

Service improvement using patient narratives: engaging with the issues

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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, xxxxxx

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

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1 transcripts and draw up a national picture of older people's
2 urgent care. This study is reported on elsewhere (ref details).
3 Conducting the analysis raised a number of issues related to
4 data quality, and these are considered below. The authors
5 also draw on the findings from a written postal questionnaire
6 completed by 22 out of 31 (71%) of the interviewers, and a
7 focus groups held with nine interviewers (29%). The ques-
8 tionnaires asked brief questions on patient selection, inter-
9 view conduct and biographical details of interviewees. The
10 focus groups explored views on discovery interview training
11 and support.

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

17 Patient sampling issues

18 Participants were permitted to choose a particular focus for
19 their work, for example, to focus on those who have visited
20 emergency care as a result of a fall. Within these parameters,
21 patients were to be recruited at random. A range of inclusion
22 criteria were subsequently used. For instance, five interview-
23 ers focused on patients who had been admitted: one on
24 patients seen in 'major' area of A&E and then admitted; one
25 on patients admitted in the past week; one on patients
26 admitted; one on patients admitted to the emergency depart-
27 ment's short-stay ward; and one selected one patient who had
28 been admitted, one who had gone home and one who was
29 'more serious'. One interviewer used a combination of
30 patients who had contacted the local primary care trust
31 commissioning officer for older people, the local patient
32 advice and liaison service (PALS) or age concern in connec-
33 tion with an emergency care experience, and work colleagues
34 with a relative known to have had a distressing emergency
35 care experience. One other interviewer also selected patients
36 who had contacted the local PALS office about an emergency
37 care experience, but excluded those who had made a
38 complaint through this route.

39 While random selection was often claimed, on further
40 investigation, just one interviewer used a random numbers
41 generator against emergency department files to identify
42 patients. One interviewer invited all eligible patients who
43 attended in a 2-week period to take part. Others used a range
44 of methods that resulted in a convenience sample. A common
45 approach was to visit the emergency department at a time
46 chosen by the interviewer and ask staff to identify patients
47 who met the criteria. One interviewer asked district nursing
48 and out-of-hours colleagues for help in identifying patients
49 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 inter-
viewed. 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 represen-
tativensness, so an expectation of random sampling may be
counter-productive. A purposive approach to sampling is
probably more useful, to identify people with certain char-
acteristics 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

1 extent to which discovery interview training and implemen-
 2 tation can be successful in helping us to understand patient
 3 and relative experiences. Interviewers who took part in the
 4 focus group mentioned in the section Background stated that,
 5 apart from initial nerves, they felt that the training course had
 6 equipped them well for using discovery interview technique,
 7 and that the action learning sets provided a useful support
 8 mechanism.

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

24 What would have made you feel better about the conversation the
 25 doctor had with you? (Interview 02)

26 What makes it excellent? (Interview 03)

27 How did you feel about waiting? How did that make you feel?
 28 (Interview 20)

29 Why were you worried? (Interview 40)

30 Would you like to tell me more about that? (Interview 40)

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

42 Interviewer: Can you remember what tests and things you had done?

43 Interviewee: No

44 Interviewer: Did the triage nurse give you any idea of how long it was
 45 going to be?

Interviewee: No

Interviewer: Did you have any tests while you were waiting to see the
 doctor, did you have any blood tests or anything?

Interviewee: Just my blood pressure I think, they might have taken a
 blood sample I’m not absolutely certain, it’s all a bit of a blur

Interviewer: Did you wait in the waiting room whilst you were
 waiting to see the doctor? How did you find that?

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 inter-
 viewers 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.

1 The preset interview spine may well reflect a deeper
2 contradiction within discovery interviews, that is, the possi-
3 ble mismatch between eliciting a person's experience, or at
4 least that which they wish to relate, and the purpose of a
5 discovery interview, i.e. to improve service provision. It is
6 difficult to uncover experience. Writing on interview method
7 in general, Weiss (1994)) and Chase (2006) suggest that many
8 interview schedules merely gain answers to professionally led
9 questions. An over reliance on returning to the spine in
10 interviews appeared to produce this effect for some in this
11 study. Discovery interviewers may need to refrain from
12 moving too quickly to questions around a particular service
13 intervention which may or may not have resonance for the
14 person being interviewed. While enabling people to tell their
15 stories of what it was like to experience care is the expressed
16 aim of discovery interviews, data from this study illustrate
17 that this may not always be achieved in practice.

18 Wengraf (2004) notes that although report and description
19 of events will be present in all interviews, it is stories that
20 uniquely reflect and retell experience. He, amongst others,
21 places more emphasis on 'inviting a narrative' with the
22 interview becoming less structured and more 'in-depth'. The
23 use of in-depth interviewing aims to transform the interview-
24 ee-interviewer relationship to one of narrator-listener. To
25 think of the interviewee as narrator is to make a conceptual
26 shift away from the idea that interviewees have answers to
27 the researcher's questions and towards the idea of narrators
28 with stories to tell. Hence within this approach, researchers
29 attend not only to the story but to the work of inviting
30 stories. With the invitation to become a narrator (Burgos,
31 1989) a stronger version of the narrator's voice is offered
32 which can disrupt assumptions that the interviewer brings to
33 the relationship. An unstructured narrative method will allow
34 these deep meanings and qualities of experience to come to
35 the fore in the process of data collection (Clarke, 2006). One
36 such method of inviting narrative is the Biographic-Narrative
37 Interpretive Method (BNIM) (Wengraf & Chamberlayne,
38 2007) which asks one open question which typically begins,
39 'can you please tell me the story of...' and then allows the
40 person to say what they want in the way that they want it
41 without interruption. This method thus works with the
42 central preoccupations which the story teller brings. A second
43 stage subsequently asks for more detail about the particular
44 experiences raised to gain more depth.

45 Clearly such an approach has limitations, particularly
46 within a time limited encounter. In a current study, exploring
47 the experiences of older people living with a degree of frailty
48 using BNIM, interviews ranged from 40 minutes to 2 hours
49 in length (Nicholson, 2007). However, such approaches are
50 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:

1 Interviewer: I think the most important thing is that you drink plenty
2 of fluid and if your preferred drink is weak tea, that is better than no
3 fluids.

4 Interviewee: What about the cranberry juice – how much should I
5 drink? I try to drink half a glass in the morning and half a glass in the
6 evening. It does cost 93 pence you know in Sainsbury but it costs
7 £1.30 in the local shop. That is why I get the man to bring it for me. I
8 can't carry it...it is too heavy.
9

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

13 Interviewee: Yes, yes. I will do that. (Interview 37)
14

15 The difficulties in managing role boundaries have been noted
16 by a number of practitioner researchers in nursing (for
17 instance, (Allen, 2004; Gerrish, 1997). Concerns about
18 research by some commentators include the concern that
19 patients may feel obliged to take part in research in case their
20 refusal affects the quality of care that they receive, or that if
21 they do agree to share their views, they may feel constrained
22 in being completely open for fear of 'payback' by staff if
23 negative comments are made. While these may be important
24 concerns to have in mind when designing a study, examples
25 here suggest that interviewees may be benefiting in concrete
26 ways from being interviewed by practitioners. Research
27 interviews are situated accomplishments, and it may be
28 neither possible nor desirable to use an interview to get to the
29 'truth' of what happened (Hardin, 2003; Nunkoosing, 2005).
30 A focus on service improvement, and the ability of an
31 interviewer to cross role boundaries, may be helpful ways of
32 achieving more from an interview than the production of
33 data, and of individual patients benefiting in very concrete
34 ways. More investigation would be helpful here, to follow up
35 these hunches.

36 Wenger (2003) notes with caution that older people may
37 provide special challenges in the research encounter, e.g.
38 sensory impairment, multiple losses of getting older and
39 fluidity in the researcher/researched boundary. It is perhaps
40 the ability of the participants and the researcher to relate to
41 each other which is important in eliciting experience. Indeed,
42 some have argued this is the core nursing skill which can be
43 taken by practitioners into the interview (Mayeroff, 1971;
44 Newman, 1994; Morse, 2001).
45

46 Conclusion

47 It is clear from this case study that the use of discovery
48 interviews for service improvement highlights both the
49 strengths of and issues associated with qualitative inquiry in
50

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, particu-
larly 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

- Allen D. (2004) Ethnomethodological insights into insider–outsider
relationships in nursing ethnographies of healthcare settings.
Nursing Inquiry 11, 14–24.
Burgos M. (1989) Life stories, narrativity and the search for self. *Life
Stories* 5, 27–38.

- 1 Chase S.E. (2006) Narrative inquiry: multiple lenses, approaches,
2 voices. In *The Sage Handbook of Qualitative Research*, 3rd edn
3 (Denzin N.K. & Lincoln Y.S. eds). Sage, Thousand Oaks, CA, pp.
4 651–679.
- 5 CHD Collaborative (2004) *Learning From Patient and Carer Expe-*
6 *rience: A Guide to Using Discovery Interviews to Improve Care*.
7 NHS Modernisation Agency, Leicester, UK.
- 8 Clarke S. (2006) Theory and practice: psychoanalytical sociology as
9 psycho-social studies. *Sociology* 40, 1153–1169.
- 10 Department of Health (2005) *Developing Excellence in Leadership*
11 *Within Urgent Care*. Department of Health, London, UK.
- 12 Gerrish K. (1997) Being a ‘marginal native’: dilemmas of the par-
13 ticipant observer. *Nurse Researcher* 5, 25–34.
- 14 Gobo G. (2007) Sampling, representativeness and generalizability. In
15 *Qualitative Research Practice* (Seale C. et al. eds). Sage, London,
16 pp. 405–426.
- 17 Hardin P.K. (2003) Constructing experience in individual interviews,
18 autobiographies and on-line accounts: a poststructuralist
19 approach. *Journal of Advanced Nursing* 41, 536–544.
- 20 Mayeroff M. (1971) *On Caring*. Harper Perennial, New York.
- 21 Morse J. (2001) Towards a praxis theory of suffering. *Advances in*
22 *Nursing Science* 24, 47–59.
- 23 Newman M. (1994) *Health as Expanded Consciousness*. National
24 League for Nursing, New York.
- 25 Nicholson C. (2007) Living at home with frailty: experiences of
26 changing circumstance. Conference presentation at “Social and
27 Psychological Aspects of Dying in Old Age”. Cancer Experi-
28 ences Collaborative, University of Southampton, Southampton,
29 UK.
- 30 Nunkoosing K. (2005) The problem with interviews. *Qualitative*
31 *Health Research* 15, 698–706.
- 32 Weiss R.S. (1994) *Learning From Strangers: The art and Method of*
33 *Qualitative Interview Studies*. Free Press, New York.
- 34 Wenger G.C. (2003) Interviewing older people. In *Inside Interview-*
35 *ing: New Lenses, new Concerns* (Holstein J.A. & Gubrium J.F.
36 eds). Sage, Thousand Oaks, CA, pp. ??–??.
- 37 Wengraf T. (2004) *Qualitative Research Interviewing*. Sage, London.
- 38 Wengraf T. & Chamberlayne P. (2007) Interviewing for life histories,
39 lived situations and experience: the biographic-narrative interpre-
40 tive method (BNIM). *A Short Guide to BNIM Interviewing*
41 *and Practice*. Version 7.1b. Available at: ascy82@dsl.pipex.com
42 (accessed 20 June 2007).

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