PRACTICE DEVELOPMENT – DISCOVERY INTERVIEWS

Service improvement using patient narratives: engaging with the issues

Jackie Bridges xxx
1Senior Research Fellow, City Community and Health Sciences, City University, London, UK

Caroline Nicholson xxx
2City University, London, UK

Submitted for publication: xx Xxxxx xxxx
Accepted for publication: xx Xxxxx xxxx

Correspondence:
Jackie Bridges
City Community and Health Sciences
City University
Philpot St
Whitechapel
London E1 2EA
UK
Telephone: +44 (0)20 7040 5469
E-mail: j.m.bridges@city.ac.uk

Service improvement using patient narratives: engaging with the issues
In this paper, the authors reflect on data quality issues arising from the UK project that trained senior practitioners to undertake discovery interviews with older people and their relatives about their urgent care experiences. These reflections are used to explore the potential for qualitative research methods to inform the development of discovery interview technique.

Key words: xxxxxxxx, xxxxx

Introduction
The use of discovery interviews as a service improvement tool is becoming widespread in the UK National Health Service (NHS). In this paper, the authors reflect on data quality issues and their implications for service improvement tools of this kind. Examples are used from a case study of 96 discovery interviews with older urgent care patients and their relatives conducted by senior urgent care nurses as part of a national leadership programme.

Background
In 2006, the Department of Health in England ran a national leadership programme for matrons, nurse consultants and emergency care practitioners in urgent care (Department of Health 2005). One part of the programme offered 1½ days training in conducting discovery interviews with older urgent care patients and their relatives. The discovery interview process is ‘used by teams to improve the way that they meet the needs of their patients and carers...through listening to their stories about the impact of their illness or condition on their everyday lives, and linking what they learn with their own professional knowledge and experience’ (CHD Collaborative 2004). Discovery interviews are one-to-one face-to-face interviews aimed at allowing patients and their carers to directly tell their story using the framework of a ‘spine’ to guide them through key stages of their experience. Interview transcripts are then shared more widely with local teams with the aim of stimulating service improvements that respond to the patient’s narrative. Urgent care is used here as an umbrella term to include a range of unscheduled, fast-response services provided in the community and hospital settings. This includes emergency services.

Following the training, leadership programme participants were then required to submit a ‘practice tape’ which was then evaluated by a qualified assessor. Each participant who submitted a tape of an acceptable standard was then able to conduct one or more discovery interviews with older patients and relatives in their own Trust, and to use the interview transcript to work with local teams in reflecting on and improving local services. Telephone support and action learning sets were also made available to leadership programme participants to enable them to reflect on progress and discuss issues of concern.

At the end of 2006, 96 interview transcripts from interviewers (leadership programme participants) in 31 NHS Trusts across England had been submitted to the leadership programme’s project manager. A University was awarded funding to undertake a cross-analysis of these...
transcripts and draw up a national picture of older people’s urgent care. This study is reported on elsewhere (ref details). Conducting the analysis raised a number of issues related to data quality, and these are considered below. The authors also draw on the findings from a written postal questionnaire completed by 22 out of 31 (71%) of the interviewers, and a focus groups held with nine interviewers (29%). The questionnaires asked brief questions on patient selection, interview conduct and biographical details of interviewees. The focus groups explored views on discovery interview training and support.

The following sections focus on the key issues identified that related to data collection. These are patient sampling, in-depth interviewing and managing practitioner/researcher boundaries.

Patient sampling issues

Participants were permitted to choose a particular focus for their work, for example, to focus on those who have visited emergency care as a result of a fall. Within these parameters, patients were to be recruited at random. A range of inclusion criteria were subsequently used. For instance, five interviewers focused on patients who had been admitted: one on patients seen in ‘major’ area of A&E and then admitted; one on patients admitted in the past week; one on patients admitted; one on patients admitted to the emergency department’s short-stay ward; and one selected one patient who had been admitted, one who had gone home and one who was ‘more serious’. One interviewer used a combination of patients who had contacted the local primary care trust commissioning officer for older people, the local patient advice and liaison service (PALS) or age concern in connection with an emergency care experience, and work colleagues with a relative known to have had a distressing emergency care experience. One other interviewer also selected patients who had contacted the local PALS office about an emergency care experience, but excluded those who had made a complaint through this route.

While random selection was often claimed, on further investigation, just one interviewer used a random numbers generator against emergency department files to identify patients. One interviewer invited all eligible patients who attended in a 2-week period to take part. Others used a range of methods that resulted in a convenience sample. A common approach was to visit the emergency department at a time chosen by the interviewer and ask staff to identify patients who met the criteria. One interviewer asked district nursing and out-of-hours colleagues for help in identifying patients who met the criteria, while another sought the advice of the acute medical team. Some others used emergency department files (either computer files or paper-based) for ‘random’ selection, but no systematic techniques appear to have been used.

Biographical details for 66 patients (72% of 92) were supplied by interviewers or gleaned from the interview transcripts, and these reveal an interesting patient profile as a whole. Sixty-nine patients and 27 relatives were interviewed. Sixty-four (72%) of patients were female and 25 (28%) were male (n missing = 3). Mean patient age was 82 years (range = 75–95 years, SD 5.8, n missing = 23). Sixty-four of the patients were classified as White British by interviewers, two as White Irish and one as White Other (Italian). Two other participants were classified as Asian or Asian British, with no other ethnic groups apparently represented (n missing = 23). Most patients lived at home (n = 64, 90%) or in sheltered accommodation (n = 6, 8%, n missing = 21).

The apparent lack of ethnic diversity in the sample, and of representation from anyone living in a care home is worthy of further exploration. It is not possible to know the reason for this lack of diversity, but important to speculate on its impact. At a local level, even an adequate use of random sampling techniques will not result in ‘representativeness’ in a sample of just one or two individuals. From a qualitative inquiry point of view, the goal of sampling is not representativeness, so an expectation of random sampling may be counter-productive. A purposive approach to sampling is probably more useful, to identify people with certain characteristics and/or who represent the variation in a range of the phenomenon of interest (Gobo, 2007). Sampling could ensure inclusion of those who are at greatest risk of their voices not being heard. This includes people whose first language may not be the same as the interviewer’s, and people who may have communication difficulties because of, for instance, cognitive impairment. Interestingly, one of the key exclusion criteria for this study was if the individual was ‘confused’, and given the high prevalence of cognitive impairment in care home settings, may be one reason why care home residents ended up not being included in the study at all.

Variations in interviewing depth

From the successful analysis of the transcripts as a whole, and their use in drawing up a national picture (ref details), it is clear that the discovery interview process generated many rich accounts of urgent care experiences. While interviewer skill is just one factor that can impact on the quality of the data gathered, there is an opportunity here to explore the
extent to which discovery interview training and implementation can be successful in helping us to understand patient and relative experiences. Interviewers who took part in the focus group mentioned in the section Background stated that, apart from initial nerves, they felt that the training course had equipped them well for using discovery interview technique, and that the action learning sets provided a useful support mechanism.

An evaluation of the discovery interview transcripts reflected variations between interviewers in skills of conducting an in-depth interview. For instance, the length of each interview was expected to be 30–40 minutes. However, interviews varied in their length from 1 to 37 minutes. The mean interview length was 12 minutes (SD 6.5), the median was 11 minutes and the mode was 7 minutes. The relatively short length of the interviews prompted an evaluation of the transcripts for the extent to which the interviewer reflected skills in picking up cues and probing lines of inquiry, helpful skills in exploring individual experiences. In 32% (n = 31) of interviews, there was evidence of the interviewer picking up cues and probing the interviewee. In these interviews, the focus was on ‘staying with’ the patient or relative’s story. For example:

What would have made you feel better about the conversation the doctor had with you? (Interview 02)
What makes it excellent? (Interview 03)
How did you feel about waiting? How did that make you feel? (Interview 20)
Why were you worried? (Interview 40)
Would you like to tell me more about that? (Interview 40)

However, in the remaining interviews, the interviewer only partially picked up cues/probed or not at all. This sometimes included asking questions that were unrelated to what the interviewee was saying. These questions may have been driven by the issues the interviewer was expecting to be raised and/or by the expectation that service improvements would result from the interviews. Topics often covered here were waiting times, pain control and information giving. These questions were often closed, rather than open-ended, in nature. They often focused on what was happening rather than the patient or relative’s experience of events.

Interviewer: Can you remember what tests and things you had done?
Interviewee: No
Interviewer: Did the triage nurse give you any idea of how long it was going to be?

Interviewee: Tedious. We were all sitting around and nobody seemed to be moving, nothing seemed to be happening at all, just sat

Interviewer: Were you given any information about how long the wait might be? (Interview 46)

The use of the preset interview ‘spine’ designed to guide the interviewee through the different stages of their journey, seemed to limit some interviews, the interviewer appearing keener to move through the spine than to pick up on what the patient was saying. If, for example, an interviewee ‘jumped ahead’ to an incident on the in-patient ward, some interviewers would invite them to return to describing what happened in the emergency department, without ensuring later on that the interviewee had opportunity to describe the incident originally raised. Is the following an example of this?

Interviewer: Do you remember arriving at the hospital?
Interviewee: Yes, I remember the journey I couldn’t see anything, but I remember the journey, when they pulled up em err I knew I was at the hospital I could see the hospital, I knew it was the hospital when they pulled up because I’d been there with my husband when he was ill you know and he got taken away

Interviewer: Okay
Interviewee: That’s when he died, the only time he went in the ambulance, and he died, so I knew I was there you know

Interviewer: And do you know where you went to then, where did they take you?
Interviewee: Err, where did they take me? Took me on the can’t remember if it was on the sitting up thing or the, yes I think I was sitting up, they wheeled me down the ambulance thing, the slope, yes
Interviewer: So, out of the ambulance. (Interview 26)

The lack of picking up cues and probing in some interview transcripts is surprising given that these are essential nursing skills in communicating with patients and carers. It may be that some interviewers were intimidated by participation in ‘research interviews’ and were not confident that their existing nursing skills could be used to good effect in the research interview situation.
The preset interview spine may well reflect a deeper contradiction within discovery interviews, that is, the possible mismatch between eliciting a person’s experience, or at least that which they wish to relate, and the purpose of a discovery interview, i.e. to improve service provision. It is difficult to uncover experience. Writing on interview method in general, Weiss (1994) and Chase (2006) suggest that many interview schedules merely gain answers to professionally led questions. An over reliance on returning to the spine in interviews appeared to produce this effect for some in this study. Discovery interviewers may need to refrain from moving too quickly to questions about a particular service intervention which may or may not have resonance for the person being interviewed. While enabling people to tell their stories of what it was like to experience care is the expressed aim of discovery interviews, data from this study illustrate that this may not always be achieved in practice.

Wengraf (2004) notes that although report and description of events will be present in all interviews, it is stories that uniquely reflect and retell experience. He, amongst others, places more emphasis on ‘inviting a narrative’ with the interview becoming less structured and more ‘in-depth’. The use of in-depth interviewing aims to transform the interviewee–interviewer relationship to one of narrator–listener. To think of the interviewee as narrator is to make a conceptual shift away from the idea that interviewees have answers to the researcher’s questions and towards the idea of narrators with stories to tell. Hence within this approach, researchers attend not only to the story but to the work of inviting stories. With the invitation to become a narrator (Burgos, 1989) a stronger version of the narrator’s voice if offered which can disrupt assumptions that the interviewer brings to the relationship. An unstructured narrative method will allow these deep meanings and qualities of experience to come to the fore in the process of data collection (Clarke, 2006). One such method of inviting narrative is the Biographic-Narrative Interpretive Method (BNIM) (Wengraf & Chamberlayne, 2007) which asks one open question which typically begins, ‘can you please tell me the story of...’ and then allows the person to say what they want in the way that they want it without interruption. This method thus works with the central preoccupations which the story teller brings. A second stage subsequently asks for more detail about the particular experiences raised to gain more depth.

Clearly such an approach has limitations, particularly within a time limited encounter. In a current study, exploring the experiences of older people living with a degree of frailty using BNIM, interviews ranged from 40 minutes to 2 hours in length (Nicholson, 2007). However, such approaches are structured to generate and tolerate the experience of participants rather than the preoccupations of the researcher. Researchers and practitioners using discovery interviews may find it useful to engage with such approaches both in terms of gaining skills to elicit experience and as a mechanism for exploring and holding the inevitable researcher bias within the interview encounter.

Managing the practitioner/researcher boundary

A number of interviews (n = 28) contained examples of interactions in which the interviewee and interviewer drew on the interviewer’s management or clinical roles, or knowledge of the service. Interviewers did not interview anyone in whose care they had been involved, but were encouraged to be open with interviewees about their relationship to the service. On a number of occasions, interviewers and interviewees used this relationship to interact in ways that may not be recognized as part of a research interview.

In the simplest examples, interviewees either asked for or were given help with using technical terms and explanations. For instance:

Interviewee: They did a heart scan. I forget what they call it.

Interviewer: An ECG. (Interview 50)

In the second kind of examples, the interviewer would undertake to the interviewee to improve services based on what the interviewee had said. For instance:

Interviewer: You also mentioned the waiting room was a bit messy with cups and papers and the not so desirable toilets. The toilets I am not sure of how we can get around this due to the vandal problem but we can certainly improve on the tidiness in the waiting room, after all it’s the first place people see and first impressions count.

Interviewee: Don’t get me wrong love, I am sure it’s not the hospital’s fault, just some people don’t care what they drop and leave they just spoil it for others.

Interviewer: That’s true, but we need to look at ways as to how we can improve. (Interview 22)

In a small number of related examples, neither interviewer or interviewee appeared to distinguish between the interviewer’s role in the service and the experience described:

Interviewee: You are all marvellous here as well and I can’t say no more.

Interviewer: Thank you very much. (Interview 58)

In a third type of example, interviewers drew on their clinical role to help the individual by, for instance, undertaking to arrange an occupational therapy assessment, or used their expertise to advise patients within the interview. For instance:
Interviewer: I think the most important thing is that you drink plenty of fluid and if your preferred drink is weak tea, that is better than no fluids.

Interviewee: What about the cranberry juice – how much should I drink? I try to drink half a glass in the morning and half a glass in the evening. It does cost 93 pence you know in Sainsbury but it costs £1.30 in the local shop. That is why I get the man to bring it for me. I can’t carry it...it is too heavy.

Interviewer: I am not sure how much cranberry juice you should drink to prevent a urine infection, but perhaps a glass or two per day is sufficient...but drink more if you get another urine infection again.

Interviewee: Yes, yes. I will do that. (Interview 37)

The difficulties in managing role boundaries have been noted by a number of practitioner researchers in nursing (for instance, (Allen, 2004; Gerrish, 1997). Concerns about research by some commentators include the concern that patients may feel obliged to take part in research in case their refusal affects the quality of care that they receive, or that if they do agree to share their views, they may feel constrained in being completely open for fear of ‘payback’ by staff if negative comments are made. While these may be important concerns to have in mind when designing a study, examples here suggest that interviewees may be benefitting in concrete ways from being interviewed by practitioners. Research interviews are situated accomplishments, and it may be neither possible nor desirable to use an interview to get to the ‘truth’ of what happened (Hardin, 2003; Nunkoosing, 2005).

A focus on service improvement, and the ability of an interviewer to cross role boundaries, may be helpful ways of achieving more from an interview than the production of data, and of individual patients benefiting in very concrete ways. More investigation would be helpful here, to follow up these hunches.

Wenger (2003) notes with caution that older people may provide special challenges in the research encounter, e.g. sensory impairment, multiple losses of getting older and fluidity in the researcher/researched boundary. It is perhaps the ability of the participants and the researcher to relate to each other which is important in eliciting experience. Indeed, some have argued this is the core nursing skill which can be taken by practitioners into the interview (Mayeroff, 1971; Newman, 1994; Morse, 2001).

Conclusion

It is clear from this case study that the use of discovery interviews for service improvement highlights both the strengths of and issues associated with qualitative inquiry in general. However, discovery interview inquiry has two key features that help distinguish it from many other forms of qualitative inquiry. Firstly, its primary aim is local service improvement, rather than adding to the body of knowledge. Secondly, discovery interviews are also distinguishable by the relatively short length of training given to interviewers. Some of the examples shown above suggest that this may be problematic in closing off potential lines of inquiry. We need to understand better how to optimize interviewer skills, particularly if they have not previously been trained in research. Within this training particular attention needs to be given to the inherent difficulty of holding a professional bias whilst trying to actively listen to the experience of service users. Utilizing training on more open narrative approaches may assist in this.

Closer scrutiny may also be needed of how best to select individual interviewees for inclusion, and clarification of a suitable sampling strategy, given the small numbers of interviews typically undertaken. For these decisions to be undertaken in relation to discovery interview technique, it may now be necessary to engage more with the wider literature on narrative inquiry and to clarify what makes a ‘good’ patient story for the purposes of service improvement. Is it one that is an accurate representation of events, is it one that best represents what happens to particular sub-groups of patients, and/or is one that moves and motivates people to look again at what they do? Such an engagement may need to look at the tension in this approach between discovering what was important to participants in recounting their experience and a focus on eliciting patient information to improve particular aspects of service delivery.

The missing piece of the jigsaw from this case study is what service improvements have been achieved through using discovery interview technique. Anecdotal evidence suggests a range of experience here from interviewers who feel that use of the technique has revolutionized their thinking and had a profound influence on services, through to those unable to identify that improvements have resulted. However, particularly given its widespread adoption in the NHS, what would be of use now is an in-depth evaluation of the technique and its impact, including an exploration of what factors promote and inhibit positive service change.

References


Dear Author,

During the copy-editing of your paper, the following queries arose. Please respond to these by marking up your proofs with the necessary changes/additions. Please write your answers on the query sheet if there is insufficient space on the page proofs. Please write clearly and follow the conventions shown on the attached corrections sheet. If returning the proof by fax do not write too close to the paper’s edge. Please remember that illegible mark-ups may delay publication.

Many thanks for your assistance.

<table>
<thead>
<tr>
<th>Query reference</th>
<th>Query</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Au: Please provide qualifications of an author J. Bridges.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Au: Please provide qualification, designation and department/division/unit name of an author C. Nicholson.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Production Editor: Please supply dates.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Au: Please supply up to six keywords for indexing.</td>
<td></td>
</tr>
</tbody>
</table>
Please correct and return this set

Please use the proof correction marks shown below for all alterations and corrections. If you wish to return your proof by fax you should ensure that all amendments are written clearly in dark ink and are made well within the page margins.

<table>
<thead>
<tr>
<th>Instruction to printer</th>
<th>Textual mark</th>
<th>Marginal mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leave unchanged</td>
<td>. . . under matter to remain</td>
<td>○</td>
</tr>
<tr>
<td>Insert in text the matter indicated in the margin</td>
<td>/ through single character, rule or underline or \ through all characters to be deleted</td>
<td>/ or / ○</td>
</tr>
<tr>
<td>Delete</td>
<td>/ through letter or \ through characters</td>
<td></td>
</tr>
<tr>
<td>Substitute character or substitute part of one or more word(s)</td>
<td>/ through character or \ where required</td>
<td>/ or / ○</td>
</tr>
<tr>
<td>Change to italics</td>
<td>— under matter to be changed</td>
<td></td>
</tr>
<tr>
<td>Change to capitals</td>
<td>= under matter to be changed</td>
<td></td>
</tr>
<tr>
<td>Change to small capitals</td>
<td>= under matter to be changed</td>
<td></td>
</tr>
<tr>
<td>Change to bold type</td>
<td>≈ under matter to be changed</td>
<td></td>
</tr>
<tr>
<td>Change to bold italic</td>
<td>≫ under matter to be changed</td>
<td></td>
</tr>
<tr>
<td>Change to lower case</td>
<td>Encircle matter to be changed</td>
<td></td>
</tr>
<tr>
<td>Change italic to upright type</td>
<td>(As above)</td>
<td></td>
</tr>
<tr>
<td>Change bold to non-bold type</td>
<td>(As above)</td>
<td></td>
</tr>
<tr>
<td>Insert ‘superior’ character</td>
<td>/ through character or \ where required</td>
<td>/ or / ○</td>
</tr>
<tr>
<td>Insert ‘inferior’ character</td>
<td>(As above)</td>
<td></td>
</tr>
<tr>
<td>Insert full stop</td>
<td>(As above)</td>
<td></td>
</tr>
<tr>
<td>Insert comma</td>
<td>(As above)</td>
<td></td>
</tr>
<tr>
<td>Insert single quotation marks</td>
<td>(As above)</td>
<td></td>
</tr>
<tr>
<td>Insert double quotation marks</td>
<td>(As above)</td>
<td></td>
</tr>
<tr>
<td>Insert hyphen</td>
<td>(As above)</td>
<td></td>
</tr>
<tr>
<td>Start new paragraph</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>No new paragraph</td>
<td>\</td>
<td></td>
</tr>
<tr>
<td>Transpose</td>
<td>\ \</td>
<td></td>
</tr>
<tr>
<td>Close up</td>
<td>linking characters</td>
<td></td>
</tr>
<tr>
<td>Insert or substitute space</td>
<td>/ through character or \ where required</td>
<td>/ or / ○</td>
</tr>
<tr>
<td>between characters or words</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce space between characters or words</td>
<td>between characters or words affected</td>
<td>\ \</td>
</tr>
</tbody>
</table>