Observing nurse-patient interaction

This article describes an observational study of nurses’ interactions with mentally ill young people in a regional adolescent unit. Nurses initiated more than twice as many interactions as patients and were consistent in the average length of time they interacted with the young people. The author recommends that future studies include more qualitative data on the nature of interactions.

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BACKGROUND

The study took place in a 20-bed regional adolescent unit for mentally ill boys and girls aged between 13 and 16 years. The young people are referred from within the region. The unit is staffed by:
Seven doctors
Seventeen nurses
Seven teachers
An occupational therapist
A social worker
A clinical psychologist.

Each trained nurse co-ordinates care for up to three young people and is responsible for ensuring that care is managed for all other young people during the shift.

METHOD

The sample Of 17 nurses in the unit, one acted as the researcher, and one could not take part due to long-term sickness. The remaining 15 nurses agreed to take part. Of these, nine were trained nurses (two of them male) operating at E grade or above and six were auxiliary staff. All nurses were assured of full confidentiality throughout the period of study and written consent was obtained.

The observation checklist The checklist was designed to:

- Be easy and quick to use
- Be easy to analyse
- Offer standardised results.

The checklist allowed the researcher to code the interactions observed. Atkinson (1992) pointed out that one disadvantage of coding is that it is based on a given set of categories. This is useful for data analysis but, as Atkinson noted, it means that uncategorised activities may go unrecorded.

The categories were:

- Where? – dining room, television room, games room, bed area, corridor, nursing office, toilets, other
- Who initiates? – N = nurse, or P = patient
- How long is the interaction? – time in minutes from the first interaction to the last verbal response in that interaction.

Pilot study The checklist was first tested with five of the nurses. The pilot study was conducted over five weeks with one observation period each week, and confirmed that the project was feasible.

The observation study The remaining ten observation periods of the study were conducted over ten weeks. All the nurses were observed for a total of four hours each. Data were recorded on the coding grid during and immediately after observation of each nurse.

A maximum of four hours for observation periods was taken as a reasonable limit for one observer (Brown 1989, Hall 1975, Pill 1970).

A similar number of observation periods were observed during morning shifts as during the afternoon. Interactions during one twilight shift were observed.

Reliability The checklist was tested using a female observer for overall and gender reliability. During two separate two-hour synchronised
observations, the data recorded were identical.

**Observer effect** Observational studies can be biased by the 'observer effect', in which those being observed change their usual behaviour to create a better impression. To help reduce this, the researcher remained discreetly on the fringe of activity while completing the checklist. In two morning meetings, the young people were told about the study and what it would involve. At first the young people were intrigued and asked what the researcher was doing. This could have affected the number of interactions with the subjects. For this reason, the young people were told that the researcher was 'a participant observer'. This helped to limit unnecessary participation which might affect the method of data collection.

Observation was also affected if an incident, such as an upsetting family visit or a fire alarm going off, occurred on the unit five minutes before the observation began. Other factors likely to affect nurse-patient interaction included the nurse/patient ratio for the shift and therapeutic activities planned for that time.

**RESULTS**

Table 1 shows that in a total of 743 interactions, nurses initiated 524 interactions compared with 219 initiated by young people. The total duration for all nurses' interactions in the four hours for which they were observed was 1,145 minutes and the average time spent by each nurse was 76 minutes. At first nurses were shocked at this finding, but when other aspects of their role such as handovers, one-to-one therapy (marked ‘other’ in Table 2) and managerial duties are considered, this low level of interaction seems more justifiable.

Table 2 shows where the interactions took place. In the dining and sleeping areas, nurse-initiated interaction is much higher than patient-initiated interaction. There is a higher level of patient-initiated interaction in the corridor, television area and the office.

**QUALITATIVE ISSUES**

The data in Tables 1 and 2 do not explain the content and context of the interactions. A number of qualitative issues were also observed which may help explain the data, and which merit further investigation.

**Location** The unit treats up to ten young people with eating disorders at a time and this is reflected in the high number of interactions initiated in the dining room. The dining room has been described by a patient as a place where 'you are made to eat and be with others even if you want to be on your own'.

One interesting discovery was the importance of the corridor, where young people seemed to initiate interaction as nurses walked past and nurses would initiate interaction between tasks. The corridor, which stretches from the bed areas to the games room, is an area of movement for both young people and nurses. It is an area which guarantees contact. During the study one young person would sit with her head in her hands crouched up at the far end of the corridor inviting interaction from anyone in the entire length of the corridor.

As well as the corridor, many patient initiated interactions took place in the TV room or the nursing office. If a young person wants a longer, less social inter-action, they appear to make contact at the nursing office.
Nature of interactions Nurse-initiated inter-actions include instructions, requests and prescriptive interventions. Many of these related to hurrying the young people to comply with the unit routines – not being late for school, breakfast or their individual care programmes.

TIME OF DAY
There appeared to be clusters of nurse-initiated interactions which depended on the time of the day. Table 2 shows a large number of nurse-initiated interactions in the young people's bed areas. The morning routine of the unit – encouraging young people not to be late for breakfast and school may explain the higher number of interactions during the early shift.

During meal times, nurse interactions were shorter, and included instructions such as 'get a knife and fork' or 'take a seat'.

 Quieter times Between meals and after school, longer nurse interactions were often initiated outside the necessary routines of the unit and were not so rushed. This suggests that ward routines affect nurse-patient interaction. Do patients automatically assume that busy nurses involved in ward tasks do not want to interact? Do patients initiate more interaction in the afternoon and evenings when the 'work's done' culture allows it?

Consistency Table 1 shows that the average duration of interactions was consistent across all 15 nurses observed. This suggests that there is an unspoken rule of how care should be delivered – that all the young people are treated the same and nurses work in similar ways.

Quality of interaction The length of interaction shown in Table 1 does not reflect the general assumption that contact is beneficial to the patient. Although the average length of interaction is 2.4 minutes, some nurses were engaged in longer interactions (15-20 minutes) consisting of several shorter interactions. Notes made during these observations refer to what Walsh (1997) termed the 'technical roles of nursing'. These longer interactions seemed to involve more formal directives of liaising, care planning and even social interactions such as playing table tennis and watching television.

'Being seen' Humanistic, patient-centred care encourages both patient and nurse to talk and express emotions. This pressure on nurses to 'be seen' to be interacting with patients conflicts with other duties and routines which may interrupt and hinder longer interactions. Such interruptions include answering the telephone, attending to other patients, and ward rounds. This culture also affects the way nurses conduct themselves during interactions. Brykczynska (1995) suggested that humanism represents a collection of positive person-centred values. Every nurse in this study tried to accommodate these values.

Language Hewison (1995) argued that the actual language used during nurse-patient interaction has not been widely studied. Investigating the ability to control and direct interaction by nurses was not an aim of the project, but the results demonstrated that nursing staff initiate two thirds more interactions than did the young people.

Relationships Appropriate role models and reducing dependency are considered to be the foundations of nursing care in this specialised area. Young people in the unit have a developmental need to form relationships and, according to Button (1979), no matter how much we
may desire a certain relationship, it cannot begin without interaction taking place. Button (1979) also suggested that most studies of interaction and relationships pay little attention to the dynamics of making friends. May (1991) and Morse (1991) explored the idea of a reciprocal relationship between nurse and patient and suggested that there were fewer complex relationships in settings where there was more routine and task orientation.

Notes made during the study show that the young people generally have at least one very close bond with a specific nurse. This may reinforce the general principles of attachment theory (Bowlby 1969).

**Power relations** Table 2 shows that 52 patients initiated interaction by knocking on the nursing office door. Perhaps both nurses and patients unwittingly accept the ‘open door’ as being ‘more open’ at certain times unless the nurse says so. This highlights unequal power relations. Satir (1972) argued that a balance of power is essential in all interactions. More recently Parker et al (1995) noted the continuing powerlessness of patients.

Young people know that if they want interaction from nursing staff all they need to do is create a reason, such as crying, being upset or being aggressive, for that interaction to be essential.

The researcher was aware of the norms, values and routines held within the unit and this can be disadvantageous, as Field (1980) suggested. The major objection is the possibility of inherent bias. Aguilar (1981) claimed that examples of this are few and there seems to be no evidence of deliberate dishonesty in this study.

There is bias in all aspects of research, including design, process and analysis of results. In this study it was important to focus on the data relevant to the stated aims and dismiss those which were not. The results may thus appear mundane and remote from the actual experience of interaction and culture. Agar (1986) criticised ‘this received view’ of science, a view that centres on a deductive systematic test of hypothesis. He argued that it is inappropriate when asking questions such as ‘what is going on here?’

**CONCLUSION**

The scale of this project and the method of counting interactions have their limitations and advantages. Triangulating the results with interviews would increase the validity of the study and confirm data which would be applicable to wider practice.

The study has helped nurses in the unit to re-assess their perceptions about the nature of interaction in their clinical work. As a team we are aware that we do not perhaps interact as much as we originally thought. The results highlight the importance of power, rituals and culture in nurse-patient interactions, and support the argument that as nurses continue to strive as advocates and care partners, the nature of their interaction will continue to be in question. Future research needs to address issues of power and interaction. Such work should concentrate on a methodology which could measure the type and quality of the interaction as well as the quantify.

**REFERENCES**


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