to him "I'm not arguing with you because we've got to work together" but he'd obviously had a bad day and didn't want to go to this old man. But I think that's the best way to deal with that"*

Other nurses explained how they were deliberately unassertive with GPs in order to get their own way and the patients' needs met, as the following extract illustrates:

> *"I think GPs are quite capable of not referring anybody if they don't like you and don't get on with you and don't think much of the service. And they actually quite like us to be fairly accommodating. It's probably manipulative on our part but it's sometimes easier than assertiveness I think...that's life don't you think? ...I sometimes think just being assertive they think "here she is again". If you can be quite friendly really" DN29*

As district nursing is so referral dependant and the cooperation of GPs is crucial in this respect, it is perhaps not surprising that some of the nurses chose to be accommodating. This is of particular importance in the new market economy of the health service where fundholding is increasingly prevalent in general practice: it is now incumbent upon the district nursing service to package itself attractively for sale to potential purchasers. In the last two examples, the district nurses concerned explained how their passivity had paid off because ultimately the patients had benefited. In the first example, "bubbly" DN27 found that when she went into the surgery on the next occasion to discuss a patient, the GP was far more receptive and welcomed her in with "yes, shut the door". Similarly DN29 commented that:

> *"The GP's given me his car phone number or phone number and they don't very often do they?...I think compromising is easier than being assertive but also when you've got a good relationship then you can say "what do you think you're doing?" "You'll have to do this" "It's not good enough" and they're more receptive to that" DN29*

It is interesting that in this example respect from the GP was not automatically conferred by virtue of the nurse's qualification and experience but had to be earned via subversion and passive behaviour.

Status difference

The GPs were almost invariably considered to be of a higher status than the nurses, which was perhaps most obvious when a nurse or doctor addressed one another. The doctors used the nurses' Christian names and the nurses used the doctors' titles, which concurs with the similar findings of Bond et al (1985). Interestingly, some of the nurses perceived the fact that the GPs knew and used their Christian names to be a sign of equality or 'collegiality' within the relationship, in the same way that approachability or willingness to "write a scrip" might be. Difference in status between team members has been described in the literature as one of the potential barriers to teamworking (DHSS, 1981b). A brief look at some of the other barriers to teamworking might also explain why the district nursing team was a more profitable place to study collaborative working in this context than the primary health care team which, for most of the nurses, was a fairly elusive concept.

What are the barriers to teamwork?

The literature describes many barriers to multidisciplinary teamwork in primary health care. These range from gender, age and pay differences to lack of contact between professionals and lack of time (Huntington, 1981; Bowling, 1983; Oaker and Brown, 1986; Sheppard, 1986; Ovretveit, 1989; Hutchinson and Gordon, 1992). Perhaps the reason that the nurses felt that they were a team, attaining the sometimes elusive ideal of teamwork was that few of the barriers recognised by the literature actually exist intraprofessionally. The main problem that the nurses identified *inter*professionally, was physical distance from colleagues, such as the GP, social worker, domiciliary care organiser and specialist nurses. Physical distance was not something that was an issue for the district nursing teams who took part in this study because the teams of nurses in this study always shared rooms. The other main barrier to teamwork the nurses articulated as "personalities". This was a problem *inter*professionally, particularly with the GPs as the data has already demonstrated, and concurs with the finding of Wiles and Robison (1994) that the attitude of GPs to either the nurses or the patients in their study, was the main reason for the nurses feeling that they were not part of a multi-disciplinary team. Personalities of colleagues were also identified, however, as a problem intraprofessionally:

> *"Well we've all got personalities haven't we? My team's alright but I can imagine it being very unpleasant at times, there are people I wouldn't choose to work with. Then of course we don't choose, we're given aren't we? We're given each other. Oh yes there can be trouble, there can be friction"* DN11

The word "personality" is a fairly blanket term. When its meaning for the nurses was clarified it became apparent that it was certain behaviours that were considered to be unacceptable and as barriers to working well together. It was evident from the data that for many of the nurses, the attribute in a colleague that was of highest priority was that the nurse's behaviour, in terms of how she approached patient care, was as similar as possible to their own. This was not something that was going to happen by chance when two or more people were assigned to work together, it appeared to be a process of "acquiescence", or becoming increasingly similar over time. The choice of this word reflects the passivity of the process: a gentle drifting into similar working patterns, as opposed to open debate about current research and guidelines for good practice.

Acquiescence in district nursing teams: "we all work very similarly"

Although it was not uniformly the case, most of the nurses interviewed said that they worked in similar ways to their immediate colleagues, who were the nurses they had most contact with on a daily basis. Although this was usually colleagues in the immediate team attached to the same GP or group of GPs, where separate teams worked closely and were under the same roof this was also sometimes the case:

> *"I find we all work very similarly. We are very lucky in that way...There are 16 district nurses who work in the (locality) and we are in two teams and each Sister works for a set of GPs. Because we do work at weekends, we do tend to get to know everybody's patients" DN22*

Becoming similar to immediate peers was not instantaneous but evolved over time. The following extracts illustrate this:

> *"I think if you work in a centre you tend to be moulded by the others who work there. So I think you find that in one centre people assess the same: centre to centre rather than individually" DN9*
>
> *JG: "So in the immediate team do you have similar perspectives on things?*

> *DN8: "I think we've grown to because the newest member of the team is a year old so we have grown together. Most of us have been together 3 or 4 years now"*

Job sharing

Having a similar approach to care was perceived to be particularly important when the nurse was in a "job share" with a part time colleague. A job share literally meant that two nurses worked as one full time equivalent so that they were rarely if ever on duty at the same time. Contact between the colleagues occurred via the telephone as they so seldom crossed paths. This was the case for DN8:

> *"(Colleague) admits a patient, prescribes some care and we find that we've kind of grown together in the way we assess and prescribe care...it's a long time since I've disagreed with anything she's prescribed and vice versa, and if we did we would just sort of come to an arrangement. There's no sort of trouble at all. It works very well" DN8*

Another of the nurses who was also in a job share, reported a similar experience:

> *"(Colleague) tends to think very much like I do... we tend to think alike and we tend to say the same things to patients" DN21*

So these nurses attempted, as far as possible, to present themselves to patients as a single entity. This was to a slightly lesser degree the aim of the majority of study participants in their working relationships with colleagues.

Discordant styles

Adopting a style of working that was in accordance with the other team members was not always possible however if that style was too discordant with the nurse's own. This was sometimes the case when one of the nurses in the team had trained more recently than her immediate peers and was therefore the least experienced team member, but was of a similar status and possibly the most up to date with current research and recommended practice. This was the situation for DN27 who was also a lot younger than her colleagues, which the literature identifies as a barrier to teamwork (eg. Huntington, 1981). The rest of the team worked in similar ways but she was sufficiently uncomfortable with the team philosophy about certain aspects of care, that she set herself apart and was confident to do so. This was particularly the case in the assessment of patients:

> *"I would say in my team no one assesses like me...they might say I'm too hard whereas I might say they're a bit soft"* DN27

The fundamental difference in assessment that DN27 describes as "soft" and "hard" reflects the way in which district nursing has been redefined over the years. At one time anything could fall within the remit of district nursing work where as now, certain aspects of the role are in the process of being handed over to social services carers and being re-named as social care (DH, 1990). Those nurses who were more willing to say that something was not their job were frequently described as "hard", and those whose definition of district nursing encompassed almost any patient need were described as "soft". Sometimes, all the nurses working in an area were described as soft or hard, as in the following quote:

> *"(Another locality) used to be very hard...In one particular instance I was horrified, this 92 year old lady was being looked after by a son who was incontinent and I think they were visiting three times a week, where as I feel sure if she'd been in this area she'd have had a daily visit"* DN19

Again, this quote is an illustration of how the nurses "acquiesce" and end up working in similar ways. In this example DN19 was working in the locality in question at the time but although she disagreed with the number of visits that this patient was receiving, she felt disempowered to do anything about it. The reason for this is perhaps best explained by the nurses' rationale for acquiescence and the process by which it occurred, which will be explored next.

Presenting a united front

There was almost complete consensus amongst the nurses that as a team they should all be saying the same things to patients, or "presenting a united front". This is something that has been identified in the literature as a feature of relationships between nurses and doctors where although "back stage" nurses might not agree with a doctor's decision, "front stage" they endeavour to support their medical colleagues (Buckenham and McGrath, 1983; Sherblom et al, 1993).

In this study, "acquiescence" into similar working patterns facilitated the nurses when presenting themselves to the patient. There was a fundamental belief, that had transposed into an informal rule, that patients should not be given conflicting information or advice from other nursing colleagues as the following excerpt illustrates:

> *"I think communication is very important and I think documentation is very important so that whoever is taking over from you will carry on and see where you are up to but I think*

> *communication is very very important...I think it's important that we talk together as nurses and that whoever is carrying on the care for me or you will do what you have told them so you are not contradicting each other's advice"* *DN30*

The reason nurses gave for giving one message to patients was that conflicting advice is confusing. The assumption is that as a lay person rather than an "expert" the patient is unable to steer a course through different pieces of information and come to an independent conclusion, a finding which is supported in the literature (eg. Ashworth et al, 1992; Hewison, 1995):

> *"I think you've got to follow each other through and reiterate what people have said the day before and things, otherwise they just get totally confused and they get dissatisfied because somebody's saying one thing and somebody's not doing another thing"* *DN20*

It could be argued that in an ideal world there would be clear, research based guidelines for practice which could be uniformly and easily applied in any given situation. This is unlikely to be the case for two reasons. Firstly, there may be no one obvious solution, particularly if the problem is of a personal or social nature; and secondly, health care workers are not always as up to date as one another in different aspects of their work because their remit is generally so broad. It could be that the reason that patients "get totally confused" about the information they receive from health professionals is the way in which advice is given.

Although the language of health care might be perceived by those without the training and background as a fairly impenetrable code, the simplification of health care messages may be equally baffling and excluding from the patient's point of view. If over simplification of complex messages translates in practice as the nurse offering a solution to a given problem without providing the rationale behind it, or "it's a long story but a good enough gist for your purposes is..." (Ashworth et al 1992:1433) then it is likely that the patient will be unable to use his or her own judgement.

Continuity of care

When they were explaining the reasons for presenting a united front, the nurses offered a persuasive argument for the value to patients of "continuity of care" or consistency in the care provided. Continuity of care has become part of the rhetoric of recommended nursing practice (eg. DH, 1993a) and is one of the rationales underpinning primary nursing on hospital wards (Porter, 1994). Continuity in the community is arguably more difficult however but is assisted, not unexpectedly, by "a good care plan":

> *"You need a good care plan so that all the details are there and you don't have to permanently keep asking the patient "what do we do for you?" which doesn't instill much confidence in the patient about you does it? ...good information about the patient and a good care plan so that although a different person's coming in the same kind of things are being carried on" DN11*

The nurses frequently commented that "it is not very reassuring" if a nurse substituting for a colleague seems unsure about what she or he is doing, as in the next quote from DN18. Goffman (1959) in his dramaturgical analysis of the ways in which teams of people work together described this as the art of impression management: creating the impression, in this example, that the team is well informed, coordinated and that the substituting nurse knows what she or he is doing whether or not this is the case:

> *DN18: "Quite often people, even if there's a careplan there would say "right what are you having done?" It isn't very reassuring is it? Some of the elderly are mixed up anyway: I think it's nice for them to have a regular person and then other things can be approached"*
>
> *JG: "Is it also quite important that the same messages are given?"*
>
> *DN18: "Yes, definitely, it's awful: ambiguous health care messages from people, "use this don't use this""*

Again, DN18 endorses the "one message to prevent confusion" philosophy of many of her colleagues, and also suggests that if a relationship is built up with a patient through continuity, other important topics can be safely discussed. This concurs with findings of Trojan and Yonge (1993) that continuity of care between Canadian home care nurses and their clients facilitated "trust" and disclosure. For this reason, the patients in their study were perceived to dislike an entourage of new faces coming through the door. DN18 is making another interesting point about the client group who are predominantly older people who, she implies, are particularly vulnerable to mixed messages: "some of the elderly are mixed up anyway". This rather stereotypical impression of the elderly can become an excuse for not giving a full explanation or allowing the patient to participate in care. This stereotype appears to underpin the following extracts where the nurses create the impression that clients are "stuck in their ways". In the first quote DN11 discusses the importance of detailing the procedure for redressing a wound or providing "general care" such as washing and dressing someone. In the second quote, the patient who remarks on differences in care is perceived to dislike inconsistencies:

> *'We list the dressing procedure and as long as people follow it and respect that patients don't want it done a different way every day. And if they say well 'she usually washes me in the bed not in the chair', stop being so bossy and saying 'I wash everybody on a chair'. Let's you know go with them as long as it's not dangerous or difficult you know try and do the same thing each day' DN11*

> *DN7: 'Patients find it unsettling when different nurses do things differently and they tell you 'so and so didn't do that''*
>
> *JG: 'They like things to be consistent?'*
>
> *DN7: 'They don't like it when you change things, dressings I'm thinking of, change of treatments, the way you put a bandage on. They'll tell you if somebody else goes in and does it differently, they'll say 'nurse so and so didn't do that''*

In the patient's best interest?

It could be argued that it is quite reasonable to provide similar care to the previous nurse if a patient is being washed and dressed, particularly if the patient prefers it to be carried out in a certain way. Washing and dressing someone is not a research based procedure and there are many minor and acceptable variations on how it is executed, so it is likely to be in the patient's best interest to do so. Presenting a united front by reinforcing what colleagues do and say however is less likely to be in the patient's best interest where more complex procedures such as wound dressings are concerned, as the next quote demonstrates. This nurse clearly shows that supporting colleagues can successfully exclude the patient from having a say in his or her care, and, in this example, commenting on the apparently negligent behaviour of another nurse:

> *DN27: "One particular patient, she wasn't mine and I went in and she said it's funny about the hygiene, you wash your hands more...I use the tack that there's no set practice about washing your hands, it's up to the individual nurse. It was only a little pin prick anyway, there's no set procedure, it's up to each nurse"*
>
> *JC: "So even if it hadn't been a pin prick, say it had been a great big gash in the leg and they'd questioned the handwashing procedure, would you still have said there's no set procedure?"*
>
> *DN27: "I would have said well I can't really comment because I wasn't here and I don't really know what went on. I mean she's saying that but there's no proof, it's only the patient's word. Sometimes patients don't necessarily tell you the truth anyway, they don't like a particular nurse and want a bit of gossip. You're a bit protective of your colleagues so's not to be drawn into an issue: it's something for them to sort out, not blowing it out of proportion. If I turned round and said "didn't she? she's supposed to, oh fancy doing that". We just don't do that"*

So in spite of current rhetoric to the contrary about patients as partners in care (eg. DH, 1993a), it could be that patient participation remains an elusive concept. DN27 was not actually present when her colleague carried out the dressing procedure but, when asked to make judgement, chose to disbelieve the patient: "it's only the patient's word". Loyalty to the team was evidently more important than creating the impression to the patient that she was believed: the message was clearly that she was not part of "the team" or, at best, an unequal team player whose opinion is devalued. Johns (1990) discussed this issue in relation to primary nursing teams where "the harmonious team" was characterised by "...its allegiance to harmony...It does not talk about difficult feelings between its members and seeks to protect its members from outside threat...(p889).

Playing off

Frequently, when patients did comment on the care provided by a colleague this was described as "playing off" one nurse against another or in the above case "a bit of gossip". The connotations of "playing off" are reminiscent of the way in which a naughty child might manipulate his or her parents: an interesting choice of words that perhaps reflect the way this behaviour was viewed. It could be that by commenting on nursing work, these patients were seen to be threatening the legitimacy of the nurses, as May and Kelly (1982) suggest in their study of non-compliant psychiatric patients. The nurses used various tactics for deflecting information that was perceived to be derogatory about a colleague, including certain stock phrases:

> *JC: "Do patients play different nurses off against one another?"*
>
> *DN10: "Oh definitely, all the time. All I say is there's more than one way to skin a rabbit!" (laughs)*

Discouraging further communication in this way is reminiscent of the subtler "blocking" strategies described by both Macleod Clark (1983) in her study of nurse-patient communication on surgical wards, and Strong (1979) in his observations of "parent-consultant" communication in the paediatric outpatient clinic. Although sometimes it might have been the case that patients played nurses off against one another, there is inherent risk in assuming that commenting on a nurse's care is always idle gossip and that the patient does not have genuine concern. DN27's earlier comment that "we just don't do that" implies that there is etiquette or tacit understanding in her team about protecting colleagues in such circumstances. This successfully excludes patients from treatment decisions, because observing what other nurses do might be the patients' only inroad into evaluating their regular nurse's care. Yet there was ample evidence in the data that patients were able to make often quite complex decisions about their care, as the following extracts from the interviews with younger disabled patients illustrate.

Patients as partners

The first example is from an interview with PT7 who was tetraplegic following a spinal injury, and suffered from autonomic hyperreflexia. This is a serious condition where comparatively minor distension of the bladder or colon can result in a massive sympathetic discharge from the autonomic nervous system, leading to hypertension and bradycardia. PT7 clearly understood not only the implications of the condition, but how to manage it in the absence of the level of service that he felt he required:

> *"I used to have 24 hour care (JG: from social services?) from social services...that was when I first moved in for about 15 months or so. Then I had a lodger move in with me: he said he would do everything (including) the night duty ie. putting me to bed and turning me if necessary for a limited amount of time until I could find my own property (sheltered housing). So I asked that the service would be suspended, and I received it in writing from (social worker) and also verbally from other people in social services that given 6 to 8 weeks at any time within a pre-set period they could re-implement a full 24 hour care team again. Now, when my lodger.. got a place of their own and they were due to move in, when I asked for 24 hour cover to be re-implemented it was turned down. I was not told until the person who was here was actually due to leave and that dropped me right in it. I then had to - and at times still do - sleep upright because of autonomic hyperreflexion that I have. And if I block a catheter, and otherwise fill a bag and so on, a urine bag, and it can't be emptied in time, I could suffer through hypertension a brain haemhorrage. And I've actually seen it kill two friends of mine. It is rare in people like myself*

> *but I happen to be one of the people that suffer from it: now that is something that I can't get round. Now with social services taking away 14 hours of my care cover... in the last 3 years or more I have spent the time either sleeping upright with my head on the pillow over there (indicates a high table) or asking friends who may be around at the time if they will place me into bed at night because social services will not provide the cover...Now I'm a survivor: I'll survive what ever they throw at me, one way or the other' PT7*

Patient 7 was almost completely paralysed, but he felt that in many respects he exerted considerable control over his life, in spite of being restricted by the organisational context of his care. In another example, a younger disabled patient with Multiple Sclerosis (PT4) demonstrated complex decision making when she decided that she needed to take an anti-spasmodic to enable her to get in and out of bed at night without waking up her mother for assistance:

> *'..She (mother) was saying 'I can't let you risk getting on and off the bed by yourself because you'll fall down' and I said 'no, no I won't' but I said 'what I'll do is I'll take these anti-spasmodic drugs so I can bend my leg'. I could get in (to the bathroom) wheeling myself if I held my legs bent you see, but when my leg was sticking out stiff I couldn't get in through the door without waking her, so I reluctantly agreed to take the anti-spasmodic drugs.. (so) I could get in and out of the bathroom by myself. I said (to the doctor) 'I want to have anti-spasmodic drugs' so he said 'well right, Baclofen, start you off on 30mg a day' and, sure enough, I could bend my legs. But what happened was when I was getting off the bed, after a few days, my knees buckled under me...taking this Baclofen. And twice in the morning, when I got out of bed I fell and the district nurses...said 'we'll have to come in again and get you out of bed and help you with the bath. Now at the time it didn't occur to me that it was the Baclofen that was causing this, but probably if I'd started off on 20 or 10. I mean one thinks of these things in retrospect you know' PT4*

It is interesting that PT4 not only made the decision to take anti-spasmodic medication, but also assumed responsibility for the dosage being too high, which is surely what the doctor is paid to do. There is evidence therefore, that the assumption underlying "playing off" that patients could not make decisions about their care, was untenable. One of the study participants was challenged on this issue:

> *JC: "It has been suggested to me that patients play one nurse off against another. Is that your experience?"*
>
> *DN17: "Oh definitely. It's all part of the game. Especially the one's who've been around for a long time and some nurses like it, some nurses thrive on it"*
>
> *JC: "Sometimes, could it be that the one way that patients can say "I don't like the way you're doing something" is to say "so and so didn't do it that way" or "so and such a nurse on your day off came in and did something a certain way". I am wondering if that is a very indirect way for a patient to have some sort of say in their care?"*
>
> *DN17: "It's an art form in some of them, it's nasty. But I take your point that it can be a patient trying to say "well this is what I want" but it often falls on stony ground"*

It is illuminating that this nurse described "playing off" as "part of the game", which was the patient-nurse game presumably. It would seem that "the game" is unevenly matched however if the patient is unaware of the rules. Commenting on another nurse's care was evidently an unsuccessful tactic for becoming a participant in care because as DN17 remarked "it often falls on stony ground". It became apparent during fieldwork and through interviewing younger disabled patients, that assertiveness was likely to be the most successful tactic in the "patient-nurse game".

The patient-nurse game

The rules of the game, it appeared, were to be affable and accommodating but direct with nursing staff. Two of the younger disabled patients (PT1 and PT4) were particularly affable and direct, and as a consequence their needs were successfully met:

> *"I've obviously realised that good people are very hard to find and when you do find them you cherish them you really do, you make it pleasant for them...The day (district) nurses are excellent at doing everything. I mean some you like better than others but then I think you would do what ever...(they) came in every day over Christmas and gave me my bath as usual: there was no variation in the service at all"* PT4

That the nurses "came in every day over Christmas" is of significance because the study participants reported that they reduced their work to a minimum over holiday periods and at weekends. In the next extract, PT1 attributes his affability to the fact that he became disabled through polio when he was a child, so he had never known anything different:

> *"I mean why feel bitterness because we all grow up with problems...Thank God I probably had a sort of upbringing with it, because when I was younger, as I say, I didn't know anything else from my younger years. So I suppose that's why my views are different. I mean the nurses tell me that patients are aggressive and there's no point in being aggressive...You can cope with the fact that you can't do anything as long as you don't take it out on people that come to help you, they will help you a lot more if you're pleasant. If you are aggressive with them they don't want to come...At eleven o'clock it takes two district nurses to get me up and... they know all my problems and they've never tried in any way to cut down on putting splints on, Tens machine and all the bits I need"* PT1

This example is notable because the nursing and medical staff were unsure about the cause of this man's total paralysis. There was no medical diagnosis to support the use of splints and a Tens machine, so it was entirely the patient's word that these were necessary. During fieldwork it was clear that applying the splints, the Tens machine and "all the bits" was very time consuming. "All the bits" included dressings on areas of skin that the patient - rather than the nurses - believed were vulnerable to pressure sores. Both PT1 and PT4 were visited by two qualified nurses each day for at least an hour, which was unusual given that other, usually older, patients with a similar level of disability were visited less frequently and for less time. This observation echoes the findings of Badger et al (1989b) that nursing auxiliaries' patients, who were often older, were less likely to be visited by qualified staff irrespective of their comparable physical dependency: visits by nursing auxiliaries were characterised by their relative infrequency compared to those of qualified staff. One of the younger disabled patients (PT3) commented on this inconsistency or "imbalance". Again he felt that his needs were being adequately met:

> *"I've got into this situation where I'm quite happy with everything. OK I might be one out of ten, but that's one, what about the other nine? Things don't tend to balance"* *PT3*

Intrinsic to the approach adopted by the younger disabled patients with their nurses, was the notion of reciprocity. If the patients were pleasant but clearly articulated their needs, they could expect a certain respect in return which conferred a sense of equality within the relationship:

> *'They get to know your problems and you get to know their problems as well. They think you don't know but you do. If I*

> *can, I'll try to help them because I know they're helping me, so why not return them - not the service - the friendship really"*
> *PT3*

Playing nurses off against one another, or appearing to do so, is arguably not in the spirit of "friendship", so perhaps this was why the direct approach of some of the younger disabled patients was often successful.

Colleagues discussing patient care

Presenting a united front to patients by supporting the decisions of others and deflecting a patient's comments about a colleague, does not necessarily preclude the possibility of discussing an issue away from the patient, as one of the nurses commented:

> *JG: "If there is any contradiction or if anyone feels differently about anything, how is it best dealt with do you think?"*
>
> *DN6: "Well I think discussing it amongst ourselves really and not letting the patient know. Discussing it and coming to some conclusion and all doing the same thing"*

This approach could however lead to a degree of acquiescence or a level of compromise that the patient might not find acceptable, which again raises the issue of patient empowerment. Discussing contentious issues away from the house is not quite the same thing as defending colleagues' decisions unquestioningly, but neither is it allowing the patient to become a partner in his or her care: he or she must rely heavily on the nurse's integrity as "patient advocate". This is particularly interesting in view of the observation in Chapter six that monologues about patients were often mistaken for discussions about care. Patient advocacy was not necessarily borne out in practice in this study.

Reducing stress

The issues raised by presenting a united front were frequently defended by the higher value placed on consistency and continuity. In some cases, however, the patient's perceived need for consistency assumed a lower priority than the needs of team members to reduce personal "stress" when dealing with "difficult" or demanding patients, as the next extract suggests:

> *"I think spreading that stress load around is worth doing, but if there isn't that stress factor then I think there's a lot to be said about the consistency...the way we've divided up the list has tried to spread out the stress anyway...I would propose from time to time to change round the lists anyway so that people got a breath and had different people" DN5*

This example is reminiscent of Menzies' (1959) suggestion that dividing up tasks on a hospital ward can be a defence against the anxiety engendered by nursing work. Dividing up the workload might be inconsistent with "new nursing's" ideal of individualised patient care (Salvage, 1990), yet it could be argued in this case that a happier, less "stressed" workforce is ultimately better for the patient anyway. Certainly the advent of skill mix, which to a large extent has superseded the single district nursing Sister working alone, has meant that where a difficult decision has to be taken, the responsibility for it can be distributed to some extent amongst a team of people, thus reducing the "stress" incurred. Although the sister as team leader or care manager has ultimate responsibility for the decision, the knowledge and experience of other trained nurses in the team can be used to inform the best course of action. An example of this was provided by DN18, who described the management of one of her patients who had an intractable and painful arterial leg ulcer:

> *DN18: "I think something difficult like that, I think we even discussed that initially within our team, so we tend to make team decisions. It's not always a one to one thing"*
>
> *JC: "Does that make it easier?"*
>
> *DN18: "It does yes, it takes the stress out of it if you discuss things because if you make a wrong decision or if you pick something which has a bad effect there's a kind of guilt thing there and if it's a team thing somehow it takes the dynamics out of the decision"*

So it would appear that there was a forum, in most cases, for immediate colleagues from the same nursing team to discuss patient care. In a safe fairly non-confrontational way, it was also acceptable to critique the work of peers as long as it was away from the patient. This perhaps explains how acquiescence in approaches to care occurred in teams. In Chapter six DN5 discussed the respect that she had for colleague's decisions: "I think there is a certain willingness to accept other people's abilities to assess the problem". Later in the interview she qualified this statement with a willingness to discuss issues with immediate colleagues:

> *"I mean I would comment on slight differences in dressings... other people's assessment isn't so sacred that you wouldn't discuss it but it would be in a very light way if you know what I mean... I'm all for discussion in actual fact from people of my own team irrespective of grade... but I feel that working well as a team is respecting other people's point of view" DN5*

What was not acceptable to most of the nurses, however, was to criticise or be critiqued by members of another team when a patient was being visited as a "one off" as a favour. Changing a colleague's care was certainly unacceptable unless something was both obviously and seriously wrong. Parallels can be drawn here with Freidson's (1975) observation of the profession of medicine, that either something serious has to have occurred or a practitioner has to be perceived to be really negligent, before the patient will benefit from a second opinion.

Changing Care

When the nurses visited a patient from another team, they were sometimes in a difficult position if the care prescribed was out of date or obviously wrong as one of the nurses explained:

> *"When other practices are short handed we help out and if I see something that I think ought to be changed or I should add to the care it's very difficult because it's not my patient and it's not really my place to do it... If I'm going in somewhere and I see something needs doing I want it done (laughs). I think it compromises my practice...I'm in the position of managing care and when it's someone else's patient I find it hard not to"* DN8

As in the issues arising from "presenting a united front", it was "not the done thing" to show the patient that a colleague's treatment decision was open to question. DN8 raises an interesting ethical issue here about compromising her practice which, by definition, compromises the care of the patients and excludes them from decisions about their care. It is something that has been discussed in the literature as a problem *inter*professionally when nurses disagree with a medical decision, particularly if a doctor is perceived to have behaved negligently (Buckenham and McGrath, 1983; Sherblom et al, 1993). This level of insight into the consequences of "non-interference" in the work of others was unusual however. More typical was the very honest opinion expressed by DN12 in the next quote, about nurses' commitment to patients other than their own:

> *"We're all supposed to be trained and know what we're doing and what have you...I think if you're visiting somebody else's patient you don't really feel as though that patient is yours and you need to work in their best interests. The patient is one of their patients. There is a definite line...It's not that you don't care about those other people but you may only see them once in a blue moon so you don't get involved I think. So perhaps that's something to do with it" DN12*

"Difficult" colleagues

Where nurses did let a patient know that the care that they were receiving might be inappropriate, this was seen as discourteous and they would often be described as "difficult to work with" or as having a "personality clash" with colleagues. For example one of the nurses (DN29), described it as "bad manners" that when she was away for a fortnight, a colleague discharged one of her patients who was on the books for observation visits, because it was thought that the visits were no longer necessary. Opinion was divided, however, about whether it was acceptable to change a colleague's care when a nurse had been away for a period of time. For one of the nurses (DN21) who worked in a job share, it was sometimes a long time before she saw some of the patients, so she was happy to surrender decision making to a colleague within her team or in another team:

> *"You know you might not go to see your patient for two or three weeks and somebody else will be going so you know it's only right they should change the treatment if they notice anything you've not been able to see because you haven't been going. I certainly don't get upset if people change my treatment,*

> *no I might be upset if I went in the morning and they changed it in the afternoon (laughs) but I don't remember feeling put out at all" DN21*

It is possible that because this nurse was in a job share she was accustomed to taking the opinions of other nurses into account, although some of the other study participants who worked full time also supported this view. DN36, for example, agreed that if it was a longer period of time than a day or a weekend, it was important to make decisions about a colleague's patient in their absence:

> *"Yes, because if somebody else's off sick or on holiday then I'm in charge of that patient. If I'm going in just on a day off or a weekend then I'm not in charge of that patient... One particular case where one of my colleagues was on holiday and I went in and this lady had a lot of pain with leg ulcers and I felt they hadn't been diagnosed as varicose ulcers and the leg wasn't being supported and I did on that occasion change the treatment because the colleague was on holiday" DN36*

It is interesting that although DN36 believed that it was important to take "charge" if the patient's regular nurse was away, she became quite unpopular when this was enacted, which could be quite off-putting should similar circumstances arise again. The colleague in question was offended that her care had been challenged, which DN36 attributed to the fact that she approached the problem "in a slightly undiplomatic way". By this she meant that it became apparent to the patient that the care was being questioned, which is difficult to avoid if something is obviously being changed. So although it might have been the belief of some of the nurses that when the regular nurse was away responsibility for the patient lay with the substituting nurse, operating this in practice was sometimes problematic.

The clear cut case

The only circumstance under which it was rarely, if ever, perceived to be discourteous to change care was if there was something clearly wrong. If a colleague was applying a caustic substance such as Eusol to a wound for example, where there is a substantial body of evidence that such practice is harmful (eg. Brennan and Leaper, 1985), the substituting nurse might not do the same. Sometimes nurses would carry on the care against their better judgement, as has been discussed elsewhere (Griffiths and Luker, 1994b), but if they decided not to, it would be unlikely to be viewed as unreasonable:

> *"Obviously if I went in somewhere and they were using Eusol or something like that I wouldn't use it, I would use saline"* DN9

> *"If it's something like Eusol or something like that, you know, has been shown that you are not to use it, I would use saline instead"* DN12

The patient need not be "let in on the act" however, to use Goffman's dramaturgical analogy (Goffman, 1959), if two products such as Eusol and non-irritant saline were swapped surreptitiously. If the patient had not been told that a different procedure had been carried out - and if he or she had not noticed - the patient's regular nurse need not be confronted if this was an uncomfortable prospect. The substituting nurse thus retained her integrity and her practice was not compromised, for the duration of the visit at least. The undergraduate student nurse data were similar in this respect: they would warm the saline that they used for cleansing wounds and irrigate the wound rather than cleaning it with cotton wool, both of which are recommended procedures (Leaper, 1986; Thomas, 1990). They were unlikely however to confront their community practice teachers about research based practice, so the patient only received the correct treatment when the student nurse visited:

> *SN1: "There are things that I do say for instance in terms of saline that you don't see other nurses doing necessarily and you cringe when you see it and I wouldn't do it like that"*
>
> *JG: "But you don't say anything?"*
>
> *SN1: "Somebody in hospital actually questioned me because I'd put some saline to warm in a pot and they said "why are you doing that?" and I explained and everything. On the district I've just gone ahead and done it and warmed it and everything and if somebody has been there and they want to say something to me then yes I'd say, but I've not confronted anybody...maybe I should but sometimes it's difficult to know how to approach it because you don't want to appear that "I know better than you" because I think being a novice within district nursing it's different and when you're settling in you don't want to kind of offend anybody"*

This reticence is interesting in view of the fact that in the previous chapter, student nurses were described by study participants as an invaluable resource for updating themselves, either as a source of information or to encourage the nurses to keep up to date. This reticence is also found in MacKenzie's (1992) study of student district nurses. She observed that during the "settling in" period, student district nurses were reluctant to challenge their field work teachers. As time went on however, MacKenzie found that the nurses began to question their fieldwork teachers about certain aspects of care, such as treatment decisions. This was perhaps because although student district nurses are "novices" in the community, they are experienced nurses unlike the undergraduates interviewed in this study who, whilst they had a sound academic grounding in research based practice, lacked experience.

If the patient's condition had deteriorated rapidly, and again there was no doubt that something had to be done, it was usually acceptable to intervene. This time however the intervention could not be hidden or disguised, and the patient and his or her regular nurse would have to be told:

> *"If for example it was a dressing and I felt this dressing needed changing over the weekend, it wasn't doing as well as it should or there was a lot of exudate, then I would change it to make the patient's life more comfortable over the weekend then mention it on Monday as to what I'd found"* *DN22*

> *"If it's somebody else's team, I mean if it was really nasty I would probably change it...if it was really disgusting and suppurating and all sorts of things I would probably change it. As they would do with us I think"* *DN21*

The preceding examples raise an important issue about the extent to which patients were viewed as partners or participants in care. Changing care or questioning prescriptions for care occurred at an interpersonal level where the reasons for challenging were firmly at the interface of the two nurses concerned. Had the substituting nurse offered a patient centred reason for changing a treatment - such as discomfort from the dressing or cleansing solution - this might have been perceived as less threatening. It is a tactic that the nurses in Hutchinson's (1990) study employed in their interactions with doctors: if the nurses disregarded a doctor's orders for the benefit of a patient, they would emphasise the part that the patient played in the decision. Hutchinson called this responsible subversion. Athough it was not inconceivable for the nurses in the current study to use this approach, placing a level of responsibility back in the hands of the patient and involving him or her in treatment decisions was uncommon.

The etiquette of challenging

This "rule of thumb" almost, that the patient should be protected from uncertainty about his or her care unless completely unavoidable, was adopted by most of the nurses interviewed. Where a nurse did feel that the care prescribed was inappropriate, and this was usually an out of date dressing procedure or if the patient was being "under" or "over" visited according to perceived need, it was believed that discussion should take place away from the patient: again, the team members were expected to "present a *united* front" and the patient's contribution was devalued. The nurses frequently wanted to say something to a colleague about an aspect of care, but in the absence of a formal platform for discussion such as team meetings, were *often* unsure how to proceed. Sometimes the nurse felt able to come back to the patient's regular nurse and discuss the care in a "diplomatic way (DN9)" as the following excerpts illustrate:

> *"I don't change the care usually then and there. I do what ever the nurse has decided to do and then perhaps if the relationship's good enough, which quite often it is here, you can say "I've tried this, what do you think of this? I've found it good, have you?" and then that can be changed" DN18*

> *"You do see things done that you wouldn't do yourself or you would change. That's very difficult when it's another Sister that's involved...in the case of a dressing or something I would use whatever the Sister had used but come back and have a word. If it had been used for a long time and the wound didn't look as if it was healing then I would suggest that they might like to try something different, but you have to carry on. I'd rather say things pleasantly and suggest "we did this with one of ours and it worked" that kind of comment" DN19*

So it would appear that there was etiquette about the way that delicate issues were addressed with colleagues. This was, understandably perhaps, non-threatening and diplomatic in the absence of a recognised forum for such discussions. The tactics the nurses used were not dissimilar from descriptions in the literature of the way in which doctors and nurses interacted in the past (eg. Stein, 1967), or perhaps still do, unless it is accepted that nurse-doctor interaction is more collegial than in the past (see Hughes, 1988; Stein et al, 1990; Porter, 1992). The nurses made gentle suggestions and hinted very indirectly rather than openly challenging a colleague. It could be therefore that the approach that Stein described in the sixties (1967) holds true for nurses' relationships with other colleagues apart from doctors.

The "one off" visit

The nurses described a difference between visiting a patient as a "one off" and seeing something that they disagreed with, and seeing the same thing on a number of occasions, as DN19 suggested in the last quote. The reason for this was that they were prepared to accept that there might be a rationale for the prescribed care that they were unaware of. One of the nurses described how in a subtle non-confrontational way, she discovered why one of her colleagues was using an unsterile product on a patient's'leg:

> *"(On visiting a colleague's patient) You think why am I doing this? This is a very awkward thing to be doing you know. Well why has she got gamgee on her leg instead of sterile pads? There was somebody today I thought, because I was doing two of (another site's) patients "why has she got gamgee on?" So anyway I'm not going to criticise the nurse to the patient. "Does she ever use those pads in little packets?" "No" she said "they irritate my skin" So we'd got an answer so I knew already, fine. Instead of going in and saying "what's she using this for?" and getting a reply of "why not? why? why shouldn't she use it?" you know the patient getting worried and so on: "shouldn't she*

> *be using that? "Is it not sterile? Oh this is terrible!" Don't go in and make a stink with any patient really but certainly not somebody else's...you just go with them, makes life easier. There's no point in upsetting everybody"* DN11

The language DN11 uses is interesting and supports an earlier suggestion that simplification of messages can complicate rather than clarify: referring to sterile pads as "those pads in little packets" could be construed as a fairly patronising message from an expert to a lay person. Although this incident was recounted at interview and not observed, it would appear that DN11 accepted a fairly implausible excuse for the use of a non-sterile product. Padding such as gamgee is a secondary dressing that does not come into direct contact with the skin, so the risk of irritation is reduced. Nevertheless, the nurses were invariably prepared to give colleagues the benefit of the doubt when their management was open to question. The following excerpts illustrate this further. There would appear to be an issue about record keeping or access to notes in these examples:

> *"Sometimes you can go into a house and see something should be different and there might be a reason why that nurse can't change the treatment but she couldn't necessarily put it on the nursing notes" DN36*

> *"I mean going in on a one off visit you don't know unless it says in the care plan what's already been tried or whether the patient has reacted to something or you know the whole situation" DN12*

The extent to which the patient can fully participate in his or her care when important events are not recorded is open to question. Record keeping is one of the purposes of the nursing process and if something is written down, it is open to scrutiny and review. It has been suggested that if nurses are uncertain about a nursing diagnosis, they are unlikely to render themselves accountable by committing it to paper (de la Cuesta, 1983), which is perhaps what was happening here. Although it is conceivable that some procedures are not recorded for reasons other than uncertainty, where the dominant culture assumes that everyone is working in the patient's best interest and a lot of "easing" behaviours between colleagues is the norm, there is inherent risk that knowledge will remain fairly static. If transmitting information to colleagues relies heavily on picking the right moment and not upsetting anybody, it is sometimes easier to say nothing as one of the nurses remarked:

> *"I would have to be in a really bad mood to be that confrontational with anybody. I think most of us like a fairly quiet life and to have an outright row or call into question someone's abilities is quite a difficult thing to do especially when everybody is a G grade and supposed to have a reasonable amount of experience and keep themselves up to date. You've got to keep your own ship in order before you can say anything to anybody anyway"* *DN20*

If the nurses were expected to have their "own ship in order" before they could legitimately comment on a colleague's care, it was perhaps unlikely that discussion would ever take place because all of the nurses interviewed had experienced difficulty in updating themselves. The issue of "everyone is a G grade" relates to the nurses' perception of their colleagues' autonomy discussed in chapter six, which resulted in a reluctance to interfere. Even if the nurse in question was confronted about her treatment decision however, there was no guarantee that she would do anything about it as the following nurse commented:

> *"I try to be diplomatic and come back and say something to the Sister. Usually they go away and think about it and sometimes it's changed"* DN27

This is something that was verified by the student nurse data. Where the student nurses' relationships with their community practice teachers (CPTs) were such that they were confident to offer an opinion, there was no guarantee that any change would be enduring:

> *"I'm quite lucky at the moment because as I say she (CPT) does let me change things. I don't think it would be a problem. It's just that when you change something you know as soon as you're not there that it's going to go back to the way it was before. It's difficult especially if the wound is getting healed"* SN2

The reason for this is that in spite of an explicit need for formal peer review to officially remove it from an interpersonal level, there was still no formal platform or recognised arrangement for formal overseeing or clinical supervision.

Preconditions for challenging

It would appear that a series of preconditions had to be in place before a nurse would consider challenging a colleague's prescription for care (table 6). Some of these considerations have been discussed already, such as the perceived seriousness of the situation and whether the nurse was a team member or from another team. Another determinant was the substituting nurse's own stress level, as DN5 commented:

> *"To be perfectly honest I feel my job's quite stressful and I have to set limits on what I feel responsible for and if I go into a*

> *patient who isn't directly under my care as an assessor and I see something I wouldn't do that way, I have to say that I don't address it that aggressively because even if I think it's wrong I can only cope with a certain level of responsibility" DN5*

Other factors included the work load and stresses of the colleague concerned. Before deciding whether to address an issue about patient care with a colleague, DN18 said that she would take the following into account, again she mentions the patient's "unknown" case history:

> *"Their workload, their stresses, the patient, because quite often they'll say I've tried these things anyway and if you become sort of 'why don't you do this?' if you're a nurse practitioner type, it's very unfair because you don't know the case history and that way it could be bad for the relationship for all concerned DN18*

It is evident therefore that workload pressures have a direct effect on patient care if they stifle the potential for transmitting information between colleagues. Another issue was of greater importance to the nurses however. Concern about damaging the nurse patient relationship by criticising a colleague's prescription for care was more important to most nurses than ensuring the patient had the most up to date dressings, or the "right" number of visits. The reason the nurses gave for this was that undermining a colleague had a knock on effect that was detrimental to the patient.

Table 6: Preconditions for a nurse challenging a colleague's prescription for care

Preconditions for Challenging a Colleague
• Perceived seriousness of the situation
• Balance between patient advocacy and respect for colleague's autonomy
• Personality of colleague or relationship with colleague
• Whether colleague a team member or from another team
• Patient's unknown case history
• Whether own practice believed to be up to date
• Stress level of nurse
• Stress level and work load pressure of colleague
• Whether challenging would damage nurse-patient relationship

Undermining Colleagues

Undermining a colleague in front of a patient was unacceptable to all of the nurses interviewed. Parallels can be drawn with Strong's (1979) description of the "ceremonial order of the clinic" where consultants were not open to discussions about their colleagues: "What parents thought of their general practitioner, of other hospital specialists, of local authority doctors and social workers was almost never mentioned: "not in front of the patients was the rule" " (Strong, 1979: p72). In an earlier example, DN11 wondered why a non-sterile pad was being used on a patient's leg and she had "diplomatically" found out why. She did not undermine her colleague because, she said, "all confidence would have gone". DN11 was challenged on this:

> *JG: "If confidence went, even though you might be thinking he should really be having something sterile on this leg, if the*

> *patient's confidence in the nurse went then what do you think might be the consequence of that for the patient or the nurse?"*
>
> *DN11: "Well their relationship's changed hasn't it immediately...and she won't believe another word this nurse says because this nurse said these pads were alright and they're not...I hope nurses aren't nasty. I hope they're all like that and don't undermine the last Sister that went in and don't sort of criticise somebody else's care because it goes a lot further than that one sentence...never believe them again probably"*

So although it could be argued that it is unethical to exclude a patient from important information, where the issue of confidence or trust in a clinician is taken into account the decision takes on an added dimension. For example Sherblom et al (1993) utilising Gilligan's ethic of care (Gilligan, 1993), argued that in a situation where a nurse covers for a negligent medical colleague, if the aim is to retain the patient's trust in the doctor and this is perceived to be crucial to the patient's recovery, the decision is not necessarily as unethical as it might at first appear.

The issues raised by patients losing confidence in the nurse, are reminiscent of a previous discussion about the effect on the nurses if they lose confidence in their ability to practice. The importance of confidence per se should not be underestimated perhaps, or confused with competence. In another example, one of the nurses (DN29) who was particularly interested in the management of leg ulcers frequently found that colleagues' practice was somewhat ad hoc and without a sound research base. Again, she would not discuss this with the patient:

> *JC: "Would you in any circumstances ever say to a patient you should be having so and such on your leg?"*
>
> *DN29: "No I'd come back and say to whoever you know "what do you think about them coming to the ulcer clinic? What do you think about doing a doppler? Something like that. No I wouldn't say to the patient"*
>
> *JC: "And if you did say to the patient, what do you imagine might happen if you did?"*
>
> *DN29: "Well it's undermining really, no I wouldn't do that"*
>
> *JC: "Right, and the knock on effect of undermining the nurse?"*
>
> *DN29: "Well I think it affects the whole relationship with the service really. Yes I think it's quite wrong. I mean I might not have been right in the first place might I? (laughs)...and the patient worrying"*
>
> *JC: "And what do you think might be the consequence of that do you think if the patient lost faith in the service?"*
>
> *DN29: "Well non-compliance and it's just difficult for more people going in...I don't think then they believe in any treatment"*

The nurses found it difficult to think of examples where the patient's confidence had been lost in the nurse through "undermining". This was possibly because it was something that the nurses rarely if ever did, partly because they did not believe in interfering in each other's work. One of the nurses (DN33) was, however, able to recall an incident where she was undermined by a colleague and the patient lost confidence in her which was not regained. She had been using a dressing that had adhered to a patient's wound, although in her opinion "anything was going to stick, it was just a matter of soaking it off":

> *DN33: "I was once nursing somebody and somebody had gone in afterwards and said "you've got completely the wrong*

> *dressing on here" and I was...all professionalism had gone out of the window. Well she could have discussed it with me first or whatever rather than saying you that know, or explaining why I'd done something. I was quite shattered there...We are all human and we can all make decisions but it's just well, anyone is open to discussion as to why they're doing a procedure but it's just sort of the patient then seems to query your expertise or knowledge or whatever and you explain to them why and then they can say well so and such said "blar, blar, blar it was the wrong dressing" and they've just got the word "wrong" in their brain and it's hard to get that out and gain their confidence again"*
>
> *JC: "Did you manage to gain their confidence again?"*
>
> *DN33: "No"*

Athough this is a retrospective account and was not observed, the language is interesting again. It would appear that the substituting nurse had inadequately explained the situation to the patient but equally, DN33 describes the reaction of the patient as rather childlike and irrational: "they've got the word wrong in their brain and it's hard to get that out again". Interpretation of events is inevitably highly speculative, but it could be that the decision to change DN33's dressing was at the nurse-nurse interface and did not include the patient. With so few examples of confidence being irretrievably lost in the service, it is difficult to assess whether excluding a patient from such decisions is beneficial or not. The rule about not undermining was the norm of the group however and was learned very early on as the next excerpt from an interview with one of the undergraduate district nurses verifies. Parallels can be drawn between this student nurse's experience and the similar findings of both Buckenham and McGrath (1983) and Melia (1984) that students have difficulty translating learned theory into practice in the ward environment:

> *'You find yourself doing things that you know you are not meant to do and you think to yourself well when I'm doing it when I'm qualified I'll do it the way I know you are meant to do it'* SN6

In view of the fact that student nurses were described by study participants as a resource for updating themselves, this raises questions about whether some outmoded practice will change, or maybe just very slowly. This links to the organisation of the district nursing service and the mechanisms that are available to the nurses for updating themselves and transferring knowledge.

It is perhaps not surprising that an invisible workforce with few structures in place for transferring information, will demonstrate marked variation in practice between individual nurses. The final findings chapter (Chapter eight) explores an example of idiosyncratic working practices in district nursing, in the decisions that the nurses made when they were required to equitably distribute their resource.

Summary

The central argument arising from the data presented in this chapter is that there is inherent risk in applying principles or relatively inflexible rules about how a group of professionals should conduct themselves in the name of teamwork, because although sometimes these principles might pay off and patients appear to benefit, at other times patients could be excluded from important decisions about their care, and receive less than optimum treatment. It is evident that rules about avoiding changing a colleague's prescription for care, presenting a united front and not undermining colleagues should not be unquestioningly applied. It is debatable whether these rules of what is really no more than etiquette should play such a large part in decisions about the care of patients.

CHAPTER 8: FINDINGS

Making Choices: *Rationing Care in District Nursing*

Introduction

It is well recognised that there is an imbalance or mismatch between patients' needs and the ability of the health and social services to meet those needs (North, 1993; Sheldon and Maynard, 1993), not least because "need" in itself is a nebulous concept. That is not to say that there is necessarily infinite demand for services (Williams, 1985; Hancock, 1993) but that there has been and inevitably always will be some shortfall between perceived need and what the services can realistically offer (Campbell, 1978; Lightfoot et al, 1992). Although this is not new, in recent years various factors have contributed to widen the gulf between minimum safe levels of care and the service that can be provided.

Demographic changes, such as the predicted increase in the numbers of frail elderly (DH 1995a), have had an insidious affect on the caseload of the district nurse. The major impact, however, has probably been the transfer of patient care from the acute sector, mainly hospitals, to the home. The impetus for this has come from the many years of debate that preceded the NHS and Community Care Act (DH, 1990), the community care component of which was enforced in April 1993. The Act gave legislative clout to the government's commitment to "care in the community", and the ways in which "needs" led care could be distributed between the health and social services. Although some of the work of district nurses has now been redefined as "social care" and delegated to social services departments (DH, 1989b), there remains immense pressure on district nurses to allocate their service equitably to make optimum use of their professional expertise.

It is the purpose of this chapter to explore how the district nurses, faced with distributing a finite resource, made decisions about rationing care. Means of controlling the flow of work will be explored and, importantly, the ways in which shortfalls in the service were sometimes unwittingly and imaginatively disguised.

Staff shortages

District nursing as a service is referral dependent. It is almost impossible to predict what the caseload will comprise from one week to the next, and nurses frequently spoke about "swings and roundabouts" implying that there were very busy periods and times when they were quieter. There was consensus however, that a lot of the time there was a shortage of staff. Due to the uncertainty created by the unpredictability of their work, it was difficult to get in extra staff when they were required because the district nurses had to convince their managers firstly that there were staff shortages, and secondly that this was likely to be ongoing. The following extracts from the data typify the commonly held view of the study participants:

> *"You feel sometimes not supported enough by management in that we've had a lot of problems here with staff.. and if we've asked for bank staff we've been knocked back, I mean we wouldn't ask unless we though it was necessary and yet we've been knocked back on it"* DN9

> *DN12: "We complained twice to management about staffing levels and nothing was done about it, but we had recorded and written everything down so we felt better in ourselves about it, but you felt bad that you were not giving your service and also the UKCC, you are not really meeting those guidelines there because you haven't got the time and that's not right really. So we did actually hand it to the manager and then also hand it onto one of the nursing officers sort of higher up"*
>
> *JC: "But you didn't get any extra staff?"*
>
> *DN12: "No"*

The "us and them" dichotomy of the values of community nurses and their managers inherent in these examples has been noted by Traynor (1994) who found that managers were perceived by nurses to be driven by financial imperatives and divorced from the reality of the workplace. Because district nursing work is relatively ill-defined and styles of assessment vary (see Chapter five and Griffiths and Luker, 1994b), convincing managers that there were staff shortages was sometimes a problem for the nurses: what precisely was it that they required the extra staff to do? Where caseloads had been augmented by an increase in the number of dressings or numbers of patients who required intensive terminal care it was easier to argue for more staff. These are areas that are irrefutably district nursing work and extra hands were required to get the job done. Where the role was less clearly defined, however, in areas such as the counselling and support of patients and carers, it was often more difficult to argue a case. Reflecting the findings of other recent studies (Lightfoot et al, 1992; Traynor 1994), the nurses reported that responding to requests from management for data on numbers of patients, or even dependency levels, gave little indication of the complexity of nursing care or the time it took to provide that care. DN37 was one of many nurses who resented providing hard data about her caseload:

> *"You need to write everything and get everything documented and like they say we are professionals but they won't take your word and get things done"* DN37

Asking for the problem in writing was sometimes perceived by the nurses to be "stalling" on the part of management, although most of them recognised that the budget might not stretch to extra staff anyway, however convincing their arguments. Staff shortages were "invisible" from management in the sense that district nursing is conducted behind closed doors in the patient's home. It was relatively easy for management to stall on requests for extra cover therefore, and perhaps easier for the nurses to offer care according to what the service could provide rather than what the patient required.

Needs based versus service led care

The philosophy underpinning the NHS and Community Care Act (DH, 1990) was that assessment for care would be "needs" as opposed to service led. The reality for the district nurses in this study, however, was quite different as the following typical extract from the interview data illustrates:

> *"You can assess for need in your head but you've got to be very careful what comes out of your mouth"* DN8

Some of the nurses, therefore, would acknowledge that there were needs that could not be met by the service but were not prepared either to articulate them to the patient, or make a written record of them. This lends support to the widely held belief that rhetoric about user involvement or empowerment in care decisions has outstripped reality (Taylor et al, 1992; Carr-Hill, 1994). Study participants were covertly ignoring unmet need in other words and concealing shortfalls in the service, confirming the fears of authors such as North (1993) about the potential for disguising unmet need. One of the nurses was a deviant case, however, and was willing to share the nursing assessment with the patient:

> *"I always make it clear to (patients) that I start off by assessing their needs but end up giving them a service that is determined by typical organisational imperatives, in other words determined by what I've got to offer rather than what they need...It's a fallacy to say our service or anybody else's is needs led. It's not, it's resources led"* DN5

This particular nurse was clear that unless unmet need was formally acknowledged patients would lose out further. If the service appeared to be coping with the demands made on it, it might be cut back even more or at best remain substantially under resourced. Interestingly, a minority of nurses believed that they were meeting the patients needs. Whether they were or not is a moot point as the following extract demonstrates:

> *JG: "When you take somebody new on the books, do you ever feel that you have to assess what else you're doing to work out what services you can give that person, how much time you can give them?"*
>
> *DN20: "No. I've never been in that situation - been so busy that it's affected that. It might affect you on an odd day here or there that you've got to rush in and rush out but I would never at an assessment think "oh we can't do this". I've never had to do that up to now and I hope it never happens"*
>
> *JG: "So you wouldn't actually alter the number of visits you would give somebody or anything?"*
>
> *DN20: "Not at a primary visit. Maybe later on in their treatment if things were getting too hectic. You'd look at your caseload as*

> *a whole to see if there was anything that could be cut down on, whether on a temporary or permanent basis. There's the odd day when you ring people up and cancel baths and things like that but I don't think a primary assessment you would, but I've never had to contemplate refusing this and that and the other because of pressures of work. You just speed up"*

It is clear that if other patients are being cut back to accommodate a new patient or if the visits to everyone on the caseload are "sped up", the input or quality of care was unlikely to be as high. This is illustrated by the following examples where again, blocking strategies in nurse-patient dialogue are evident:

> *"Sometimes when you've got like a full list, you are going in and you sort of deliberately don't talk about something because you know it's going to take somebody ages to talk to you about it or what ever. So you do find that you are doing that, and sometimes you are just doing the bare minimum that you need to do, and getting out and getting on to the next patient" DN12*

> *"What you tend to do is to do quick pop-in visits to some people and not allow them to off-load their problems. Or take whatever is their most pressing problem, but with a view to making arrangements for a later time, so the next time they'll be the person who gets the most time. So you rationalise it like that" DN18*

Whether it is possible to divide the service up as DN18 recommends is debatable, as the next quote from the mother of one of the younger disabled patients (PT2) suggests. It would appear that the amount of time that PT2 is offered by the service is fairly consistent and dictated by the level of input that her mother is expected to provide. PT2 was tetraplegic following a road traffic accident and awaiting monetary compensation to pay for private nursing care:

> *"I saw a nurse break down here the other week and ask (me) "will you please just phone up" and she said "you've got the gob, phone up". And she said "we are going to other people who never see anybody all day long" and she said "we can't even have a talk to them, we are just in and out, rush in and rush out" she said "...because we've got that much work to do". It's not a service, the service is nil and I really feel sorry for anybody who has to suffer it, I really do...*
>
> *... the nurses don't know where her head is to wash her hair, they don't know where her feet are to wash her feet, they never ask can they wash her hair. They never ask can they do her feet or her legs, they are here a quarter of an hour. I do all that. (PT2) has her bowels done twice a week: I do that. I do her catheter, I do everything. All those nurses walk in and do is they just get her out of bed because they're so pushed. And three quarters of the time she's already out of bed and in the chair when they walk in because sometimes it's 12 o'clock when they're walking in and I can't be doing with it. Neither can (PT2), she's only a young girl. She wants a life and she's got a three year old child" (mother of PT2)*

Rushing is a consistent feature of district nursing work and is a recognised source of patient dissatisfaction (Luker and Perkins, 1988; Ong, 1991). Sometimes the knock on effect of rushing was potentially quite dangerous for study participants and their patients, as the following extract illustrates. DN32 was prepared to carry out a lift when time was limited, in spite of the fact that the patient she discusses was heavier than the 8 stone maximum for lifting a patient with two nurses (Health and Safety Executive, 1992):

> *DN32: "If I went in to visit that person and I was on my own for any reason then I would use the hoist but if there are two of us, then sometimes it just seems if you know the person you're lifting with, and you're both agreeable to doing the lift it's quicker, and the patient's agreeable as well, we do it. For the speed really more than anything"*
>
> *JG: "So that's quite an important consideration?"*
>
> *DN32: "Yes because you mind's always on the clock?"*

> *JG: "...so you're weighing it up: it's putting yourself at risk in a way, so you can get round the rest of the patients?"*
>
> *DN32: "Plus since the comcare (palm top computer for data entry)...so you're conscious of that all the time. It's like big brother really...if you key the code in before you go in the house it times how long you're in there, so your time comes up when you come out, how long it took you to travel there. It's like you've got to account for every moment of your day..."*

Rushing or speeding up was termed "dilution" of the service by one of the nurses (DN9), who saw it as the only way that she could distribute care equitably. Although in this next extract DN9 suggests that each patient would have their visits cut back when time was limited, she implies that the time available would be rationed where possible according to need:

> *"I mean my heart tells me that I should be purely assessing on what the patient needs but my head says that if I do that then the service would break down totally because I would just overstretch it too much and there would just be no service. So it has to be diluted and I weigh up what we can offer and what the patient needs and hopefully we can come to a happy medium" DN9*

Dilution of care or "speeding up" relates to an earlier point about the inadequacy of presenting numbers of patients to management rather than data about the content of the visit. In reducing visits to numbers, quality of care can be overlooked. It is also interesting that there were different views about whether assessment was needs or service led within the same locality. DN5 who believed that the service was "resources led" and DN20 who believed she met patients needs, shared the same office space yet DN20 appeared to assume that colleagues would assess similarly to herself. DN20 works in the same nursing team as DN8 who in an earlier quote said "you have to be very careful what comes out of your mouth". This highlights the isolation from colleagues of district nurses working in the community because certain beliefs that underpinned their practice were not necessarily transmitted to their immediate colleagues.

The issue of re-prioritising care is interesting. The data suggest that nurses are far more likely to speed up their work and cut down on the time spent with each patient than cancel anyone or substantially re-evaluate the caseload. The reason for this, which will be discussed next, is that the nurses were reluctant to set precedents and were concerned at giving with one hand and taking away with the other.

Setting a precedent

Unless the patient's circumstances had changed dramatically, the nurses found it difficult to reduce visits to accommodate differing demands on the caseload. This echoes the similar findings of Badger et al (1989a) who found that patient's got "stuck" on the caseload, and Trojan and Yonge (1993) who found that the same thing happened when patients became "dependent" on the nursing service. All of the study participants talked about "setting precedents" and how hard it was to change someone's care, unless it was something like wound care when reducing visits might be viewed as a positive outcome. Avoiding taking on "social" care such as bathing was an example of avoiding setting a precedent. There was a risk that if a need was identified and met it would be difficult to withdraw, or in the following case, to offer something that could be legitimately described as nursing such as "support":

> *"I can think of people who have pulmonary artery disease, very bad hearts, who would be desperate for a bath and who aren't getting attendance allowance, but don't have any family and I think I wouldn't mind doing a bath here but I wouldn't do it because it would be setting a precedent and quite often that's all people want, somebody to bath them and they don't realise the implications of some things we do for support" DN18*

This illustrates the extent which district nursing is defined, by the patient in this example, by hands on physical tasks. The district nurses felt that if a need had been identified and still existed, it was unfair to withdraw nursing input:

> *"Well it's awful, I mean the patient would resent you terribly for removing all these wonderful things you've given him or her" DN11*

DN11 implies that removing a service would damage the nurse patient relationship, which was something that the nurses valued. Sometimes setting a precedent was about the physical input someone had been offered in the past that was difficult to change. At other times it was about a routine that had been set up such as drinking tea with a patient or carer. The next extract illustrates the former:

> *DN30: "Well we've got a lady at the moment that my predecessor had assessed to shower her weekly, she's visited daily anyway, but she had assessed her for a shower. But she is taken from her flat to a communal shower in the building which is on the next floor, and we've got a lot of complaints from the other staff because they find it hard to take her down in the lift and shower and then you get your feet wet in the shower, but having discussed this with my managers we can't*

> *withdraw the service because it was offered a couple of years before I took over in this practice'*
>
> *JC: 'So that's actually policy?'*
>
> *DN30: 'Yes, you can't withdraw... because the service has already been offered I can't withdraw, even though I think it would be better to try and get her into her own bath because she's got her own bath aids anyway, because this had been offered as I say you can't withdraw. Or at least that is what I've been told by my manager, so unless circumstances change I can't withdraw that service that has been offered'*

It is interesting that in this example management endorsed the concept of not cutting back on the service if a precedent had been set, which is the opposite of Traynor's (1994) finding that managers described community nurses as unable to prioritise care. When asked what would be the consequence of withdrawing or changing the care in this example, DN30 said of the patient that "she has a husband who would probably go straight to the media". Perhaps a little more exposure of the pressures community staff work under would lead to change or at least some acknowledgment of the difficulties: it might not be a bad thing depending on how the incident was reported. DN37 described another typical example of setting precedents:

> *DN37: 'We go to a paraplegic and we go to him every Tuesday morning to shower him. Now he has home care aides the rest of the time to help his wife but it's always been the nurses who have gone in on a Tuesday morning and I can't change that now'*
>
> *JC: 'Have you tried to change it?'*
>
> *DN37: 'I sort of hinted at it but it would cause a bit of trouble. His wife is going in to have a prolapse done so I thought well I'm afraid we will still have to keep going in. She catheterises him. He had an accident about 25 years ago. She does everything for him so really there isn't any nursing there'*

Definitions of nursing and social care are raised again here. Showering someone is social care by most definitions and carried out by social services staff. Catheterisation is nursing care but it is a lay carer, in this example, who carries this out. It is interesting that male catheterisation is usually considered to be especially complex and the district nurses require extra training to perform it. It could be that the nurses were not prepared to damage their relationship with the carer because she gave essential nursing care to her husband which in different circumstances they would have to provide (Twigg, 1992; DH, 1993a). Examples of setting precedents with younger disabled patients, such as this paraplegic man, were plentiful in the data. It was suggested by the study participants that this was because they were particularly articulate and able to express their needs. In the next example the precedent that had been set was to do with drinking tea with a relative of someone with Alzheimer's disease. The patient was described as "a severe CVA with hemiplegia and also she was suffering from Alzheimer's disease":

> *"...her relative needed a lot of support. But we used to find that with this patient it was the norm to sit back and have tea and biscuits afterwards and stay there really a lot longer than was necessary and yet the relative... quite often if you were to say look I'm sorry I can't have 'tea this morning I'm pushed. Tomorrow would be a better day she used to get very uptight about it "well the other Sister always has time to sit and have coffee"...I think sometimes that you've got to start right at the beginning and say no, on the odd occasion yes but not regularly. On the other hand we often think that could be a cry for help then, you've done your physical hands on care but the carers need a bit of support as well... Unfortunately with this economic climate and the staffing levels as they are we don't always have time ... You've got to be strict with yourself or you're going to find yourself overloaded. Really overloaded" DN28*

Again the issue of reciprocity is raised in this example. Carers, and the patients themselves, often provide the bulk of the care themselves with the nurses "topping up" where a deficit in their ability to care or self-care exists. It was perhaps worth the nurses' while investing in the relationship in this way, to ensure that the level of input was maintained.

One way to avoid setting a precedent was to offer as little as possible at the assessment visit. The nurses would often leave something in reserve when offering a level of input so that they had something to "fall back on" should the need arise. The following approach to assessment was typical:

> *"I don't put too much in to begin with because I think sometimes first visits can be off-putting on both sides really and you can get a lot of people that are I want this, this this and this and if you put it in immediately you've got nothing to fall back on. I think it's important that you've got something to fall back on. So perhaps I tend to be a little more strict when I'm assessing somebody because I know I've always got plenty I can fall back on whereas if you put too much in you've got nothing to fall back on. And people don't expect things to be put there.." DN28*

So although the service is highly referral dependent, the district nurses could exert some control by holding back information about what was available. As long as the patient was unaware of what might be on offer, the nurse would succeed however incompatible this is with the ideals of joint care planning or patient empowerment. It is interesting that the onus is put on the patient to some extent in this example, the implication being that patients can become overwhelmed if offered too much. Other nurses could justify "holding back" because the assessment of a patient is an ongoing process. DN10 was amongst these:

> *'Once you put in an amount of nursing care it's often difficult to withdraw that care later on. People tend to be very reluctant to let you go...I tend to put, hopefully, it's a bit difficult isn't it, but you tend to put as much as is necessary and increase that if necessary rather than try and decrease it. Try and put less in and increase if you should find it necessary. Because I find it very difficult to assess on one occasion, do a full assessment, I mean people don't tend to open up so it's very difficult to do a complete assessment on one occasion, you know, one or two follow ups after that you get a bit more. So I think it would be better to perhaps just slightly under assess it rather than over assess it. You can gradually increase over 2 or 3 days' DN10*

There is inherent confusion here. DN10 "under assesses" so that she does not offer too large a share of the service, but she states that more issues or "needs" are likely to be raised on subsequent visits: the initial visit does not present the full picture. Some of the nurses visited patients fairly intensively when they were first admitted to the caseload in order to conduct the "complete" assessment that DN10 alludes to. DN5 was amongst these:

> *'I tend to assess fairly intensively over a short period of time at the beginning while I weigh up what I feel I need to do but I do make it clear to the client that the level of input is temporary and doesn't necessarily imply an ongoing commitment to that level of visiting' DN5*

It is possible that a full assessment can make savings in nursing time and commitment in the long run: effort well invested in other words. DN28 gave an intriguing example of this in the next excerpt. It would appear that the patient in question had not been fully assessed according to district nursing criteria at some stage. She had either been asked the wrong questions or had not been asked to walk across the room:

> *"Once with a patient who I went into everyday to give general care and then I found that this patient was, I'd gone to get some hot water one day to do this patient and she said "oh I know the water's hot because I've just been in the kitchen washing the pots". And I thought why am I going in washing her if she's just been into the kitchen to wash the pots. Because she really gave the impression when she came out of hospital that here was a really frail old lady who could not do anything for herself " DN28*

The implication here is that this patient was pulling the wool over the nurse's eyes: she was being dishonest somehow about her ability to manage at home. It could be however that being washed by a nurse was a very real "need" for this patient, even though it did not accord with DN28's assessment criteria, which is something that other authors have discussed (see eg.Ong 1991). DN28 continued:

> *JG: "How easy was it to withdraw from going in every day with that particular patient?"*
>
> *DN28: "Very difficult because it was her right and this was what we used to get "it's my right to have it therefore I should have it, I'm 80 plus therefore I should have it". The fact that she was 80 plus but still capable of doing her own housework didn't matter. You know "I've been in hospital I should have the district nurse" and it's very difficult to pull out"*

Involving the patient in the decision making process was less likely to lead to irretrievably setting precedents. DN26 was someone who would keep patients informed in this way, although it is not clear whether she is describing patient involvement in care decisions or a "fait accompli":

> *"I certainly explain if it's purely for district nursing that we will be at some stage reducing the visits. We are not going to every day of the week of your life sort of thing. Not as bluntly as that obviously but you do explain to them obviously the better they're getting then obviously the less I would need to come"* DN26

Clearly this is only the case when someone is likely to get better. In terminal care, visits increased rather than reduced, with some of the nurses visiting terminally ill patients up to four times a day. Younger disabled patients were another group who were unlikely to get better, and where precedents were set that were often regarded as irreversible. Some of the issues around visiting the younger disabled will now be explored in more depth.

Younger disabled patients

Many issues relating to rationing services were raised by the nursing care of the younger disabled. It was quite often the case that these patients would get extra visits or favours that someone equally disabled but older would not receive. When rationing services therefore, these patients might be more likely to get their needs met and therefore receive an unequal share of the service:

> *"I would say we accommodate them more, early visits if they are going somewhere. We do that with most patients but we do really make efforts with them. We do things that perhaps we wouldn't do for other patients, go before the official work time. We do a very early visit for some reason because it suits them, this kind of thing, and take them things, clothes and what not, that kind of thing"* DN8

The ageism inherent in this example reflects the age discrimination that is increasingly prevalent in the rationing decisions of the rest of the health service (Doyal, 1993; Grimley Evans, 1993). One reason for favouring the younger disabled was that the nurses appeared to adopt a loss model. These patients were closer to the nurses' age and it was easier to empathise with the way they were "losing out" through their disabilities.

> *"I think perhaps I'd be more aware of the young person's need for an earlier timed visit you know because of their age. They've got a right to some kind of life like the rest of us, whereas somebody past the age of retirement, they probably wouldn't want to be get out and do things in quite the same way as a young person would"* DN19

A parallel can be drawn here with the "social loss" described by Glaser and Strauss (1965) in relation to nurses caring for dying patients of a similar age to themselves. Another reason for the inequity was that these patients' needs were often well articulated which, like DN28's patient who was capable of "washing the pots" but not herself, the nurses often described as "they know their rights". Knowing one's rights is an explicit aim of the Patient's Charter (DH, 1991), yet in the following example it is described in the same pejorative sense that the word "demanding" is now understood (Johnson and Webb, 1995; Wolf, 1988):

> *"They can be very very demanding and very aware of their rights... they are very good at manipulating you to doing what they want, what they have decided is their right. I've had experience with a particular patient who manipulated all the staff to the point where no one wanted to go there because you would go in with the best intentions in the world and she would manipulate you to doing what she wanted"* DN30

Although "no one wanted to go" to this patient the nurses continued to visit her. The issue might not have been "I know my rights" but "I know my needs", which is something quite different (Ong, 1991). DN21 visited a young disabled patient who was able to articulate her needs very well and was bathed every day by two nurses. DN16 who visited this particular patient in the evenings commented:

> *"I've got one who gets a bath everyday. There's some old ladies who only get bathed once every three weeks. I think it's unfair but how are they going to change it? It should have been assessed properly in the beginning" DN16*

A precedent had been set therefore that was difficult to change. It was not uncommon to find that bathing younger disabled patients assumed a high priority. This was in spite of the fact that bathing, in most cases, was no longer considered to be district nursing work and was delegated to social services carers (DH, 1990). There were similar biases in favour of the younger disabled in all localities:

> *JC: "If it's a question of this person wanted to have a bath every day rather than once a week or once a fortnight are you more likely to, would that be right?"*
>
> *DN24: "Yes I think it would, plus I think you would press very hard for (building) extensions and to make their life as easy as possible, knowing you are going to get maximum use out of it. Because one of the difficulties of course with the elderly is that it's very costly and you think, is it worth it? Luckily that isn't our decision anyway but yes we do push very hard for the young disabled"*
>
> *JC: "And for bathing and things, some people have said to me that it's actually quite marked if they think about it, that the elderly will usually get baths say once a fortnight but if somebody who's young and disabled if they want it will have it much more frequently"*

> *DN24: "Yes, simply because we would work very closely with social services, get the bathrooms fitted so it's easier. I mean the elderly people, it's not safe practice to put them in the bath, whereas if you've got a young disabled you'll press social services to rip the bath out, get the showers and of course if it was easy to use you would do it"*

Interestingly, the patient in DN21's caseload who was bathed every day was lifted into the bath, a lift which was described by her colleagues as unsafe: "an awkward twisting lift" (DN8). The patient did in fact have bath aids, but was particularly vocal about her objections to using them. The district nurses conceded in spite of the risks to their own safety. There was a sense in which the person who was most vocal or "shouted loudest" got the most, therefore which is something that is recognised in the literature (Carr Hill, 1994). DN5 agreed with this:

> *"There is a definite sense, however much you resist it the louder someone shouts the more they get their own way whether that's appropriate to their needs or whether it's appropriate within the context of how you divide up your resources" DN5*

Most of the nurses alluded to more "vocal" patients getting their needs met, as in the following quote from DN18. Taylor et al (1992) have described this as the societal stereotype of "passive older women and aggressive males in wheelchairs":

> *JG: "What about bathing and things with the young disabled, do they get more baths than the elderly?"*
>
> *DN18: "Yes, definitely. Mainly because they're more vocal in their needs and when care is planned whatever they perceive as their problem and their needs are taken into account. They are with the elderly as well but an elderly person won't say. "I want a bath daily". Very few will"*

The nurses often acknowledged that their colleagues were spending an inordinate amount of time with certain patients but frequently dismissed this as "if more people were (demanding) then it would be a better service" (DN9) or "you've got to admire them really (for articulating their needs)" (DN21). DN5 commented that:

> *"There's people I think should be more stringent or one person in particular - more critical about what she puts in - but in a way I don't think it's an important kind of ethical issue for me to question people's assessment or putting too much in, I think it would be more if they were putting too little in"* DN5

The premise of the NHS and Community Care Act (DH, 1990) that the service should be "needs led" supports this viewpoint but there is an ethical issue, surely, if individual needs are placed above the collective needs of the caseload. With finite resources it is likely that in terms of time and input, one person's gain is someone else's loss.

The needs based assessment appears to be a double edged sword to some extent. If patients are viewed as partners in their care and asked to describe what their needs are, the nurse runs the risk of being asked to provide something that the service will not stretch to. Equally, the more diffident patient might request less than they need, so maybe in terms of the collective demands on the caseload it evens out. The caseload is still organised according to "need", perhaps, and to some extent inequity in provision can be justified. The following quote from DN26 illustrates how this might be the case:

> *"I usually start by asking them "how can I help you?" when I'm going in, which makes them think about what it is that their needs are... I think it's important to put the onus back on them"* DN26

The move towards patients as partners in care, which is inherent in current legislation and committed to paper in the Patients' Charter (DH, 1991), puts some of the onus back on the patient. It serves the interests of the organisation that patients are to some extent responsible for their own health care, and are as independent as possible. The issue of promoting independence was raised repeatedly by the study participants and it will now be explored in more depth.

Promoting independence

The nurses saw their role as supporting patients, but keeping them as independent as possible which is inherent in recent legisiation about the aims of community care (DH, 1989b,1990). If there was a district nursing philosophy promoting independence was probably it, which was partly because many of the patients were on their own for the majority of the time. One of the nurses remarked that "we are not a take over bid" (DN10), and her colleague (DN19) expressed the opinion that:

> *"I think everybody, particularly people with problems need to be encouraged to do absolutely as much as they are able to do for themselves"* DN19

Dependence on nursing staff was not encouraged and was cited as one of the reasons to avoid setting a precedent as the following two extracts illustrate:

> *"I think patients have always become dependent on us to some degree and they find it difficult to let go" DN8*

> *"I tend to see how much they can do themselves before I go in and take over...I step very carefully... I've stopped rushing in, whereas one time I would rush in, whereas now I would be more gentle at it...I think it's because you can't always get out (discharge the patient), they like you coming and they lose some of their independence... I'm here to support you, the bits you can't do, I'm not here to take over" DN22*

DN9 was another nurse who found it difficult to withdraw when hands on nursing care was no longer required, but the patient had become somewhat dependent on her input:

> *"Patients who maybe have just been discharged from hospital and need quite a lot of nursing input and gradually they recover and they are rehabilitated. And you try to cut them down, and sometimes you are met with quite a lot of resistance because they are used to having you around. And they feel safe and secure knowing that you are going in every day, even if you are not actually doing anything for them" DN9*

Encouraging independence was also seen as a valid reason for holding back on the service offered when someone was newly admitted to the caseload. Holding back is characteristic of the district nursing service who, unlike social services, are reluctant to say "no" to a new referral (Traynor, 1994). DN30 commented:

> *"On my first assessment I will always offer as little as possible so I've got something to build on. I wouldn't go in guns blazing and say this is available. I would go in gently and gradually introduce because otherwise you've got nothing to build onto and you can suddenly take people's independence away and I*

> *think it's very important for people to retain their own independence. They can quite easily sit back and not do anything for themselves, but I would certainly have something to build on rather than offer everything that was available on the first visit" DN30*

Promoting independence but at the same time building up "the relationship" that was so valued by the nurses was a tricky balancing act. The following quote illustrates the dichotomy quite clearly:

> *"I personally think that before I can give anything concrete, anything positive I've got to get to know that patient and I think that that patient has got to get to know me, even though you keep yourself at a certain distance there has got to be a certain relationship, they've got to get to know you and open up slowly. I think that's most important.." DN28.*

DN28 then went on to say:

> *"... I believe that we should make our visits as infrequent as we can because we are not there to take over their lives. We are there to put in that little bit of extra to bring up the balance and with the dressings now if you can cut your visits down you are cutting your costs and we've all got to be budget conscious" DN28*

The way that cutting back on dressings can reduce costs is apparent: dressings are expensive and the fewer that are used the cheaper it is. Further to this, it is an approach to wound care that is supported by research (Thomas, 1990). The less a wound is disturbed, the quicker it is likely to heal because newly granulating tissue is not destroyed, and the wound surface can remain moist and warm which assists wound healing. A similar but less overt philosophy can be adopted with other areas of care. If independence is better for the patient, or perceived to be, then to an extent this legitimises cutting back on the service. It also enables the service to be distributed more economically, or at least to a greater number of patients. However, if patients are able to provide their own care, in many respects this demystifies and deskills nursing work:

> *"I think a long time ago people expected you to do a lot of things for them whereas people are willing to learn to be more independent now...If they're in hospital they don't get washed any more do they, they're expected to make their own beds. In hospital you've got to be dying before they actually nurse you really... but I think it's better that people, if they can, do their own. Like dressings. I think a lot of people could learn to do their own dressings. As long as you're visiting them to advise them and probably just do it once a week. I think they could do the changing of dressings" DN37*

One of the other nurses, however, was under no illusions about the reasons that she encouraged independence. The example she used in the next extract is the self-administration of eyedrops:

> *"We only do them twice a day in the community for this area. Now if you went to a rural area you'd probably get them once a day you know. We try to make the patients as independent as possible, as soon as possible, I think that's really important because no sooner do you get one patient on your books then you are taking one off and taking one off and you might get three, like today, four assessments of however many, I've stopped counting, you know, that are dealt with" DN26*

So it suits the needs of the organisation to promote self-care and, on the whole, independence was likely to be encouraged. There was an exception to this however and that was when someone was terminally ill.

Terminal care

In chapter five of this thesis it became apparent that the nurses invested a lot of time in building up relationships with patients who were terminally ill. They were happy to foster dependence at an early stage in the illness and befriended the patient so that they were a familiar face when intimate hands on care was required. In the final stages of their illness, terminally ill patients were of top priority in the district nurses' caseloads and the care of other patients would be organised around them. They were the "popular" patients in other words, which is interesting given that the literature suggests that terminal illness is a criterion for unpopularity (Kelly and May, 1982):

> *"They are always the first person that I visit in the morning. First thing. Even if I don't do any care I'd just call, just to know what kind of night they've had and then I prioritise my day around that person. So that person may need three or four visits in the day, depending on what's in my day whether I will ask another member of staff to go in the afternoon, but they are the one who are a priority on that particular day" DN22*

Within reason, there was no limit to the time that would be given to someone who was terminally ill:

> *"I think we just stay there until we've done the job. We don't put a time on it, no" DN21*

Inevitably then, other patients' care would be cut back at the expense of attending to someone who was dying, which again raises issues about equity in caseload management. In the earlier stages of the illness, however, when no hands on care was required, they were the most common patients to have their visits cancelled or postponed. This was because of the value placed by the nurses on physical care and if time was short, hands on nursing assumed highest priority. The patients who were least likely to be cancelled were those who were most articulate. In this case it was unlikely to be the younger disabled because as well as being particularly articulate, they were heavily physically dependent. If it was a dressing or any other care, the patients who complained the most were least likely to be cancelled.

Cancelling visits

Cancelling visits was in fact relatively uncommon. If the nurses were pushed for time they were more likely to speed up the visits and fit them into the day or work unpaid and unacknowledged overtime. A look at who the nurses would cancel however, gives an indication of the value placed on different types of patient and categories of care. If there was no way to avoid cancelling someone, it was unlikely to happen to the patients who were most likely to object as the next few extracts illustrate:

> *'To be honest a lot of it you would think about how hard a time you were going to have on the next visit, how hard the patient is going to be on you about it and you cancel the one who isn't so hard on you'* DN8

> *'If you've got someone who's stroppy then obviously you are less likely to cancel them because it's not worth the earache that you are going to get.. The thought that you've got to go through an uncomfortable conversation with somebody because you are trying to put them off. It's human nature really isn't it'* DN21

> *"It's personalities I think. Some people are very understanding and some people demand what they think is their right"* DN30

It could be that the benefit to nurses of developing a good relationship with patients was that it led to a greater degree of reciprocity in the form of "understanding" when time is short. Bignold (1995) for example, has suggested that befriending in the nurse-patient relationship has a reciprocal element. When the vociferous patients had been ruled out as a possibility for cancellation, the "supervisory" visits were most commonly cancelled, followed by patients who required dressings:

> *"Initially we would cancel the supervisory patients that don't actually need any nursing care but that you want to keep in contact with. Mainly they're terminal and by doing the supervisory visits you can prevent them needing more visits in the future but those are the first ones we would cancel. But dressings we either cancel them or put them forward to the next day or if they're Monday Wednesday Friday we might miss Monday altogether and put them on til Wednesday but that again can cause a build up of problems... The patients that are totally dependent, that need help with washing and dressing etc we just wouldn't cancel those. We've been told that we should if we've been really desperate the management have said "well cancel them and tell the families to manage" but at the end of the day nurses just can't do that. We just manage and work through the lunch hour and overtime"* DN19

Presumably DN19 meant that by visiting terminally ill patients and discussing issues as they arose, this prevented "a build up of problems": they will inevitably require "more visits in the future", surely, as their condition deteriorated. It is interesting that management endorsed disguising unmet need in this example by suggesting that patients were cancelled. Most of the nurses however expressed the view that cancelling was counterproductive and would not do it:

> *"It's counterproductive cancelling patients because whatever it was that you were going to see must be worse. It must be if you've not gone or there was no point in you going in the first place"* *DN11*

The most common solution therefore was to cut the time of the visits down and some how get through the day:

> *"I don't think I've often had to cut people down because we are busy. You cut the time of the visit down rather then the actual visit"* *DN20*

This is a clear example of the way in which the district nursing service is able to disguise unmet need. Unless caseloads are overseen or otherwise monitored, the nurses are likely to develop individualised approaches to distributing their resource. There is a need to strike a balance between respecting the autonomy of district nurses to allocate the service at their discretion and ensuring that the service is distributed equitably. It is predictable perhaps that a service which is largely invisible will develop indiosyncracies in the way that it is delivered, which accounts for the difficulties the district nurses had in describing their work. These issues will be discussed further in the final chapter of the thesis which addresses the wider implications of the issues raised in the findings chapters, within a broader political context.

Summary

The data demonstrate that with finite resources and understaffing, the solution to distributing care lies in rationing the service. It is apparent however, that there were criteria for rationing that were based less on need than the relative value placed on different types of patient or categories of care. The data suggest that relatively speaking, the elderly chronic sick assumed lowest priority and the acutely terminally ill the highest. In addition, where someone was particularly articulate, irrespective of age or condition, and likely to complain if a service was withdrawn or reduced, they assumed a high priority.

Setting precedents when assessing a patient was seen as an irretrievable problem by many of the nurses. When a service had been offered to a patient it was difficult to withdraw or reduce it. This caused problems when the collective needs of the caseload had to be reassessed. The nurses preferred to speed up their visits instead, which inevitably meant reducing nursing input to all patients and therefore quality of care. In this sense they were unwittingly disguising unmet need. The value placed on encouraging independence in patients helped the nurses to cope with the intractable problem of stretching an already over burdened service.

CHAPTER 9: Discussion

Introduction

The purpose of the following discussion is to evaluate the methods used in this study and to discuss the wider implications of the findings of the study.

This study has taken an in depth look at the caseload managers of district nursing teams and has explored the contextual factors affecting caseload management. One of the conclusions of this research was that district nursing caseload management was highly individualised and often idiosyncratic. The following chapter re-visits the finding that the district nurses had different styles of caseload management, and discusses the explanations for this that arose from the data. Possible reasons for differences in management styles are then re-evaluated within the broader context of recent policy changes in primary care. The implications of the findings of the study for both the patient and the future of the district nursing service are discussed.

Methods

The theoretical stance to social enquiry taken in this study was described fairly loosely as practitioner ethnography. This reluctance to categorise the approach firmly is born less of uncertainty about the choice of research method, than recognition of the increasingly complex world of qualitative research. Ethnography has evolved considerably since the original anthropological studies of that name, and as descriptions of methods have become more detailed - and honest - the need to categorise the critical stance adopted by the researcher has lessened accordingly. What remains crucial to all accounts of qualitative research is that the reader is given the maximum opportunity to assess the plausibility of the study. This is greatly assisted by a detailed and honest explanation of the methods used, and a description of the author's relevant biography.

The unique contribution of this study to the literature is that it has provided detailed insights into the ways that district nurses manage their work. Prior to this, with the notable exception of the early qualitative work of Kratz (1978), there were highly reductionist accounts of the tasks performed by district nurses (McIntosh and Richardson, 1976; Dunnell and Dobbs, 1982; NHSME, 1992), but the contextual information about the process of caseload management was missing. We now have qualitative data with which to understand the quantitative findings of previous studies. In the current quest of the reformed health service for evidence based health care (DH, 1993b; 1993c) driven by the need for greater cost-efficiency in the NHS, there is a tendency to emphasise the importance of "hard" scientific data underpinning practice. This study has clearly demonstrated the vital contribution of qualitative studies to our understanding of the processes of care delivery.

The methods of participant observation and semi-structured conversational style interview were invaluable for accessing very detailed information about the context of district nursing work and insider information about the way that the work was organised. As discussed in the working methods (Chapter four), although the observational data were not drawn on explicitly in the findings chapters as the research had evolved considerably since these data were collected, the data did inform the course of the research. Importantly, the process of observation in itself enabled a rapport to be established with the nurses which facilitated disclosure at interview. One of the advantages of being a district nurse was that it was possible to engage in extremely frank discussions about district nursing work, which might have been difficult for an outsider with little or no prior insight into the district nurses' world. This is not to suggest that other social scientists could or should not comment on district nursing, but that their perspective would be different and they would elicit other information. I would argue however that as this study was conducted in the wake of the Audit Commission report into district nursing skill mix (NHSME, 1992) which had resulted in a loss of confidence in the service, the nurses were suspicious of all outsiders. As an insider it is possible that I was able to access information that an outsider would not have been privy to. Speaking the same language as the district nurses encouraged them to open up and to be very candid about their work because they knew that the researcher was likely to have shared some of their experiences and frustrations. It is also possible that only an insider would be fully aware of the idiosyncratic practices that inspired this research.

The extent to which the nurses were unguarded in their conversations with me is evident in the data which did not present them in the best light. Often prefixed with "to be honest..." the nurses recounted examples of treating patients in ways that were against their better judgement, in order not to ruffle the feathers of colleagues or add to their own personal stress. The data are rife with reports of such incidents and I am indebted to the nurses for their honesty. In turn, I have tried to produce as accurate and balanced an account of the nurses' world as possible.

Limitations of the method

The trade off for depth of enquiry in qualitative research is that the sample is small, not necessarily representative of the wider population, and the findings cannot be generalised. This limitation is exaggerated in a PhD study which is essentially small scale, and restricted by having just one researcher on the project. This thesis presents a snapshot in time in other words, and although readers may find that many of the ideas presented here have resonance for them, this is about the limit of any claims for the generalisablity of the findings.

All qualitative research is temporal in the sense that it captures certain contextually bound events that will never recur in exactly the same way. But there are snapshots and snapshots. If the research is conducted at a relatively stable period in the history of the society or organisation being studied, then it is likely that the findings will ring true for readers of the completed text for many years to come. This study however was conducted at a time of immense upheaval in primary care, and in district nursing in particular. GP fundholding had just been introduced and was extended to include community nursing in 1993, the community care component of the 1990 NHS reforms was implemented during data collection in April 1993, and the nurses were reeling from the implications of the Audit Commission's review of district nursing skill mix that the service was not value for money (NHSME, 1992).

So although some of the more general findings of the study might remain constant for the group of nurses studied, the policy specific data, although fascinating, could have a fairly limited shelf life. For example, most of the nurses now work for fundholding GPs whereas only one of them did at the time of the study; and there was little evidence of skill mix in any of the nursing teams. This is not to detract from the value of a piece of work like this, which has explored how an established occupation has had to assimilate considerable political upheaval. This is an important issue in itself and has raised many important topics for further research into a service which is not only underresearched, but poorly understood. It is simply that the findings should be read in the context of these limitations.

Limitations of practitioner research

As a practitioner researching practitioners the settling in period was greatly reduced during participant observation. However, there was always the risk that I would either stop seeing things, or not see them in the first place because the setting was so familiar. It was partly for this reason that participant observation was kept fairly short. The issue was not so much loss of objectivity, because all qualitative data is inextricably bound up with the biography of the researcher, than a tendency to overlook the obvious. Exhaustive validity checks minimised the risk of this, the most valuable of which was probably discussing early data with my supervisor. Slightly distanced from the field, she was able to challenge many of my assumptions.

The claim that I engaged in practitioner research is in fact slightly deceptive. Strictly speaking practitioner research is more akin to action research than the rather more distanced role I adopted, which Reed and Procter (1995) would define as "hybrid" practitioner research. The literature on practitioner research, however, offered invaluable insights into the unique position of the nurse researcher (eg. Hammersley, 1992; Reed and Procter, 1995) and enabled me to make best sense of the impact of my biography on data collection and data analysis. Until the timely publication of Reed and Procter's book, there was a sense in which I was squeezing my methods into a methodological framework which was the best fit, but uncomfortable nevertheless.

An ethical dilemma arose when I was in participant observation, which was perhaps inevitable in my "hybrid" role. Sometimes I observed practice that as a clinician I was unhappy about. Hunt experienced a similar dilemma in her ethnographic study of midwifery practice (Hunt and Symonds, 1995). On one occasion she chose not to interject when, undetected by inexperienced staff, a baby was in foetal distress during labour. The neonate subsequently required resuscitation and at this point Hunt decided that she would always intervene when she believed that her clinical expertise was required. Ironically perhaps in the light of the findings of this study, I never directly intervened during participant observation if I perceived something to be wrong with a nurse's clinical management. I would have done so if the care had been either dangerous or life threatening - and if the nurse had been oblivious to it - but fortunately this never occurred.

There were occasions however when I believe that if I had interjected the patient might have benefitted. On these occasions I encouraged the nurse to talk to me about her care in the hope that she would explain what she was doing and why, and reflect on her practice. Sometimes this worked. For example in one fairly extreme example, a nurse I was accompanying appeared to be missing the possibility that a woman had undiagnosed diabetes. I probed until the nurse concerned reached this conclusion herself and put the relevant diagnostic procedures into action.

The ultimate aim of practitioner research is to improve practice (Reed and Procter, 1995). Although this was the case in the current study because the findings have *indirect* relevance for patient care, this is more by implication than via specific recommendations for practice. Certain broad recommendations are made in the conclusion to this thesis. The question that remains therefore is whether research is important *per se* for the generation of knowledge as many would argue (eg. Hammersley, 1992) or whether it should have a particular application.

Usually in practitioner research, the practitioner researches his or her place of work guided by a research question derived from practice, and the workers themselves are intimately involved in the research process. My interviewing style was non-directive and although there were topics that I intended to cover, the nurses were given the time and space to steer me off course. It was in the *spirit* of practitioner research therefore that I encouraged the district nurses to influence the direction of the research, but this was the extent of their involvement.

A criticism of the basic tenet of practitioner research in its purest form is, somewhat inevitably, whether workers who are not trained in research methods can conduct methodologically sound research. It is perhaps more likely that this is possible if the practitioners are led by an experienced researcher who, by definition, may have less idea about practitioner issues. Another question mark hanging over practitioner research is addressed by Hammersley (1992) who asks whether only the practitioners in a setting know what the important research questions are. It could be argued that practitioners have a handle on the most pressing problems, but that it. takes an outsider to address the broader, researchable issues. In the current study for example, the district nurses were in a policy void of their own - or their managers' - making. Most of the nurses appeared to be oblivious to the details and implications of the latest health service reforms, yet these are pivotal to the future direction of the service. If this research had been guided entirely by practitioner problems, the broader issues affecting caseload management could have been missed.

Nursing is constantly struggling to define itself as a discipline with a knowledge base that is distinguishable from medicine. It would appear that in a similar sense nursing research is searching for an identity that is separate from social sciences research. Yet it is clear that the discipline of nursing is anything but a pure subject, nor should it be: it is an amalgamation of many social science subjects such as social psychology and medical sociology. On a similar tack, the techniques of practitioner research are the same as in other social sciences research, and based on the seminal works of for example Blumer and the symbolic interactionist school (Blumer, 1969). It could be that nursing is once again attempting to attain the often elusive academic respectability due to it, by owning a style of research that is exclusively its own.

The value of practitioner research in encouraging nurses to address research should not be overlooked however. The profession and latterly the Department of Health (DH 1993b, 1993c) have recognised the pressing need to bridge the gap between theory and practice in nursing and medicine. If practitioner research increases the acceptability of research findings to nurses then it will have achieved a great deal.

Before moving on to the findings, a further comment is required about the transition from Phase one to Phase two of the data collection and the decisions that led to a modification in the course of the research. It will be recalled that although I was interested from the start of this study in differences in caseload management between district nursing sisters, the original focus of my research was etiquette or the invisible rules guiding practice. Perhaps the most important reason that the focus of my research changed in the intervening six month period between Phases one and two, was that etiquette proved to be a contentious issue. In order to talk about etiquette with the nurses, I approached the subject from many different angles. It was in doing this that I discovered firstly, some of issues that were of greatest concern to the nurses and secondly, other issues that seemed to have important implications for patients and the service. In this sense therefore, etiquette was an excellent entry point to data collection for this study, and it was an issue that I travelled with, as a continuous thread, throughout the course of the research.

The findings

In the first findings chapter of this thesis (Chapter five) it was apparent that district nurses found it difficult to describe their work, not that this difficulty is something that is exclusive to the district nursing service (eg. Cowley, 1995). For example, the nurses disagreed about whether washing and dressing a patient and carrying out other more basic domestic chores such as cleaning a patient's shoes could be described as nursing. They also had difficulty deciding whether observation visits to people who did not actually require any hands on care was nursing work or not and had similar difficulty deciding whether counselling patients fell into their role. Some of the nurses continued to lift very heavy patients because in spite of the recommendations of the latest Manual Handling Regulations (Health and Safety Executive, 1992) that they should rarely if ever lift, they believed that they would be failing as nurses if they refused, irrespective of the risk of injury to either party. On a more clinical level, although all of the nurses dressed wounds such as leg ulcers, there were major variations in the techniques they used, some of which were clearly out of date according to current research guidelines (Cullum and Roe, 1995). This has important implications for the research base of certain district nursing practice, which is an area that needs further exploration.

The difficulties that the nurses experienced in defining their work were complicated by the requirement of the community care component of the latest NHS reforms (DH, 1990) for a description of those aspects of the nurses' work that fell into the category of health care, and for those which could be re-classified as social care to be handed over to social services carers. Although the concept of trained but medically "unqualified" carers carrying out personal care is nothing new (eg. Challis and Davies, 1986; Davies and Challis, 1986; Twigg, 1986), guidelines for implementing this aspect of community care were formally introduced by the reforms (DH, 1988; 1989b; 1990). Data were collected for this study literally as the reforms were being implemented, so perhaps now that community care plans have been drawn up definitions of health and social care will be clearer. The nurses at the time of this study however, were very confused by what they perceived to be an artificial distinction between the two.

A particularly contentious issue was the bathing of patients. The nurses differed in their descriptions of what would be defined as a medical bath as opposed to a social bath. Although some of the nurses were very clear which was which according to their own personal criteria - and one of the nurses even said that there was no such thing as a medical bath - others were less clear. The catheterised patient was someone who was difficult to categorise. The nurses had trouble deciding whether these patients fell under a medical or social definitions of care. Catheter care is a skilled procedure that requires an understanding of asepsis, yet on the other hand patients themselves and patients' carers often carry it out with the minimum of training, so is it social care? It is clear that these issues need to be tackled, not least because patients pay for social care while health care is free at the point of delivery. This issue could be addressed by detailing rather more explicit eligibility criteria for the service which, for the district nurses studied, seemed to be long overdue.

The thrust of successive governments towards care in the community had led to changes in the types of patients the nurses were seeing. Patients were by and large more acutely ill and the care that the nurses were giving in the community was far more technically complex. The nurses were often faced with the decision to either take on the care of an acutely ill patient themselves or refer the patient to a specialist nurse. Sometimes acutely ill patients were being attended to by outreach nurses from hospital based consultants without the knowledge of either the district nurse or the GP, much to their annoyance. The divide between specialist nursing and generalist nursing was often blurred therefore. This was particularly the case in terminal care, which in district nursing is classed as acute nursing care. While some of the nurses preferred to give all terminal care themselves, others were happy to use the services of the MacMillan nurse emphasising again that opinion and definitions of nursing work varied. Without withdrawing the right of district nurses to use their discretion in caseload management, it is clear that unless some of these issues are addressed and explicated, whether a patient will see a specialist nurse or not will remain rather arbitrary.

The physical context of district nursing work has facilitated the development of differences in working practices. District nursing is invisible in the sense that it is carried out in the patient's home and away from other colleagues or managers. This has led to district nurses having a lot of freedom to develop individualised styles of caseload management. As long ago as 1971 Jupp described the district nursing service a frontline organisation, a term which applies equally well today as it did 25 years ago. Drawing on the work of Smith (1965) Jupp described a frontline organisation as one where the initiative is in the hands of the frontline workers, where each unit performs its task independently of other similar units, and where there are barriers to the supervision of units. This is precisely the case in district nursing which is a service that is notoriously difficult to manage.

Many of the study participants said that they had come into the community from hospital nursing for the freedom to practice as they chose. This freedom has often been described as district nurses' autonomy (Dingwall et al, 1991), although it became clear from the findings of this study that to some extent district nurses were autonomous by default due to the isolated context of their work. In reality, district nurses have always been referral dependent. The patients that they visit are usually referred by GPs and hospitals who will have a varying amount of say in firstly, whether the patient is actually seen by a district nurse and, secondly the type of nursing input required. District nursing has been described as a service that seldom says "no" to potential patients (Evers et al, 1991). These considerations immediately detract from district nurses' sense of personal autonomy. Autonomous or not however, the nurses appeared to have had plenty of freedom to allocate their resource at their discretion, which is acceptable if resources are distributed equitably according to need, but less so if they are not.

There is an interesting tension here. There seems to be a fine balance between encouraging the nurses to use their professional judgement to carry out care as they see fit, and externally regulating their work. There are advantages to be gained from the autonomous style of working that has been an important characteristic of district nursing work. The nurses have, for example, had the freedom to provide extra care or special favours for their patients that are beyond the call of duty. These aspects of their work are unlikely to be amenable to measurement, nor are they necessarily evidence based, but they are arguably no less important for that. In the current drive towards evidence based health care inherent in the new managerialism of the health service, it would be a great shame to lose sight of some of the less quantifiable benefits of nursing and medical work. This study highlights the value of applying qualitative methods to studying the processes of care delivery in district nursing: processes which, it could be argued, would not easily be quantified.

There are however other important consequences for the patient and the service of the differences in caseload management between district nurses. Firstly, the freedom that district nurses have always had, has had certain less desirable effects on patient care that have so far gone either unnoticed or unreported; and secondly, policy changes and a reform in the philosophy of the health service have necessitated a shift in the culture of district nursing, if the service is to emerge relatively intact.

Dealing with the first point, it became clear in this study that the freedom to practice autonomously, or without interference, has had repercussions for the patients. The nurses in this study claimed that all district nurses assessed patients differently and that there was no standard assessment procedure; as one of the nurses put it "there is no right or wrong in district nursing" or as another nurse said "there's more than one way to skin a rabbit". Although flexible definitions of nursing work may benefit certain patients if nurses are carrying out extra care, there clearly is right and wrong in district nursing, which is why the nurses are given an extra year's training to practice in the community. Yet the nurses enjoyed the autonomy of district nursing and in turn respected their colleagues' autonomy, which meant that they tended not to interfere in each other's work. This perpetuated differences in practice. It could be argued, however, that the resulting inertia in the service has meant that their patients did not always receive the most appropriate care. The ethical issues raised by this non-interfering, non-challenging culture were complex.

In certain circumstances it was possible that the decision not to interfere by commenting on a colleague's work could be rationalised. An example was when a nurse was substituting for a colleague on that colleague's day off and noticed something she was unhappy about with one of the patients. She was likely to present a united front with her absent colleague when conversing with the patient, by conveying the impression that she agreed with the care that was being given. Presenting a united front however could exclude the patient and flies in the face of patient participation and the rise of the consumer voice as exhorted by both the profession and the government (eg. Patients' Charter, DH 1991& 1995c). But the nurses could sometimes justify this however by the value they placed on trust within the nurse patient relationship. They believed that to challenge a colleague by undermining the colleague's care would destroy the trust that the patient had in his or her nurse. As the therapeutic importance of trust is unknown it might be an oversimplification to describe this decision as unethical; unwise maybe, but not unethical.

Perhaps the suggestion that every patient wants to be involved in decisions about his or her care is too much of an assumption. It is important to recognise that having trust in one's nurse could also imply that the patients had willingly surrendered some of their decision making to the nurses. If it is the case that patients do not necessarily wish to become active partners in their care (see eg. Waterworth and Luker, 1990), it could be that some of the patients in the district nurses' caseloads did not want to be viewed as equal team players and involved in decision making processes, which is an alternative way of looking at user involvement in care decisions. .

Another example of the importance of a non-interfering culture is inherent in the value placed by the nurses on the confidence needed to practice in isolation in the community. All of the district nurses had trained and worked in hospital where there were other colleagues to refer to if they were uncertain about an aspect of clinical management. The nurses described building up the confidence to practice autonomously as a major hurdle when they first came into district nursing and used words such as "lonely" and "nerve wracking" to describe their early experiences. One of the problems with being challenged by colleagues about treatment decisions was that it threatened their self-confidence. The issue then became whether the nurse could function effectively if her self confidence had been knocked. What would be the effect of this on the care of her other patients? This was another unknown, hence the tendency of district nurses to turn a blind eye on practice that they considered to be out of date, lacking a sound research base, or irrational in some other way.

In these two examples then, the issues of trust and confidence to practice are unknowns in terms of the effect that it could have on patients if either were threatened. It could be argued that the decisions made where trust or confidence to practice were at stake were ethical decisions and defensible using the principle of an ethic of care, where "caring" is the guiding moral principle (Gilligan, 1993). But there were exceptions to this in the data. Sometimes it was clear that the decision to be made was not between two conflicting but equally valid demands. The non-interfering culture seemed to thrive devoid of any rationale in such situations, which is where the etiquette that was the focus of Phase one of this study came into play (Chapter seven). For example, sometimes when a colleague was perceived to be out of date in some aspect of clinical management, there was a reluctance to do anything about it because to challenge someone else's decision would be to cause bad feeling with the colleague concerned, and to disrupt team harmony. Where loyalty to the team took priority over patient advocacy it was clear that respecting a colleague's autonomy - or right to lack of interference in caseload management - was misplaced.

Patients who were apt to comment on one nurse's care to another nurse were described as playing colleagues off against one another, irrespective of whether the patient had a valid complaint or not. In a similar sense the word "demanding" to describe a patient who was prepared to voice either their needs or their concerns was used pejoratively by many of the nurses. It is clear that the established forum for criticising peers in district nursing should be removed from the current interpersonal level. The nurses might well benefit from a formal, depersonalised platform for clinical peer review.

Invisible working and a non-challenging culture have however perpetuated idiosyncrasies in working practices. Clear examples of idiosyncratic practice and the implications of this for patient care were given in Chapter eight on rationing care. District nursing is and always has been a finite resource. The implication of this is that there has always been implicit rationing of the service. The invisibility of the service and the imprecise nature of district nursing have meant that over the years the way that care has been distributed has been subject to the personal choice of the caseload manager. In Chapter eight, the priority setting of the district nurses was particularly interesting, coupled with their ability to disguise unmet need. While both of these factors favoured certain patients, it meant that there were less resources for other patients. There was clearly inequity in the way that the district nursing resource had been distributed therefore. The issue was less about differences in caseload management, than idiosyncratic priority setting.

There was evidence in the data for example that articulate patients who shouted the loudest got the greatest share of the service, and that hands on tasks took priority over hands off counselling or observation visits. The nurses reported biases in favour of the younger disabled patients on their caseloads, who were often in receipt of services that older people with equal disabilities did not have. There were examples of younger disabled patients being bathed every day for example, and an equally disabled older person being bathed once every two or three weeks. This seemed to have something to do with the loss model that the nurses adopted when nursing patients closer to their own age. They said that they were able to empathise with these patients and understood how much they were losing out as a result of their disabilities.

Another idiosyncracy in caseload management related to the way that unmet need was often unwittingly disguised by the nurses. A patient who had newly arrived on the caseload would be assessed for the portion of the service that was available rather than according to need. The needs based assessment exhorted by the government appeared to be a myth for most of the nurses. This would have been less of an issue had the remainder of the caseload been reprioritised to accommodate the new arrival but this was not necessarily the case. In common with the findings of other authors that patients got "stuck" on district nurses' caseloads (Badger et al, 1989a; Trojan and Yonge, 1993), the current study found that where the nurses had set a precedent by introducing a certain level of service, it was difficult to change this even if the caseload required it.

As there was no overseeing from management of the district nurses caseloads in this study, which might be expected as G and H grade nurses are the caseload managers, and no platform for peer review, patients would remain on the books for years for no sound reason. It is clear that a greater degree of overseeing from management, and periodic requests for the district nurses to explain the rationale for their caseload management could begin to remedy this problem. It is understandable that given the complex, unquantifiable nature of certain aspects of their work that district nurses might feel threatened by having to make their work increasingly explicit, but it could benefit patients, and the cost-effectiveness of the service, if district nursing caseloads were open to scrutiny.

District nurses enter the community to practice autonomously and there is evidence that they percieve an "us and them" culture with nursing management who are believed to hold different values (Traynor, 1994; 1995). So although clinical supervision as for example Butterworth and Faugier (1992) describe it might be unpractical in the "front-line organisation" of the district nursing service where there is very little overseeing of work, there are possible alternatives to the current situation. If a traditional top-down approach to clinical supervision would be resisted, the answer could lie in empowering the district nurses to develop their own standards or guidelines for practice. Empowerment in organisations is after all the nineties equivalent of Jupp's (1971) front-line organisation. This would involve building on the skills of the G and H grade caseload managers who in the wake of skill mix will become firmly established as the team leaders, rather than imposing standards from above or outside the service.

The fact that for decades district nursing has been ill-defined and the nurses have had the freedom to practice at their own discretion is actually unremarkable. Until relatively recently, district nurses used to meet virtually any patient need, irrespective of whether they were over qualified for the particular task. As their caseloads were never overseen by managers and colleagues were unlikely to interfere, individualised styles were inevitably going to develop. Today however, imprecise definitions of district nursing work are increasingly less acceptable. Since the introduction of the internal market to the health service, cost-effectiveness has become a top priority, and health care spending is now resolutely at centre stage. The Audit Commission report into district nursing skill mix (NHSME, 1992) brought this starkly home to the district nursing service, coupled with the conclusions of the York study of nursing establishments (Lightfoot et al, 1992). Both reports emphasised the extent to which district nursing skill or grade mix was highly arbitrary with little in the way of rational planning.

Traynor (1995) found that district nurses were suspiscious of the changing culture of the health service, particularly as it was manifested in the financially driven values of their managers; yet it is clear that district nurses cannot afford to stand still. The market place of the health service necessitates a clear indication of the services that are available for purchase. Provider units - trusts in particular - need to know what they are offering in order to sell the service to fundholding GPs and district health authorities. It would appear to be imperative now that district nurses define their work clearly so as to sell their service in order to secure a future for themselves and their expertise in the new primary care led NHS. GPs have been employing practice nurses in increasing numbers for over a decade - perhaps for financial reasons - but it is quite a threat to the district nursing service if fundholding GPs requirements for district nurses are lessened accordingly. Although only one of the nurses in this study worked for a fundholding practice, the data indicated that the relationship between GPs and district nurses is still a troubled one, which might not bode well for the employer/employee relationship that fundholding has introduced. This is a subject that could benefit from further research.

Many publications have exhorted the contribution of primary health care teamwork to high quality patient care, yet for the nurses in this study the primary health care team was not a reality for a number of reasons. One of the prerequisites of teamwork according to the literature (eg. DHSS, 1981b) is that team members should understand the role and functions of fellow team players. If the district nurse's role is ill-defined by the district nurses themselves it follows that it will be difficult for others to understand the unique contribution of the district nurse to the team, and to value their work. Primary health care teamwork has not really happened in the workplace, and it might not even be desirable, but it is less likely to occur if information is missing about the team's constituent professions.

There is now much emphasis in the reformed health service on cost effective health care and evidence based practice is perceived to be one means to this end (DH, 1993b, 1993c). Although the idea is not new (Cochrane, 1972), it is reasonable that if practice is to be cost effective it should have some proven efficacy (Sheldon et al, 1993) or there should at least be some indication of the outcome of interventions. An important implication of evidence based practice for district nurses is the availability of information to district nurses, which the Prep reforms go some way towards meeting (UKCC, 1991). But it would be misleading to assume that because the research base for district nursing is scant, district nurses lack any evidence for their practice. It is clear that certain less tangible or visible aspects of their practice could be addressed using qualitative research techniques. It is important that we do not lose sight of the subtle nuances of the same "task" carried out by differently qualified personnel. For example, the nurses in this study described how they bathed patients and conducted "basic" nursing care with "a trained eye".

Another important issue in relation to the evidence base for district nursing is that because district nurses have varied biographies and bring with them a lot of experiential knowledge, there will inevitably be much valuable information available within district nursing teams. If this is accepted, the issue then becomes how can this information be accessed? It is clear from this study that the issues around teamworking and transmitting information between colleagues need to be addressed.

The future of district nursing is unclear. It is likely that the current government's emphasis on cost-effectiveness will steer district nursing sisters into an increasingly managerial role within nursing teams, of assessing and reassessing patients' needs and providing far less hands on care. This is happening already, and it might be no bad thing in some respects if it enables the nurses to be both more dispassionate and uniform in their assessment criteria. Explicit eligibility criteria and the formulation of working standards would begin to address the current problems of inequity in service provision that this study has begun to highlight. There is currently talk in the literature about the feasibility of timed appointments in district nursing (Ellis, 1995; Thomas, 1995), which is something that social services are able to offer. Timed appointments might begin to even out some of the existing inequities in the service.

Skill mix with the fragmentation of care that this connotes, could mean that district nurses will be unable to adopt the professional ideal of "holism" espoused by the new nursing movement (eg. Beardshaw and Robinson, 1990) because this is not a cost-effective use of resources. Professional and financial concerns are likely to remain in conflict with the therapeutic nurse-patient relationship arguably becoming a thing of the past for the district nursing sister, who will not have the same intensity of input into individual patients as she has had in the past. The effect of skill mix on relationships within the district nursing team and with the patients is another topic that warrants further exploration.

When the white paper *Caring for People* (DH, 1989b) was published and the concept of care management was introduced (Challis and Davies, 1986), a possible future role for district nursing was predicted by some commentators (eg. Ross, 1990). Care management is at the centre of health needs assessment for the client or patient who requires health or social services input at home. It was initially seen as a clear opportunity for district nurses, because although the white paper stated that care managers were likely to come from social services departments - who hold the purse strings - it did not rule out the possibility of district nurses becoming care managers where this was more appropriate. This would arise when care packages were being devised for people whose needs were more medically than socially oriented. Progress has been slow however and there was little evidence of district nursing input into care management in the trusts who took part in this study. This is consistent with the national picture (Bergen, 1994).

It is unclear whether the role of the district nurse as a generalist is still valued. Skill mix, the arrival of the social services carer and the employment of specialist nurses have raised doubts, although the district nurse is evidently valued as a gap filler where existing provision is missing. A decade ago it was argued that the Cumberlege report (DHSS, 1986) provided the opportunity for district nurses to enter centre stage in primary health care, yet it has since been regarded by many as a missed opportunity. The recently reformed primary care led NHS has been similarly alluring in some respects with its requirement for specialised community nursing care, health needs assessment and care management, all well within the capabilities of the district nurse. But district nurses are characteristically apolitical and have been marginalised by policy in the past. It is clear that district nurses are constrained by the structure of their work and the wider political agenda, but maybe this time the future of the service really is in their hands.

Conclusion and recommendations

To conclude, this study has provided insights into the hidden world of district nursing and has made an original contribution to nursing knowledge. For the first time we know about the difficulties district nurses have in describing their work, not least because their role is increasingly defined by the work of others, and we know how the isolated context of their work has affected the ways that they manage their caseloads. It is recommended that the evidence base for district nursing is explored and that clearer definitions of the boundaries of district nursing work are developed.

We now have detailed insights into how district nurses interact with their same status peers, which may have important implications for the way that the wider primary health care team operates. It is recommended that etiquette and the non-challenging culture of district nursing are explored in team building workshops and that a formal platform for peer review is established. It is also recommended that standards are set for clinical district nursing procedures.

Given finite resources, district nurses have become expert in rationing care and disguising unmet need. It is therefore recommended that eligibility criteria for the service are established and that caseloads are open to scrutiny. Within reason, timed visits might begin to address current inequities in the distribution of the district nursing resource.

District nursing is underresearched and to some extent poorly understood. This study has gone some way towards addressing the important qualitative aspects of district nurses' work and has provided a contextual backdrop for the existing quantitative data on district nursing tasks. The value of qualitative studies such as this should not be overlooked during the quest for evidence based health care, where the emphasis is often on "hard" data that can be provided by, for example, the randomised controlled trial. Qualitative studies need not be viewed as exploratory precursors to "harder" quantitative studies, but as an important source of data in their own right, not least because certain aspects of nursing work are not amenable to measurement in any meaningful way. Clearly more work needs to be done.

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Appendix 1

An example of excerpts from field notes: District Nurse 2, 7/12/92

: Exploring the issue of gender and status difference in the primary health care team

11am: Visit 7: Female patient with gout in her fingers

In car afterwards JG asked how willing the GPs were to go out on visits. DN2 replied that the trainees were the best. The easier relationship between the nurses and the trainee GPs was later demonstrated at the presentation (to the GPs of plans for a nurse run leg ulcer clinic), when a young female trainee obviously wanted DN2 to visit someone but made her request by holding up the notes of the patient concerned, winking, smiling and asking if she had seen the woman *(theoretical note: GP also female, similar age to DN2, similar college background: colleagues therefore? No status differential? Explore gender and age difference in nurse-GP relationships)*

The female GP in the practice uses the GPs a lot: DN2 "she doesn't like us going to her for things. She's unsure, she confides in us for advice (JG: "for example?") "...like an observation visit for terminal care" *(theoretical note: this is encouraging: the GP is asking the nurse for advice to ensure the safety and wellbeing of the patient. Is gender important here? Would a male GP be as willing to ask for such advice, especially from a younger female nurse?)*

....later in the nurses' room (12pm)

DN1 (same team as DN2) said that she had spent some time with a former colleague of theirs, and that the person had said "you were a great team, the best team she's ever worked with". I felt that to an extent that this was for my benefit (following my observation of DN1 last week). DN1 didn't make eye contact with me while she was saying this. *(methodological note: this is a problem: if trying to create a good impression and masking what is really going on. There are issues around trust here and building rapport).*

...later in the surgery (1pm)

Presentation to GPs in main surgery (the nurses' room is in a separate annex. *Theoretical note: the nurses had to go to the GPs to give presentation and not the other way around: status differential?)*
Seating:Everyone (nurses, receptionists, midwives) sat around the main table except the one nursing auxiliary present who sat at the edge of the room *(theoretical note: her perceived status/position in the hierarchy?)*. The GPs arrived last (late), the senior GP refused to sit at the edge of the room (there was no room left at the table by this stage). He made a space for himself at the head of the table. The presentation was addressed to him by all of the nurses *(perceived to be the team leader, by himself and the nurses).*

Appendix 2

Interview guide: part one interviews

The following very broad areas were derived from the field notes and covered during interview:

The primary health care team and whether it is a reality for the nurse

Nurses' relationships with GPs

Why chose district nursing as a career

Autonomy in district nursing

Relationships with patients and patient advocacy

Following colleagues' care plans

Changing colleagues' prescriptions for care

Dealing with colleagues who are not up to date

Terminal care

Doing special favours for patients

Role boundaries in primary care

Assessing for colleagues

Relationships between colleagues

The role of the patient's family in caring for a relative

Specialist nurses

Relationships with female GPs

Caseload management

Relationships with the evening service

Barriers to teamwork

Issues when first came on to the district

Appendix 3

Informal analysis of phase one interviews: listening to tapes and making notes

: Interview with DN5, emerging themes in capital letters, categories and notes in lower case

GUEST IN HOME: "You're the guest as opposed to them being the guest in hospital"

SPECIALIST NURSES: "I'm not a great fan of the concept of specialist nurses. I suppose as a district nurse I feel... I am not sure what they do that I can't"
"What she (MacMilllan Nurse) has that I don't have is more time *(theoretical note: is this the difference between the generalist and specialist?)* and I suppose I slightly resent that because I think I could do that if I wasn't chasing my tail all day long" *(recurring theme of feeling overworked/ understaffed).*
"I wonder to what extent these specialists erode our role really" *(role boundaries; primary health care teamworking).*
"If they're not on the phone easily you don't use them as much I'm afraid" *(lack of contact; teamworking).*
Methodological note: the issue of the specialist nurse appears to be quite threatening, move to later in interview or ask neutral questions immediately before and after.

FAIRNESS IN TEAMS: "I think there are cultures that develop in teams... for example I feel a pressure on me to do my share of physical work.... as a G grade I feel we need to be seen to be doing physical work, and your fair share" *(hands on work valued in district nursing; deskilling; undervaluing managerial role, especially in the light of recent legislative changes?).*

Methodological note: the intention of the question was to find out about unspoken rules. DN5 has described a culture in her team but has not really answered the question. Direct questioning about a sensitive issue such as etiquette and unspoken rules may prove unfruitful. Need to think about indirect questions that will elicit the information.

FEMALE GPS: "As generalisations go... I think women are better communicators. Or certainly in terms of what a nurse would be interested in which is more to do with the person, the case. I think perhaps they have more of a grasp of that" *(is there a difference between male and female GPs in their interactions with patients and nurses?).*

Appendix 4

Interview guide: part two interviews

Opening question: Have you had to make any difficult/ tricky decisions this morning perhaps, or in the last week?

(first prompt): ...or are there any situations where you've had a lot of things to consider?

(second prompt): Have you done any first assessments recently? (district nurse: yes). Could you describe the assessment to me?

The following areas are covered in the interview but not necessarily in this order:

Changes pre and post the 1993 community care legislation (delayed introduction of community care component of 1990 NHS and community care act)

The division between social care and nursing care
- *Which is which?*
- *Do you ever leave people without services?*

Specific issues when caring for the younger disabled
- *Different services?*
- *Assessment process?*

Referrals to social services carers
- *When and how made?*
- *Any follow up?*

Rationing services and first assessment visits
- *Needs of individual versus needs of all patients*
- *Controlling the flow of work*

Setting precedents/ "inherited" patients
- *Holding back with services "just in case"*

Assessing for a colleague and issues around committing services
- *Needs of the individual versus needs of the team*

Appendix 4 - continued

Visiting colleagues' patients
    - *If see something wrong?*
    - *Issues around autonomy*

Changing a colleague's care
    - *When and how?*

Issues around undermining colleagues
    - *Losing faith (nurse? patient?)*
    - *Consequences of this*

Presenting a united front

User involvement in care decisions *versus the professional knows best*

Differences between hospital and community nursing

Grey areas in community nursing
    - *What is nursing?*

Problems encountered when first came into the community
    - *Confidence? Trust?*

Working unsocial hours

Issues around staff shortages and cancelling patients
    - *Cancel who and why?*
    - *Masking shortfalls in the service*

Boundary issues: eg. specialist nurses

What makes a team work?

Relationships with GPs

Relationships with carers and their involvement in care decisions/ the care itself

Appendix 5

Excerpt from an interview transcript demonstrating coding:
themes in capital letters, categories and notes in lower case

JG and DN28 are discussing assessment visits...

DN28: When I first qualified as a district nurse, I had an F grade post for the first 12 months and yes I used to go in and do the first assessments; and then I got the G grade post here 2 years ago and by this time I think I was assessing quite strictly (*hard and soft assessments)*, prudently, and when I got here and I saw the caseload I thought crumbs why are they going in every day to these patients *(patient independence)* and yes it was very difficult *(setting precedent/ COLLABORATIVE WORKING)*. People do assess differently *(DESCRIBING NURSING)* and even though you sit here in the same room, if for any reason you have to cover another practice you see *(visiting colleagues' patients)*.. well I wouldn't have that particular case on my books going in daily. I would go in twice a week or what ever, but that's not for me to say to the other sister *(respecting AUTONOMY)*

JG: So did you have to cut any visits back from anybody when you took on the caseload?

DN28: Yes I did *(reassessment)*. Mainly the dressings to start off with because there are a lot of dressings on the market nowadays that there is no need for a daily dressing *(patient independence) (theoretical note: and reduced dressings could be seen as an improvement in the wound by patients and is therefore non-threatening)*. Plus studies have shown that with daily dressings you are just breaking down all the new tissues *(evidence based practice)*, so yes I changed a lot of the dressings and I do try to keep them to twice a week instead of daily. I don't think there is any need for daily dressings.

JG: How did the patients feel about having their dressings reduced?

DN28: Very difficult *(setting precedent)*. You have to really work with them and show them that yes, it is for their good and yes things will improve *(partnership in care, and promoting independence to enable others to get a bigger share of the service: equity)*.

JG: What about some visits that are perhaps "pop- ins" or favours or some people perhaps got visited more than other people, did you inherit anything like that?*(methodological note: leading the nurse too much?)*.

DN28: No I don't think I did. The only on I would say was a patient really did need daily visits, she was a severe CVA with hemiplegia and also she was suffering from alzheimer's disease so her relative needed a lot of support *(reciprocity) (theoretical note: support the carer so that they can provide nursing care, invisible workforce)*, but with that patient it was the norm to sit back to have tea and biscuits afterwards and stay there really a lot longer than was necessary *(DESCRIBING NURSING; definitions of need; setting a precedent)* and yet the relative quite often if you were to say "look I'm sorry I can't have tea this morning, I'm pushed, tomorrow would be a better day" she used to get very uptight about it *(nursing as negotiation)*. "Well the other sister always has time to sit and have coffee" *("playing off"; patient partnership) (theoretical note: the cup of tea is the carer giving something back to the nurses. Enables her to take control).*

Appendix 6

Patient explanation

Department of Nursing	Jane Griffiths
Whelan Building	Work: 051 794 5677
University of Liverpool	Home: 061 881 9428

We would be grateful if you would agree to take part in a study which will explore the extent to which the changes brought about by the NHS and Community Care Act has affected the way that your care is delivered. We believe that this study may help us to gain a better understanding of the way in which the people involved in your care work together.

If you agree to take part you will be visited at home and asked some questions about your health care problems and the type of care you receive and by whom. This should take approximately 40 minutes. Your involvement will be at your convenience.

This study is being undertaken as part of a Queen's Nursing Institute research studentship. It is being supervised by Professor Karen Luker at Liverpool University. Complete confidentiality will be maintained.

You are free to choose not to take part or to withdraw from the study at any time without giving your reasons; this would have no effect on your future treatment or your relationship with those involved in looking after you.

Appendix 7

Patient consent form

I ______________________________ of

____ hereby consent to participate in a study which will examine the effects of the changes brought about by the new community care legislation. The researcher Jane Griffiths has explained to me that this study is being carried out in order to gain a better understanding of the way in which professionals work with patients in the community.

I understand that the extent of my involvement will be limited to answering questions about my care and that no additional tests or medical procedures will be undertaken. It has been explained to me that the study is being carried out as part of a research studentship.

I understand that I am free to withdraw my consent at any time without detriment to my future treatment and without affecting my relationship with those caring for me.

Signed ___________________________ Date ________________

Witnessed ________________________ Date ________________

I confirm that I have fully explained the purpose and nature of this study

Signed ___________________________ Date ________________

Appendix 8

Interview guide for the younger disabled study participants

General Information

Participant number

Date of Birth

Condition

Contact with health services professionals: who and frequency of contact

Contact with social services professionals: who and frequency of contact

Contact with voluntary agencies: who and frequency of contact

Significant others (lay care who assist in daily care)

Social/ Educational background of participant (occupation if have or had one/ education/ who live with/ hobbies and interests)

The participants were encouraged to speak at length for the remainder of the interview, using the following headings as general guidelines

History in own words of health problem

Evaluation of services post April 1993

Evaluation of services pre April 1993

Comments on tailoring of services to meet perceived needs

Appendix 9

Interview guide for the undergraduate district nurses

Do you think you would like to go into district nursing?

What do you like about district nursing?

Is there anything you dislike?

How does district nursing differ from hospital nursing?

How do you perceive the interpersonal relationships between nurses on the district?

- *Do they get on?*
- *Critique each other's work?*
- *Present a united front?*

Do you feel free to critique your Community Practice Teacher's work?

- *Is this easier or more difficult than on the ward?*

How do you perceive the theory practice gap in the community?

Have you noticed/heard district nurses talking about setting precedents?

- *Have you been with a district nurse when she's assessed for a colleague?*
- *Does she commit services/ do a full assessment?*

Do you think that there are any unspoken rules in district nursing?

- *If there was a rule about challenging a colleague's prescription for care what would that be?*

Unsocial hours

- *Are any patients left off at weekends that you feel should be on?*
- *Do the nurses carry out Monday, Wednesday, Friday dressings?*

Inequity

- *Is there any difference in the numbers of visits patients get?*
- *Do the nurses differentiated between the young disabled/ the articulate?*
- *Is care rationed?*
- *Do assessments vary?*
- *Can the nurses explain the numbers of visits given to patients on the caseload?*
- *Is there anyone on the books who you are not sure why they are visited? (frequency etc... 'pop-in' observation visits)*

Is there any care you would change?

Relationships with doctors

- *Are they equal? Who uses whose first name?*

Appendix 10

Extract from interview with younger disabled participant including notes/memoing

Patient 4 describes how she intricately organises 24 hour care for herself

This excerpt is broadly categorised under the heading of patient empowerment or partnership as it illustrates the extent to which an articulate patient can have considerable influence over their care package. This is the one excerpt from a lengthy description of the services PT4 has organised for herself.

PT4: When I had my assessment we jiggled it around a bit *(nursing and social care is interchangeable for the younger disabled?)* and social services undertook to get me up in the morning and stay for a couple of hours, and then three times a week a home help would come and make my lunch for me. The other day my cousin comes in and she covers me, makes my lunch and at weekends my lunch is done by private carers. Now what happens is: I'll go through it from Sunday to Saturday, on Sunday at this moment I have an auxiliary nurse who comes in - whom I pay privately for an hour and she turns me on my side so that I move - at 7 o clock and she stays until 8 and then at 8.30 someone from social services comes in and stays until 10.30. Now that happens every day except, well there are occasions every other weekend she goes away: she has a weekend off so I don't have that cover in the morning; but that's most days. So on Sunday I have a private carer ie. an off duty district nurse for an hour *(she has a close relationship, bordering on friendship with the district nurses who visit her; is there a tension here when these nurses are employed by the health authority and not privately to carry out her care?)*, and social services for two hours from 8.30 til 10.30, they make my breakfast and I go back to bed. From one til 3 on Saturday I have a private carer who comes to make my lunch, it's all for toiletting really as well, and then she puts me back on the bed. Sometimes the nurses make a mid afternoon visit if I ask for them *(flexibility in the district nursing service; patient partnership/voice)*. If I have a student coming the student stays from one til 4 merely because I pay students and the amount works out less than if pay a private agency. So instead of having a someone from one til 3 I can have them from one til 4 (JG: Students from...?) Well students from anywhere really, students whom I know. Students who need the money, the ones I have are ex Crossroads students who are now doing Social Workers' course, ex social service students who are doing Social Worker's course, erm, a degree nurse student who saw a notice that the nurses put up on the notice board *(special favour for a popular patient?)* at the medical school: she's been coming to me for over two years at the weekend, she's now reduced it to every other weekend because of the pressure of exams..